Independent Healthcare Commission for North West London

Submissions of Written Evidence

Volume 3

Contents:

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.

SUBMISSION BY KEITH PERRIN (KP) AND ELIZABETH GAYNOR LLOYD (EGL)

Dated 23 February 2015

1 Personal Background

1.1 Both KP and EGL are members of the Brent CCG Equality Diversity and Engagement Committee, KP as a representative of Long Term Conditions, and EGL as representative of the Wembley Locality Patient Participation Group (WLPPG). We have lived in the London Borough of Brent for 26 years, and our family has had outpatient experience, in particular at Northwick Park and Central Middlesex Hospitals but also referred to University College Hospital, RNOH and others.

1.2 As to long-term treatment, KP is a long term sufferer from Rheumatoid Arthritis, and EGL (his wife) is his carer, involved in his treatment. We are both members of the Northwick Park Arthritis Centre Patient Panel.

1.3 We have a daughter who suffers from Ehlers Danlos Syndrome, a rheumatoid condition. KP and our daughter were diagnosed at Northwick Park Hospital, where KP's treatment continues. Our daughter is currently under University College Health Trust, under their pain management programme.

1.4 We therefore have personal interest in - and experience of - the local hospital system, and in particular the continued success of the

Rheumatology Service at Northwick Park Hospital, which is also designated as a specialist service site by NHS England.

1.5 We participated in the Consultation for Shaping a Healthier Future (SaHF) , making written submissions through the Consultation booklet format. (We found it notable that, in the IPSOS Mori Presentation of the findings of that consultation that only 90 Brent Residents were suggested as having so participated)

1.6 KP is a Labour Councillor for our local ward, Northwick Park, on Brent Council. He also runs his own small business and individual IT company. EGL is a now retired commercial property solicitor, having worked in the City for 35 years. She was also a Non-Executive Director of Northwick Park and St Marks Hospital prior to its merger with Central Middlesex Hospital in 1999, and a shadow director on the Community Interest Company which took over our local GP Surgery in 2013 under the Government's "Right to Request" initiative. (This followed the decision by the then Brent Teaching Primary Care Trust to tender out its 3 remaining employed GP Practices, and a concerted patient led campaign lasting some 9 years to procure the retention of its highly respected then employed GP 's.) EGL was also elected as a Community Director for HealthWatch Brent, resigning in April 2014. She presented to the IRP requested by Ealing Council. **(Copy attached)**We are both members of Keep Our NHS Public.

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1.6 More recently, we have been members since February 2014 of the Stakeholder Engagement Group for the Wave 2 (MSK) commissioning strategy (in view of our particular interest in the rheumatology aspect). EGL applied to be on the Procurement Board – one of 3 applicants for 2 places, and was unsuccessful. She has been awaiting feedback on her application from Brent CCG for some months.

1.6 We have seen the Submissions made by the Four Locality PPG Chairs for Harness, Willesden, Kingsbury and Kilburn (endorsed by the new organisation, Brent Patient Voice), and broadly agree with its conclusions. We wished to have the opportunity to comment in much more detail on individual aspects touched upon in that submission.

1.7 Our particular concerns relate to the Out of Hospital strategies element of SaHF, as interpreted by Brent CCG, although apparently

presaged and commenced in Commissioning Initiatives under the previous PCT from 2009. We focus below on Commissioning decisions and processes: (1) Waves 1 and 2 and Out of Hospital Strategies; (2) GP Networks, hubs and localities and conflicts of interest ; and (3) general effect on local health economy.

Some of the issues highlighted below were raised at the meetings of the EDEN Committee, particularly in the context of KP's position as community representative for Long Term Conditions (and personal and representative concern in respect of future services for rheumatology conditions).

1.8 Discussions in the EDEN Committee frequently became fractious. The discussions did lead to some changes in engagement strategies by the CCG – but also probably contributed to the conclusion by the CCG that the EDEN Committee was not "fit for purpose", and not fulfilling the assurance requirement in the CCG Governance structure. This led to the CCG commissioning an independent review by Dr Angela Coulter and others (at a cost of £50,000), leading to the CCG decision to abolish the EDEN Committee, and close the Locality PPG's, a process which is currently underway. (NHS England has to approve the constitutional amendments following on that decision).

1.9 Informing our comments are public documents, observation from attendance at CCG and acute trust board meetings, and our correspondence with various members of the CCG staff (principally, Jo Ohlson, Sarah Mansuralli, Deborah McBeal (respectively previously Chief Operating Officer, Acting Chief Operating Officer, and Acting deputy Operating Officer) and, Sarah Thompson chief responsible officer and Jatinder Garcha and Russell Foster, successively Programme management offices for wave 2) in connection with the various aspects of the above.

1.10 We have also raised various Freedom of Information (FOI)requests, and have had sight of FOI requests made by others. In some cases, copies of extracts are attached, and web links provided.

1.11 In her capacity as a Community Director of HealthWatch Brent, EGL was also one of the Brent representatives on the SaHF PPRG. Reference is made below to comments made at her first meeting in

September 2013 relating to the relationship between CCG's and the then North West London Hospitals Trust, and the speed at which Brent CCG was proceeding with its Out of Hospital Strategy.

1.12 EGL left the SaHF PPRG following her resignation from HealthWatch Brent. The Commission may wish to enquire of the SaHF Project Team to obtain agendas and minutes of the meetings of the PPRG, which was to provide assurance from the patient perspective of the process. At the point EGL stopped receiving emails from the PPRG Communications team, particular queries were being raised about the closure of maternity at Ealing Hospital. EGL was bound by confidentiality, and therefore is unsure that it is appropriate to share the content of those queries. A formal approach from the Commission for papers would be a different matter.

1.13 EGL understands that the PPRG was considering the Implementation Business case for SaHF over the Christmas period. For the foreseeable future, however, all the patient engagement and involvement activities are now being brought under a Lay Partners Forum. I understand that the chair of HealthWatch Brent, Miranda Wixon, attends the PPR G as a patient representative, and it would be interesting to note if evidence has been given to the Commission generally by HealthWatch Brent, and in particular from Ms Wixon in that representative capacity.

2 Cost of OoH strategies/effect on Local Health Economy and Breakdown of Provider/Commissioner relationship (Northwick Park Hospital)

2.1 We have become increasingly concerned about the effect on the entire local health economy of the decisions made by Brent CCG in the pressing forward with its Out of Hospital strategies, citing – as the CCG does – the part of those strategies in the SaHF programme.

There is a further particular concern, however, about the process as **part of** SaHF. Whilst applied specifically to other CCG's within the North West London group of 8 CCG's, it is notable that the independent HealthWatch Central West has written a report in relation to the SaHF process, which is **attached.** The issues raised are serious, and equally applicable to our area. For us, the concerns are exacerbated because of what we regard as serious flaws and

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questions arising in the procuring of Out of hospital services by Brent CCG.

We are unsure as to whether Colin Standfield of Ealing Hospital SOS will be submitting to this enquiry. We are aware from his analysis of the A&E statistics, and his attendance at the meeting at Northwick Park Hospital with the Chief Executive on 29th January 2015with us and Robin Sharp (referred to below and in the 4 Locality PPG Chairs' submission) of his in-depth understanding of the history of the Project. We attach a link to his submission to the IRP, which contains considerable evidence-base.
http://www.peoplesinquiry.org.uk/pdf/PE-ColinStandfielddossier.pdf

Section 4.17 of the IRP report to the Secretary of State sets out some premises about the implementation of the out of hospital strategy but the remit of the strategy bears no relation to the implementation strategy of Brent CCG, and the caveats inferred – at least to us – do not appear have not been heeded in the Brent programme. There is no way of easily ascertaining how strategic the planning is of out of hospital strategies across the 8 CCG's involved in the SaHF project.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/358743/000_LNW_report_13.09.13.pdf

2.2 The Brent PCT Annual Report 2012/2013 at link
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/253287/Brent_Teaching_PCT_Annual_Report_and_Accounts_2012-13.pdf

refers in section 12 "***Support the development of the new commissioning and provider landscape"*** to "*Action was* ***coordinated*** *across North West London between CCG's and supported by strategy development team and a workforce transformation strategy. There was a rigorous assurance plan and detailed implementation plan 2013/14 agreed by the Board.*"

2.3 Decommissioning notices in respect of various OoH services were served by the Commissioning Support Unit on behalf of the (shadow) Brent and Harrow CCG's on 28 March 2013. A copy of the letter serving the "suite" of notices is **attached** ; the services believed

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to have been covered were (1) gynaecology and MSK (Wave 2 tendering – Brent CCG) (copies **attached**), (2) endoscopy – Brent, (3) cardiology, endocrinology and diabetes, dermatology, gynaecology, MSK, ophthalmology, urology, and respiratory - Harrow CCG (copies available).

2.4 It seems to us to be clear that Brent CCG failed to comply with its statutory duty under section 14Z2 of the National Health Service Act 2006 as amended by section 26 of the Health and Social Care Act 2012 by failing to carry out any or any sufficient public consultation and involvement **before** giving notice of termination of these contracts. No impact assessment in terms of clinical risk or otherwise appear to have been carried out, and the exercise seems to be in pursuit of QIPP savings. The terms of the covering letter are explicit in referring to a lockdown meeting, at which representatives of the CCG made explicit their intention to pay substantially below tariff for numerous outpatient services. It is not hard to see that, while all the services referred to in the decommissioning notices to be removed from the hospital, in a funding situation where money follows the patient and elective treatment will normally follow the referral provider route, the potential loss of all those services would be catastrophic for the viability of a hospital designated as a major hospital in SaHF. For example, in the case of endoscopy, NWLHT (as it then was) is the home of a national specialist hospital (St Mark's). Endoscopy carries significant risk and must form part of acute hospital service. We do not know of a more local service that can provide endoscopy compared to L NWLT. The idea of the CCG seeking a more local, safe and specialist service service compared to L NWLT is not credible.

2.5 At the September 2013 SaHF PPR G meeting referred to above , there was some discussion among representatives from Hillingdon, Ealing and Brent about concern on implementation of out of hospital strategies, and coordination across CCG's and as part of the overall SaHF project. SaHF had always been "sold" on the basis that changes would await proper provision of out of hospital services in the community. Apparently, discussion had previously taken place at

some joint HealthWatch meetings from the same areas. It was not clear at that SaHF PPRG meeting which CCG's had already served decommissioning notices.

Patient HealthWatch representatives asked as to whether it was the case of the CCGs not understanding the overall scheme with SAHF, or whether it was part of SAHF itself, a question raised by Kay Olivierre, representing Hillingdon HealthWatch at that meeting (She is now equalities officer at Brent CCG).

Dr Mark Spencer said that there was "*some concern*" on the SAHF team and wondered whether there had been some *"jumping of the gun*" in decommissioning. On EGL's particularly highlighting issues with the rheumatology service, and the effect on the stripping out of the service from a hospital designed to keep the main A&E provision, Dr Spencer indicated that rheumatology was not relevant to the acute/ A&E provision. EGL queried this, since our consultant rheumatologists are regularly in accident and emergency, and form part of the duty rota.

2.6 Dr Spencer then indicated that the problem was the relationship with the local provider – i.e. Northwick Park Hospital – had "*broken down*". The question was asked as to why such a "breakdown" could not be mediated if the relationship between provider and Commissioner had broken down in the overall interest of patients who relied on the acute hospital in question.

However, this comment is the 1st of a series to which we refer in this submission. As users of our local hospital, we are concerned that local poor relationships and other factors – including GP networks and desire to obtain out of hospital services contracts – may be influencing the Brent CCG's implementation of the out of hospital strategies, although ostensibly excused as an integral part of a competitive tendering process. We should make it clear there is no intention to impute lack of integrity to individual GP's or networks of providers. As the Royal College of GP's has made clear, even the

suspicion is that GP's could be operating on the basis of personal interest is sufficient to be of concern, in that it destroys the particular relationship of trust and confidence between GP's and patients. It is a serious issue

In a subsequent telephone conversation with Dr Spencer, he referred to Brent CCG's actions as – in his opinion – certainly carrying out the process in a "more aggressive manner" than any other CCG in North West London.

2.7 This is then reflected in comments reported in a board paper presented to the Brent CCG Governing Body in March 2014 http://brentccg.nhs.uk/en/governing-body/governing-body-meeting-papers/cat_view/1-publications/3-governing-body-meeting-papers/167-26-march-2014 (paper 18 – cardiology – page 32). There is reference to the CCG's reply to Monitor in response to complaints about decommissioning, equality impact assessments, etc to a "*requirement by Northwest London Cluster Executive Team... To ensure the impact of procurements did not undermine plans under Shaping a Healthier Future that Northwick Park become one of the 5 major hospitals in London.*" Appendix 3 of that paper (page 32 onwards) refers. http://brentccg.nhs.uk/en/publications/governing-body-meeting-papers/cat_view/1-publications/3-governing-body-meeting-papers/167-26-march-2014

2.8 The decommissioning and re-commissioning of services process carried out by the CCG appears to ignore – amongst other things – a potential outcome in **undermining the sustainability** of provider trusts which have served our community over the years, and whose existence and offering of comprehensive major hospital services also were ostensibly to have formed a fundamental part of the SaHF programme.

2.9 By way of contrast, from the evidence of the Wave 1 and 2 processes thus far, no case for improvement of patient care, or preserving patient choice has been made. The documents produced by Brent CCG for the cardiology process as being in the nature of Impact

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Assessment in July 2012 (**attached**) undertake no such analysis, and refer to the desire to obtain power over the local providers (page 20) as a rationale.

This is reflected in the current 2015/16 Commissioning Intentions http://brentccg.nhs.uk/en/publications/cat_view/1-publications/12-plans-and-strategies/18-commissioning-intentions on page 39 referred to the QIPP savings

> *" Target budgets include gross savings of* ***£18.5m (£5.6m re-provision), to achieve net savings of £12.9m.***
>
> *The* ***majority of savings are targeted at the main providers*** *in the acute setting (NWLHT and Imperial) with other schemes in mental health (CNWL) and community (Ealing ICO)."* (Our emphasis)

2.10 Since LNWHT(formerly NWLHT) , one of our main provider trusts, was already in major deficit (owing in part to its PFI debt, which differentiates it from the position of Imperial) how is it justified that Brent CCG - currently in surplus (although such surplus is to be shared across the 8 CCG's on a fair basis) - should aim further to undermine one of Brent residents' main provider trusts – and one destined to remain one of the 5 remaining hospital out of the previously existing 9 under SaHF ?

This is particularly the case when elsewhere in the Commissioning Intentions referred to above; the CCG refers to the anticipated further difficulties for NWLHT following its merger with Ealing Hospital, and the effect of that on the CCG's "contracts" with the Trust.

As to the position going forward, however, it is notable that, in the TDA papers for the LNWHT merged Trust relating to the final authorisation of the merger, reference is made to the necessary merger agreements, including as to the contribution to funding of the deficits to the merged Ealing Hospital Trust with Northwest London hospital trust to form London North West Health Trust 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

Page 10 refers to the **original** letter in support from Brent CCG which was explicitly conditional on the Trust's support of the CCG's out of hospital strategy. The **current** paper makes it clear that the CCG's have to join in with the financial support package, ostensibly as support for Central Middlesex Hospital deficit at £11 million per year until 2017.

However, no reference is made to the necessity not to destabilise the merged Trust by removing substantial outpatient delivered sources of income, an issue raised at a recent Trust Board meeting by one of the Ealing Hospital Trust based Non Executive Directors..

2.11 Of more focused concern is the issue of **proportionality and cost** in dealing with the entire tendering process to all parts of the provider and commissioner network in Brent (and no doubt outside Brent, e.g. the Royal Free and any other Trust outside Brent spending time on bids competing on the provision of services).

2.12 Looking at the (almost) end point of the Brent CCG Wave 1 bids, it seems to us that the CCG must have incurred (and caused other organisations to incur) substantial costs in terms of relocating the services, fitting out new premises, consulting with staff on TUPE, printing documents, holding consultations in primary care about the service change (leaflets, room hire, etc, etc), let alone costs on external consultants, some of which are referred to in this submission. An example of external consultants' costs can be seen at pages 10 and 11 of the CCG Governing Body papers for 26 September 2014 Item 8 http://brentccg.nhs.uk/en/publications/governing-body-meeting-papers/cat_view/1-publications/3-governing-body-meeting-papers/339-24-september-2014.

These costs are not entirely related to SaHF, although the Whole Systems Integrated Care project now "sits above" and relates to SaHF. Few other costs are transparently declared.

2.13 EGL is pursuing via FOI requests the costs of wave 1 bids to date. We attach the current position on queries about the "subsidy" which appears to have been given in the case of the two Wave 1 bids and illustrating how the CCG's actions in putting services into the community appear to have been equally generated by its own Estates requirements (to obtain contributions and reduce the substantial

LIFT/PFI building costs it carries at its premises in Sudbury/Wembley and Willesden). These are referred to in the Brent PCT annual report referred to above.

2.14 We also have concerns that the issues have become "personal" between the Brent CCG governing body, and the North West London North West health trust. Please note the comment recorded in the December Finance and QIPP Committee published with the January governing body papers

"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***." (Our emphasis)

http://brentccg.nhs.uk/en/publications/governing-body-meeting-papers/cat_view/1-publications/3-governing-body-meeting-papers/356-28-january-2015 (part of Item 18 paragraph 2.32).

This seems a fairly extraordinary statement to put in public papers about a provider, and obvious partner in the SaHF project - especially as it purports to represent the views of the almost 200 GP's in Brent, and this provider trust is engaged in bidding for the Wave contracts. As a published document from an organisation running a procurement, it can be seen as somewhat prejudicial - and combined with what has happened on the cardiology bid referred to below raises perturbing questions for us.

3 Unfairness and lack of transparency of Wave 1 process

3.1 We are very conscious of constant warnings about the "necessity" to control costs within the NHS. We highlight what we do know about issues of costs - and transparency and fairness of tender process - in the case of **cardiology**.

Specifically as one where NWLHT (as it then was) was assessed as equal to the '*winning*' bidder, the Royal Free, we feel that common sense might have indicated at that point of assessment a proportionate outcome and one least disturbing for current patients might have been simply to leave the service with the current provider As recommissioned, it relocates an entire service to a different site.

3.2 It is notable that the press release recently made by Brent CCG referring to the commencement of the service on 2 March 2013 is headed "***Improved*** *cardiology service to launch in Brent*" and a quote that the service – not yet commenced – will be "*more efficient*". We attach a copy of the letter written by the service users group of the community cardiology service, as Brent Hearts of Gold which reflect a different picture, at least of the position as it applied prior to the tendering process.

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3.3 A fellow patient representative has supplied us with a copy of NWLHT's original complaint to Monitor (**attached**). That letter makes many points better than I can but the point I wish to make here is that NWL:HT were clearly not aware of some facts which have subsequently come to light and which I set out below, when NWL HT made their complaint to Monitor.

4 Concern for the potential precedent formed by Brent CCG's methodologies in Wave 1 processes for future waves

4.1 We have a particular interest in the decision to decommission the rheumatology service which effectively keeps KP and our daughter in economic activity (and as out of pain as their respective conditions will allow). We have concerns as to how a proper process can be assured in Wave 2 .

4.2 As to issues such as initial planning, proper risk assessment, patient input in the decision to reconfigure, in the case of cardiology and ophthalmology, we considered the attached impact assessment documents. These were not in the public domain – although dated from summer 2012 – until January 2014 at a result of patient "agitation", by which time no meaningful patient input could be given. They appear to pay scant regard to analysing issues such as **the demography** of Brent in relation to the cardiology service patients, no **critique of current services** involving patients, no evidence of **input of local expertise** in the secondary sector, no **Clinical Senate** involvement nor holistic assessment of the position in relation **to SaHF or overall services - in particular the necessity for medical co-location of expertises for A&E** in our part of North West London.

4.3 Whilst it might be argued that the individual Waves of OoH services are not major reconfiguration of services, put as a rolling programme, they clearly will form such a reconfiguration. It would seem appropriate, therefore to have regard to compliance with the process in the section "The Four Tests" on pages 23 to 26 (part) of **Planning and delivering service change for patients** http://www.england.nhs.uk/wp-content/uploads/2013/12/plan-del-serv-chge1.pdf

On page 22 of this publication as to the later elaboration of evidence:

"Retrospectively attempting to fit evidence around a predetermined change to a particular service is not good practice."

There is no clear clinical evidence base, nor engagement with front line providers in commissioning the service (see page 28). It would appear that current cardiology patients receiving community nursing from Brent Community Services will be forcibly transferred to a new provider. This will disrupt their treatment and create clinical risk. This is contrary to Brent CCG's duty to ensure patient safety and high quality care.

To quote an earlier complaint:

"An integrated, highly praised cardiology service led by consultants at NWLHT will be broken up to the detriment of cardiology patients. This decision by Brent CCG has been taken without clinical analysis, engagement with providers, reference to patients or any ***meaningful*** *public consultation. (There was an exercise undertaken in which patients were asked to state whether they would like new services to be based locally and gave every impression that the service in question would be the current hospital service simply being relocated). In this regard, Brent CCG has failed to comply with its statutory duty under section 14Z2 of the National Health Service Act 2006 as amended by section 26 of the Health and Social Care Act 2012. "*

4.4 Current cardiology patients discharged from hospital after receiving treatment will have no choice regarding follow on outpatient appointments unlessLNWHT continue what they can of services, had potentially greater cost to the overall NHS budget. Should that not be the case, that would severely undermine continuity of care, create clinical risk as well as undermine patient experience, and limit patient choice. Should the Trust continue – as above – that will involve additional resources from the limited funding of the NHS generally.

Inevitably for current and future patients, it will also have an effect on future "*funding streams* " for providers of the inpatient and other services for patients who will follow their treatments to the "mother" provider trust. (This begs an interesting question in the case of ophthalmology - being a the private provider - but is pertinent here in leading patients to the Royal Free.)

4.5 There was no community input to the assessment and hence does not specifically relate to needs of the residents of Brent. The report only uses published material and it is difficult to make an assessment of the validity of the material without being given access to the material. Furthermore the assessment was kept secret so no analysis of the report has been possible.

4.6 The process which is now being undertaken in regard to MSK Wave 2 re-commissioning ostensibly includes patient involvement. There is a Stakeholder Engagement Group, a Clinical Services Redesign Group (with 4 patient members) and the project board (as above with 2 patient members). However, as to the model being adopted, it appears that Brent CCG has adopted a "Lead Provider Model", having appointed as their clinical independent adviser Dr Steve Laitner (Dr Steven Laitner General Practitioner Freelance Health Consultant http://www.programmesforhealth.co.uk) who has written with Paul Corrigan on this particular model .

We do not know but there may be issues of conflict of interest in Dr Laitner's appointment and advice, and no implication is intended as to the probity of that appointment or advice. Our concern, however – as can be seen from the report on the Beds CCG model attached – is its complexity and need to use sub-contracts (at levels of payments likely to destabilise acute providers which in this area are likely to be operating at below national tariff, a problem exacerbated for a Trust carrying PFI debt as with LNWHT). However, no public rationale has ever been expressed in respect of the use of a Lead Provider Model. Indeed, at the Health and Overview Scrutiny Committee of Brent Council in October 2013, the then deputy chief operating officer informed the Committee that the design of services was being based on a "best practice" elsewhere in the country, and the various countrywide models of service supplied both to the committee and to us did not appear to be based at all on "lead provider model". App 8

4.7 Using the same and insisting on using the lead provider model may make it likely that this would exclude an acute secondary care hospital as a bidder. If the lead provider has to run the whole programme budget – or effectively commission – it is likely to be outside such acute trusts ' remit to run contracting at this level of complexity.

4.8 In fact, the current lead officer on the wave 2 MSK project, Russell Foster, reported some issues to the November Brent CCG executive meeting (part of item 18, section 16) , http://brentccg.nhs.uk/en/publications/governing-body-meeting-papers/cat_view/1-publications/3-governing-body-meeting-papers/356-28-january-2015

which casts some doubt on the lead provider model. It also raises queries about premises issues (see below). None of these have been raised at the stakeholder engagement group, although each issue is within our remit.

4.9 Please note that EGL has also raised a complaint against Monitor for failing to investigate anti-competitive behaviour on the part of Brent CCG in awarding the cardiology bid, and then subsidising the same in terms of alterations to premises, IT and rent.

5 GP's as commissioners and providers - localities and networks - patient interest and potential for conflict of interest/ Consultation and Scrutiny

5.1 Locality moves and networks

5.1.1 Although very conscious this submission is extremely long, we would like to stretch your patience by referring to the background to our concerns of conflict of interest. Recently, there have been "Locality moves" of GP practices within Brent, without any form of consultation, and the creations of new federations of GP practices and the new "networks", i.e., **provider** organisations.

5.1.2 As to localities, as originally set in the CCG constitution, Brent CCG was divided into five – essentially (apart from Harness) – geographical areas, linked with divisions used by Brent Council. EGL was one of the members of 38 degrees, working with Sarah Mansurall, now Acting Chief Operating Officer, on the constitution, prior to the changes put to the July 2013 GB meeting. In that context, by letter, we were assured that locality moves would involve certain considerations: to quote:

" To this end, member practices will consider:
The best interests of patients on the practice list
The ability of the practice to work with other practices in the locality
The geographical location of locality based services and plans"

The formation of the localities (5) is praised in the original NHSE Assurance letter of July 2013.

5.1.3 We have now been told that it is the view of the CCG that the doctors forming "networks" is entirely a business decision up to them. That may well be the case for commercial business provider units - networks - but Brent GPs working in localities in respect of **commissioning** should be in a different category.

The CCG appears to be confusing the commissioner basis and the original locality model, and the new "business arrangements" for GP's and their federated networks. As stated in item 8.6 of the CCG executive committee of 13 August 2014 "*However, there was a need to reconcile the 5 locality groups to the 4 networks, in particular the ongoing need for locality commissioning structures, given the duplication and that commissioning on locality basis was not practical".*
The CCG has not been open about this in terms of patient service; what does this mean, and how is the patient benefited?

5.2 Networks as business arrangements

5.2.1 As to conflicts and networks arrangements, EGL already raised with Sarah Mansuralli the RCGP CP leaflet on "*Managing Conflicts of Interests in clinical commissioning groups*",("the RCGP Leaflet") forwarded to EGL by the Brent FOIA CSU unit as part of the CCG Constitution conflicts of interest paperwork. This contains various scenarios which are startlingly similar to the business arrangements now being undertaken by GPs within the CCG, without ostensible attention being paid to the issues flagged in that leaflet. Ms Mansuralli has yet to let me have the promised reply on that and other issues raised by me in the email and a reply about issues on the GP access hub provision

5.2.2 We have also attended various meetings in which the new hub services are being signalled as future bases for other "*out of hospital services*", again in context of federations being formed across "localities", reducing 5 localities services to 4 networks (further muddled by the locality practice moves).

5.2.3 This is further illustrated by quotations from two of the papers put before the August Brent Council Scrutiny Committee – the 5 Year Plan and the Summary:

" *The future model of primary care will increasingly focus on holistic patient care with* ***GP practices delivering services as networks and acting as a central organising point (hubs) for out of hospital care*** *and integrated care with social services:*

Multi functional team members

Urgent care

Evening and weekend access

Choice of flexibility"

Out of Hospital Strategy including Primary Care Transformation. This covers:

☐ *Strengthening out of hospital services to meet growing demand for care* ***that hospitals cannot manage*** **

☐ *Development of primary care centres to offer a flexible range of out of hospital services in South Kilburn and Kingsbury*

☐ *Better care closer to home, e.g. outpatient services provided in the community (cardiology, ophthalmology, MSK and gynaecology)*

☐ *Access, convenience and responsiveness of primary care through developing GP networks to extend the primary care offer to patients"*

5.2.4 **What is the evidence that "*hospitals cannot manage*"? Surely this is rather a matter of the appropriate funding - and the complex interrelation with the domino effect of bed requirements following A&E closures and bed needs to "clear" A&E?

5.2.5 Importantly, we believe that these proposals should be assessed as a whole and with full financial impact assessment on the local health economy as a whole - and consultation..

5.2.6 In addition, where is the evidence that the GP's **can** "manage"? What essentially is the "business case" and "patient care case" for the networks being better able than the acute sector to deliver out of hospital community services dealing with issues previously seen in the secondary sector?

With the additional burden on the GP service, the increased expectation on the GP service to its own patients, how has the CCG evidenced that the additional services to be given by the GP will work and will not affect patient care? This is particularly the case when there are many complaints within Brent about the unavailability of GP appointments – although doubtless partly stimulated by the national picture.

5.2.7 The latest Brent Commissioning Intentions (referred to above) at page 4 again illustrate the blurring of the edges between commissioning locality based and networks:

" *Supporting the establishment of GP* ***provider entities in the form of localities*** *which have* ***become four networks across Brent.***

- *Commissioning of Out of Hospital Contracts at* ***locality*** *level, replacing practice level local enhanced services and ensuring a wider population coverage.* " [our emphasis]

5.2.8 See also sections 6.1 and 9.1 of the CCG November 2013 Executive Board Paper re GP Networks as to explicit competition and funding by the CCG http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&ved=0CC0QFjAC&url=http%3A%2F%2Fbrentccg.nhs.uk%2Fen%2Fpublications%2Fdoc_download%2F460-item-12-briefing-paper-on-gp-network-development-jan-21st-v3-0&ei=_yXqVNOdI8OrU6DUgpAH&usg=AFQjCNG6OkCe6g0TJ6IhHGbOfnP89p0b3A

5.3 Consultation and Scrutiny on effect of moves/reconfiguration

5.3.1 The August 2014 report to Brent Council Scrutiny Committee does not appear to be entirely accurate, referring as it does (page 80) to the CCG extending the network services "*to allow patients to be seen within their practice or locality hub within four hours for urgent appointments and 48 hours for routine seven days a week.*"
http://democracy.brent.gov.uk/documents/s25755/transforming-brent-health-services.pdf

5.3.2 SaHF is predicated on 7 day services. In Brent, additional GP appointments were made available through a pilot "hub" service, at named practices within the localities (one per locality, save for Harness, were there was one hub in the North and one in the South of the Borough). Following the end of the pilot project, future hub business cases are being worked up to give extended evening hours and hours during the weekend. However, the locations are now linked to networks rather than the localities, As Kingsbury and Willesden have agreed to work together, there is concern as to convenience for patients of the location of the hubs – particularly bearing in mind the recent changes in "locality" by various GP practices. This will lead to patient whose practices have moved locality in, for example, Kilburn to have to go to a Kingsbury network hub. In addition, government directive has indicated that the hours will be more limited than the aspirational 24/7 hours.

5.3.3 Harness in particular has become even less geographically based as a result of its new total of 21 practices spread across the borough. We refer later in this submission to the dominant position of Harness GP voting members on the Brent CCG governing body

5.3.4 There does not appear to have been any consultation or consideration of how patients will benefit (see page 81 of report to Brent Scrutiny Committee, in answering the question "*what engagement has the been with patients*?"). This paper represents an entire raft of reconfiguration proposals put before Brent Council's

Scrutiny Committee at the same time as it was expected to do to scrutinise a paper on the locally politically "toxic" CMH A&E closure , and other unrelated issues . (Brent now only has one Scrutiny Committee - with no longer any "dedicated" Health Scrutiny, as previously).

As to proper scrutiny, it is notable that the very short covering report by officers simply suggested by way of advice " *The committee is recommended to question representatives on the viability of these transformation plans, the timescale for their implementation, as well as on what contingency plans are in place in case any of the proposals turn out not to be possible or feasible. In particular the committee is asked to considerthe adequacy of proposals to expand capacity within primary care services.*"

You may conclude that the likelihood of effective Local Authority scrutiny seems remote and those circumstances, with perhaps limited possibility of that committee properly understanding, let alone effectively scrutinising the effect of some of the CCG's proposals – save in the case of already very experienced members.

5.3.5 We therefore fear that an additional effect of the SaHF reference to increased out of hospital services is secondary care reconfiguration by the back door, by – in Brent – the combination of "Waves" of Out of Hospital services, and the creation of networks. Anything that impacts on secondary care services should be subject to public consultation – not further down the line when it happens as a fait-accompli – but now when the critical decisions are being made

5.3.6 As the Council has a duty under the **Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013** to examine substantial developments, reconfigurations and variations and, in particular, evidence of the effect or potential effect of the same on the health service in the area, we are concerned by the failure by the CCG to explain the linked and overall effect of the implementation method of its out of hospital strategy and the promotion and development of the GP network approach in context of the overall health economy, and of the local authority failure to scrutinise.

5.3.7 It is only recently that the CCG has published the list of contracts entered into by the CCG as required by statutory regulation, the CCG initially maintaining that it did not intend to do so but operates on an 8 CCG wide basis. We are aware that Harness bid in the cardiology provider wave 1 process, and understand that Harness are involved in Wave 2, both in connection with the gynaecology services, and – we understand from the declaration of interest given by a Harness GP in the MSK Stakeholder Engagement Group – MSK.

As above, there is the express intention to bid for OOH services. Where is the assurance that the commissioning intentions decisions taken are not influenced by the GP provider commercial interests - e.g., the desire to remove services out of hospital contexts and to be tendered is potentially generated by the networks of GP's desiring to bid for those services themselves. Again, we seek to say nothing adverse about individual GPs but the point made above about even the suspicion of motive for changes without evidence-based and rational paperwork is valid here.

This is a risk highlighted in the RCGP Leaflet, which forms part of the CCG's policy on managing conflicts of interest. The fact that federations being formed may well be "not-for-profit" does not, of course, exclude increased remuneration for individuals.

5.4 Harness

5.4.1 We have some specific concerns about Harness. See below in **Section - Gynaecology**

5.4.2 In addition, however, , we are concerned by the extent of Harness representation on the CCG Board. Of the 12 voting members, 4 clinical members are in or associated with Harness practices: the Chair Dr Ethie Kong, the Vice-chair Dr Sarah Basham (even though she is referred to as co-chair Willesden), the Brent wide GP representative Dr MC Patel and the Harness Clinical Director Dr Sami Ansari

5.4.3 The Whole Systems Integrated Pilot is for patients registered with a Harness (or Kilburn) GP.

Until a decision was taken relatively recently that referral management systems should be re-considered, 4 out of 5 Localities used the Harness Referral Management Systems.
http://brentccg.nhs.uk/en/publications/cat_view/1-publications/358-contract-log-full-list

Against that lengthy general background, we have the following issues on the Wave implementations to date.

6. Wave 1

6.1 Ophthalmology

6.1.1 Premises - Brent CCG's estates issues

6.1.1.1 Again, the principal concern is of effect on financial viability of LNWHT at the removal of service and income but also of the placing of a contract with a private provider, which in public forums since has given rise to patient concerns. The rate of transfer of existing patients to the service (and implicitly new referrals) has been low – items 1.1.3 and 1.1.4 to CCG board paper 26 November item 17 http://brentccg.nhs.uk/en/publications/governing-body-meeting-papers/cat_view/1-publications/3-governing-body-meeting-papers/344-26-november-2014
This may be influenced by the perception that the service is now provided by a private provider, based on such comments in patient forums. Leaving aside any issue of approval or otherwise of private providers in this context, it may reinforce the impression of the waste of money involved in the whole exercise.

6.1.1.2 There was a long delay in completing this contract, partly caused – we believe – by a problem which BMI - the successful bidder - had with the lease of the premises from which they propose to deliver services. Certainly we were told in Eden committee is of delays caused by the negotiation of premises heads of terms with BMI.

6.1.1.3 We are aware of the issue of rents, service charge and alterations issues within PFI/LIFT buildings through our involvement with the lease to be negotiated with our GP surgery (referred to above in " Personal Background" as to the shadow director of the community interest company and the right to request). It occurred to us that BMI might have balked at paying those very high levels of rent and service charge and might have required a subsidy from the CCG.

6.1.1.4 However, having been aware that the contract was placed on the basis of competitive dialogue, including a section of the score for "*financial evaluation*", We were concerned as to whether – if such a subsidy were to be paid in any form to the successful bidder after evaluation of the tenders – this must affect the integrity of the whole process.

6.1.1.5 We have received confirmation by the FOIA process (email 13 August 15:06) that the contract awarded contains changes from the public specification of costs and responsibilities. The original specification on is on the CCG website, in particular as to the moving of responsibility from provider to commissioner to provide *" premises that are fully compliant with statute and clinical requirements necessary for delivery. The commissioner has funded a minor works alteration on the Willesden site relating to IT.*" (This is consistent with more recent reports of the funding by the CCG of IT connections at Wembley and Willesden (including in the latter case the need to obtain way leave licences presumably at cost as yet unspecified. The cardiology cost for IT was £60,000 at Wembley. All these additional costs are funded by the CCG and not referred to as available in the original tender)

6.1.1.6 This is quite different from what it states in the specification as to responsibility for premises and IT http://www.brentccg.nhs.uk/en/publications/plans-and-strategies/cat_view/1-publications/12-plans-and-strategies/22-out-of-hospital-plans/166-wave-1-ophthalmology-and-cardiology

6.1.1.7 We have asked for clarification from FOIA as to when this change was made (i.e. was its notified to all bidders before they finalised their bids and certainly before the prospective bidder was chosen?), and to forward details of the difference between costs as quoted in the specification on which the bidders were asked to base their bids, and those actually charged – i.e., trying to elicit from the responses exactly that the bids were dealt with fairly on the issue of the costs for premises/equipment, etc.. Unfortunately, clarity is not always forthcoming.

It seems likely, however, that there was and continues to be a subsidy to BMI either as to rent or funding alteration requirements, and there must be doubt whether there was a fair basis for bidding - in the light of the information which has been revealed in respect of the cardiology bid.

6.1.1.8 It seems that Brent's "requirement" to use existing under filled PFI/LIFT buildings in the Project is not unique in North west London.

6 1.2 CQC improvement plan for BMI

6.1.2.1 When updating the EDEN Committee on 15 May 2014 on Wave 1, CCG officers made a reference which we – along with other EDEN members – queried, as it related to the Clementine Churchill Hospital premises.

To quote: –
"*Brent CCG patients are offered choice to use Clementine Churchill Hospital operated by BMI Healthcare for a range of clinical services. Clementine Churchill Hospital had a CQ C visit in January 2014 and the CQ C report that visit was published on the CQ C website with an action plan for improvement against some of the standards, the progress of which will be contractually monitored by Croydon CCG who leads the BMI contract the London in close liaison with NW London CSU. Brent commissioners will work with Croydon CCG on this matter.*"

6.1.2.2 We asked whether it was proposed that the ophthalmology service would be offered from Clementine Churchill – obviously an unattractive prospect in the light of the very poor CQC report for that hospital received last year – but also as those premises are out of the Borough boundary.

6.1.2.3 We received assurance from Sarah Thompson (Senior Responsible Officer for waves 1 and 2) that this was not the case, and also raised a query as to why Brent CCG was expending public resources on this monitoring, as it appears to be the job of Croydon CCG to deal with the overall contract, in respect of which Sarah Thompson's reply indicated the comment was directed to (i.e., that Brent patients can be directed to the Clementine Churchill through choose and book for certain services paid for by the NHS).

It seems odd to incur such expenditure in respect of one particular private hospital, when others are evidently used under choose and book, and it seems likely the monitoring is in some way linked to the ophthalmology bid – see below as to original "mother" establishment for ophthalmology satellite service.

6 1.3 **CQC registration for BMI**

6.1.3.1 A colleague's FOI request revealed that the delay in the completion of the Wave 1 ophthalmology contract was – at least in part – caused by the issues arising from the adverse CQ C inspection of the Clementine Churchill Hospital.

6.1.3.2 It is concerning enough to read the content of the CQC report on issues as various as safeguarding, lack of cleanliness and failure to record and/or learn from risk events, which may have caused an issue for this contract.

The report of the CQC was published on 1 May 2014. Was the "lead time" into this contract influenced by any problem with BMI's CQC registration at the Clementine Churchill, which presumably was the "mother base" for the provision of services in the 2 Brent locations. However, our overall concern about the placing of a contract with a company whose local hospital can so comprehensively fail 4 out of 5

standards in a CQC inspection, so that there are significant problems with the main local hospital service base from which they are operating.

6.1.3.3 At the very least, how can patients be satisfied that BMI will operate the safeguarding and "*learning from events*" processes which we patient representatives are intent on seeing embedded throughout all health service provision in Brent.

6.1.3.4 Paper 19 of the Governing Body papers of September 2014 reveal how the CQC regime will be dealt with for the premises as a satellite service of BMI Garden Hospital at Hendon - a less than satisfactory situation in light of the reduced responsibility for CQ C matters for private providers(see below).
http://brentccg.nhs.uk/en/publications/governing-body-meeting-papers/cat_view/1-publications/3-governing-body-meeting-papers/339-24-september-2014

6.1.4 Issues arising from BMI Garden Hospital Hendon being the "mother" base for the Brent OoH service and (by way of analogy) from the recent CHPI Report on Patient safety issues in Private Hospitals

6.1.4.1 According to the FOI request reply, "... *for good governance and to ensure continuity it has been agreed that the Provider will operate the Out of Hospital Ophthalmology service as a satellite service of its BMI Hendon Hospital location.*" This may have practical implications for the OoH services operated in Wembley and Willesden; certainly Hendon much further away than Clementine Churchill hospital but there may have been assertions made in the bid which are inaccurate as a result of the change in "mother" Hospital.

6.1.4.2 In particular, Clementine Churchill's CQC registration was cited by BMI in the Pre-Qualification Questionnaire in support of their bid, and its Final Tender Submission, the Provider proposed to

operate the Out of Hospital Ophthalmology service as a satellite of its BMI Clementine Churchill Hospital location.

6.1.4.3 (Whilst produced in respect of incidents in inpatient treatment, please note the reference to patient records in the attached August report (***Patient Safety in private hospitals - the known and unknown risks*** CHPI - http://chpi.org.uk/wp-content/uploads/2014/08/CHPI-PatientSafety-Aug2014.pdf). A question arises of where will the patient records be kept, a point of some importance if the consultant element of medical team's relationship with BMI is as indicated for their consultants generally as per the report). The standard contracting provisions ought to have made BMI as new provider:

1 entirely subject to all the same reporting requirements; and

2 subject to FOI applicability;

3 subject to the remit of the Parliamentary and Health Ombudsman;

4 subject to the same clinical governance

5 subject to the same complaints procedures (support and advice)

in each case as an NHS Trust provider;

5 will make patients aware of the different clinical risks;

6 staff the facility with the appropriate specialism (both doctors and nurses)

(pages 6 and 7 of the report) - and the other aspects highlighted in the report, as applicable to outpatient services. We query whether this was thought of.

6.1.4.4 If anything goes wrong with the treatment provided by BMI, does the CCG contract provide that costs generated in dealing with the problem with an NHS provider will be recouped from BMI?

6 1.4.5 On an allied issue, a fellow member of the EDEN Committee has raised with the CCG issues of insurance in these contracts. (See, e.g., the following article -an issue on which assurance is required - and clear indication where liability sits, as the article appears to indicate that liability for the extreme problems was unclear as between CCG and provider .
http://www.theguardian.com/society/2014/aug/14/nhs-eye-operations-private-provider-musgrove

What is the position in the event that a patient has to take legal action? Will this be overseen by the NHS Litigation Authority? . A claimant against a private provider can be faced with complications over whether it is the hospital or the individual surgeon or sub-contractor who is liable; what position is in the CCG's contract?

6.1.4.6 The relevance to the project is that, if CCG's adopt tendering approaches, then they will inevitably potentially involve the private sector – much more in a position and ready to bid for contracts – and result in these type of risks, as well as fragmentation of services.

6.1.5 "Consultant led" and the comparison with the proposed new MSK service

6.1.5.1 The CCG appears to be "learning" from the tendering process, and now changing for the next "Wave" of out of hospital services, and potentially downgrading the requirements. In the case of cardiology, the service is described as "consultant led". How is this defined in the contract? On page 9 of the CCG website specification ,there is a definition of consultant led

"The service will have a suitable level of clinical delivery, supervision and leadership, and will be consultant-led. ***This means a consultant will be accountable for the delivery of the service, available and on site while the service is open, and involved with the delivery of care.*** *The consultant will triage all new referrals to ensure they are on the right pathway; subsequent appointments may use different skill mixes."*

Is this how the contract specifies?

6.1.5.2 By contrast, in the case of the wave 2 MSK process, where engagement and consultation is led by Mott McDonald, the latest leaflet supplied by Mott McDonald (29 September 2014 sent to Northwick Park Arthritis Patient Panel) states:

"Patients will have their referral clinically assessed by a consultant-led team.1

□ *Patients who need to see more than one type of MSK specialist will be referred directly and will not need another referral by their GP".*

The relevant footnote reads:

1 A consultant led service is a service where a consultant retains overall clinical responsibility for the service, care professional team or treatment. The consultant will not necessarily be physically present for all consultant-led activity but does take clinical responsibility for each patient's care.

6.2 Cardiology

6.2.1 Failure to consult

6.2.1.1 We mention this to completeness but are aware of specific complaints made by Brent Hearts of Gold in connection with the failure to consult with that body, notwithstanding their position in connection with the community cardiology service operated out of Central Middlesex Hospital.

6.2.1.2 It seems that there was a lack of awareness on the part of Brent CCG as to precisely what services were offered by its existing provider trust, in particular in this instance, to the community cardiology service. We understand that its provision was something which had to be advised - after the main bidding - to the Royal Free, which may explain in part the circumstances which have led to our substantial complaint on the issue of the additional costs being paid

by Brent CCG in respect of the community cardiology service, essentially - we would submit – anti- competitively, **after** completion of the bidding **and** appointment of the new provider.

6.2.1.3 This is not only in the context of use of NHS funds which may not need to have been expended – see below – at a time when all NHS patients are being told of the extreme shortage of funds (often attributed to increasing elderly population and the existence of long term conditions - although, in Brent, the main increases in population is amongst the young)). Our concern Is also in the context of the way in which these funds "appeared" and their expenditure authorised.

6.2.2 The scoring of the bids, the "legal advice" which followed a "dead heat" between Ealing ICO and the Royal Free and the additional subsidy of £450,000

6.2.2.1 When the EDEN Committee was told that the Royal Free had won the cardiology bid, so that services would be moving away from the existing provider (NWLHT), the matter was discussed. This took place both inside and outside meetings

6.2.2.2 Anecdotally, we were told that the bid had been decided on a " show of hands", which to some of those hearing that seemed somewhat disproportionate as a basis for moving an entire outpatient service in cardiology away from the existing provider.

6.2.2.3 One might have thought that the effect on patients should have outweighed this "show of hands" by those assessing the bid, particularly as the consultation process appears from the documentation supplied by the CCG (July and August 2012) not to have been particularly extensive. (As above and as we now know, a substantially affected cohort of patients – Hearts of Gold – were not consulted at all)

6.2.2.4 However, as above, when becoming concerned about a potential subsidy to a private company – BMI – in relation to the premises aspect, for completeness, EGL included in an FOI request a similar question for Royal Free.

6.2.2.5 EGL did not receive a conclusive answer – but eventually seeing in EDEN Committee papers that alterations were indeed required to the premises intended for community cardiology. Pursuing the FOI request, and EGL eventually received confirmation that the CCG had found non recurrent funding of **£450,000** for the requisite alterations. EGL immediately complained to Monitor (who were dealing with an existing complaint on various aspects including the failure to consult - Brent Hearts of Gold aspect) about a very serious issue – which could skew the whole tender process.

6.2.2.6 In that correspondence, Monitor referred to a *"Lessons Learned"* document; I requested a copy. In that document, we learned that – far from the matter of the equal scoring of Ealing ICO and the Royal Free being decided on a "show of hands" - "*legal advice*" was sought - we speculate - on what to do in the light of the dead heat, and themes that that *"legal advice"* recommended (re-) **scoring the financial evaluation aspect to 2 decimal points.** On that basis alone, Royal Free won the tender. No consideration about whether patients might best be served by staying with their current provider nor any other such – to a lay person – common sense approach. A failure to put patients first.

6.2.2.7 We have a real concern about the CCG's rationale in (once again) opting to take external legal advice, when there could hardly be any risk of challenge in a process where a CCG might sensibly have decided to stick with an existing provider, known to patients and with a service base in both the North and South of the Borough, with ease of transport access and plenty of parking. It appears to be another issue of how the aggressive tendering out of services has resulted in expenditure of consultant money (in this case on lawyers) – when patients are being told that money is desperately apparently needed for patient services within the NHS. Where can the overall cost of these exercises be identified?

Looking at the end game – where we are now – and the complexities of the arrangements for the 2 Wave 1 services and associated capital costs not referred to in the original bidding documents *– what implication does this have for overall funding of the project, if Brent

estates and legal issues are examples of side-effects of such out of hospital strategies in finding community buildings?
*Item 17 http://brentccg.nhs.uk/en/publications/governing-body-meeting-papers/cat_view/1-publicationhttp://brentccg.nhs.uk/en/publications/governing-body-meeting-papers/cat_view/1-publications/3-governing-body-meeting-papers/356-28-january-2015s/3-governing-body-meeting-papers/344-26-november-2014 and item 15

6.2.2.7 Looking at the specification for the cardiology bid, it was clear that the CCG anticipated that a certain amount of services would be delivered at Wembley and Willesden but it is equally clear that clinical space was already available (e.g. the existing space in the acute provider trusts). Presumably, bids were made on that basis.

It also seems clear that the CCG were not looking for refurbishment. However that may be, it is absolutely apparent that there was no mention of an extra £0.5 million plus being available for the new community service .

Although the service is due to start on 2nd March, it is apparent that further work is being done on the specification – and further it is by no means clear that all the services to be provided in the community in terms of cardiology as specified will be being provided.

Further, there will be an assessment about the numbers of sessions/days of availability for clinics after a pilot project of 6 months. What accountability is that for a process which has resulted in major disruption, concerned to staff and patients, and the expenditure of vast amounts of money? Further, did Brent CCG understand whether all the services they specified to be carried out in the community were **safe** to be provided in the community?

6.2.2.8 If there had been mention of the £0.45 million capital subsidy to both potential providers, perhaps the bids might have been very different and bidders might have thought of patient centred ways to spend it rather than on doing up some of Brent CCG's spare estate (weighing down its budget). Something with which we sympathise –

PFI/LIFT costs are decimating both Commissioner and provider budgets but it is no reason to skew the bidding process.

(We note that Estates issues are now very much to the fore in the latest MSK outline specification where premises are to be **mandated**, although details of the precise rents and other costs are not in the draft issued 20th October to SEG members, although there may be further detail not yet available).

6.2.2.9 How will the CCG ensure that costs elements will be dealt with to ensure equity of treatment for prospective providers in the bidding process.

The extra spending has come up subsequently for reasons and on a specification which the CCG has not made known to anyone in the community.

No-one has made a case about the Royal Free's needs – since their base is a long way away from here, however, we speculate that it is because they have no other accommodation locally. There is also the question as to whether their staff would wish to travel to the Willesden and Wembley "outposts", particularly in view of poor parking provision and difficult public transport.

Whatever may be the case, it still makes the bidding process transparently unfair and it should have been reopened., Or - better - abandoned and no more money wasted that could be spent on patient care.

6.2.3 Costs to the local health economy of the bidding process, and how that should have been taken into account in assessing the final bids/effect on overall SaHF budgeting (where do the capital costs come from?)

6.2.3.1 The expenditure of CCG/NHS money – ranging from the £101,000 spent on Public Private Ltd to advise on and project manage the Wave 1 bid (at least arguably, in view of all the failures, a waste of money – the initial procurement process had to be halted in view of various faults) - the legal advice on all aspects of the tender including

the queries arising afterwards, to – no doubt – legal advice and time spent by our current and other provider trusts (that could have been spent on proper hospital administration), on TUPE by the existing provider trusts (including on staff/union consultation) - must be enormous.

6.2.3.2 Since these costs have not, in the main, been declared, it is impossible to quantify those costs to assess the overall impact on the local health economy. Just because it does not directly affect the CCG or its budget, we believe it is completely irresponsible for the SaHF Project generally and, in this instance specifically, for the CCG not to take this into account when considering the slightly extraordinary circumstance of a "dead heat" on assessment of a tender, where one of the final tenderers is actually the local hospital trust and the existing provider. Quite apart from the consideration of disturbing patients and staff.

6.2.3.3 As our local Trust is in deficit, we are reminded the report of the National Audit Office of 29 November 2012 into the financial catastrophe at the Peterborough and Stamford Hospitals NHS Foundation Trusthttp://www.nao.org.uk/wp-content/uploads/2012/11/1213658es.pdf

At page 8, amongst the key findings as to why finances at the Trust deteriorated so much that paragraph 14 *"NHS Peterborough, the Trust's main commissioner is not reimbursing the trust for all that healthcare it is providing. The level of activity the trust undertakes is much greater than that envisaged in the business case. Activity levels have increased by more than 20% in all main categories. However, NHS Peterborough has reduced payments the Trust that underachieving against some national and locally developed indicators of performance... The Trust and local commissioners continue to discuss ways the Trust can be remunerated appropriately for delivering the right level of care in the right setting"*

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""Local commissioners everywhere should have to demonstrate That their plans consider the overall needs of the local health economy. In Peterborough, for example, commissioners have struggled for a number of years to fund health services while staying within their

budget allocation. Commissioners have an important role to play in helping to provide a stable financial environment within the local health economy through measures to discourage inappropriate hospital attendance and funding based on realistic assessments of likely activity levels. Given the failure of the Trust and PCT to achieve agreement on the appropriate funding of activity, with the need for an independent body to take the lead in developing a strategic solution for the local health economy"

We note that Parliament is carrying out an investigation into the costs of competition and tendering. This issue should be a major part of the consideration of the costs and the effect of SaHF. The costs should be referred to and declared within a global budget for procurement so that total value for money decisions could have been made, and any – allegedly – SaHF generated out of hospital tendering process fairly and transparently considered in an overall cost benefit analysis.

6 2.4 Interoperability of IM & T systems

6.2.4.1 Interoperability is a word much used in many of the CCG's documents. A query must arise about costs on this. If Ealing ICO and NWLHT already have joint systems, is there not an additional cost which could have been avoided – let alone an additional administrative headache which may arise from the introduction of the Royal Free as service provider? See also specifically the latest cost of IT infrastructure required at Wembley (expressed as £60,000) and Willesden (unquantified) for the community cardiology bid.

6.2.4.2 Is there any additional complication depending on which provider trust or other provider is involved when considering the new IM & T systems for the GP networks/the diagnostics introduced such as ECG technology? As above, the bid specifications made it clear that all IT costs should have fallen on the provider.

6. 2.5 Additional sites - the benefit for patients had the bid stayed with the existing provider

It has occurred to us that, had the bid stayed with the existing provider, there would have been four sites potentially where the

service could be offered in different places in the Borough – Wembley, Willesden, Central Middlesex and Northwick Park - not just two.. Was this potential benefit to patients never considered when the CCG chose simply to go for legal advice and tinker with decimal points in one part of the scoring – ironically, financial evaluation? Again, how is this bringing care closer to patients in the community?

6.2.6 Lack of Transparency in allocation of funds

6.2.6.1 It is only now apparent from the July 2014 Governing Body papers

http://www.brentccg.nhs.uk/en/publications/cat_view/1-publications/3-governing-body-meeting-papers/262-23-july-2014

that the decision on the allocation of **£450,000** was made in a QIPP subcommittee of the CCG in April, and the expenditure was authorised by "*Chair's Action*". Is this a proper process for authorising expenditure of CCG funds? It is certainly not transparent.

6.2.6.2 There was no opportunity for any party to ask the obvious question : "***Had the existing provider been aware of an extra £450,000 available for the new community service, might that have affected their bid, or – from the patient point of view – might any prospective provider might have thought of more flexible, patient centred ways to spend it?".*** What authority for this additional capital expenditure was there – is it from SaHF capital budgets?).

6 2.7 Quality of care and effect on Northwick Park hospital as a major hospital under SaHF

6.2.7.1 As above, we are extremely concerned in that Northwick Park Hospital as an acute provider, being our major hospital with its A&E services – clearly involving access to cardiology (particularly in the light of the major/ stroke unit located there) - will lose access to outpatient records on their own system of a cohort of patients who would normally naturally have gone there – which seems to me particularly problematical if they come to A&E, or even use other

services there. If the problem has been overcome, again was the additional cost and from where was that funded?

6.2.7.2 Should primary weighting in the tender bids for these out of hospital services not be given to **quality and safety**? It is again interesting that the current Commissioning Intentions (page 6) refers to:

> "*Provide a proportion of outpatient appointments in community settings, rather than in acute settings, at lower cost* ***and higher quality****, where it is clinically safe and cost effective to do so*."[our emphasis]

If assertions are to be made, then where can the evidence base of the previous quality be found, against which any new service in the Waves can be measured?

7 Wave 2 MSK and gynaecology-general

7.1 Method of Procurement and Harness conflict of interest

7.1.1 A complaint has previously been raised by a patient about lack of consultation prior to decommissioning and re-procurement. The Ombudsman found that – with adjustment – the CCG's process of procurement – up to that point – could be in accordance with its statutory obligations under Section 14 Z2.

7.1.2 The CCG has always said that it intended to procure all its Out of Hospital Services (OO H) by competitive dialogue. This was - apparently - to encourage innovation through provider dialogue and suggestion. CCG Papers recommending that route contain a brief summary of that rationale – in fact using wording lifted direct from a Charles Russell solicitors short briefing note (**attached**) available on the Internet, outlining potential advantages

> *"Overall, the competitive dialogue procedure is thought to be a positive additi*
> *where used appropriately. There was general consensus that the procedure re*
> *competition, imposes discipline, establishes good working relationships betwe*
> *the parties, delivers a better deal for the public sector and avoids scope and p*
> *creep often found in negotiated procedure procurements. "*

but not including the entire remainder of the Charles Russell briefing note which outlined disadvantages – rather than detailed legal advice. In fact, both original European law guidelines, and the HM Treasury guidance referred to in the briefing note are somewhat different.

7.1.3 A subsequent HM Treasury review has further highlighted the inappropriateness of this process for these type of services, not least on ground of expense.
Https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/225318/03_ppp_competitive_dialogue.pdf

For example, " *The Competitive Dialogue Procedure is an exceptional procedure and should only be used where the contracting authority wishes to award a particularly complex contract. A particularly complex contract means a contract where the contracting authority is not objectively able to:-*

a) define 'the technical means' in terms of a British, European or international standards or technical specifications; and/or in relation to the performance or functional requirements[1]*; or*

b) *specify the legal and/or financial make-up of a project."*

7.1.4 Therefore, we already have a process which is recognised by HM Treasury as extremely expensive and not value for money, in competitive dialogue, and presumably some of those costs would have been spent in the initial stages of the Wave 2 procurement. However, the pure competitive dialogue route seems to have changed – in different ways – for gynaecology and MSK (see below).

7.2 Gynaecology

7.2.1 Change in procurement policy for gynaecology – rationale, potential conflicts of interest and lack of transparency

[1] Public Contracts Regulations 2006 [as amended] 9 (6 -8).

7.2.1.1 At the CCG Governing Body of 20th March 2014, the GB was told that to be procurement method for gynaecology was to be by "*invitation to tender*", and indeed revealed as based on a pilot project which had been running – it was then said – for **six months**.

Later, we were told it had been running since 2010. The evaluation for the project which has been produced only in the last month took place in **October 2012**, just after the paper produced by Brent PCT setting out the "waves" and constituent services for the out of hospital strategy was issued, which paper clearly stated that **all** procurement would be by way of competitive dialogue, and not mentioning the then two-year gynaecology pilot project.

7.2.1.2 That project was a joint Harness Cooperative and St Mary's Hospital project involving only Harness and Willesden localities. There was already a conflict of interest even in the days of Brent PCT but the decision reported to the governing body of March 2014 involved a major conflict, as the Chair and other Board members were part of the Harness group.

7.2.1.3 Aside from the conflict of interest issue, there is a contrast in the preparation for the 2 parts of the Wave 2 process. For gynaecology, this was prefaced by a lengthy pilot now running for over 4 years as a test base. In the case of the Wave 2 rheumatology, no clinical risk assessment – see below – was undertaken, let alone consultation with current providers, clinical senates all patients, and the redesign of the service was simply to be the subject of a "competitive dialogue", i.e. devised by prospective providers – with nominal patient input (see below), and no test pilot whatsoever before potentially dismantling the existing service.

7.2.1.4 Up to the Governing Body of March 2014, at all times when the Wave 2 process has been questioned, for example by Brent Council HOSC, competitive dialogue has been the method universally specified. Even in the first meeting of the Stakeholder Engagement Group ("SEG") (of which we are members), which was set up as a joint stakeholder engagement group on MSK and gynaecology there was to be no differentiation in procurement methods.

7.2.1.5 When EDEN Committee members have raised queries about the change, we have been told that the pilot is to be used

because it has been given chance to demonstrate good effects. However, despite consistent enquiries (in particular, by Robin Sharp also in the SEG and a Locality PPG chair) as to the documentary evidence about the favourable assessment of the pilot project, the only evidence which has been forthcoming dates back to October 2012 with little comprehensible or independently measurable outcomes and which fails to take into account that it "*sits within*" the current health economy and existing provision, in particular the services at NWLHT (including FGM specialist services).

7.2.1.6 As an example of how the process is proceeding, please see paragraph 16 of the CCG executive minutes for December 2014 (part of item 18 at http://brentccg.nhs.uk/en/publications/governing-body-meeting-papers/cat_view/1-publications/3-governing-body-meeting-papers/356-28-january-2015)

7.2.2 FGM

7.2.2.1 Speaking of FGM, whilst on the joint wave 2 Gynaecology and MSK SEG, we made consistent requests for FGM specialists to be on the SEG. We were severally informed that they had been invited and then – somewhat curiously – told that none of them wanted to participate in public dialogue in such a committee.

7.2.2.2 In a Borough such as Brent, it is essential that FGM be taken into account and – in so doing – consideration given to the interlinked specialties of obstetrics and gynaecology and the likelihood of joint obstetric/gynaecology consultant provision in provider trusts.

7.2.2.3 Once again, we are concerned concerned that there has been no risk assessment on the aspect of FGM and generally, from a **clinical** point of view before this whole process was undertaken.

7.2.2.4 In addition, if no account has been taken of the overall effect on the provision of gynaecology and obstetrics, were NWLHT to bid and fail, that runs the risk of being discriminatory of a particular ethnic minority. We are concerned this is part of a pattern of CCG behaviour in decommissioning and re-procuring to ignore

equality strands: in the case of gynaecology, ethnic, in the case of rheumatology, disability and age. (See further below).

7.2.2.5 It is perhaps notable that in the recent CQC Report about Northwick Park Hospital maternity services, the Inspectors chose to include the following 3 separate quotes:

"A senior member of staff mentioned that the Brent and Harrow Clinical Commissioning Groups were not engaged with maternity services, despite commissioning for them."

"Staff told us that the service did not have effective relationships with the external local Clinical Commissioning Groups."

"• Senior staff mentioned that the Brent and Harrow Clinical Commissioning Groups were not engaged with the maternity services, despite commissioning them."

7.2.2.6 However, it is also notable from the CQC Report that NWLHT does best where there is co-operation with commissioners. Areas of care were praised – e.g. their integrated care pathway around asthma care plus training for medical students - and physiotherapy / OT praised, together with medicine, surgery at CMH, all elements requisite in MSK. What characterises these services is strong collaboration between primary and secondary care. Please see elsewhere in these comments about the apparent attitude of Brent CCG to LNW HT.

7.2.3 Why are the two Wave 2 service s treated differently in Commissioning Intentions?

Page 33

- *" Deliver Specialist Multi disciplinary Community Musculoskeletal (MSK) service.*
- *Deliver Community Consultant led Gynaecology service".*

We have raised elsewhere in this submission the September 29th Mott McDonald leaflet new definition of "Consultant led "but here there is not even any reference to consultant input in the case of MSK.

7.2.4 Gynaecology interim impact assessment – Mott MacDonald

7.2.4.1 The interim assessment is at http://brentccg.nhs.uk/en/governing-body/governing-body-meeting-papers/doc_download/1735-interim-gynaecology-iia-report-january-2015

7.2.4.2 EGL has had the opportunity to input following the publication of the interim impact. There are particular concerns that a female doctor in this area is not specified as default and that an already reasonably lengthy wait time for the community service of 4 weeks could be extended if a patient "insists" on seeing a female doctor.

7.2.4.3 Of more concern is that the impact assessment makes varying and inconsistent and generalised comments about the effect on the overall health economy of taking gynaecology outpatient services out of the provider trust where FGM specialist services are provided. Further, no account is taken of the link in specialisms between gynaecology and obstetrics, and, for example, the recent guidance to the Royal College of midwives concerning specialist education in respect of FGM for midwives

7.2.4.4 Of particular interest are the **comments made to Mott Macdonald by GPs,** referred to from page 59 onwards. Apart from the fact that the GP respondents seemed mainly to come from the localities (Harness and Willesden) in which the pilot has been taking place, there are some telling comments:

7.2.4.4.1 As to waiting times referred to above *"Gynaecology should be able to do minor things like pessary change, retrieve of IUCD etc. within a few days"*

7.2.4.4.2 As to lack of consultation with acute providers

"It is concerning to hear of the lack of consultation of these models with local consultants. Without input from local specialists the model of care in the community cannot work. Community clinics need sufficient support and back up from secondary care consultants. I am also concerned about the lack of training received with respect to DMARD monitoring in the community. This is a potential area of great clinical risk. Community based clinics have not been shown to save money nor hospital outpatient activity" **(as to DMARD, see below)**

7.2.4.4.3 As to transport and accessibility

"*Our patients mostly live 3 buses (almost 2 hour journey) from all the 'community' locations and we end up referring to Edgware or Royal Free/Barnet as they prefer these locations. The idea of a community service is great, but unfortunately, those on the geographical 'fringe' of the community usually do not benefit from the services. For Gynae community- this would only be accessible for those patients who do not require transport?*"

7.2.4.4.4 As to quality of service

"*Re: Gynae-this has not helped our patients greatly. More seems to have gone wrong than right."* and

7.2.4.4.5 As to quality of survey and comprehensibility (Brent CCG spent £71,000 on the process with Mott MacDonald)

and speed of travel

"*This survey is one of the most confusing and poorly constructed that I have ever attempted to fill in. The questions are phrased in a confusing and unclear way and therefore difficult to answer (and English is my first language) .I think it would be dangerous to rely on any answers you receive to this survey. The greatest risk to a service that all cases have to go to with a SPA is patient choice. With the*

vocal politically astute population in Brent we can only move services in a staged way by the service proving it's worth and becoming popular"

7.3 Wave 2 MSK

7.3.1 Initial process of decommissioning/consultation and specification for re-commissioning

7.3.1.1 As above, **decommissioning** notices were served in respect of (amongst others) the rheumatology service on 28 March 2013 at the then NWL HT. The CCG claimed to the Brent Council Health and Overview Scrutiny Committee in 2013 – and, we believe, the Ombudsman – that such decommissioning notices are not really notices to determine a service but simply a warning as to poor provider performance. However, Brent CCG has since confirmed that there is no question of poor provider performance in connection with the provision of the rheumatology service at North West London Hospitals Trust. (EDEN Committee September 2013)

7.3.1.2 Although reference has been made in CCG documents to **consultation** having taken place with patients and the general public, this appears to relate to references to MSK, and the process of starting *" specifying and commissioning new style outpatients in the community to go live from April 2013 with one-stop services"* in a presentation to Brent LINk on 13 November 2012.

7.3.1.2 Whilst adding to the ength of an already lengthy document, it may be worth exploring what that "consultation" comprised, and how the meeting progressed. We attended that meeting – which was, to say the least, shambolic, and encountered widespread discontent amongst the cohort who attended. No-one had had previous sight of a 37 page densely printed Integrated Plan - presented only in slide form on that evening, and excused by the fact that the team presenting wanted it to be "*as up to date as possible*"

7.3.1.3 People could not follow what slides where quickly presented, especially as many acronyms were used with no attempt at explanation, and he team stopped showing the slides and tried to

answer a plethora of questions from increasingly irritated and confused patients. Many of these were very experienced in participation groups. Participators were trying to flick through the hard copies which they had just seen, and ask questions but it was just too complicated and there were some heated exchanges.

7.3.1.4 In course of that meeting, we had picked up on the fact that they were intending to change DMARDS administration in some way, and Methotrexate monitoring, as these were forms of medication which KP was on earlier in my journey in finding the right treatment. We were particularly aware of the care needed in monitoring and the disadvantages of patients carrying a "yellow book", and we raised a question about how that change would be for Brent patients. (NB the comments in paragraph 7.2.4.4.2 above). We saw no other reference to rheumatology. Until we became involved in the process, we do not know that we would have appreciated MSK - as a term - included rheumatology.

7.3.1.5 However, looking back, all we can see in the document are references in investment priorities to physiotherapy capacity (and reducing the number of patients who: go on to develop chronic musculoskeletal conditions) and, under the heading long-term conditions to "*reducing fragmented care pathways by developing networks of care closer to home*" and to "*integrated care pilot to improve joint working between primary and secondary care as well as education awareness training.*". There are also references to decommissioning services - but nothing about rheumatology in that context.

7.3.1.6 Despite the close interest which we have paid to the commissioning intentions of the CCG and the PCT, and despite KP's position as long term conditions representative on EDEN, the first we – very informed "patients" - heard that the CCG were intending to put out to the procurement the rheumatology service was a mention in a calendar item at the very back of the EDEN committee papers in June 2013 of a planned consultation on procurement of rheumatology.

7.3.1.7 Matters proceeded rapidly to the preparation of a Memorandum of Information in readiness for a market engagement event in February 2014. At the point of the market engagement event, attended by EGL as an observer, it was apparent that the various prospective providers were confused about the scope of services.

7.3.1.8 The EDEN committee pressed for further information about what services were comprised in those that were decommissioned, what services being put out to tender, and what the CCG envisaged putting in place .

The MSK umbrella term – the exact content of which is still being clarified – was advertised as orthopaedics and rheumatology and (originally) including trauma - now confirmed as not including trauma. It might or might not include podiatry. It should include physiotherapy.

In any event, the original proposal for the working up of the specifications by "competitive dialogue" set out at the Market Engagement Event has been abandoned. Bidders who attended that event and worked up their preliminary ideas are thus disadvantaged.

The service specification for the next stage appears to be being been designed by a Clinical design group, comprising GPs, one external consultant in rheumatology (despite requests by the SEG for there to be more than one consultant rheumatologist because of the wide-ranging nature of the conditions under the umbrella term "rheumatology"), one consultant in orthopaedics and one physiotherapy consultant. 4 patients are also involved in the clinical design group but not from the outset.

7.3.1.10 The clinical design group is also joined by Dr Steve Laitner,, on the basis of his expertise in putting MSK services together. Dr Laitner has an interest in the Lead Provider model, which has now been adopted by the CCG. We note that a principal project with which he was involved was in Bedfordshire, from which the two national charities Arthritis Care and NRAS have pulled out as their contribution to self care Management part of the module was not sustainable from their point of view in view of the money is to be paid

to them
http://www.arthritiscare.org.uk/NewsRoom/Latestnewsstories/ucbt

There is now further concern, both as to the Bedfordshire project and the Lead Provider Model in any event. See **attached** report to Bedfordshire scrutiny committee and the following web links http://www.hsj.co.uk/comment/leader/prime-contractor-model-looks-old-before-its-time/5076645.article#.VLQjI95qbUQ and http://www.pulsetoday.co.uk/news/commissioning-news/ccg-faces-deficit-of-29m/20008820.article#.VLL6PmdyZaQ

Similarly, at the very late stage in the placing of a contract for MSK services, and following an adverse late impact review by PWC,BUPA CSH has pulled out of the west Sussex Coastal CCG contract.
http://www.wscountytimes.co.uk/news/health/health-news/bupa-csh-pulls-out-of-south-downs-msk-contract-talks-1-6542430

Again, as substantial reason is the likely effect on accident and emergency services at the local hospitals - see article below

Bupa and CSH Surrey pull out of £235m MSK contract

26 January, 2015 | By Sophie Barnes

Private provider Bupa and social enterprise CSH Surrey have pulled out of a £235m contract to run musculoskeletal services in West Sussex.

The joint venture said it made the decision because an impact assessment concluded that Western Sussex Hospitals Foundation Trust's financial position would be harmed if it lost MSK services.

Following strong criticism from the trust and the public, auditor PwC was commissioned by the trust and Coastal West Sussex Clinical Commissioning Group to complete an impact assessment into the effect the loss of these services would have on the trust.

The auditors concluded last month that the "cumulative impact of loss of MSK services" would result in the trust falling into deficit over the next five years.

Western Sussex Hospitals had warned that the loss of the contract could destabilise its trauma services.

The contract had been awarded to the joint venture in September but had not been signed. The parties had also failed to agree the terms of the contract and there was no draft contract in place. The service was due to start in April.

The auditors said: "There is a considerable amount of work to be completed by all parties if the new contract is to be signed and commence on time."

- *MSK procurement model could 'destablise' local health economies*
- *Sign up to receive regular regional updates*

In a statement, Bupa CSH said the conclusions of the impact assessment had led them to decide that they would not be able to deliver the new service without "either compromising on the quality of care or destabilising other local services".

Peter Lock and Jo Pritchard from Bupa CSH said: "Our priority was to provide high quality and better coordinated care for local patients, and we have worked hard with the CCG to try and find a solution.

"However, the recent impact assessment means we cannot deliver the model we proposed without either compromising on the quality of care or destabilising other services.

"This is disappointing, but we fully support the CCG's vision to improve MSK care in Coastal West Sussex. We acknowledge that transforming local health systems in these challenging times is extremely difficult for commissioners who want to introduce new care models.

"We remain committed to working in partnership with the NHS and the public sector to deliver high quality health and care services."

Katie Armstrong, Coastal West Sussex CCG clinical chief officer, said the group was "disappointed" but "understands and accepts, the Bupa CSH position".

She added: "This procurement has always had one key driver, improving the care for patients with musculoskeletal problems in coastal West Sussex. Bupa CSH's bid was very strong, they echo our patient values and would have been a good partner to work with in Coastal West Sussex.

"The CCG remains committed to improving outcomes for our MSK patients, we need time to discuss the options with our board but expect to be able to outline our next steps shortly."

Readers' comments (8)

- *Anonymous | 26-Jan-2015 1:18 pm*

  Why wasn't the impact assessment undertaken before the service contract was offered, to inform what / how much of the service to put out to tender? and can this really be allowed to be a show stopper?

  Unsuitable or offensive?

- *Anonymous | 26-Jan-2015 1:26 pm*

  Agree with above comments. Interesting also to know how much money was wasted on the tender process, all money lost to MSK and other patients. The "quality" aspect that could not be guaranteed is also interesting but not clarified - maybe not enough money in the contract?

  Unsuitable or offensive?

- *Anonymous | 26-Jan-2015 1:30 pm*

  This is not unsurprising. The prime provider model is a very complex model which achieves little that could not be achieved by other existing mechanisms that have been ignored due to overly powerful vested interests and weak commissioning. The CCG, (a government department), has failed to understand that

by protecting its budget it would transfer expense and risk to another government department (the local acute). Net benefit to the state = Zero. Coastal West Sussex will have spent a large amount of tax payers money on management consultants. Bidders, NHS and non-NHS will have spent large amounts of money and it has all been wasted. There is no evidence base that such a contract model improves patient care that could have been achieved via other existing means.

Unsuitable or offensive?

- *Anonymous | 26-Jan-2015 1:37 pm*

  Have real concerns about senior leadership at CSH, how did the top team let this come about? are other services they provide being Well Led

  Unsuitable or offensive?

- *Anonymous | 26-Jan-2015 1:40 pm*

  Western Sussex destabilised... ! More like the age-old cliche of the big local acute - let's word this delicately - 'strongly influencing' its key CCG's strategy. As a shiny new FT can't they manage even a 'wee' bit of competition? Or maybe a new MSK provider might have supplied a little backbone for the CCG - they're going to need it if they want to see new models of anything in Sussex. As for PwC didn't they make a lot of money helping to orchestrate the huge Sussex Together programme - which was all about dramatic new models of care? And now we've paid them again from the public purse to understand the impact of a new model of care.... oh please. Any new neurology services planned Coastal? We're going to need them after banging our heads against a brick wall for so long.....

  Unsuitable or offensive?

- *Anonymous | 26-Jan-2015 1:57 pm*

  It is difficult to understand the criticism of the CSH leadership as it appears that they and BUPA are victims of an acute trust

losing a tender and then crying foul.I agree with the earlier comment that the optimal time to analyse impact is not immediately before go-live. I am also surprised that the effect of MSK puts the trust at risk of deficit within 5 years. I would have thought almost every trust is in that position already, hence the FYFV call for additional funding.

Unsuitable or offensive?

- *Anonymous | 26-Jan-2015 2:17 pm*

  The Trust has behaved disagracefully. How long are we going to go on tolerating this, putting up with (ahem) the 'future stability of the local acute provider', at the cost of improving patient care? The CCG should have stuck to its guns. And the centre (DH, NHSE, etc) should decide once and for all whether it prefers fish or fowl.

  Unsuitable or offensive?

- *Anonymous | 26-Jan-2015 2:36 pm*

  So COBIC help the CCG put together a specification. The spec doesn't consider the implications of splitting the Trauma & Elective workload. School person error.
  Mysteriously not available as a case study on the COBIC website.

  The local Trust doesn't win the contract and then a chorus of disapproval.

  Re-appraise tender and impact assessment conducted by PwC. A commercial partner of COBIC on outcomes based commissioning.

  PrivateEye-esque.

  Unsuitable or offensive?

7.3.1.11 Dr Laitner is a freelance health consultanthttp://www.programmesforhealth.co.uk

whilst not wishing to impute any bad faith or otherwise to Dr Laitner , despite requests at the SEG, we have not seen any declarations of interest, and have some concern as to conflicts of interest in the appearance of this particular scheme model.

This is particularly the case because the Lead Provider Model may result in acute provider trusts pulling out of the tender. Effectively being a lead provider, running the whole programme budget (effectively commissioning) is not within a secondary care acute hospital's remit to run contracting at such a level of complexity.

7.3.1.12 Establishing a baseline of what services are being (de)commissioned is essential:-

a) to ensure that, in a global de-commissioing such as took place by the issue of de-commisioning notices - all services requisite for a proper inclusive service to patients are considered for/ included in a specification going forward so as to provide a comprehensive safe service for patients: and

b) a proper impact and equality assessment can be fully undertaken for any proposed changes in service considered; and

c) clarity for tenderers is essential to ensure that all those who consider bidding understand what is proposed, that it is articulated so as not to allow fudging of bids, and are bidding on a clear basis and a level playing field; and

d) the improvements articulated as required by the CCG can be measured in a meaningful and concrete way for the benefit of patients and commissioners/providers, and the contract.

7.3.1.13 To ensure that the CCG understands what is currently commissioned is a vital assurance for future patient safety and care. It

also could bear on the position post contract if not everything is covered, and elements have to be added/negotiated . See the position above with cardiology, when - as we understand it - the CCG had to "add in" the community heart failure service to a contract already negotiated. (Similarly, on a contract in respect of pathology services going out to a private provider, the contract with TDL where the temperature controlled transport element was omitted and a new provision had to be added, with the consequences to sample testing and patients' welfare as set out in the RCA of March 2013, and substantial additional cost to the commissioners.)

7.3.1.14 In brief, , the MoI for MSK made no reference to a proper assessment of **the demography** of Brent in relation to the MSK conditions, no **critique of current services** involving patients, no evidence of **input of local expertise** in the secondary sector, no **Clinical Senate** involvement nor holistic assessment of the position in relation **to SaHF or overall services within the umbrella term MSK** in our part of North West London. See below as to the proper process of analysis recommended by ""***Expert Opinions in Rheumatology Issue 2 The PCR Society Guide to Commissioning Musculoskeletal Services***". referred to in paragraph 7.3.2.5 and following.

7.3.2 Risk Register MSK– or lack thereof and the evidence of good practice supplied to the SEG by the CCG

7.3.2.1 We raised an FO I request re: the risk registers for the Wave 2 MSK project. This risk register is attached. However, when making the request, we had in mind **clinical** risk.

On raising this with the CCG FO I, we were told

" As to your query about clinical risks. I have spoken to the team and they confirm that there is no separate clinical risk register. "

7.3.2.2 When this is combined with the failure even to have a specification of the services commissioned originally by the CCG until the stakeholder engagement group insisted on this and it was produced for a July meeting (see below), this raises serious questions

in our minds about the process undertaken by the CCG/its predecessor PCT, when considering patient care.

7.3.2.3 Having regard to the cardiology impact assessment documents of July 2012 (and to quote from that document), this appears to have been part of a desire to "*gain power*" over the local health economy, rather than an initiative to improve life for patients.

In respect of the viability of the local health economy, the desire was to procure a lower tariff than the national, clearly damaging in the case of a provider trust already affected by the use of the national tariff, as it has a PFI liability.

7.3.2.4 it appears, therefore, that a decision was taken to procure new services with no knowledge of what the existing commissioned services were, and without undertaking any formal risk assessment save in respect of financial/litigation risks but without examining the effect on the patient cohort of Brent residents.

7.3.2.5 We are confirmed in that view of how to frame a commissioning process after reading a publication produced to the SEG for its meeting in August: ""***Expert Opinions in Rheumatology Issue 2 The PCR Society Guide to Commissioning Musculoskeletal Services***".

7.3.2.6 It suggests involving local secondary care clinicians in commissioning decisions, carefully mapping the services and costs and outcomes before deciding whether to commission - if only Brent had done so.

7.3.2.7 It asks the very question ***"What makes good commissioning?"*** (Page 4), with very pertinent bullet points. For example, the second bullet point deals with potential conflicts of interest between GPs as commissioners and GPs is providers.

7.3.2.8 The third bullet point requires an initial complete review of current local MSK needs and health care provision, identifying services which work and failing, requires costings and assessments of ability to meet required outcomes.

7.3.2.9 The sixth bullet point refers to "***support[ing] providers in developing additional capacity and capabilities as removal of pivotal MSK services from a current provider can have major consequences for that continuing ability to provide other MSK and non-MSK services***".

7.3.2.10 It refers to the involvement of Clinical Senates (page 3), and to analyses On page 6, to quote ***"No future service can be planned without accurate information about local epidemiology such as population size, incidence and prevalence of MSK disorders, current treatment needs and numbers of healthcare professionals providing current services. For this baseline audit, current levels of care can be compared with the recommended standards, such as those produced by NICE and ARMA***" .

7.3.2.11 It is absolutely clear through our involvement throughout the consultative process and the SEG that none of this has been looked at by the CCG. The provision of this document exposes the extremely risky approach to the commissioning of my services.

7.3.2.12 I also note that, as also referred to below, the PCR Society appear to understand the relevance of research and training, in respect of the effect on which I have seen no reference in any of the Brent CCG documentation for the de/re- commissioning of MSK services.

7.3.2.13 The following quotation from the document seems to me to expose the difficulty in the provision of rheumatology services solely in the community, at a distance from the secondary care providers.

"A hospital-based service has the advantage that specialist expertise is on-hand, but leaves specialists on site so they are available to handle emergencies within the hospital. It also supports the continuing viability of district general hospitals which risk losing "critical mass" if all but emergency services are sited elsewhere. In

addition, some patients support the idea that their specialist care is provided at specialist centres, many of which are located in the centre of large communities, with good transport links.

A community-based service encourages greater primary care involvement and is more convenient to patients if it reduces the time and cost of travelling for appointments and investigations. It can be designed to ensure that necessary expertise is available when required, with specialists holding joint clinics with GPs and other members of the primary care team."

7.3.3 Effect on LNWHT (viability of rheumatology service as it stands , effects on A&E, acute medical care specialisms and training and research), patient safety and care, and local health economy

7.3.3.1 In the event that the contract is awarded other than to the London North West Hospitals Trust ("LNWHT"), there is a serious risk that the service on which KP and our daughter currently rely will be severely affected.

7.3.3.2 We attach a copy of the provider Impact assessment ("PIA") obtained by a fellow campaigner on the suggestion of the CCG. ; We have seen nothing of these concerns reflected in any of the work done by the CCG or its consultants Mott McDonald ("MM") to whom this PIA was provided, as part of their original scoping for their impact assessment for the proposed change in services. (As per the draft gynaecology Impact Assessment, MM do "nod" to issues for provider trusts and not in any rigorous or specific form)

7.3.3.2 please see extract:
" A worst-case scenario would be that 75% of the outpatient rheumatology activity in Northwick Park Hospital is lost (all of Brent and Harrow). This would clearly be catastrophic for the organisation,

and also an extremely difficult for the remaining patients who attend the arthritis centre."

7.3.3.3 This is crucially important because to damage the services at Northwick Park – where NHS England has recognised that the Arthritis Centre, as a specialist service providing *"specialised adult rheumatology services" "as the service has subspecialist expertise*" – could be irreversible. As we understand it, the reason for the existence of such a high quality specialist clinics is because they need a particular "critical mass" of catchment area to survive.

At the moment, LNWHT's Brent patients represents 40% of Northwick Park activity and 70% Central Middlesex activity for MSK. A loss of that work obviously will affect the viability of the service.

7.3.3.4 Whilst we are assured by the CCG that patients will still have patient choice (as to which see below), the service may simply not be there at Northwick Park. We are already aware of a feeling of "blight" within the Department, in issues such as staff anxiety, and quite possibly affecting recruitment. Because we are part of the Arthritis Centre Patient Panel, we are aware that the status of the Department arises from its status as a centre for training.

7.3.3.5 Simply dealing with the removal of outpatient services from the hospital shows that the CCG may have paid no regard to training/education within an important part of the local health economy when launching its procurement process.

It is clear when looking at the statistics from the papers provided to the SEG that L NWHT will be the most substantially affected by a change of provider. The other trusts providing services to Brent are comparatively small. Imperial does not suffer from the blight of a deficit, probably because it does not have a PFI (as stated at its last AGM).

7.3.3.6 Through our long-term contact with the Arthritis Centre, and its patient panel, we are only too well aware of the numbers of training posts within the Department, and the trainees' experience which they gain in the Department in both medical and acute care. We understand that L NWHT had 4of the rheumatology trainees out of the 14 in Northwest London. That figure alone should speak for itself as to the importance of the Department of the whole, and the risk which I believe the CCG is running of destroying the service which looks afte r KP and our daughter, and our fellow cohort of very disabled patients at the centre.

7.3.3.7 We are also more than conscious of the importance of the rheumatology service to the accident and emergency department and other acute departments within the hospital . We have occasionally experienced having to wait for appointment time within the Arthritis Centre, because KP's consultant and other members of staff are in accident and emergency, or elsewhere in the trust dealing with colleagues in allied specialisms. Only last weekend when the Accident and Emergency figures for Northwick Park were in fact slightly improved, we are aware that our consultant was on duty in accident and emergency all weekend.

7.3.3.8 Within L NWHT, there are renowned specialist clinics in metabolic bone disease, connective tissue disease, early inflammatory arthritis, ankylosing spondylitis and hypermobility. We became aware of these at the first large meeting of the Patient Panel last September, it became clear that the service also deals with patients from further afield, whose treatment could well be prejudiced by Brent CCG's "silo" approach.

7.3.3.9 Similarly, KP having taken part in some of this research, we are aware that this clinic has a major research agenda across a variety of specialist clinics. All this could be prejudiced, to the detriment of KP's treatment and that of all those patients in the future in a disease which is potentially extremely disabling.

The overall economic effect if people like KP and our daughter are unable to work – as KP is was when his condition was not properly managed – will be catastrophic. All rheumatology patients are disabled, and Brent CCG's failure to take account of this particular "equality strand" when taking a step decommissioning the service we

regard as a breach of the public sector equality duty. This is particularly the case because the CCG appears to have entered into it - as above - blind.

7.3.3.10 We have substantial concerns, arising from the articulated desire of the GP networks to run out of hospital services, combined with our experience of attending various presentations by CCG leads on this matter, which - with all due respect to their undoubted skills as general practitioners - did not evidence extensive specialist knowledge of this complex specialism, with at least 200 separate conditions - which could be perceived as cavalier of the care of the patient. We have a fear that the MSK services will be designed so as to fragment services into parcels which the GP networks can offer from their hubs, e.g. the Lead Provider Model and its basis of subcontracting.

7.3.3.11 If the service were to go to another provider, from the figures available to me, the 40% reduction in the rheumatology outpatient service at NWLHT will greatly affect our service, and patients remaining in the service there may have to be moved to general clinics.

7.3.3.12 We understand from one member of the Clinical redesign group that the rheumatology consultant on that panel expressed a view that rheumatology services can be conducted anywhere. That may very well be true as a remark without context.

However, here, what is the **practica**l proposal for the various specialist consultants to be present as required in the community clinics, without delaying patient treatment in the acute sector, amongst others? What is the practical proposal for informed triage involving actual examination of patients? How will specialist clinics physically operate on the sites within DoH guidance for rheumatology patients? Not even expert consultants can be in more than one place at once, and anecdotal evidence suggests that staff may be unwilling to travel, whether from existing providers or – arguably – and new providers out of area.

7.3.3.13 Even worse, if we lose consultants from the physical space of the acute hospital hospital, and their availability for emergencies, what will be the overall the effect on emergency and acute care in

hospitals? In particular, as Northwick Park hospital will be a major hospital under SaHF, how can it be sensible for it to lose potentially the rheumatology service? Consultants need to differentiate between patients whose symptoms are infectious as opposed to inflammatory, for example.

7.3.3.14 How will the trainees share their time across the community hubs, and the acute hospital requirements ? There seems to be no requirement on the CCG to consider any of this, despite the duty under the Health and Social Care Act 2012 as to training and education. It is notable that the Mott Macdonald impact assessment on gynaecology casually states that trainees ought to be available in the community clinics which appears to evidence no understanding of how training posts are managed, and accredited by deaneries.

7.3.3.15 This "silo" approach by Brent CCG to commissioning in a total vacuum and disregard of the general health economy is of particular concern to us because of the history of the commissioning in Wave 1 referred to above. We fear that the process will not be conducted in a competent, fair or transparent way. and will inevitably cost substantial amounts of money.

7.3.3.16 The Stakeholder Engagement Group for MSK has recently been informed that the Senior Responsible Officer for the wave 2 programme is standing down, and the wave 2 programme manager lead is also standing down (the 2nd to do so in the last few months) to be replaced by an entirely fresh officer combining the 2 roles. We understand that – in the longer process involving the provider trusts – more officers may have been involved, and the process is bound to be adversely affected by the changes in personnel and loss of knowledge, including in patient engagement processes

7.4 Lack of proper consultation

7.4.1 As above, the CCG employed Mott McDonald to undertake an impact assessment, and undertake consultation. A consultation booklet was produced; members of the CCG's Equality, Diversity and Engagement Committee were given an opportunity to comment on a draft. Limited input was accepted but the consultation booklet presented many difficulties. The Locality PPG Chairs pointed

out fundamental problems mentioned in a considered paper about the initial draft.

7.4.2 Both Wave 2 services - gynaecology and MSK - were shoehorned into one booklet. More information was given re gynaecology, because the CCG then incorporated detail from the gynaecology pilot which turned out to be the model. As to MSK, there was no possibility of informed consultation based on the information in the booklet.

7.4.3 Neither in the booklet or in any other reasonably accessible paper was it explained what services are now provided by the several outpatient clinics for rheumatology, orthopaedics, trauma and related physio currently commissioned by Brent CCG. Still less were their strengths and weaknesses assessed on an evidential basis. No indication was given as to what aspects of the MSK package might be (a) reconfigured and (b) moved out of hospital. So how could the question such as "*to what extent do you think that our proposals will help to reduce waiting times for access to the services under review?*" be answered at all in any meaningful way?

7.4.4 At the risk of stating the obvious, even those who devote hours and hours voluntarily to trying to help the CCG involve the public - eg EDEN members - do not know what the current waiting times are for all the various clinics at Northwick Park, St Mary's, CMH, Royal Free, RNO and elsewhere. The MOI suggests 15-17 clinics. Who is going to be able to compare them for some unspecified new services by unknown providers at an unknown cost? How much less will the person in the supermarket desperately trying to find a ready meal for their family's supper and suddenly buttonholed by a representative of Mott McDonald know about the matter? Since the position on waiting times for each of the [17] existing clinics could be good, bad or indifferent how can one answer for this question be possible?

7.4.5 If people were going to be asked if they have used one of the clinics concerned in one of the specified hospitals in the last five years and if so which and were they satisfied with waiting times, the consultation, subsequent treatment, continuing care including the

interface with their GP and whether having the clinic in Willesden or Wembley as opposed to the hospital they have used would be of benefit, there could be some point to the exercise.. A local patient could have devised such a sensible question without the need for vast expenditure and effort. Perhaps the CCG did not want to know this. Whatever may be the case this is part of the expensive consultation exercise, where the CCG has appeared to have decided the outcome.

7.4.6 The consultation booklet persisted in perpetuating the myth that it is other than the action of the CCG which has resulted in consultants within the rheumatology service having to refer patients back to their GP for a referral to another consultant. (It was advertised as an advantage of the new service that direct referral consultant to consultant would be able to take place under the new service but, in fact, limitation on such consultant to consultant referral is a condition of the CCG's contract with the provider trusts).

So it would have been perfectly possible for the CCG to say that this aspect of its contracting did not deliver for patients and change it without this new process where a. It was dishonest to imply that this was the fault of the providers and therefore a provider-driven delay. This same fault now appears again in the later booklet "Update", for which see below.

7.4.7 We carried out "mystery shopper" random visits to the "manned stands" Mott McDonald put on. We may have been unlucky but the employee manning had no idea of what the consultation was about. We listened to the dealing with questions, and the most information that was given was the fact that services were currently at local hospitals and the consultation was complicated and you needed to read the booklet. We saw questionnaires left by the boxes and have no idea what arrangements were made for their collection if people did the questionnaire there and then. We actually picked up three questionnaires by the box in Chaplin Road leaving a late evening meeting, when only reception was manned, found envelopes for them and put them in the post.

- 7.4.8 This was illustrated by what happened at the Arthritis Centre (outpatients clinic). After the consultation was over - although Mott McDonald were supposed to collect the

questionnaires, questionnaires remained uncollected. We informed the CCG and arrangements were made to collect them and we were assured that they would be added to the final report for the first phase. Curiously, however, on reading that report addendum to cover the late Reponses **NHS Brent CCG Wave Planned Care Programme Consultation Report (v3) - with late responses 11 08 14** http://www.brentccg.nhs.uk/en/publications/patient-and-public-engagement Appendix D - extra responses., according to page 70 - **none of** these extra questionnaire patients had used rheumatology. Yet, as above, the issue raised with MM was that questionnaires had not been collected from the Arthritis Centre This appears to cast doubt on the revised results.

7.5 Scope of service – focused on discharge and episodic care

7.5.1 Whilst the specification remains to be drawn up, schemes seem predominantly directed around short lived conditions/short pathways such as those leading to orthopaedic surgery.

From an analysis of the various specifications supplied by Sarah Mansuralli (acting chief operating officer Brent CCG) and others to Brent Health and overview Scrutiny committee (following the description of the best practice model the CCG said it was following, at the meeting of that Committee in October 2013) and to us, it seems that most MSK schemes previously considered by Brent CCG prior to their adoption of the Lead Provider Model do not include long-term conditions, and geared towards treatment of acute and short lived MSK conditions, and not the ongoing treatment of chronic conditions.

The quote for the tender includes the cost of drugs and, whilst it is now being made clear that high cost drugs (such as biologics) are excluded from that costs envelope, nonetheless there is a risk of a perverse incentive in relation to prescription of drugs. It is probably not that important, if almost all are relatively cheap compared with other costs but it does represent a fixed cost that cannot be slimmed in line with reducing the overall budget.

7.5.2 There is next to nothing in the documentation about whether patients get better, and whether they see the right clinician at the right time - a 6 week delay for self resolving conditions may not be inappropriate but any prolonged wait for referral for rheumatological conditions on which there are strict NICE guidelines for first referral (already delayed in Brent by Referral Management systems.) causes irretrievable damage.

The Brent Referral Management system appears not to apply but there is real concern about triage, and the stage at which this takes place and whether there will be compulsory reference into the MSK service – and so delay may still be a factor.(Already an acknowledged local problem in rheumatology referrals within NICE guidelines and contract requirements).

There is also the issue about diagnostics, and whose responsibility, where they will be carried out and how they will interact with recent contracts placed by the 8 N. West London CCG's for diagnostics generally

7.6 Patient Choice

There continues to be argument about what the outline specification will say on the subject of patient choice. The precise details of the discussions cannot be made public because members of the SEG are subject to confidentiality arrangements but it is apparent from the comparison of the draft service specification on the Brent CCG websites that the patient choice paragraphs in the specification for wave 1 i are less clear than those proposed for Wave 2.

7.7 Concerns re proposed triage arrangements in the new service , chronic pain service content and prescribing element of outline specification

7.7.1 KP has been a sufferer from rheumatoid arthritis for approximately 17 years. The actual rheumatoid arthritis type was only diagnosed some six or seven years ago, as it does not show up on many conventional tests, and he was referred to various other centres

and disciplines for consideration until receiving his diagnosis. This arose as a result of the opening up of his hand in an operation.

7.7.2 Since final diagnosis and reference to the Arthritis Centre at Northwick Park Hospital (part of the North West London Hospitals Trust) , KP has received excellent and intensive care. That "road" to current medication (anti-TNF's) has not been an easy one – and literally very painful. At one point a couple of years ago, he was referred to the chronic pain clinic specialists at University College Hospital, because my levels of pain made sleep impossible, life unbearable and returning to work an unattainable aim.

7.7.3 This brings us to another concern, that the very effective chronic pain management services at the UCLH unit should remain available - hopefully as a last resort but even so essential for those suffering with rheumatoid conditions.

The only reference in the service specification is to psychological therapies. If that is to be the only element required by the CCG for chronic pain management, it will be a severe disservice to rheumatology patients. Please see the link for what is dealt with at UCLH - again a specialist centre.
https://www.uclh.nhs.uk/OurServices/ServiceA-Z/Neuro/PMC/Pages/Home.aspx

7.7.4 Pain is a huge contributing factor to inability to work and it would be grossly irresponsible to limit the element to psychological therapies, particularly when the CCG is intent on ensuring patients "self-manage" their conditions in its Commissioning Intentions.

7.7.5 Part of the reason KP was previously unable to receive a prescription for anti-TNF's was because his "score" was not sufficiently high. The reason for this was largely because – if you do not have a "score factor" to include from a blood test –other score factors have to be so high as to be virtually impossible to reach. This is pertinent because it will be important that any fresh service acknowledges the problems of this type of rheumatology patient.

Hopefully this will be included in the process of triage (face to face) and diagnostics in the new draft specification.

7.8 Training and research

7.8.1 There is a reference to training and education in the new outline but it is very vague and segues into the issue of training provided to GP MSK Leads. How many practices will have MSK leads?

7.8.2 How is the issue of medical training in this service factored into the overall Clinical Senate plans and the way these training posts are dealt with by the Deaneries - critical mass, amount of patients treated, both in the new and current provider services? Where is the quality assurance for the patients going forward in the context of the overall health of the patient cohort in Brent?

7.8.3 There is no mention of research, a matter of supreme importance to any patient suffering now or in the future from rheumatology conditions.

7.8.4 As long standing patients of the rheumatology service at NWLHT, we are aware that part of the essential function of the rheumatology service includes the issue of training and have participated in research projects. The status of the Arthritis Centre is recognised in its Specialist Commissioning status. Has it been considered how this may be affected if the changes result in withdrawal of new outpatient services ?

7.9 DMARDS

7.9.1 This was one of the few potential changes highlighted at the final LINks sponsored engagement event in November 2012 on a complex set of slides referred to above.

From the time of that meeting onwards, in meetings about Wave 2 (both general, with the CCG's advisers Mott Macdonald, in the Eden committee, and in specific SEG and other meetings) we have consistently highlighted the danger of separating DMARDS out.

Apart from the danger of which we are only too well aware of the paper based assessment of such DMARDS treatment as methotrexate, particularly for vulnerable patients, it is illogical to separate out the monitoring of the serious drugs. Our understanding is that approximately 70% of patients are taking these drugs. In view of the possibility for accidental overdose, and emergency admissions, it is essentially good practice that these are monitored in secondary care, with computer-based monitoring to avoid issues.

7.9.2 However, coupled with developments elsewhere, we have become concerned that this change appears geared to maximise the involvement of GP's in the service. I understand that there are several GPs on the CRG (and one consultant each in orthopaedics and rheumatology and a physiotherapy consultant). The CCG have moved disease modifying drugs into the specification for Wave 2. At last audit, approximately 70% of patients were taking these drugs. Please see above GP comment to introduction of the DMARD service in the GP comments in the Mott Macdonald interim impact assessment for gynaecology rep mentioned at paragraph 7.2.4.4.2 above.

8 Additional comments relating to current position on accident and emergency at Northwick Park hospital

8.1 We, together with a fellow Locality PPG Chair, Robin Sharp and Colin Standfield from Ealing, had a meeting with the Chief Executive and the Director of Operations of LNWHT to answer queries raised by local patients.

8.2 In the course of those discussions, we learned some interim conclusions from the discussion document requisitioned by NHS England and being undertaken by McKinsey (at a cost we understand pf approximately £419,000).

8.3 We have an exctract from that document and have been promised the full document once completed. It appears there are emerging hypotheses for causes of underperformance that can be addressed directly by staff in the trust.

There is no doubt that there is an insufficient bed base and major issues on cutbacks in social care. The then NWLHT bed capacity was over quoted in all SaHF working documents by approximately 100.

The actual bed capacity was considered in a Capita report prior to closure of the CMH A&E at 583, short of what was necessary by between 74 and 81 according to the then modelling http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=0CCwQFjAB&url=http%3A%2F%2Fbrentccg.nhs.uk%2Fen%2Fpublications%2Fpolicies%2Fdoc_download%2F1100-trust-board-capita-demand-and-capacity&ei=2A7aVPHvG9Xaav3GgeAG&usg=AFQjCNEvR4tbZ900-fUsFS2z1Ilczt9Usg&bvm=bv.85464276,d.d2s.

8.4 There are about 50 extra beds in place now at Northwick Park and 60 due by the autumn but there is also an acute shortage of nurses caused by national policy, reductions at nursing schools and Northwick Park is recruiting abroad now. The CEO referred to the problem being the worst he had seen in 40 years.

Other factors are a high attrition rate among nurse recruits and recruitment crises for 3 of the big specialties, lack of local GPs, loss of midwives, difficulty with weekend filling shifts, apart from extra admissions which were not modeled. There are also some puzzling additional activities from Harrow postcodes.

Local GPs do not send patient straight to the acute medical unit in hospital. If that were to be done rather than by ambulance, the patient would not have to go through A&E. There are also issues about getting Ward rounds consistent throughout the hospital, as early and regular and consistent ward rounds can result in quicker discharge.

8.5 However another more difficult issue is the vicious cycle and pervasive sense of failing to meet national standards and targets which has caused staff to lower their aspiration and sense of what is possible, and retreat into thinking locally (even to individual patient level) rather than collaborating with colleagues across the pathway.

We hope that our above comment - though long and focusing mainly on the specific processes undertaken by Brent CCG in commissioning out of hospital services - may prove of some use in a different perspective on the implementation of SaHF in our part of North West London.

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App 1

INDEPENDENT REVIEW PANEL NOTE

My name is Gaynor Lloyd, I am 60 years old, resident at Brent for almost 25 years, living approximately a third of a mile from Northwick Park Hospital. I have recently retired as a commercial property solicitor working in the City of London. I sat on the Board of Northwick Park and St Mark's Hospital for the two years immediately preceding its merger with Central Middlesex Hospital and – from 2004 – co-led a PPG campaign to retain the services of our GP's – then one of the last three employed GP services in Brent – which Brent Primary Care Trust proposed to tender out competitively. In 2013, our GP's – through the Right to Request – took the Contract for GP services as a social enterprise (after the PCT had spent at least £27,000 on legal fees opposing the patient group). I have just been elected as a community director of Healthwatch Brent.

I am also the carer of two patients with different severe rheumatological diseases – my husband has suffered from rheumatoid arthritis for about 18 years. My daughter has Ehlers-Danlos Syndrome – in vascular form this can result in premature death. For both, pain – often severe – is a constant in their lives.

So I have much experience of our local NHS. I participated in the SAHF consultation. It was not easy. Meetings were not easy to attend whilst working. The consultation document was lengthy, involved consideration of a detailed "business case" in multiplke schedules and appendices on line, and

asked questions that seemed to me to require particular directive answers. (I have learned from an ex client whose statistician partner moved to London from abroad to employment within IPSOS MORI who carried out the consultation –of that partner's astonishment to find the job was not so much dealing with statistical evidence as devising surveys to get the answers required by the commissions of the survey). The £7m cost of that "consultation" is greatly resented by those who did not feel properly consulted and whose services are being taken away on the ground of cost.

My principal concerns relate to developments since SAHF in relation to certain practical aspects, and the destabilising effect of the out of hospital strategy which is part of SAHF Brent CCG is tendering out "planned care" in 13 specialities. Waves 1, 2 and 3. . I am neither an economist nor a medical expert but I do live in Brent, my daily life takes me through Northwick Park hospital often on several occasions at different times a week, I have been a user of accident and emergency both as patient and carer – patients and carers allegedly being at the centre of service provision. Since retirement, at the beginning of April, I have attended various meetings of both Brent and Harrow CCG, and for Brent Council Health and Overview Scrutiny, and of the Health and Wellbeing Board. I have reviewed earlier Board papers.heard the Chief Operating Officer of Brent CCG say that the reasons for the changes in service are "the patient not the institution" and GPs on the Brent CCG voicing their concern that the outsourcing of outpatient services should not however destabilise the institution. Again as a health forum officers of the CCG say that they spend most of their money in acute hospitals and it is that budget

which has to be cut. That is one of the points I wish to make here. The "business case" between SAHF has evidently already been the subject of a serious professional critique by Ealing Council. From their paper to the Secretary of State, it appears to be inadequate to say the least. However, that "business case" was carried out at a particular point in time. The whole SAHF is predicated on the gaps being covered by Out of hospital services (which are to be in place before implementation) and it is the avalanche of implementation that I am concerned about and its financial consequences. The whole thing – after reading many papers and attended meetings at both Brent and Harrow CCG's and Brent council – appears a massive experiment.. Brent's Wave 1 has already tendered out ophthalmology and almost completed its tendering of cardiology. Ophthalmology is to go to BMI (a private institution), taking services out of CMH and no specification available. Health Watch Brent is to host a piece of work in September with Thomas Pocklington Trust, and I attach two pages from latest HWB Bulletin. This is an example of outreach but one which may be too late. Where is the evidence that the ophthalmology bid takes the issues briefly flagged in that bulletin into account.? Brent's review was led by a doctor from Hillingdon and – together with the other wave 1 service (cardiology) – "informed" by a six month piece of work by a company named Public Private Limited (whose website shows mainly work with local authorities not on health matters), which cost £107, 000 Cardiology in the first bidding round for Brent was awarded to the Royal Free but the tender process appears to have been flawed and is being re-run. Harrow CCG are tendering out cardiology to Any Qualified Provider. Both CCG's are principal users of North West London Hospitals Trust. There

appears to be no link between the two CCGs action – although they of course share a chief accountable officer. If both sets of outpatient services for cardiology are tendered away from Northwick Park – what will be the effect within Northwick Park Hospital – budgetary - on consultant numbers, staff doing diagnosis, training in cardiology? So – as ambulances rush to Northwick Park – with outpatient services potentially at Royal Free – what will that mean for the quality of the service? What about the co-location with the acute stroke unit at Northwick Park and generally the hospital's financial viability as items are stripped out of the budget? The same for paediatrics. Harrow CCG is tendering that out using Part B. Brent anecdotally may have decided not to because of the "high risk". Meanwhile A&E at Northwick Park is being refurbished – at a cost of £21m but without a single extra cubicle bed – but with a specialist paediatrics unit. What if another provider gets the Harrow tender for paediatrics? What if the paediatric services are then diminished and Brent's (anecdotal) risk assessment then changes?

My family's rheumatology (and MSK) services are on Brent's "Wave 2" planned care list. There is no public evidence of a proper description of what they mean by rheumatology. The Brent CCG's papers shilly-shally between MSK only and rheumatology and MS care Brent CCG intend to develop the specification through "competitive dialogue". There will be patient consultation possibly through Health Watch but we know from long and detailed experience within the arthritis clinic at Northwick Park that consultants are frequently in A&E or in different areas within the hospital. The complex web of conditions that rheumatology covers – diseases of the joints – auto-

immune diseases, which can affect any organ system in the body (such as lupus), localised MSK conditions, diseases of bone metabolism (such as osteoporosis) and inflammatory conditions which are frequently organ/limb or life threatening. Our consultants have to work together with lung/heart/kidney and blood specialists and infectious diseases specialists – because inflammatory diseases are often hard to distinguish from infectious diseases. They regularly have patients who are in high dependency or intensive care. I have a paper recently published on the NHS England website (of which I brought copies) for adoption from 1st October 2013. This relates clearly to specialist rheumatology centres but its pages make clear the vital links with other services, and the importance of the availability of a wide range of skilled staff from different disciplines. Slicing and dicing the service up into a business case possibly provided by a plethora of providers will struggle to provide a joined up, proper and cost effective service which will help patients with chronic and essentially incurable diseases. That paper emphasises the cost efficiency of having a fully joined up service.

This is just one of the 13 services which Brent CCG to my knowledge plan to outsource using "competitive dialogue" to prepare the specification. Not led by consultant local to the service. Not by asking patients what needs changing/could be improved led. But pre qualified provider led, taking up an inordinate amount of time for teh acute hospitals busy trying to provide teh service already. Rheumatology happens to be one service in which I have quite of lot of lay experience. Another service in "wave 2" is trauma and orthopaedics. From its very name, common sense would indicate that

potentially outsourcing trauma and orthopaedic away from a hospital taking main A&E burden cannot make sense. How is a "fracture clinic" to be put out into the community? What is the benefit of bringing services perhaps a few miles closer to a patient but away from all the back up services? Who has looked at the local health economic impact of this "thrust" push out of hospital services?. Once tendered, they have gone for good and the money is lost to the acute hospital – i.e., Northwick Park where additional traffic will be sent by the SAHF programme.. . NHS funds are only paid to hospitals per item of treatment delivered so every patient diverted away takes the money with them undermining the viability of the hospital.

Our local health economy is already destabilising. Ealing CCG now wants to pull out of the Outer London Federation. Price Waterhouse Coopers have been employed to advise – at what cost? At Harrow CCG, casual reference was made to £500,000 being channelled to the Outer London Federation to compensate for the year 1 cost of teh pull out - a pull out is after four months of operation. Clearly this came as a shock to the members of the Harrow CCG Board. They wanted to know when the process started. Their chief accountable officer, of course, Rob Larkman is also the chief accountable officer for Ealing – which of itself appeared to reveal some potential conflict of interest in planning. Where is the joined up thinking? If Ealing CCG leave the Outer London Federation, will the merger with Northwick Park or Ealing Hospital go ahead? The tenor of the Ealing CCG paper at the Harrow Board indicated may be not. Harrow CCG members certainly thought so. Even if Ealing CCG continue to support, will the competition commission intervene? What effect does all this have on the SAHF budget?

All this taking place at a time when there is going to be a 1000 planned hospital bed reduction across the affected hospitals required by 2015 which was not highlighted in any way in the consultation but appears in Shaping a Healthier Future pre consultation business care volume 8 appendix C page 15.

Community service staff numbers has already been cut from over 1000 to 600. CMH has been so destabilised by service cuts that it probably cannot support an A&E in any event. It will be left with only an urgent care centre. The College of Emergency Medicine said that urgent care centres need to be co-located with full emergency services. Fine at Northwick Park but not at CMH. The poorest will have to travel further for any kind of emergency medicine. When I was on the Board at Northwick Park Hospital, the absolute requirement for the merger was proper transport both with staff and patients between the two sites. The staff buses were recently discontinued by the North West London Hospitals Trust. SAHF has absolutely no control over TFL. Over 15 years after the merger, there is still not satisfactory bus service. I attach an extract from Northwick Park's website, detailing car parking charges and a copy of the TfL page to which patients are refereed for the public transport "options" between the two sites – which speak for themselves as to costs, time and accessibility. How is it proposed to allow for the poorest in the borough to access hospital services? No consultation was undertaken with schools. At the IPSOS MORI Consultation Presentation at the Hilton Hotel in Edgware, one slide revealed that only 90 Brent residents replied to

the actual consultation paper. I am not surprised. As a lawyer I am well used to complex documents but the form itself was complex with questions directed to particular answers and the detailed background information was in numerous papers described as a business case – which rather speaks for itself. No proper consultation was undertaken. The CCGs have evidently taken SAHF as the opening of floodgates to tender out outpatient services, the payment for which will tear the financial viability of at least my hospital – and even the existence of the Outer London Federation of CCGs seems to have resulted in any joined up responsibility for those budgets. It was interesting at the last Brent CCG in considering the outsourcing of rheumatology and MSK, the Board were told that consultation had been undertaken with Harrow CCG about a possible joint commissioning of services. When I put the question to the Harrow CCG Board (since it did not appear in their MSK –only paper), none of the members of the Board appeared aware of any joint Brent approach and the head of strategy at Harrow CCG later told me that there had been only brief formal consultations. Certainly nothing approached a proposal for joint commissioning. I also have severe concerns about ambulance availability. At a recent health and wellbeing board with Brent Council, the Borough Commander of the London Fire Authority told me that there are up to two hour waits for ambulances. Further the ambulances that arrive are not always London Ambulance Trust ambulances. When attending an accident, the Fire Officer in charge cannot hand over care of the casualty unless they know that they have a London Ambulance Service ambulance. A great deal of the time, apparently private ambulances or St John's Ambulances will turn up and care of the casualty

cannot be handed over to them. Anecdotally, I am aware of a 1½ hour for a suspected concussed patient outside the Royal Albert Hall, two weeks ago (no ambulance turned up at all in the end) and a two hour wait for an ambulance at Harrow Crown Court for a concussed disabled member of staff. For ambulance blue light arrival at Northwick Park ,I live very close to Northwick park Hospital on Watford Road. I have experienced gridlock to the Harrow/Brent border roads for years. The utter "un- likelihood" of ambulances getting along the congested and relatively narrow Watford Road in those circumstances is apparent. One relatively major accident involving 5 cars (and mercifully no deaths) occurring on the bend immediately to the south of the Hospital closed the entirety of that section of Watford Road leading to the Hospital for 24 hours just over a year ago..

Worrying flaws in the 111 Service (run by Harmoni part of Care UK) were exposed on the Channel 4 Dispatches Programme.

Conversely, Brent CCG claim it is good but the actual results are that it is in the upper quartile of poor performance throughout the country. The Dispatches Programme revealed that the provider operates a minimal risk criterion. Reassuring in one sense but that results in extra traffic to A&E – very worrying if the Dispatches programme's findings for Bristol and Dorking extend to London, and 111 has inadequate clinician staff cover. Further, I am very concerned because both urgent care centres at CMH and Northwick Park are run by Care UK. If Care UK are paid on a patient through put budget, surely there is a conflict of interest. Once patients are triaged through A&E into urgent care, is a 111 Service operating a minimal risk strategy with low clinician cover resulting in sending to A& as prime resource resulting in Care

UK receiving higher profits? Has analysis been undertaken as to whether this minimal risk approach is resulting in increasing already critically high A&E attendances at Northwick Park (which is already the subject of corrective reports from the CQC)? In terms of (vulnerable) patient satisfaction, I am familiar with Age UK Brent's submission and the level of concern by the patients represented by AGE UK Brent - and dissatisfaction with the 111 service.

Our own experience of sights of ambulances at Northwick Park is that they can be queuing down the ramp, and we are aware of the staff at the stroke unit having to come out to attend to people in ambulances. The proposed refurbishment will not result in any more A&E cubicles over those presently supplied. Tina Benson of NWLHT has already in a Brent health and overview scrutiny committee in July that, in A&E planning, she has no control over the urgent care centres.

There are also serious problems currently with diagnostics. TDL, the new supplier, of pathology/blood tests has had severe problems since inception , which were reported as a serious incident with a root cause analysis document of 28th March 2013. Their laboratory was not yet accredited as at the July 24th meeting of Brent Health and Overview Scrutiny committee.. Issues are so serious that Harrow GPs are keeping their own independent evidence of faults with blood tests. The same is happening in Northwick Park Hospital. This is resulting in patient dissatisfaction with GPs because of

inadequate/late/lost results., and I am told that there has been hospitalisation of patients. At a health forum last week, we also heard our problems with scans. These have already been contracted out as a diagnostic service to ensure initial reporting to GP's. We were told that many consultants would not take referrals without these scans from GP's.. This raised concerns about delay in diagnostics and also potential waste if the acute provider would not have required a scan. The GP member of the health forum panel indicated that patients should attend follow ups with their GP's carrying their scans on disks with them. Speaking to hospital consultants, the scans are sometimes of no use whatsoever and of such poor quality that they have to be done again. There is also a risk of loss of the disks by the patient (particularly vulnerable patients) or their simply forgetting to take them with them. Some GPs are simply summarising what they see on the scans to the patients. I have seen the Age UK submissions to the AIP confirming patient experience highlight the difficulty about results of blood tests and investigation. This is an example of out of hospital services closer to the patient where there is a severe problem. Contracting out to TDL – although experiencing severe problems – may not be "undoable" because there is simply now no alterative provider. If this is the future for other outpatient services contracted out on an ad hoc basis, how will a healthier future be shaped?

Gaynor Lloyd

16 Pebworth Road

Harrow

HA1 3UD

Brent resident

App 2

healthwatch
Central West London

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

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)[1] 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[2] 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 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.

[1] http://www.healthiernorthwestlondon.nhs.uk/
[2] http://healthwatchcwl.co.uk/wp-content/uploads/2013/09/HFLINkStatementSaHF081212.pdf

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[3] 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 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

[3] http://www.irpanel.org.uk/lib/doc/000%20lnw%20report%2013.09.13.pdf

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[4] 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[5]. 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.

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.

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[4] http://healthwatchcwl.co.uk/wp-content/uploads/2013/09/Use-Of-Services-Report-FINAL.pdf
[5] http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/Healthwatch-CWL-RBKCDischarge.pdf
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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.[6]

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

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] http://healthwatchcwl.co.uk/wp-content/uploads/2013/09/Use-Of-Services-Report-FINAL.pdf
7

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[7] 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[8] 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.'
- 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.[9] We also note the recent

[7] http://www.kent.ac.uk/sspssr/research/centres/trust-healthcare.html
[8] http://healthwatchcwl.co.uk/wp-content/uploads/2013/09/Use-Of-Services-Report-FINAL.pdf
[9] http://www.theyworkforyou.com/debate/?id=2013-10-30b.921.1

clinical strategy published by Imperial College Healthcare NHS Trust states that Charing Cross Hospital will have an "Emergency Centre"[10]
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.

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?

[10] http://www.imperial.nhs.uk/prdcons/groups/public/@corporate/@communications/documents/doc/id_045151.pdf
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- 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,[11] [12] 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, 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?

[11] http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/CharingCrossdignitydischargereportFinal.pdf
[12] http://healthwatchcwl.co.uk/wp-content/uploads/2014/01/Dignity-and-Discharge-at-Chelsea-and-Westminster-Hospital-Nov-2013.pdf
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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"[13]
- 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.

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[13] http://lithgow-schmidt.dk/sherry-arnstein/ladder-of-citizen-participation.html
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App 3

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28 March 2013

David McVittie
Chief Executive
The North West London Hospitals Trust
Watford Road, Harrow
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Dear David

Re: Planned Care (Brent and Harrow) and STARRS (Harrow) Contract Notices

Please find enclosed a suite of contract notices from Brent and Harrow CCGs in relation to planned care services (Brent and Harrow) and STARRS (Harrow) provided by the Trust.

As advised at the Acute contract lock-down meeting on Monday 25th March, the CCGs have considered their position and the "take-it or leave it" offer from the Trust received on the same date. Both CCGs believe that they now need to protect their contractual position by issuing notice to the Trust, as I am sure you might expect.

Harrow CCG would however prefer to continue to work with the Trust on a collaborative basis and would like to pick up this discussion with you after the Easter break. However, it is important to note that any way forward will need to represent value for money that has been the theme of all the discussions during the last 12 months.

I will be keen to discuss this matter with you further after the Easter break and look forward to hearing from you then.

Yours sincerely

Rob Larkman
Chief Officer (Designate)

cc Etheldreda Kong, Brent CCG Chair
Amol Kelshiker, Harrow CCG Chair
Mohini Parmar, Ealing CCG Chair
Jo Ohlson, Brent COO
Javina Sehgal, Harrow COO
Joanne Murfitt, Ealing COO
Kathryn Magson, NWLHT & EHT Account Director, NWL CSU

North West London
Commissioning Support Unit

Kathryn Magson
Account Director
NHS North West London CSU
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David McVittie
Chief Executive
The North West London Hospitals Trust
Watford Road
Harrow
HA1 3UJ

28th March 2013

Dear David,

CONTRACT NOTICE - Termination of service - Brent CCG - MSK services

I am writing in accordance with the terms of the Standard NHS Contract for Acute Services, Section E, Clauses 31, 56, particularly 56.2 and 57 between NHS North West London and North West London Hospitals NHS Trust.

Brent CCG is currently commissioning new services via competitive dialogue that will reduce the need for acute outpatient services. The Brent Clinical Commissioning Group Executive (CCGE) has decided it is preferable to commission outpatient services that are delivered in community settings closer to patients' homes.

This letter confirms Brent CCG intention to decommission MSK outpatient services providing six months notice from the 1st April 2013, with an effective date of 1st October 2013.

The entire outpatient service for rheumatology, pain and orthopaedics (excluding fracture clinic) and associated diagnostics is within scope. The precise scope will be determined as part of a competitive dialogue with providers to determine the service specification. Further details will be provided at the stage the specification is agreed by the CCG and as part of determining the scope of the specification, attention will be given to any outpatient or diagnostic services that are required to support planned day surgery and inpatient treatment.

The Brent CCG QIPP plan and business case previously discussed further outlines the detail for the scope of the service that will be decommissioned. Therefore, with effect from the 1st October, the full value of these services will be removed from the baseline and will be redirected towards the reprovision of these services in alternative settings.

Maintaining continuity of the service during transition

It is recognised that the mobilisation of the new services will need to be managed effectively to ensure continuity of service to patients, maintain patient safety and to ensure there is no adverse impact on the performance of any aspects of the services which are not being decommissioned.

Subject to the reprovision arrangements, which are intended to commence on or after the 1st October 2013, should it be necessary to amend the timetable for any reason the Trust will be required to continue to provide these services in the interregnum up to and including the revised date and time of

commencement of the new service. In keeping with the necessary collaborative approach to such a change, commissioners will provide fair and adequate notice of any change to the intended timetable. The provisions of the NHS legal contract for 2013-14 shall continue to apply and shall take precedent.

The Trust is required to work with Commissioners and other parties, as may be identified or nominated by the Commissioners, to ensure that effective arrangements are in place to facilitate the transfer of services to the provider of alternative service provision and to maintain patient safety during the transitional period.

The Trust will be required, where it may be relevant, to provided TUPE information to support the decommissioning process; this will be requested in due course, if required.

Please note that any request from a third party to NWLHT for information that may be relevant to the provision of the alternative service should be redirected to the Brent CCG in the first instance for a response.

I would be grateful if you could acknowledge formal receipt of this notice within 5 working days.

Should you have any queries in relation to this matter please do not hesitate to contact Jo Ohlson, Borough Director, Brent CCG or Jane Rooney, (new) Account Director for the NWLHT acute contract.

Yours sincerely,

Kathryn Magson
Account Director

cc

Rory Shaw	Medical Director, NWLH
Dena Marshall	Operations Director, NWLH
Kishamer Sidhu	Director of Finance and Contracts, NWLH
Dr Amol Kelshiker	Chair, Harrow CCG
Dr Ethie Kong	Chair, Brent CCG
Dr Mohini Parmar	Chair, Ealing CCG
Dr Kanesh Rajani	Chair of the NWLHT Clinical Quality Group
Stephen Dixon	Associate Director of Commissioning, CSU
Sharon Robson	Associate director of Finance, CSU
Dr Sami Ansari	CQG Brent Borough Representative
Dr Ajit Shah	CQG Brent Borough Representative
Javina Seghal	Borough Director, Harrow
Jo Ohlson	Borough Director, Brent
Joanne Murfitt	Borough Director, Ealing
Rob Larkman	Accountable Officer, BEHH

App 4

NHS Brent

Planned Care Outpatient Procurement Ophthalmology and Cardiology

Feedback and Findings from the Public Consultation

21st August 2012

I. Executive Summary

As part of the development of ophthalmology and cardiology services, a range of consultations were conducted during a 15 week period from April to July 2012, with the objective of gathering information on patient needs and preferences. The consultations took the form of online questionnaires and consultations held with patients and with the public, where questionnaires were also handed out. In total, 104 completed questionnaires were collected (62% of respondents included those that have used secondary care services for their ophthalmology and cardiology needs).

The responses that were received from the questionnaires were very similar to the views gathered through meeting consultations; responses have been analysed in full in this report. Overall, it was determined from the consultations that the top four most important aspects of the delivery of the service, as viewed by patients are: 1.Proximity to public transport 2.Delivery within the neighbourhood 3.Easy access to parking 4.Services that provide the patient with a single named professional who is available each time they visit the service

Furthermore, the majority of patients (69%) indicated that they would be willing to travel out of and within their borough for their treatment, hence the importance of such services to be located close to public transport. In addition, the majority of respondents have also reported that their preferred time for using the service would be between 08:00 – 17:00, with afternoon appointments being the least preferred. A large proportion (37%) indicated that the main determining factor in terms of assessing whether a service is good should be the impact of the treatment on their health. Respondents have taken positively to the idea of a patient centred service and most define this as being treated with greater care and respect in consultations.

The findings of the report will be incorporated into the provision of ophthalmology and cardiology services in NHS Brent.

II. Introduction

This report brings together the feedback from the public consultation on NHS Brent's plans to develop two new outpatient care services for ophthalmology and cardiology.

The public consultation was run in parallel with the design of the new service. As a result, feedback from the interim survey findings and the consultation meetings would be incorporated into the development of the service specification.

III. Background

On the 14th December 2011, NHS Brent agreed the shape of service provision in Brent should be changed by shifting services from acute care to community and primary care. The development of the two outpatient care services, ophthalmology and cardiology form part of this shift.

The aim is to ensure care is delivered closer to patients' homes, improving the quality of care, and to ensure Brent's outpatient services offer value for money.

On 11 January 2012, GPCE (now CCG Executive) agreed to prioritise the procurement of ophthalmology and cardiology.

IV. Consultation – proposal and benefits

The public consultation ran for fifteen weeks commencing 2nd April 2012 and ending 18th July 2012. A short document was prepared to explain the purpose of the public consultation. It summarises what NHS Brent is considering: the benefits, predicted impact and how people could make their views known. The main body of the document is shown below:

NHS Brent is considering how some elements of the two following outpatient services: cardiology (disorders of the heart) and ophthalmology (disorders of the eye), maybe provided in the future.

We intend to:

- Improve access to services for patients: services should be located closer to homes.
- Provide a better patient experience: providers will be assessed against the experience of the people using their service.
- Improve patient and clinical outcomes: the service will focus on outcomes, rather than outputs.

We are focused on outcomes. We want the new services to improve on current provision in terms of:

- the patient experience
- clinical effectiveness, and
- quality aspects

1. We would like to know your views on how the services may be provided in the future so when we design the services we can tailor it as much as possible to patients' needs and preferences.

In order to help facilitate this, there is also a questionnaire available for you to complete. This will help us to find out more about what is important to patients so that we can develop new ways of delivering services in the future. The questionnaire is anonymous and can be filled at the end of the session and it can also be found online on NHS Brent website and the Council website.

The feedback we get from the consultation will be used to help develop new services. Once we are clear about how the services will be delivered, we will ensure the most appropriate organisations will provide them.

Patients and the public were made aware of the consultation via the following methods:

- Questionnaire:
- Leaflets (in GP practices, patient groups, involvement groups)
- Web form on Brent Council Website (Link to the consultation response form to complete online: http://www.bmgresearch.co.uk/brent/KMS/dmart.aspx?NoIP=1&strTab=PublicDMart&filter_Status=1)
- Patients Involvement Meetings discussions and feedback at each locality (PPG):
    - Willsden
    - Harness
    - Wembley
    - Kilburn
    - Kingsbury
- Info sent to the Brent Citizens Panel (600 members via email from Brent Council including the link to the online questionnaire)
- LINKS Meetings discussions and feedback

All responses were processed through a dedicated consultation co-ordinator to ensure all feedback was recorded in a consistent format in preparation for analysis and the production of this report.

V. Overall responses

Overall, there were 104 responses from the survey questionnaires and consultation with the following groups:

- Patients Involvement Meetings discussions and feedback at each locality (PPG):
    - Willsden
    - Harness
    - Wembley
    - Kilburn
    - Kingsbury
- Info sent to the Brent Citizens Panel (600 members via email from Brent Council including the link to the questionnaire online)
- LINk meetings discussions and feedback

VI. Summary of patient views

This section summarises the views of patients from both surveys and public consultation meetings.

2. **Priorities in Service Delivery**
It was analysed that the most important aspects of service delivery (as patients view them from a list), would be in the following order: ▪ Location near public transport ▪ Delivery within the neighbourhood ▪ Services offering easy access to parking ▪ Services providing the patient with a single named professional who is available each time they visit the service (note that patients also identified this as an aspect the service should be assessed upon). ▪ Accessibility during evenings and weekends ▪ Services are accessible during evenings and weekends ▪ Provision within a hospital setting In general, respondents think that all of the aspects listed are important in terms of provision for the service. The design of services should take into account all aspects listed, especially the four most important ones.

2. Assessment of Services

According to patients, the most important ways to assess the Service are:

- The impact of treatment on their health: the majority of respondents from the questionnaire identified the impact of treatment on their health as the key way to assess the service. This was also consistent with what was mentioned in the sessions (patients were concerned about getting good treatment).
- Patient satisfaction levels with the consultation: this can be linked to the clarity and compassion of staff.
- How long they waited for the service: this was mentioned in the sessions as a priority. Patients defined two types of waiting time: 1) Waiting time in the surgery and 2) Length of referral time.

To be given a choice of practitioner/qualified professional for your appointment.

Patients also identified the service should be assessed according to:

- Whether the patient was given a choice of practitioner/qualified professional for their appointment
- Cleanliness of premises

During the public consultation sessions, patients highlighted that the opportunity to feedback their opinion to the service was also important, and this should additionally be used as part of assessing the service.

Furthermore, patients mentioned that the referral system between GP, provider and acute secondary needed to be improved

3. 'Patient Centred' Services

In line with the Trust's objective in delivering a "patient centred service", patients were asked as to what they understood, and how they would define this term:

- Treated with respect and compassion was the most important category.
- For patient welfare to take precedence over budget and financial targets was the second most important category.
- To be seen in a more convenient/timely manner was also raised: this was mainly around appointments being conducted in a timely manner, with reduced waiting times etc.

Other responses included:

- Holistic approach to treatment: seeing the patient in terms of their psychological and physiological wellbeing
- Accessibility of services: having a multitude of services under one roof and for the

services to be easily accessible.

A particular view point was interesting as it was unsupportive of the shift of the provision of such services to primary care, holding the view that certain services should remain in secondary care: "The changes mean down-grading hospitals and fixing something that is not needed."

4. Location and accessibility of services

Patients' willingness to travel for their service:

The majority of respondents (69%) are willing to travel for their health services within the borough or outside of it.

Patients' preferred time for using services relating to eyes or heart:

Patients should be given the option for their appointment time and ideally the availability of appointment should be all day and evening appointments (from 08:00 till after 19:00). The preferred time of using the service is between 08:00-17:00, with a preference of midday appointments (11:00-13:00). The afternoon appointments are considered the least attractive.

17% of responses stated they would like early evening (17:00-19:00) appointments or later evening appointments (after 19:00). Patients that attended the sessions stated that they would like to be offered evening and weekend appointments as well.

Patients listed the following, as being important aspects relating to service accessibility:

- Location near public transport
- Delivery within the neighbourhood
- Services offer easy access to parking

Location near public transport is an important aspect, as patients have stated that they are willing to travel for their service (out of the borough and within the borough). For similar reasons, easy access to parking is also important. In one of the patient involvement sessions, participants stated that payment for parking should be abolished.

5. Notification of Appointments

Patients' preferred method for being notified of appointments, takes the following order :

1. Letter (most respondents classified this as their first preference and patients who attended the sessions also preferred this method)
2. Email
3. Phone
4. Text message

In some cases, patients expressed the wish to be notified of their appointment by more than one method.

Patients who attended the sessions stated that they would like to be given the option they prefer in this respect. They also mentioned that online appointment booking would be very useful.

6. About the participants

Overall, 62% of the respondents used an outpatient service that related to their eyes or heart, leaving 38% of respondents who had never visited an outpatient service for their eyes or for their heart.

Of the respondents that visited the outpatient services relating to their eyes and heart, this was almost equally representative for eye and heart services: 33% (20 patients) visited the service for their heart, 46% (28 patients) visited for their eyes, and 21% (13 patients) visited the service for their eyes and for their heart. 3% of respondents chose not to specify the reason.

This enables analysis of the questionnaire results to be applicable for both services (Ophthalmology - eyes and Cardiology – heart).

Other statistics include:

- Gender: 50% of respondents were male and 50% were female.
- Age: The majority of responses were from individuals aged 55 or over (71%). The highest percentage of responses was between the age group 55-64 (32%), whereas the second highest was from the age group 65-74 (22%).
- Ethnicity: 36% of the people responding to the question classified themselves as White British. The second largest represented group is Asian Indian (30%) and the third is White Irish (8%).

- Disability: 33% of people answering this question reported that they have a disability. The majority of people responding reported that they do not have a disability (67%).
- Of those who reported they have a disability, 77% reported that their disability or impairment affects their daily life.
- Religion: 38% of those who responded to this question reported to be Christian. 20% reported to be Hindu and 11% reported to have no religion.
- Sexual Orientation: 66% of those replying to this question state that they are heterosexual, 2% of those who replied stated they are homosexual and 27% of those that replied preferred not to state their sexual orientation.

VII. Summary of responses from patient involvement meetings

This section is a summary of the priorities stated by patients at the public consultation meetings. Appendix 1 has more detailed meeting notes.

On the whole, patients' priorities were:

- Quality of treatment / Service: i.e. getting good treatment
- Reducing waiting time for appointments and in the surgery
- Improving Professionals' communication skills
- Being given the opportunity to feedback their opinion at the clinic on an on-going basis
- Being able to use convenient public transportation to travel to their appointment
- Being able to park near the service without pay or with minimal payment
- Easy access for disabled people
- Being offered appointments over the weekend and evenings
- Being notified of appointment via a letter and being given the option they prefer
- Booking appointments online
- Improving the referral process loop

VIII. Summary of questionnaire responses

The questionnaire was designed to gather patient views for both the development of ophthalmology and cardiology services for NHS Brent. It was disseminated on-line on Brent Councils website. Leaflets were distributed through GP practices and patient groups.

The first question focused on the relative importance of different aspects of the service, respondents were asked to rate the importance of the following aspects of the health service relating to eyes or heart (1 - not important; 5 - very important):

- Delivery within the neighbourhood
- Location near public transport
- Easy access to parking

- Provision within a hospital settings
- Provision with a single named professional who is available each time the patient visits the service
- Accessibility during evenings and weekends

Reponses indicated that in general all the aspects listed are regarded as important. However, in order of importance, the aspects would be ranked as follows:

- The majority of respondents felt that proximity to public transport is the most important aspect of service delivery (services 'are located near public transport'): 67% responses ranked it as the most important, 84% ranked it as important or very important.
- The second most important aspect of service provision is delivery within the neighbourhood (services 'are delivered within your neighbourhood'): 64% [63 out of 98 responses] ranked it as very important, and 76% ranked it as important or very important.
- The other most important aspect of service provision is offering easy access to parking (services 'offer easy access to parking'): 57% [55 out of 96 responses] ranked this aspect as very important, 80% ranked it as important or very important.
- Respondents also believe that providing a single named professional is important. 50% [48 out of 96 responses] think it is very important (score of 5) and 35% [34 out of 96 responses] think it is important (score of 4), therefore overall 85% ranked it as important or very important.

The least important aspects, according to respondents include:

- Services accessible during evenings and weekends. Even though most respondents think that accessibility of the service during evenings and weekends is not as important as the other aspects, 47% maintain it is very important and 23% think it is important.
- Services are provided within a hospital setting: 41% believe this is a very important [5] aspect of the service, 21% think it is important [4] and 24% see it is as important but not high priority [3], 13% think it is not important [1] or has very little importance [2]. There seems to be the most division in opinion around service provision in hospital setting.

Other questions were as follows:

2. How far are you willing to travel to access an outpatient health service related to your eyes and heart?

The responses received on this question seemed to suggest that the majority of respondents are willing to travel for their health services:

- 69% are willing to travel within the borough or outside of it (70 out of 102).
- 29% of total respondents are willing to travel out of the borough.
- 39% are willing to travel within the borough.
- 30% are willing to receive the service only within their neighbourhood.

- 1% of respondents are not willing to travel at all.

3. What is your preferred time for using outpatient health services related to your eyes and heart?

The majority of respondents (81%) reported that their preferred time of using the service would be between 08:00-17:00. In addition, 31% reported that their preferred time is during midday (11:00-13:00). Afternoon appointments (14:00 – 16:00) are considered the least attractive, with only 4% of respondents indicating a desire to attend these appointments

4. What according to patients is the most important way to assess whether a service is good? (Given option to select up to 2)

The most important ways to assess the Service according to patients are:

- The impact of treatment on their health (medical quality of the service) – 37% of options selected related to 'the impact of the treatment on their health' as the most important way to assess the service.
- The level of satisfaction the patient has with the consultation (which can be linked to the level of clarity and compassion of staff) - 24% of selections indicated that it should be measured based on this metric.
- The waiting time for appointments (how long they waited for the service) - 14% of responses indicated that the service should be assessed according to the length of time they had to wait for the service.
- 13% of responses indicated that it was to be given a choice of practitioner/qualified professional for your appointment.

5. What is your preferred method for being notified of appointments?

Most respondents classified letter as their first preference (59% classified it in first place), email was the second preference, followed by phone and lastly text message (11% classified this in first place). It is worth noting that in some cases patients expressed the wish to be notified of their appointment by more than one method.

6. We are aiming to develop services that are "patient centred", i.e. providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide clinical decisions. What does "patient centred" mean to you?

There were 84 responses to this question; responses included in many cases more than one element. The responses were content analysed and then statistically analysed (frequency and percentages).

The most prevalent mentioned areas were:

- 31% of responses related to being treated with greater respect and care.
- The second most frequent category, with 12% responses related to patient welfare being given precedence over budget and financial targets, such as profitability.

- 10% of responses related to being seen in a more convenient and timely manner, i.e. relating to shorter waiting times etc.

The other areas that were mentioned include: taking a more holistic approach (7%) i.e. taking into account the physical and physiological needs of the patient, another minority of responses (7%) related to accessibility, i.e. services being in accessible places as well as the majority of services being available under one roof.

7. Have you ever used an outpatient service related to your eyes and heart?

There were 103 responses to this question; the majority (62%) indicated that they have used an outpatient Service related to their eyes or heart, leaving 38% that had never visited outpatient Service for their eyes or for their heart.

8. If you answered 'Yes' – What was the reason? (Could give up to three reasons)

63 responses were collected to this question, of which 28 respondents (46%) had visited the service for their eyes, 20 (33%) visited the service for their heart, 13 (21%) visited the service for their eyes and for their heart, 2 (3%) respondents did not clearly specify as to what the exact purpose of the visit was. Both ophthalmology and cardiology have been well represented in this survey, and conclusions from the survey can be applied to both services

This suggests that the design of services should take into account all aspects listed, with an emphasis on the following most important aspects:

- Location near public transport
- Delivery within the neighbourhood
- Services offer easy access to parking
- Services provide the patient with a single named professional who is available each time they visit the service

IX. Patient Demographics

Ethnicity

97 out of 104 respondents filled in this question, respondents represented a broad range of ethnicities:

Ethnicity	Count	Percentage (%)
Asian Indian	29	30
Asian Pakistani	2	2
Asian Bangladeshi	0	0
Asian Other	2	2
Black African	6	6

Black Caribbean	7	7
Black Other	2	2
Chinese	1	1
Mixed White Asian	0	0
Mixed White & Black African	0	0
Mixed White & Black Caribbean	0	0
Mixed Other	1	2
White British	17	36
White Irish	4	8
White Other	0	2
Other Ethnic group	1	1
Total Responses	97	100

Disability

90% of respondents answered this question, the majority of respondents reported not to have a disability:

Disability	Count	Percentage (%)
Yes	31	33
No	63	67
Total	94	100

Out of the respondents that have a disability, 77% (24 out of 31) of respondents also claim to have a disability/impairment that affects their daily life:

Disability or impairment affects daily life	Count	Percentage (%)
Yes:	24	30
No:	55	70
Total Responded to this question:	79	100

Religion

Respondents represented a range of religious backgrounds: 38% of those who responded to this question reported to be Christian, 19% reported to be Hindu and 11% stated that they have 'no religion'.

There were 95 responses to this question:

Religion	Count	Percentage (%)
Baha'i	0	0
Buddhism	1	1
Christianity	36	38
Hinduism	19	20
Jainism	4	4
Judaism	7	7
Islam	6	6
Sikhism	0	0
Taoism	0	0
No religion	10	11
Prefer not to say	6	6
Other	6	6
Total	95	100

Sexual Orientation

82 respondents (72%) answered this question, the results are as follows:

Sexual Orientation	Count	Percentage (%)
Bisexual	4	5
Homosexual	2	2
Heterosexual:	54	66
Prefer not to say:	22	27
Total Responded to this question:	82	100

VI. Appendices

Appendix 1: Patient Consultation Meeting Notes

Service Quality

The proposed service needs to be a high quality one and provide good treatment. Wherever it is situated, it needs to be able to accommodate all types of patient treatments adequately.

Patients mentioned that the services will need a better understanding of the patient's requirements and needs a more holistic approach to the patient's experience and overall treatment.

Waiting times need to be reduced

Waiting time both in terms of being seen by a professional (queuing for appointment slot) and in terms of waiting physically in the clinic / hospital were highlighted as a current issue.

There are two key improvement areas:

- Receiving the service sooner (appointment scheduling)

Patients suggested that perhaps the booking system should change, as they have to wait a long time to be seen by a specialist.

- Waiting time in the clinic to be reduced

Their view was that hospitals over-book appointments and one patient mentioned that he spent an hour and a half at the clinic to be seen for his appointment.

Patients' feedback / opinions need to be taken into account

Mechanisms to gather patients' opinions should be established in all clinics (they mentioned that there are clinics that do not have a suggestion box).

Appointment time

- Patients mentioned that weekend appointments (specifically Saturday mornings) are preferred. Evening appointments and early morning appointments were also welcomed.
- It was also mentioned that provisions should be made for patients that work outside of Brent that need to access services during work hours. They should be able to get treatment from the borough in which they work.

Location and accessibility of services

Patients were happy to travel to hospital or a suitable clinic as long as:

- appropriate care was received

- public transportation was available to the premises (highlighted as very important)
- they did not have to wait for the appointment

Car parking charges

Patients would like these to be abandoned / reduced as they view these as an issue

Access for disability

Patients mentioned that there needs to be provisions for patients with disabilities or with heart conditions. Cardiology services need to be easily accessible e.g. not having a cardiology ward at the end of a long corridor.

Assessment of Services (what elements are important in terms of assessing the service)

- Compassion of staff – 'doctors should listen to you as a human being and respond'. Doctors' interpersonal skills and communication skills were mentioned as very important.
- Communication with patients and referral process to be improved – one patient told of a case where he was sent a letter post referral that was supposed to be sent to his GP with results notifying of cancer. He also mentioned that his test results were lost. The referral loop process needs to be clear and feedback from any examination within it.

Notification of Appointment Preference

- The preferred way by patients in the meeting is to be notified of appointment is via a letter.
- Patients also mentioned that booking appointments online would be useful.
- They also mentioned that they would like to be asked how they would like to be notified by the service and to be given 2 methods of their choice.

App 5

NHS
Brent

Assessment of the impact of commissioning new outpatient cardiology and ophthalmology services

July 2012

CONFIDENTIAL

Contents

1. Introduction

1.1. The assessment

Since February 2012, NHS Brent has been procuring new community cardiology and ophthalmology services to replace acute outpatient services. To understand the impact of this procurement on patients and the local health economy, the Clinical Commissioning Group (CCG) Executive requested an assessment of the impact of the changes in provision.

This assessment considers the positive and negative impacts of moving cardiology and ophthalmology care into the community. It also considers mitigation measures for any adverse consequences identified and ways in which service proposals could be further improved to maximise the quality and equality of outcomes for Brent's population.

This assessment has been conducted slightly later in the process than might be usual, as the commissioning route selected was one where the service design was developed through the procurement process. Therefore, only now are we clear about the changes that will be made to the local health economy and therefore able to assess the impact.

1.2. Objectives and scope

This assessment aims to identify the impacts of commissioning new cardiology and ophthalmology services with regard to the likely effects on:

- Health outcomes;
- Access to services;
- Equality groups; and
- The local health economy.

The scope of this assessment covers:

- The service changes to outpatient cardiology and ophthalmology;
- The geographical boundary of Brent; and
- The likely impacts related to health outcomes and access, in particular for health inequalities and equalities.

It does not cover:

- Further service changes to planned care planned for 2012/13;
- Broader service changes resulting from the out of hospital strategy;
- Acute reconfiguration; nor
- Service changes instigated by other commissioning organisations.

1.3. Purpose

The assessment examines the health, equality and wider impacts that are likely to be experienced as a result of commissioning new services. Specific equality groups and geographical areas that are likely to experience greater impacts than others are also highlighted. It makes recommendations for actions that could be taken to mitigate any potential adverse impacts arising from proposed changes to services identified by the impact assessment. Finally, the report also makes a number of suggestions as to how potential benefits of the changes can be maximised and equality of outcomes improved and enhanced

2. Context

This commissioning is the culmination of a number of Brent's strategic initiatives expressed over the past three years, and is central to the delivery of its current strategic objectives.

2.1. Commissioning Strategy Plan 2009–14

In 2008/09, NHS Brent developed a Commissioning Strategy Plan[1] (CSP) that set out a five-year investment programme to deliver its vision of making a significant improvement to the health and wellbeing of the people of Brent.

Within this, Brent decided to improve planned care by:

- Improving primary care provision;
- Developing clear pathways for elective care; and
- Commissioning services from community providers to replace acute services.

As a result of this, the CSP expected a significant shift in activity from acute to community and primary care settings. This is outlined in Table 1.

Table 1: Impact of CSP initiatives on planned care attendances

Attendances	2010/11	2011/12	2012/13	2013/14
Outpatients	-	-21,561	-64,684	-215,611
Elective	-	-454	-1,361	-4,536
Emergency	-460	-1,875	-1,875	-1,875
Total	**-460**	**-23,890**	**-67,919**	**-222,022**

The CSP finds expression in this commissioning, which promises to commission planned care services from community providers to replace acute ophthalmology and cardiology services.

2.2. Out of hospital strategy

In 2012, CCGs across North West London have developed out of hospital strategies to support the delivery of care in setting outside of hospital.[2]

One key strand of the strategy for Brent is that wherever possible, care will be delivered outside a hospital setting and patients will have access to services closer to home. This will be delivered via a number of key initiatives, including:

- A new referral facilitation and peer review system to support GPs making referrals on from primary care;
- Providing some outpatient appointments in the community;
- Redesigning pathways of care, encouraging providers to increase productivity by employing new ways of working;
- Implementing a new model of care so that different providers work together in multi-disciplinary groups to provide seamless, integrated care for patients; and

[1] NHS Brent (n.d.) *Commissioning Strategy Plan 2009–14.*
[2] NHS Brent (2012) *Brent Out of Hospital Strategy.* Available at http://www.healthiernorthwestlondon.nhs.uk/sites/default/files/documents/PCBC-Vol09-AppD1-v1.1.pdf.

- Investing and developing in primary care capacity so our existing GP practices can support more care outside hospital.

One of the first ways this strategy will be delivered is through the commissioning new ophthalmology and cardiology services, which will be delivered closer to patients homes by offering integrated outpatient care in the community.

2.3. Acute reconfiguration

As a result of several initiatives across London, acute providers to North West London CCGs are facing financial pressures, including QIPP, Trust CIP, cost inflation, deflations in tariff payments, and demand growth.

As a result, NHS London and NHS North West London have explored the potential for acute re-organisation to ensure best use of available resources.[3] NHS London found that six of eighteen London trusts are in a viable long-term financial position in their present form, even after significant productivity gains are made. NHS North West London modelled several alternative solutions to this problem by way of transforming some hospitals into local or elective hospitals and encouraging the development of specialist sites.

The most immediate impact of such plans will be to Brent's nearest hospitals. Under all the options considered, Northwick Park remains a major hospital and Central Middlesex remains as a local or elective hospital. St Mary's could become a local hospital or remain a major hospital.

These plans are caused by factors beyond the control of Brent, let alone this commissioning. However, they are also being addressed at a system-wide level, meaning that the impact of this commissioning on the local health economy will be mitigated by NWL-wide work to ensure a sustainable future for hospitals in the area.

2.4. CCG authorisation

In order for the CCG to take full control of the commissioning of healthcare in Brent, it will need to be authorised by the NHS Commissioning Board (NHSCB) by October 2012.

The authorisation process is built around six domains. The NHSCB will assess CCGs through these six domains to assure itself that CCGs can safely discharge their statutory responsibilities for commissioning healthcare services. They are also intended to encourage CCGs to be organisations that are clinically led and driven by clinical added value. The domains are:

i. A strong clinical and multi-professional focus which brings real added value.
ii. Meaningful engagement with patients, carers and their communities.
iii. Clear and credible plans which continue to deliver the QIPP challenge within financial resources, in line with national requirements (including outcomes) and local joint health and wellbeing strategies.
iv. Proper constitutional and governance arrangements, with the capacity and capability to deliver all their duties and responsibilities, including financial control, as well as effectively commission all the services for which they are responsible.
v. Collaborative arrangements for commissioning with other clinical commissioning groups, local authorities and the NHS Commissioning Board as well as the appropriate external commissioning support.
vi. Great leaders who individually and collectively can make a real difference.

[3] NHS London (2012) *Acute Hospitals in London: Sustainable and Financially Effective*. Available at http://www.london.nhs.uk/webfiles/SaFE%20repoer/SaFE%20report%20February%202012.pdf; NHS North West London (2012) *NWL Reconfiguration Programme*. Available at http://www.healthiernorthwestlondon.nhs.uk/sites/default/files/documents/PCBC-Vol08-AppC-v1.1.pdf.

This commissioning exercise is one way that Brent's nascent CCG can evidence its ability to commission in a clinically-driven way (domain (i)), deliver its QIPP challenge (domain (iii)) and effectively commission the services needed by the local population (domain (iv)).

3. Proposals

3.1. Improving planned outpatient care in Brent

In December 2011, NHS Brent's CCG Executive decided to change the shape of service provision in Brent by shifting services from acute to community and primary care. The aim of this shift was to ensure care is delivered closer to patients' homes, offer an integrated clinical pathway, and ensure Brent's outpatient services offer value for money.

To achieve this, the CCG Executive decided to re-commission outpatient services for certain planned care specialties and thereby procure new, community services. The CCG Executive took the opportunity to encourage innovation; drive productivity and quality improvements; meet the healthcare challenge it faced; and develop new, patient-centred models of care closer to patients' homes.

In January, the CCG Executive agreed to commence the re-commissioning with two specialties: ophthalmology and cardiology. The procurement process for these two specialties began in February 2012. The scope was to re-commission the maximum range of outpatient services in the two specialties from new providers with the aim of improving quality and reducing cost.

3.2. Competitive dialogue

The process used for these procurements was one of competitive dialogue. Through this process, Brent discusses potential service models with a range of short-listed providers before setting on a final service specification. This allows the commissioner to utilise the ideas and experience of providers during specification development, improving the quality of service commissioned.

This was a deliberate break with traditional models of procurement, which stress the commissioner's role in developing a service specification and can limit the innovations providers are able to offer. Competitive dialogue gives providers a role in shaping the service commissioners specify, and allows them to suggest ways the commissioner can better achieve its aims for the service.

Brent has been operating this process since February, and in July issued the final service specifications for new cardiology and ophthalmology services. Only at this point was it clear which types of outpatient activity would be moved from current acute providers to the new community service; therefore, the impact of the commissioning could not be estimated until this stage.

To date, the process has enabled Brent to successfully develop new service models for ophthalmology and cardiology that harness the best provider developments in outpatient care. Significant improvements to the model of care in both specialties have been discussed and incorporated into the service specification. New features include:

- direct access to diagnostic tests for GPs;
- pre-appointment triage to reduce unnecessary trips to the service;
- one-stop outpatient appointments to see and treat most patients in one visit;
- integrated, outcome-driven management of long-term conditions; and
- integration with primary care via clear referral and discharge protocols.

These features were all suggested by a range of providers and developed by their clinical leads, providing us with confidence that their use will be sustainably and clinically sound.

3.3. Service commencement

The new cardiology and ophthalmology services will commence in January 2013 and will gradually increase in capacity until they can deliver their maximum volume in April 2013.

4. Service changes under review

4.1. Ophthalmology

4.1.1. Current configuration

Currently, outpatient ophthalmology services are provided by a range of local acute hospitals. In 2011/12, these hospitals saw 8,900 first and 28,500 follow-up appointments.

The breakdown by provider is outlined in Table 2.

Table 2: Current ophthalmology providers

Provider	First appointments (000s)	Follow-up appointments (000s)	Total (000s)
North West London Hospitals NHS Trust	3.3	12.3	15.6
Moorfields Eye Hospital NHS Foundation Trust	2.7	9.3	12.0
Imperial College Healthcare NHS Trust	2.1	4.4	6.5
Royal Free London NHS Foundation Trust	0.6	1.8	2.5
Other	0.1	0.2	0.3
Chelsea and Westminster Hospital NHS Foundation Trust	0.0	0.1	0.2
Guy's and St Thomas' NHS Foundation Trust	0.1	0.1	0.2
University College London Hospitals NHS Foundation Trust	0.1	0.1	0.2
The Whittington Hospital NHS Trust	0.0	0.0	0.1
Total	**8.9**	**28.5**	**37.4**

4.1.2. Reconfiguration proposals

The commissioning of a new ophthalmology service will result in a single provider seeing and treating most ophthalmology outpatients in a community setting. A single new provider will offer:

- Triage of ophthalmology referrals to improve the clinical appropriateness of referrals made to ophthalmology services.
- Investigation of and/or treatment for appropriate eye conditions, including:
    - Eye/eyelid lesions requiring minor surgery;
    - Blurred vision;
    - Watery eyes;
    - Dry eyes;
    - Floaters;
    - Blephartis;
    - Field defects;
    - Dry AMD; and
    - Retinal lesions.
- Treatment and/or management of appropriate long-term ophthalmic conditions, specifically glaucoma.

The successful bidder estimated that this affects 86% of all outpatient ophthalmology once the impacts of triage and first:follow-up ratios are considered. Therefore, this proportion will be moved from current providers to the new provider. This totals approximately 7,000 first and 25,100 follow-up appointments.

This shift is reflected in Table 3.

Table 3: Change in ophthalmology volume

Provider	First appointments (000s)	Follow-up appointments (000s)	Total (000s)
New provider	+6.3	+10.7	+17.0
Not seen (due to triage or first:follow-up ratios)	+0.7	+14.4	+15.1
North West London Hospitals NHS Trust	-2.8	-10.6	-13.4
Moorfields Eye Hospital NHS Foundation Trust	-2.3	-8.0	-10.3
Imperial College Healthcare NHS Trust	-1.8	-3.8	-5.6
Royal Free London NHS Foundation Trust	-0.5	-1.6	-2.1
Other	-0.1	-0.2	-0.3
Chelsea and Westminster Hospital NHS Foundation Trust	0.0	-0.1	-0.1
Guy's and St Thomas' NHS Foundation Trust	0.0	-0.1	-0.1
University College London Hospitals NHS Foundation Trust	0.0	-0.1	-0.1
The Whittington Hospital NHS Trust	0.0	0.0	0.0
Total	**0.0**	**0.0**	**0.0**

4.2. Cardiology

4.2.1. Current configuration

Currently, most outpatient cardiology services are provided by a range of local acute hospitals. In 2011/12, these hospitals saw 8,400 first and 10,800 follow-up appointments.

In addition, cardiac rehabilitation and heart failure services are offered via an existing community cardiology service delivered by Ealing Hospital NHS Trust (merging with North West London Hospitals NHS Trust (NWLH) in 2013). In 2011/12, this service saw 2,100 first and 1,300 follow-up appointments.

The breakdown by provider is outlined in Table 4.

Table 4: Current cardiology providers

Provider	First appointments (000s)	Follow-up appointments (000s)	Total (000s)
North West London Hospitals NHS Trust	4.4	5.6	10.0
Imperial College Healthcare NHS Trust	2.7	2.7	5.4
Ealing Hospital NHS Trust	2.2	1.4	3.5
Royal Brompton and Harefield NHS Foundation Trust	0.1	1.2	1.3
Barnet and Chase Farm Hospitals NHS Trust	0.6	0.3	0.9
Royal Free London NHS Foundation Trust	0.2	0.4	0.6
University College London Hospitals NHS Foundation Trust	0.2	0.4	0.6
Other	0.1	0.1	0.2
Chelsea and Westminster Hospital NHS Foundation Trust	0.0	0.0	0.1
The Whittington Hospital NHS Trust	0.0	0.0	0.0
Total	**10.5**	**12.1**	**22.6**

4.2.2. Reconfiguration proposals

As with ophthalmology, the commissioning of a new cardiology service will result in a single provider seeing and treating most cardiology outpatients in a community setting. A single new provider will offer:

- Triage of ophthalmology referrals to improve the clinical appropriateness of referrals made to ophthalmology services.
- Non-invasive tests, with direct GP access, including:
    - Holter monitoring;
    - Echo; and
    - Exercise testing.
- Investigation of and/or treatment for appropriate cardiac conditions, including:
    - Hypertension;
    - Atrial fibrillation;
    - Arrhythmia;
    - Chest pain;
    - Shortness of breath; and
    - Syncope.
- Treatment and/or management of long-term cardiology conditions, including:
    - Heart failure, including rehabilitation;
    - Stable angina;
    - Valvular heart disease; and
    - Cardiac rehabilitation.

The successful bidder estimated that it will be able to see all acute outpatient cardiology appointments; therefore, this proportion will be moved from current providers to the new provider. In addition, the existing community service will be replaced by the new service and the existing diagnostic volumes moved over. This totals approximately 10,500 first and 12,100 follow-up appointments.

This shift is reflected in Table 5.

Table 5: Change in cardiology volume

Provider	First appointments (000s)	Follow-up appointments (000s)	Total (000s)
New provider	+9.9	+10.1	+20.0
Not seen (due to triage or first:follow-up ratios)	+0.6	+2.0	+2.6
North West London Hospitals NHS Trust	-4.4	-5.6	-10.0
Imperial College Healthcare NHS Trust	-2.7	-2.7	5.4
Ealing Hospital NHS Trust	-2.2	-1.4	-3.5
Royal Brompton and Harefield NHS Foundation Trust	-0.1	-1.2	-1.3
Barnet and Chase Farm Hospitals NHS Trust	-0.6	-0.3	-0.9
Royal Free London NHS Foundation Trust	-0.2	-0.4	-0.6
University College London Hospitals NHS Foundation Trust	-0.2	-0.4	-0.6
Other	-0.1	-0.1	-0.2
Chelsea and Westminster Hospital NHS Foundation Trust	-0.0	-0.0	-0.1
The Whittington Hospital NHS Trust	0.0	0.0	0.0
Total	**0.0**	**0.0**	**0.0**

4.3. Combined service changes

4.3.1. Current configuration

The total number of outpatient appointments for cardiology and ophthalmology are included in Table 6.

Table 6: Current cardiology and ophthalmology providers

Provider	First appointments (000s)	Follow-up appointments (000s)	Total (000s)
North West London Hospitals NHS Trust	7.7	17.9	25.6
Moorfields Eye Hospital NHS Foundation Trust	2.7	9.3	12.0
Imperial College Healthcare NHS Trust	4.8	7.1	11.9
Ealing Hospital NHS Trust	2.2	1.4	3.5
Royal Free London NHS Foundation Trust	0.8	2.2	3.0
Royal Brompton and Harefield NHS Foundation Trust	0.1	1.2	1.3
Barnet and Chase Farm Hospitals NHS Trust	0.6	0.3	0.9
University College London Hospitals NHS Foundation Trust	0.2	0.5	0.7
Other	0.2	0.3	0.5
Chelsea and Westminster Hospital NHS Foundation Trust	0.1	0.2	0.2
Guy's and St Thomas' NHS Foundation Trust	0.1	0.1	0.2
The Whittington Hospital NHS Trust	0.0	0.1	0.1
Total	**19.4**	**40.7**	**60.1**

4.3.2. Reconfiguration proposals

The combined impact of the changes to cardiology and ophthalmology are estimated in Table 7.

Table 7: Change in cardiology and ophthalmology volume

Provider	First appointments (000s)	Follow-up appointments (000s)	Total (000s)
New ophthalmology provider	+6.3	+10.7	+17.0
Ophthalmology appointments not seen	+0.7	+14.4	+15.1
New cardiology provider	+9.9	+10.1	+20.0
Cardiology appointments not seen	+0.6	+2.0	+2.6
Sub-total: New providers	*+16.1*	*+35.2*	*+51.3*
North West London Hospitals NHS Trust	-7.2	-16.2	-23.4
Imperial College Healthcare NHS Trust	-4.5	-6.5	-10.9
Moorfields Eye Hospital NHS Foundation Trust	-2.3	-8.0	-10.3
Ealing Hospital NHS Trust	-2.2	-1.4	-3.5
Royal Free London NHS Foundation Trust	-0.7	-1.9	-2.7
Royal Brompton And Harefield NHS Foundation Trust	-0.1	-1.2	-1.3
Barnet and Chase Farm Hospitals NHS Trust	-0.6	-0.3	-0.9
University College London Hospitals NHS Foundation Trust	-0.2	-0.5	-0.7
Other	-0.2	-0.3	-0.5
Chelsea and Westminster Hospital NHS Foundation Trust	-0.1	-0.1	-0.2
Guy's and St Thomas' NHS Foundation Trust	-0.1	-0.1	-0.2
The Whittington Hospital NHS Trust	-0.0	-0.0	-0.1
Sub-total: Existing providers	*-16.1*	*-35.2*	*-51.3*
Total	**0.0**	**0.0**	**0.0**

5. Impact on patients

5.1. Health impacts

The commissioning of new cardiology and ophthalmology services is expected to significantly improve the quality of care offered across Brent.

The new services will ensure sustainable health outcomes for their patients. To reflect this, the new service will reduce re-presentation rates, the rate of admission to hospital following an outpatient appointment, and the rate of unplanned admissions and A&E attendances.

For long-term conditions, the service will be responsible for support patients to manage their condition and will be paid based on whether these achieve key recovery outcomes, not on the number of appointments with the patient. This represents a significant break with the conventional model, where providers are paid per appointment and as a result offer episodic care. This will result in improved recovery outcomes, to be measured via patient-reported outcome measures, against which the service will be monitored. For example, the cardiology service will improve the number of patients returning to work following cardiac rehabilitation, which is a key indicator of whether a patient has recovered.

This shift to a more effective and sustainable model of management of long-term conditions will help the local health economy manage the expected increase in demand for services, in particular the growth in long-term cardiac complaints.

Several of the new features of the cardiology and ophthalmology services have been shown to improve health outcomes for patients and patients' experiences of care. However, some risks have been identified in association with the proposed service model; these are also outlined below.

5.1.1. Direct access diagnostics

Rapid access to diagnostic tests – either via direct access diagnostics or improved access via a community service – improves the speed of diagnosis for all patients and the management of long-term conditions. GPs are able to order tests without an associated outpatient appointment, and receive expert opinions that enable them to make a diagnosis and, where appropriate, continue to manage the patient in primary care.

Elsewhere in the UK, direct access sigmoidoscopy clinics have reduced the use of health resources and reduced the need for outpatient appointments.[4] The benefit of fewer appointments translates into an improved patient experience, as diagnoses will be quicker and require fewer trips to hospital.

5.1.2. Triage

Expert triage of a referral before the patient makes an appointment helps enable a see and treat approach and reduces unnecessary referrals, as the service can support GPs to manage suitable patients in primary care rather than seeing them in a clinic.

Triage by a consultant has been shown in emergency settings to reduce the length of time a patient is seen for, improving the experience for the patient.[5]

5.1.3. See and treat services

[4] *Ibid.*
[5] Castille, K. and Cooke, M. (2003) 'One size does not fit all. View 2'. *Emergency Medicine Journal* 20: 120–122. Available at http://emj.bmj.com/content/20/2/120.full.

'See and treat' models, where a patient is seen and treated in one visit, significantly reduce the number of patients needing to visit a service more than once, and so result in faster diagnosis and treatment.

Such models have been implemented in outpatient gynaecology to shorten the treatment pathway, expedite recovery, reduce the need for outpatient and inpatient services, and improve the use of NHS resources.[6] For example, a similar model of ambulatory diabetes care in the US, which reduced the need for multiple outpatient appointments, improved the rate of optimal diabetes control and reduced the cost of outpatient services.[7]

5.1.4. Integration of payment for long-term care

Existing services to manage long-term conditions are fragmented, to the detriment of patients. Typically, they will be provided by different providers on an episodic basis, with efforts to integrate the management of patients working against the economic structure of the healthcare system. Integrated payment mechanisms, where services have an incentive to offer seamless pathways and effective management of a patient, align the economic incentives with the interest of patient.

Research into integrated models of care for long-term conditions suggest integrated payment mechanisms for the management of long-term conditions are vital to aligning incentives across the system.[8]

5.1.5. Referral and discharge protocols

The quality of referral and discharge information can vary across different GPs and different providers, creating some inconsistency in the information received. This means services may need to duplicate enquiries and tests, and GPs may be left without a plan for the management of a patient following discharge, increasing the potential for deterioration. Improving referral and discharge, via clear pro formas and management plans, will improve the quality of the first appointment in the new services and ensure GPs can effectively manage patients following discharge.

Improved discharge planning and referral criteria improve health outcomes and reduce future service use.[9] In Norway, electronic referral forms (including guidelines and patient information), together with a one-stop outpatient model, reduced waiting times by 25%.[10]

5.1.6. Risks of negative impacts

While not certain, there are a number of areas where there exists a risk the service will not work in the manner intended and will be detrimental to the health of patients.

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[6] Jones, K. (ed.) (2008) *Ambulatory Gynaecology: A new concept in the treatment of women*. Available at http://www.rcog.org.uk/catalog/book/ambulatory-gynaecology.
[7] Chartis Group (2011) *Ambulatory care of the future*. Available at http://www.chartis.com/files/pdfs/Ambulatory_Care_of_the_Future.pdf.
[8] NHS Confederation (n.d.) *Building integrated care: Lessons from the UK and elsewhere*. Available at http://www.nhsconfed.org/Publications/Documents/Building%20integrated%20care.pdf.
[9] Singh, D. (2006) *Making the Shift: Key Success Factors*. Available at http://www.bhamlive2.bham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/publications/2006/Making-the-Shift-Key-Success-Factors.pdf; Roland, M. et al. (2006) *Outpatient Services and Primary Care: A scoping review of research into strategies for improving outpatient effectiveness and efficiency*, available at http://www.netscc.ac.uk/hsdr/files/project/SDO_ES_08-1518-082_V01.pdf.
[10] Augestad, K. M. et al. (2008) 'The One-stop trial: Does electronic referral and booking by the general practitioner (GPs) to outpatient day case surgery reduce waiting time and costs? A randomized controlled trial protocol'. *BMC Surgery* 8: 14. Available at http://www.biomedcentral.com/1471-2482/8/14.

First, during transition, there is a risk the quality of the service will diminish, despite the quality standards in place. While this has been mitigated by the provisions of the contract, it will need to be managed throughout the mobilisation period and during the initial months of the service to ensure there is no reduction in service quality and therefore a negative impact on the health of patients.

Second, there is a risk of repeat or unnecessary investigations, either due to miscommunication between primary, community and secondary care or due to over-use of direct access services. These investigations have a negative impact on patients, who receive unneeded testing and concern, and on the commissioner, who will need to fund the investigations. This will be mitigated by the Brent referral facilitation system, which will monitor referral behaviour, and by the contract, which requires the provider to ensure effective communication of test results between the service and secondary care.

5.2. Impact on access

The new service will be delivered from two sites within the border of Brent, with one site in the north and one in the south of the borough. This is a significant change from the current arrangement. Currently, only two providers (NWLH and Ealing Hospital NHS Trust's community services) offer sites within the borders of Brent; as a result, only 51% half cardiology and ophthalmology patients are seen within the borders of Brent. Under the new arrangements, 87% of cardiology and ophthalmology patients will be seen within the borough.

Furthermore, services will see and treat the majority of patients in a single visit. This means patients will not need to travel to the clinic more than once unless absolutely necessary, significantly reducing the number of trips needed.

Therefore, we would expect that travel times for patients will significantly reduce as a result of the new services, both per visit (through fewer trips out-of-borough) and per course of treatment (through fewer visits to services).

To ensure there are no adverse impacts on access, the new service should be encouraged to work with Brent GPs to continue to improve the accessibility of services, especially to groups that may find access to services more difficult than others (such as refugees and asylum seekers).

5.3. Equality impacts

Impacts by equality group will not vary by design, as all the services will be equally accessible to all patients. However, differences in disease incidence may mean certain groups use services more frequently than others. The focus of these impacts is primarily long-term conditions, where these variables have the greatest influence on incidence.

5.3.1. Sex

Of the long-term cardiac conditions, men are at higher risk for heart failure than women. Therefore, it is likely that improvements to the management of heart failure offered by the new cardiology service will have a more significant positive impact on men than women.

Within ophthalmology, women are more likely than men to develop age-related macular degeneration (AMD).[11] Therefore the positive impacts of this new service will benefit women slightly more than men.

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[11] Age-Related Eye Disease Study Research Group (2000) 'Risk factors associated with age-related macular degeneration. A case-control study in the age-related eye disease study: Age-Related Eye Disease Study Report Number 3'. *Ophthalmology* 107(12): 2224–32. Available at http://www.ncbi.nlm.nih.gov/pubmed/11097601.

5.3.2. Age

Heart failure becomes more common with increasing age. About 1 in 15 of people aged 75–84 and just over 1 in 7 people aged 85 and above have heart failure.[12] Similarly, hypertension is most common in the over-55s and the prevalence of coronary heart disease increases with age.[13] Age is also a risk factor in a range of eye conditions, including AMD and glaucoma.[14]

Therefore, improvements to the management of long-term conditions in both services will have the greatest positive impact on older people.

5.3.3. Disability

Patients with coronary heart disease and/or congestive heart failure are more likely to be disabled than the general population; many of these patients are disabled by their condition.[15] Similarly, certain ophthalmic conditions, including AMD, can cause blindness.[16]

Long-term conditions are themselves risk factors. Diabetes is a risk factor in the development of glaucoma.[17] Glaucoma patients have a heightened likelihood of developing hypertension, while hypertension is a risk factor in the development of AMD.[18]

For all these reasons, these services will be treating a higher proportion of disabled patients than their share of the population would suggest, and this group will therefore experience the positive impacts of improvements to care more than the general population.

5.3.4. Race

For long-term cardiac conditions, the prevalence of coronary heart disease is highest in Pakistani and Indian men. The prevalence of cardiovascular disease is highest in Irish men. Hypertension is most common in the African Caribbean population.[19]

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[12] Patient.co.uk (n.d.) *Heart Failure*, available at http://www.patient.co.uk/health/Heart-Failure.htm.
[13] Patient.co.uk (n.d.) *Epidemiology of Coronary Heart Disease*, available at http://www.patient.co.uk/doctor/Epidemiology-of-IHD.htm.
[14] Australian National Medical and Medical Research Council (2008) *Risk factors for eye disease and injury*. Available at http://www.health.gov.au/internet/main/publishing.nsf/Content/71FBCE0AF8F09F2ECA25755C0000B2EE/$File/EYECompiledReport.pdf.
[15] Pinsy, J. L. et al. (1990) 'The Framingham Disability Study: Relationship of various coronary heart disease manifestations to disability in older persons living in the community'. *American Journal of Public Health*. 80(11): 1363–1367. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1404890/.
[16] Australian Institute of Health and Welfare (n.d.) *Eye health facts*, available at http://www.aihw.gov.au/eye-health-facts/.
[17] Australian National Medical and Medical Research Council, *Op. cit.*
[18] Langman, M. J. S. et al. (2005) 'Systemic hypertension and glaucoma: mechanisms in common and co-occurrence'. *British Journal of Ophthalmology* 89: 960–963. Available at http://bjo.bmj.com/content/89/8/960.full; Age-Related Eye Disease Study Research Group, *Op. cit.*
[19] WebMD (2012) *Hypertension/High Blood Pressure Health Center*, available at http://www.webmd.com/hypertension-high-blood-pressure/guide/understanding-high-blood-pressure-basics?page=2; British Heart Foundation (n.d.) *Ethnicity*, available at http://www.bhf.org.uk/heart-health/prevention/ethnicity.aspx; British Heart Foundation, *Ethnic Differences in Cardiovascular Disease*, 2010 Edition.

East Asian and African patients are at higher risk of developing glaucoma than the general population.[20] Significantly for Brent, the increased incidence of diabetes amongst South East Asian populations will also increase the risk of glaucoma among Indian and Pakistani communities. However, white patients are at higher risk of AMD.[21]

Given the population of Brent, the largest positive impacts will probably be on Pakistani and Indian men at risk of coronary heart disease, but there will also be more positive impacts for Irish and African Caribbean populations than for the general population.

5.3.5. Sexual orientation

Homosexual and bisexual individuals exhibit higher prevalence of risk factors associated with cardiovascular disease. Therefore, improvements in the management of associated conditions will have a greater positive impact on patients exhibiting such risk factors and therefore these groups.[22]

[20] Wang, N. (2002) 'Primary angle closure glaucoma in Chinese and Western populations'. *Chinese Medical Journal* 115(11): 1706–1715. Available at http://www.cmj.org/Periodical/paperlist.asp?id=LW8642&linkintype=pubmed.

[21] Age-Related Eye Disease Study Research Group, *Op. cit.*; Heiting, G. and Haddrill, M. (2010) *Primary Open-Angle Glaucoma*, available at http://www.allaboutvision.com/conditions/primary-open-angle-glaucoma.htm.

[22] Case, P. (et al). (2004) 'Sexual orientation, health risk factors, and physical functioning in the Nurses' Health Study II'. *Journal of Women's Health* 13(9): 1033–1047. Available at http://www.ncbi.nlm.nih.gov/pubmed/15665660; Conron K. J. (2010) A population-based study of sexual orientation identity and gender differences in adult health. *American Journal of Public Health* 100(10): 1953–1960. Available at http://www.ncbi.nlm.nih.gov/pubmed/20516373.

6. Impact on the local health economy

6.1. Impact on existing providers

Most of Brent's acute provider serve a wide range of commissioners and deliver outpatient care across a wide range of specialties. Therefore, the volume of outpatient work being moved from acute services is relatively low.

As a commissioner, NHS Brent is privy only to the volume of its own patients an acute trust sees. However, we have used Hospital Episode Statistics to estimate to proportion of all outpatient activity affected by the re-commissioning of cardiology and ophthalmology services.[23] This is included in Table 8.

Table 8: Impact on outpatient departments

Provider	Total outpatient activity 2010/11 (000s)	Outpatient activity de-commissioned (000s)	Total reduction (%)
North West London Hospitals NHS Trust	187.9	-23.4	-12.4
Imperial College Healthcare NHS Trust	368.2	-10.9	-3.0
Ealing Hospital NHS Trust	120.9	-3.5	-2.9
Moorfields Eye Hospital NHS Foundation Trust	360.2	-10.3	-2.9
Royal Brompton and Harefield NHS Foundation Trust	58.2	-1.3	-2.2
Royal Free London NHS Foundation rust	255.1	-2.7	-1.0
Barnet and Chase Farm Hospitals NHS Trust	177.5	-0.9	-0.5
University College London Hospitals NHS Foundation Trust	275.1	-0.7	-0.3
Chelsea and Westminster Hospital NHS Foundation Trust	192.1	-0.2	-0.1
The Whittington Hospital NHS Trust	172.9	-0.1	-0.1
Guy's and St Thomas' NHS Foundation Trust	352.5	-0.2	-0.0
Total	**2,520.6**	**-51.3**	**-2.0**

Major impacts are limited to NWLH, which could lose up to 12% of its outpatient work and associated income. All other providers will lose less than 3% of their activity.

As existing cardiology community services are being de-commissioned, Ealing Hospital NHS Trust community service will also experience a significant impact as a result of this procurement. However, this is unlikely to have a significant impact on the organisation, which will be merged with NWLH in 2013 and therefore benefit from the stability of the larger organisation.

These impacts are, overall, small in the context of total trust income. The reduction in outpatients will cost NWLH about £3.5m a year and Imperial £1.7m a year. NWLH's total income in 2010/11 was £198m; Imperial's £385m.[24] These reductions represent 1.8% of NWLH's income and 0.4% of Imperial's income.

To mitigate any negative impacts, all the major providers have been given prior notice of Brent's commissioning intentions via its CSP, out of hospital strategy and QIPP plans. Following this, a reduction to the contracts for NWLH and Imperial College Healthcare NHS Trust was already agreed for 2012/13 before this

[23] Hospital Episode Statistics (n.d.) *Outpatient data*. Available at http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=890.
[24] House of Commons (n.d.). *Reported Provider Tariff Income (including market forces factor) by NHS Trust*. Available at www.parliament.uk/deposits/depositedpapers/2012/DEP2012-0165.xls.

commissioning began. Therefore, this reduction in activity will have been considered in their financial plan for 2012/13 and 2013/14 and the hospitals will have planned for the impact the loss of volume may have.

Moreover, all current providers have had the opportunity to bid to become sole provider of cardiology and ophthalmology services, and therefore receive the additional volume and funding associated with the contract.

The financial sustainability of local hospitals will not depend on outpatient cardiology and ophthalmology. Rather, it will rely on acute trusts' ability to address the system-wide issues considered in the broader acute reconfiguration plans being developed by NHS North West London (see Section 2.3). This work will help acute trusts adapt the changes occurring across North West London, of which this commissioning is one small element.

6.1.1. Departmental impacts on staff

While the overall impact on most providers is modest, at departmental level there may be an impact on the viability of clinics and staff.

Where a member of staff spends the plurality of their time seeing NHS Brent patients, they will be eligible for transfer to the new service under TUPE. In this way, the skills and experience of existing clinicians will be retained where their post may be unviable with their current provider.

The only providers affected in this were NWLH and Ealing Hospital NHS Trust. NWLH has identified 28 members of staff eligible for transfer, who may be re-employed by the new service. The five members of staff employed by Ealing for the community cardiology service will also be transferred to the new provider.

In this way, the skills and experience of existing staff will be retained, mitigating the negative impact of services changes.

6.1.2. Training

With the reduction in outpatient activity in hospitals, there may be a need for more training of medical trainees to be conducted in community settings. The potential providers of both cardiology and ophthalmology services are satisfied with working with the Local Education and Training Board to provide opportunity for such training, and some have been in discussion with the Deanery about the suitability of community placements.

6.2. Impact on new providers

These new services will change the provider landscape for community services in Brent as two new providers will receive a significant volume of new work and associated income. This will result in the development of new community providers within Brent who will be strengthened by the shift of patients from acute services to the new providers. As a result, Brent will enjoy a diverse provider environment in the future, improving the competitiveness of any future procurements and driving up service standards as a result.

6.3. Impact on primary care

The new community services have been designed to enable primary care to increase its role in the provision of care.

First, the services allow a wider range of services to be offered in primary care. This includes, in cardiology, 24-hour blood pressure monitoring, ECGs and BNP testing. This will allow local GPs to improve their capacity to deliver a range of service.

Second, the new services are required to work with local GPs to improve skills. This will mean as the contract progresses, the skillset of primary care will be improved and local GPs will be able to provide a wider range of services than they do currently.

Third, the services will improve the support available to GPs when a patient is discharged. It will provide GPs with a management plan for the patient, which the GP will be able to follow, and will be penalised if the plan fails and a patient has to be returned to the community service or referred to an acute hospital.

6.4. Impact on commissioners

The financial benefits of this commissioning will make a significant contribution to NHS Brent's QIPP plan for 2013/14–14/15. Based on current estimates, these new services will save the Commissioner £3.3m a year, £2.2m more than was estimated in the Brent QIPP plan. This, in turn, will assist the CCG with the process of authorisation, making this a key strand of the organisation's strategy for the next few years.

Concentrating outpatient cardiology and ophthalmology services with a single provider will significantly improve NHS Brent's power over the local health economy. Already, through the process of competitive dialogue, Brent has been able to extract significant value from potential providers by virtue of the volume of work offered; this will only continue if the service is a success.

Currently, similar re-commissioning initiatives are progressing in Harrow. However, Brent is further ahead with its procurement. As a result, a number of organisations have discounted their prices in order to command an improved position in the local market – this has given Brent something of a first mover advantage in this area, improving the value of the contracts it will be entering into.

7. Overall impact

7.1. Positive impacts

For patients, key improvements include improved health outcomes (in particular for patients with long-term conditions), an improved experience of care, reduced travel times, and improved access to services.

For providers, key positive impacts will be a significant increase in activity and income for the selected providers of cardiology and ophthalmology services.

For commissioners, this opportunity will deliver an important part of the CCG's QIPP plan and assist with the process of evidencing sufficient competency to achieve authorisation.

For GPs, the new services will offer significantly improved interactions with primary care, including clearer referral and discharge protocols and more support to manage patients before and after using the service. Primary care will be further enhanced by training provided by the new service and referral feedback provided via Brent's referral facilitation system.

7.1.1. Maximisation

There is a risk that the positive impacts of this service change will not be realised due to under-referral. Therefore, it will be important for GPs to refer to the new services. This can be supported through the CCG via robust clinical leadership and appropriate use of Brent's referral facilitation system.

7.2. Negative impacts

The negative impacts of these changes are limited to existing providers, who will suffer a loss of activity and income from 2012/13. This reduction is slight in the context of the acute sector's overall financial situation, representing just 1.8% of the income of Brent's main provider. However, it may impact on the quality of local staffing and the training of new staff.

There are also risks of negative impacts around the transition period, when quality might drop and unnecessary appointments increase.

7.2.1. Mitigation

These negative impacts on the acute sector have been mitigated in several ways.

First, all current providers were informed of Brent's plans through its CSP and QIPP plans, and these reductions were recently confirmed through notice letters. Therefore, they have been able to plan for the reduction in activity.

Second, NHS North West London is supporting the acute sector to reconfigure itself in response to the broader financial pressures it is facing. This will include managing the impact of the QIPP schemes being implemented by CCGs across the region, of which this is one small element.

Third, providers have been given the opportunity to bid to supply the outpatient services being decommissioned and therefore compete to retain the outpatient work included in this impact assessment.

Fourth, provisions are in place to ensure the staff and expertise of existing providers is not lost. Staff will be transferred from current providers to the new provider, ensuring their skills and experience are retained, and the new service will need to offer appropriate training arrangements for clinical trainees.

The risks around negative impacts have also been mitigated by provisions in the contract and other NHS Brent initiatives.

The mobilisation team, including dedicated project management support, will ensure the service is ready to deliver a high quality service from January 2013. Any reduction in quality will be quickly highlighted via robust and regular performance information, which the provider will be able to provide weekly. If quality does suffer, Brent will be able to penalise the provider and, if necessary, terminate the contract.

To ensure appropriate referral activity, the NHS Brent referral facilitation system will be used to support the shift of referrals from current acute providers to new community providers. In addition, the provider will work with local GPs to secure a strong referral pipeline and ensure the service is popular enough to sustain itself. As the service is tariff-based, a shortfall in referrals will not result in the Commissioner paying for two services, but will reduce the savings made by the service.

8. Conclusion

8.1. Conclusions

Overall, the commissioning of new cardiology and ophthalmology services will have a positive impact on Brent patients and the wider health economy. It will offer significantly improved services closer to patients' homes that help achieve the CCG's objectives to planned care and strengthen the provider market within the borough.

The negative impacts of this commissioning are limited to the loss of income for current providers who lose referrals to the new service. While this is the cost of any re-commissioning, the impacts should be considered carefully and this commissioning has sought to mitigate them wherever possible. The wider changes the acute sector is facing from CCGs across North West London will have a larger impact on current providers, and will be further managed via Cluster-wide work.

As these impacts are being managed to a satisfactory degree, the net impact of these service changes is significantly positive.

CCG Wave 2 Planned Care Procurements: Project Risk Register

Ref	Event Type (Category / workstream)	Risk (Description of the risk)	Lead (Risk Owner - Organisation and name of individual)	Other Relevant Bodies (Other organisations that may be effected)	Risk Identification Date	Risk Identification Body	Status	Risk Closure Date	Potential Impact / Adverse Consequences	Impact (safety, Service Delivery, Economic, Reputation)	Likelihood	RAG Score	Risk Response (Prevent, Reduce, Transference, Acceptance, Contingency)	Embedded Monitors, Controls and Mitigations (current actions to prevent threat occurrence or limit impact)	Response: Mitigation and Control (possible future actions to prevent threat occurrence or limit impact)
Column1	Column2	Column3	Column4	Column5	Column6	Column7	Column8	Column9	Column11	Column1S2	Column16	Column17	Column18	Column20	Column21
1	Programme Management	Wave 2 procurement is not delivered by planned timescale - resulting in financial benefits being delayed and knock on impact to QUIPP projections.	CCG	NWL CSU	02.01.14	CCG	Open	-	Delays to project Missed financial saving targets Delays to new services coming on line for patients Impact on Shaping a Healthier Future Strategy reliant on this investment.	4	3	12	Prevent	Detailed programme plan developed Required resource in place to commence service specification devt and procurement commencement.	Continue to review resource requirements.
2	Finance	Projected financial savings not forthcoming through Tender process.	CCG	NWL CSU	02.01.14	CCG	Open	-	Business case for procurement anticpates financial saving projections. Business case may need to be reviewed to continue with the projects.	4	2	8	Prevent	Business case uses 'scenario planning' for different financial scenarios. Tender process and specification to be set up in a manner that supports value for money.	Further financial analyses to be undertaken following additional development of service specification.
3	Finance	Tenders not affordable within CCG budget.	CCG	NWL CSU	02.01.14	CCG	Open	-	CCG may not be able to continue with procurement process to Contract Award if Bids are unaffordable.	4	1	4	Reduce	Competitive procurement and process for clearly defining specifications to reduce ambiguity built into processes put in place.	Develop affordability model to provide internal cost up approach to services being tendered. Ensure dialogue discussions seek to achieve solutions from the market that are affordable to the CCG.
4	Market	Market interest for the procurement is low.	CCG	NWL CSU / MM	02.01.14	CCG	Open	-	Low interest in the procurement opportunity may limit the competition possible through a tender process. Limited interest may also result in less innovative solutions being proposed through tender stage> Risk to not having enough bidders through later stages of procurement.	3	2	6	Prevent	Market engagement event delivered to encourage interest from potential providers. MOI and other procurement documentation to present the procurement as an attractive opportunity. Through MM impact assessment on providers - the may increase provider awareness / interest.	
5	Stakeholder Engagement	Outcomes of consultation exercise can not be incorporated into service specification to the satisfaction of stakeholders.	CCG	Mott MacDonald ("MM")	17.12.2013	CCG / MM	Open	-	Specification not inline with consultation outcomes. Risk of challenge by stakeholders.	4	2	8	Prevent	Detailed impact assessment exercise and public consultation commissioned from independent agency Governance proposal to include stakeholders and service users on Project Board and on evaluation panels. Separate Stakeholder Engagement Group to support development process. Additional final consultation period (4 weeks) after formal 12 week process - covering final specification.	Develop and implement robust stakeholder engagement plan. Produce patient and stakeholder information material on process and needs. Engage stakeholders in procurement process - specification development and evaluation.
6	Judicial Challenge	A member of the public or stakeholder launches a challenge against the process or decision to award a contract.	CCG	Legal	15.01.2014	Project Team	Open		Process is delayed, halted or overturned resulting in cost implications, reputational damage or inability to effectively meet CCG commissioning intentions. Resource impact of dealing with response to challenge queries - unquantified.	4	3	12	Reduce	Robust process to be followed which embeds the principles of fair, open and transparent procurement. Robust process for stakeholder engagement and consultation embedded into process.	Ensure legal advice taken where potential for challenge is increased. Continued engagement with key stakeholders including OSC. Website to make open information on procurement and changes.
7	Finance	Validation of financial projections results in business case requirement not being met.	CCG	QIPP	15.01.2014	Project Team	Open		Business case requirements not being met and projected financial savings not being achievable.	3	2	6	Prevent	Commissioning responsibilities taken into account for financial projections.	Service scope (following expert input) to be reviewed again from financial perspective to review any assumptions made in business case.
8	Stakeholder Engagement	Stakeholders do not support the changes to service proposals.	CCG	MM	29.01.14	Project Team	Open		Delays to project from additional requirements to satisfy stakeholder information or to provide evidence that CCG is undertaking proper and satified process.	4	4	16	Reduce	Set up Stakeholder Engagement Group to share proposals and take input into the development process. Ensure up-to-date information provided on Brent CCG website for public to view.	
9	Premises	Delay to availability and mobilisation of premises solution.	CCG	NHS Property Services	05. 03.14	Project Board	Open	-	Significant delay to mobilisation. Premises not meeting service delivery requirements.	5	2	10	Prevent	Engage early with NHS Property Service. Identify current property utilisation vs need for new. Determine space requirements for new services - identify potential solutions - factor into Tender process. Learn from Wave 1 Mobilisation.	

Brent CCG Wave 2 Planned Care Procurements: Project Risk Register

Ref	Event Type (Category / workstream)	Risk (Description of the risk)	Lead (Risk Owner - Organisation and name of individual)	Other Relevant Bodies (Other organisations that may be effected)	Risk Identification Date	Risk Identification Body	Status	Risk Closure Date	Potential Impact / Adverse Consequences	Impact (safety, Service Delivery, Economic, Reputation)	Likelihood	RAG Score	Risk Response (Prevent, Reduce, Transference, Acceptance, Contingency)	Embedded Monitors, Controls and Mitigations (current actions to prevent threat occurrence or limit impact)	Response: Mitigation and Control (possible future actions to prevent threat occurrence or limit impact)
10	Information Technology - readiness	IT requirements and readiness cause delays to mobilisation (including N3 connection requirements)	CCG	NHS Property Services	05 03 14	Project Board	Open	-	Delays to mobilisation process. Service start delayed Providers not ready to deliver services - or authorised for data sharing	4	2	8	Prevent	Procurement documentation to require Bidders to detail IT proposals and confirm information / governance compliance. Bidders to be requested for detailed mobilisation plans - including IT mobilisation. Availability of network connections and requirements to be identified in conjunction with NHS Property Services	
11	Activity	Changes to activity requirements change basis of procurement.	CCG		05 03 14	Project Board	Open	-	Activity volume changes - change basis of procurement and increases risk of challenge from market. Changes to activity render Bidder assumptions and bases for Bids invalid.	3	2	6	Prevent	Detailed service specification exercise - in conjunction with stakeholders and clinicians. Activity data to be mapped to OPCS codes. Final specification to be included in final tender stage - before awarding a contract.	
12	Consultation	Delays to start of consultation process - resulting from review / comments on consultation booklet	CCG	Mott MacDonald ("MM")	05 03 14	Project Board	Open	-	Comments on consultation booklet require extended review - additional time for response Causing delay to procurement process	4	4	16	Reduce	Comms Ref Group and EDEN members given 5 day review period. MOI publication should provide additional information previously sought from groups.	Proposals for revised consultation process put to NHS Brent CCG Governing Board. Response sent to PPG to address concerns raised by stakeholders.
13	Programme Management	Delays resulting from stakeholder engagement requests and management and resource required to respond diverts resource from procurement and service scope development.	CCG		19 03 14	Project Board	Open	-	Delays to project delivery and related additional resource costs.	3	5	15	Reduce	Stakeholder Engagement Group set up as a constructive development group - but may require additional resource time. Expectations on resource and time given to handle group questions and enquiries to be set clearly.	

App 6

58 Preston Hill
Harrow
HA3 9SG

3 April 2014

To: Mr Rob Larkman and Colleagues

Dear Sirs,

Re: Brent Cardiology service contract – CRM 035170

We are the Brent Heart of Gold patient support group in Brent, and we are concerned to hear that you are considering granting the contract for outpatient services both in the community and in our local hospitals to an outside organisation.

As the main patient support group in this area with around 300 members, we were not consulted about our view or experiences on existing services before they were decommissioned, or informed about the decommissioning when it took place. In fact we have been left in the dark throughout the two years that this has been going on.

We sent a letter of support to NWL Hospitals NHS Trust when they made their bid in July 2012, and this was based on our membership's view that the existing services are friendly, accessible and good. We believe that if the service is awarded to an outside body it will:

1. threaten integrated care and undermine existing preventive initiatives to educate patients on heart health and how to manage their chronic conditions;
2. introduce a cadre of specialists who will
    a. not have the interests of the local health economy at heart

b. take work and funds out of cash-strapped secondary care
c. prevent access to the secondary care doctors that we know and trust.
d. confuse patients who are admitted to hospital under a different consultant;

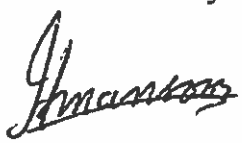
3. Undermine the award-winning heart failure service.

We would like an explanation as to why we were not consulted. Now that you have our views, how are you going to modify your plans to reflect them? We would also like your assurance that if your plans were to go ahead we and our GPs would retain the choice to consult the NWL cardiologists without going through the new service.

It does not seem logical to break up a service that works well. We suggest that the preferred bidder status of Royal Free should be withdrawn, and we wish for the existing arrangements to continue and be improved, involving local clinicians and consultants.

Looking forward to hearing from you.

Yours sincerely



Iqbal Mansoor
Chair , Brent Heart of Gold Support Group
Email: iqbalhmansoor@hotmail.com

App 7

The North West London Hospitals NHS
NHS Trust

Northwick Park Hospital
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David.Cheesman@nhs.net

28th August 2013

Luke Dealtry,
Inquiries Lead,
Cooperation and Competition Directorate,
Monitor,
133-155 Waterloo Road,
London,
SE1 8UG

Dear Luke

Re: Formal Complaint - Community Cardiology Service Procurement (NHS Brent CCG)

Further to our helpful discussion on 13th August 2013, we regret to inform you that The North West London Hospitals NHS Trust (the "Trust") is still unsatisfied with the responses it has received from NHS Brent CCG (the "NHS Brent") in respect of the above procurement process, as a result of which NHS Brent intends to decommission services from us and award them to the Royal Free London NHS Trust (the "Royal Free"). Accordingly we are submitting this formal complaint to Monitor and request that you investigate the conduct of this procurement and take such action as you consider appropriate.

In order to assist we have set out the background to this matter and the specific issues which remain of concern to us.

1. Background

1.1 *Tender Advert and Initial Stages*

1.1.1 The tender exercise for the community cardiology service (the "Service") commenced in February 2012. An invitation to bid was placed via the *Supply2Health* website following NHS Brent's decision in December 2011 to re-commission certain planned specialties beginning with Cardiology and Ophthalmology.

1.1.2 This was a two stage tender process and following the initial short-listing phase 3 of the 7 original bidders were taken through to the second stage of the tender exercise and asked to submit formal bids. We understand the three bidders remaining in the process at this stage were the Imperial College Healthcare NHS Trust ("Imperial"), the Royal Free and the Ealing Integrated Care Organisation (Ealing ICO) – which included The North West London Hospitals NHS Trust as a subcontractor.

1.2 Contract award – December 2012

1.2.1 Although the Trust understands that the original evaluation of bids took place in August 2012, the Trust was not notified until 10th December 2012 of the intended contract award. The contract award letter of 10th December confirmed that although the Royal Free and Ealing ICO had achieved the same total mark following completion of the bid evaluations, NHS Brent was intending to award the contract to the Royal Free. This decision had been reached based on a show of hands by the procurement panel on the grounds of 'better clinical outcomes[1]'. A copy of this letter is attached to this submission at Annex 1.

1.2.2 The Trust asked NHS Brent to indicate where in the tender documentation it had been explained that this would happen in the event of a tie. A copy of the Trust's letter is attached at Annex 2. The Trust did not receive a response to this request. However, on 20th December 2012 the Trust received a letter from NHS Brent (a copy is set out in Annex 3) indicating that the tender exercise had been suspended.

1.2.3 No further information was received until 12th April 2013 *when* NHS Brent notified the Trust (and presumably all other participants in the bid process) that there had

> *'been an error in the scoring of one bidder...[requiring] a detailed review of all of the scorings to check for any other errors arising in order to understand what impact this may or may not have upon the outcome of the procurement.[2].'*

The Trust was not then appraised of any further detail relating to this matter until receiving a second contract award letter on 2nd August 2013 (the "Second Contract Award Letter"). A copy of this letter is included at Annex 4.

2. Revised contract award – August 2013

2.1 The Second Contract Award Letter confirmed that NHS Brent was intending to award the cardiology contract to the Royal Free following a voluntary standstill period which would end on 12th August at 10 am. The Second Contract Award Letter confirmed that the decision followed on from 'internal and external reviews' of the procurement process.

2.2 The Second Contract Award Letter set out the Trust's scores as against those of the preferred provider. Accordingly, just one point separated the Trust's submission (347/400) from that of the Royal Free (348/400).

[1] Letter to Trust from Brent CCG, 10 December 2012
[2] Letter to Trust from Brent CCG, 12 April 2013

2.3 Following receipt of the Second Contract Award Letter the Trust arranged for one of its officers (Tina Benson – Operations Director) to attend a de-brief meeting with NHS Brent on 8th August 2013 as it wished to better understand the process and the errors that had originally been identified. In order to prepare for this meeting the Trust engaged with its solicitors (Browne Jacobson LLP) to get advice as to how to seek initial clarification about:

- the sequencing of events which led to the suspension of the tender exercise and subsequent reviews of the scoring process (including how and when errors came to light during the bid evaluation process);
- the reviews performed both internally and externally;
- what exactly happened as part of the review process (the extent to which papers were remarked, whether scores had change etc);
- the scores awarded for each question for the Ealing ICO bid and why they were awarded;
- rationale used for marking the Ealing ICO bid; and
- the apparent marking down of the Trust's bid in respect of procedures which if performed in the community would be in the Trust's view unsafe; and
- how the weightings were calculated.

2.4 Following the de-brief meeting the Trust followed up its outstanding concerns by way of email to one of NHS Brent's officers who had attended the de-brief meeting and sought an extension to the standstill period.

2.5 NHS Brent granted an extension to the standstill period until 14th August 2013 at 6 pm and responded to the Trust's email in part on 9th August 2013 and then again on 12th August 2013. These responses from NHS Brent raised additional concerns and queries for the Trust and we instructed our solicitors to write a more formal letter of concern to NHS Brent requesting:

- the actual scores received by the Trust for each individual question in the bid document;
- clarification on the extract from the RSM Tenon report which had been provided;
- details as to whether the criticism of our client's proposal to keep stress echoes in the acute setting (when it believed it was unsafe to do otherwise) had been the reason for the relevant response not achieving full marks;
- clarification as to who had been involved in evaluation;
- clarification as to comments made in the de-brief meeting about *"it all being down to the money"*; and
- clarification on scorers' comments for some question which appeared to indicate that the scorers had considered matters outside the evaluation criteria;
- confirmation as to whether NHS Brent had given any thought as to the impact a change of provider would have on patients.

2.6 Accordingly, our solicitors sent that letter on 13th August 2013 and a substantive response was received on 20th August 2013 and the standstill period was extended until 5 pm on August 23rd 2013. Unfortunately this response did not address all of the Trust's concerns and it became necessary for our solicitor to send further letters to NHS Brent's solicitors in an attempt to extract the necessary responses.

2.7 The additional and continued areas of concern relate to:

- the anonymised references to Bidder A and Bidder B in the extract from the RSM Tenon report which did not accord with what we knew about the ranking of the bids;
- the process applied to the marking of scores and to the moderation process applied thereon;
- statements made at the debriefing session;
- inconsistencies between markers comments and marking criteria.

2.8 The latest response from NHS Brent's solicitors in response to our enquiries was received on 22nd August 2013 but still leaves the Trust unsatisfied that this process was conducted in an appropriate manner.

3. Referral as a formal complaint to Monitor

3.1 The Trust remains deeply concerned with the manner in which this procurement process has been carried out and the lack of transparency offered by NHS Brent in responding to the Trust's concerns.

3.2 Accordingly we would be grateful if Monitor would now accept this letter as a formal complaint and initiate an investigation pursuant to the National Health Service (Procurement, Patient Choice and Competition Regulations) (No.2) 2013 or in the alternative the Principles and Rules of Cooperation and Competition. Please see Sections 4 and 5 below for the alleged breaches.

4. The National Health Service (Procurement, Patient Choice and Competition Regulations) (No.2) 2013 (the "Regulations")

4.1 Pursuant to the Regulations commissioning bodies such as NHS Brent must act in a certain manner when procuring health services. Regulation 2 requires a relevant health body to act with a view to:

"(a) securing the needs of the people who use the services,
(b) improving the quality of the services, and
(c) improving efficiency in the provision of the services,

Including through the services being provided in an integrated way (including with other health care services, health related services, or social care services)."

As such, we submit that NHS Brent is in breach of this Regulation for the following reasons:

4.1.1 The Trust believes that the level of prior public engagement undertaken by NHS Brent was inadequate and that consequently the process undertaken by NHS Brent was not appropriate. Although the correspondence between NHS Brent and Brent LINK (refer annex to 6) states only 'public engagement' began in April 2012, the letter also states that

"It was not our intention to formally consult on the re-commissioning of diabetes, musculoskeletal services and some elements of outpatients services, the first wave of which is cardiology and ophthalmology."

The Trust is of the view that the level of consultation undertaken was not sufficient to satisfy Regulation 2.

4.1.2 Furthermore, the Trust submits that NHS Brent has failed to act in such a way as to try and secure the needs of the people who use the services as it has not considered the wider impact of removing the services from the Trust. This is particularly important as it is the resultant loss of consultant staff which will make providing an emergency (unplanned) acute medical service for cardiac care at the Central Middlesex Hospital (CMH) unsustainable. In addition the low weighting of the award criteria applied to capacity and resilience manifestly applies a heavier risk of a wider health economy upheaval – it adversely penalises incumbent providers, i.e. those with proven capacity, and therefore applies a heavier risk towards assigning contract awards to those who resilience and capacity remain unproven. Please see the Trust's impact assessment (Annex 5) as to how the loss of planned care services will consequently affect the sustainability of the other services the Trust delivers to meet the needs of its patients.

4.1.3 The Trust has concerns that insufficient due diligence has been applied by the Commissioner in ensuring that patient choice is sustained. This is evidenced by the lack of proper public consultation on the entire planned care commissioning agenda. The Trust has also been in receipt of comments from various local patient groups who have registered concerns at these developments and this supports the Trust's contention that NHS Brent and its predecessor has failed to act with a view to securing the needs of the people who use the services as is required by Regulation 2.

4.1.4 The Trust submits that NHS Brent is not acting with a view to improving the quality of the cardiology services by reference to the manner in which stress echoes will be performed. The Trust's bid did not purport to move the performance of stress echoes into the community despite the fact that an aim of the procurement was to put cardiology services into the community. The reason for this is that the Trust has real and significant concerns about the safety of carrying out stress echoes in a community setting.

In its submission the Trust quoted a paper by Geleijnse et al on the risk of major complications in stress-echos which was published in the journal Circulation in 2010. This states that there is a 1 in 474 risk of a major life threatening complication from having a stress-echo. These, therefore, must be done in a setting with full emergency resus capability. The Trust believes that the Royal Free is proposing to carry out stress echoes in the community and that its proposal to keep it in the acute setting is a fundamental reason it was scored down in the section (Question A4) but that this is flawed given the inherent risks of performing stress echoes in the community which compromise patient safety.

4.1.5 There is also no evidence to suggest that the clinical quality outcomes would be improved based on "innovative" approaches to service delivery outlined and described in the award letters. In the Trusts view simply by virtue of being an innovative new service delivery model will not necessarily improve clinical quality outcomes.

4.2 Regulation 3(2) further requires relevant bodies to:

"(a) act in a transparent and proportionate way, and".

We submit that this Regulation has been breached for the following reasons:

4.2.1 The Trust is of the belief that matters which were not relevant to certain questions were considered when those questions were scored. The Trust has asked NHS Brent to comment on these issues but no substantive response has been forthcoming. In particular, the Trust noted in the scorers comments the following:

4.2.1.1 (Question A4. Service Delivery) – there were divergent opinions from the scorers on this question. However, one critical point is that the first scorer states *"Also, their education programme I do not believe is achievable nor will it be looked upon favourably by GPs with the amount of up skilling in the time period they are looking at."* Clarification, which has not been forthcoming, has been sought as to why consideration seems to have been given to what GPs will think when it was not evident that this would be an evaluation criterion.

4.2.1.2 (Question A11. IM&T Proposals) – The Trust has sought to ascertain whether it was marked down for failing to mention specific providers in the response to this question. The Trust strives to offer patients choice in accordance with the general NHS principles of choice and accordingly did not consider it necessary to specifically name other providers. Again NHS Brent has not specifically answered the query and the Trust is sceptical as to why there is a lack of transparency on this point.

4.2.1.3 (Question A14. Patient Outcomes) – the scorers' comments indicated a reference to discharge planning and the Trust sought confirmation that this was a reference to discharge from an outpatient service and not following admission as this is clearly an outpatient service and this appears on this face of it to be a stray reference. Confirmation has again not been forthcoming further evidence that NHS Brent is not running a transparent process.

4.2.1.4 (Question B1. Resourcing) – a reference to *"I cannot see total bid cost so no idea if this translates into good value for money compared to other bids"*. This question asked whether the Bidder proposal has a detailed understanding of the resource, sourcing and leadership requirements, with an innovative patient centred approach that is likely to produce good results. There was no reference in the question to indicate this answer would be measured as against value for money. It would, therefore, be inappropriate to do so and yet NHS Brent has refused to confirm whether that was the case despite the clear indication that it was in the scorer's mind. The Trust recognises that it was awarded full marks for this question but this is demonstrative of NHS Brent failing to act in a transparent manner both in terms of the scoring of the bid and its subsequent dealings with the Trust over its de-brief.

4.2.1.5 In other instances the Trust has noted that other factors outside the scope and remit of the bid submissions appear to have been taken into account in evaluating questions, e.g. post admission discharge matters which are not pertinent to planned care and reference to referral pathways to named alternative secondary care providers which again was not pertinent to the bid award and raise issues of transparency both in terms of NHS Brent's handling of the de-brief and subsequent queries and, perhaps more pertinently its evaluation methodology for the tender exercise. Monitor's own (current) guidance on the Regulations states at paragraph 3.3.1 that *"Commissioners must ensure that they conduct all of their procurement activities openly and in a manner that enables their behaviour to be scrutinised"*. This is clearly not the case in these circumstances. The guidance also goes on to refer to the need to provide feedback to any providers that have offered to provide services that have been unsuccessful.

4.2.2 The Trust has also noted that the papers detailing scorers' comments do not contain scoring commentaries for all the questions or do not contain commentaries from both scorers for the questions. This is particularly concerning to the Trust as this latter instance is the case in several questions where the scorers were required to agree consensus marks and yet NHS Brent is unable to properly address the Trust's concerns in this regard and demonstrate the requisite transparency in the process and permit its process to be properly scrutinised.

4.2.3 The Trust also submits that the entire evaluation process was not transparent and is in fact fundamentally flawed given the numerous errors that came to light together with the questionable process NHS Brent initially sought to employ in choosing between the Trust's bid and that of the Royal Free after the initial tie particularly as NHS Brent had no basis on which to employ 'a show of hands' to differentiate between the bids. That in itself would also be indicative of a failure to follow its own processes

4.2.4 The Trust is also bemused by the difference in scoring applied to the legal section. This was marked down in the Cardiology bid by 2 marks (a score of 14/16) and yet in a complementary bid submitted by the Trust (Ophthalmology) the Trust scored 16/16. The Trust submits that this is also indicative of non-transparent behaviour.

4.2.4 The Trust was informed verbally at the debriefing session, that it was "all about the financial section and the way this is scored" and yet the Trust had been notified it was not awarded the contract because of quality issues. It is the Trust's opinion that this inconsistency again reflects a lack of transparency in the process.

4.2.5 Finally, on the issue of the obligation to act in a transparent way, the Trust submits that NHS Brent failed to do so, when it delayed its contract award procedures for nearly 8 months with no on going communication with bidders to notify them of the reasons for this. While bidders were notified of errors discovered in the scoring templates, there was no explanation for the significant delay incurred when the external review into the matter was conducted and concluded around 4 February 2013 (the date of a report commissioned from RSM Tenon by NHS Brent).

4.24.3 Regulation 3(2) also requires commissioning bodies to act in a "*proportionate way*" when procuring health care services for the purpose of the NHS. The Trust does not believe that NHS Brent and its predecessor have acted in a proportionate way in relation to this tender exercise. To this end the Trust submits that:

4.3.1 it is disproportionate to decommission health care services currently provided by the Trust and award them to another provider when on an assessment of those two potential providers' ability to deliver the Services, NHS Brent has never been able to separate these bids by more than one mark. It would, therefore, be wholly disproportionate to transfer service delivery and risk issues associated with such service transfer for the sake of one mark. It would further be disproportionate to transfer the service when to do so risks de-stabilising the provision of other services at the Trust. The impact assessment attached (Annex 5) underpins this point and as such the Trust's view that is that it amounts to irresponsible commissioning.

4.3.2 even if it were appropriate for NHS Brent to decommission and re-tender the relevant services, NHS Brent should have structured the procurement in such a way as to give appropriate weight to the impact of a change of provider upon patients without favouring the incumbent provider. Clearly, it is possible to include criteria which enable non incumbent bidders to score full marks in relation to minimising the impact of any change on patients. Neither the questions nor published award criteria reflect this approach.

4.4 NHS Brent is obliged pursuant to Regulation 3(3) to procure services from the providers most capable of delivering commissioners' objectives and that provide best value for money. The Trust submits again, based on Monitor's own guidance, that NHS Brent has failed to do so because NHS Brent has not *"considered both the* short term *and long term impact of their commissioning decisions (including the sustainability of services)"* (paragraph 3.3.2). The Trust refers you to the impact assessments at Annex 5.

5. Principles and Rules of Cooperation and Competition

5.1 If Monitor is of the view that the conduct of this procurement should be assessed as against the Principles and Rules of Cooperation and Competition (the "PRCC"), The Trust submits that there has still been breaches of relevant provisions as set out below.

5.2 The PRCC applied, when they were in force to commissioners of NHS services. Accordingly, they would apply to commissioning of cardiology services by NHS Brent (and/or the relevant PCT which preceded NHS Brent).

5.3 Pursuant to the PRCC, commissioners must comply with Principle 1: *"Commissioners must commission services from the providers who are best placed to deliver the needs of their patients and populations"*. The Trust submits that this principle has been breached for the following reasons:

5.3.1 The rules which underpin the first principle include: "*Commissioners must commission services from providers who are best placed to deliver the needs of their patients and populations having regard to their overall present and future needs and the sustainability of the services"*. If the Trust does not remain as provider there will be a significant risk to the future delivery of the CMH acute medical service in terms of medical staff cover and appropriate supervision of inpatient diagnostics. The reasons set out in paragraphs 4.3 and 4.4 above in relation to the Regulations are equally as valid here.

5.3.2 The first principle is further underpinned by the following rule *"Commissioners must hold all providers to account through their contract for the quality of their services in a proportionate manner, in accordance with the Procurement Guide, and give existing providers two opportunities to address underperformance or implement incremental improvements, prior to engaging potential alternative providers."* The actions and behaviours for this Principle which state *"where an existing provider is underperforming commissioners should work with the provider for a reasonable period to foster improvement, for example, utilising the two stage escalation process set out in the Standard NHS Contracts."*

Principle 1 only anticipates termination or non-renewal of contracts and engagement with alternative providers when there is a failure to improve services. The Trust was not underperforming on the current contract and had no issues to address nor incremental improvements to implement which had exceeded the level set by this rule before commissioners should consider engaging other potential providers. NHS Brent's failure to renew in these circumstances can be said to be inconsistent with the first principle.

5.4 Commissioners are also required to comply with Principle 2 "Commissioning and procurement must be transparent and non-discriminatory and follow the Procurement Guide issued in July 2010". Whilst the Trust submits, that pursuant to Principle 1 it was not appropriate for NHS Brent and its predecessor to engage with alternative providers in the event that Monitor does not agree, the Trust submits that this principle applies and has been breached for the following reasons:

5.4.1 The rules underpinning Principle 2 include *"Commissioners must be able to demonstrate at each stage of the procurement process that they have acted in a transparent and proportionate manner.* For the reasons detailed above in section 4, the Trust submits that the process carried out by NHS Brent and its predecessor was not a transparent process and ultimately a breach of this Principle. The actions and behaviours which are indicative of compliance with this Principle and its rules include *"Commissioner should engage fully and transparently with existing and potential providers regarding future procurement requirements and timetables.* For the reasons submitted above the Trust submits that NHS Brent has not done this.

5.4.2 In addition, Principle 2 is also underpinned by the following rule: *"PCT Boards and other commissioners must ensure that their organisations comply with the Procurement Guide, including when considering proposals from practice based commissioners."* The Procurement Guide also refers to obligations to act in a transparent and proportionate manner and is supportive of the rule referred to at 5.4.1. above.

6. Conclusion

As you know the Trust has wider concerns in relation to the CCG decommissioning agenda and has been in separate contact with you in relation to the issue of twelve (12) decommissioning notices in March this year. However, in this matter the Trust has considerable concerns that in this case care and due diligence has been missing from the procurement process. We are of a view that considerable departure from Health Procurement Regulations and/or the PRCC (as relevant) has taken place and the Trust would appreciate that this matter is subject to your review.

Our solicitors have informed NHS Brent's solicitors that the Trust is submitting a formal complaint to you and that there have already been informal discussions. This letter has invited NHS Brent to extend the current standstill period until such time as you have completed your investigation. However, the Trust should be grateful if you would also instruct NHS Brent not to formally award the contract until your review of this complaint is completed.

I appreciate the short notice, but the extended standstill period is due to finish on Wednesday 28 August 2013 at 5pm after which time we expect NHS Brent to award the contract to Royal Free Hospital. We have discussed the possibility of pursuing this matter through the courts with our legal advisors. However, the Trust does not wish to engage in formal litigation proceedings with another health body and is of the view that a complaint to Monitor is the appropriate forum in which to resolve this matter so as to avoid the costs and negative publicity associated with formal court proceedings. Bearing in mind the stance we have taken in this matter we therefore seek your support

We trust that this is sufficient information. However, should you need anything further from the Trust please do let us know.

Thanking you in advance.

Yours sincerely

David Cheeseman

Director of Strategy
North West London Hospitals NHS Trust

cc David McVittie, Chief Executive
Rory Shaw, Medical Director, NWLHT
Tina Benson, Operations Director, NWLHT
Chris Pocklington, Deputy Chief Executive, NWLHT
Simon Crawford, Director of Finance and Contracts, NWLHT
Paul Jankowiak, Associate Director of Finance & Information NWLHT

Annex 1 – Contract Award Letter dated 10th December 2012

20121210 NWL
EALING ICO CARDIO

Annex 2 – The Trust's Letter of Response Dated 13th December 2012

RobLarkmanltr 13 12
2012.doc

Annex 3 – NHS Brent's Letter of Suspension dated 20th December 2012

To be forwarded separately

Annex 4 – NHS Brent's Second Contract Award Letter

Ealing Final 02 Aug
13.pdf

Annex 5 – Trust's Impact Assessment

Brent Planned Care
procurement Impact /

Annex 6 – Brent LINK Correspondence

Scanned Letter to
Brent LINK Represent

App 8

NHS
Bedfordshire
Clinical Commissioning Group

Agenda Item: 17

MEETING OF THE GOVERNING BODY

Date:	3rd December 2014
Subject:	MSK service
Report of:	Thomas Wilson, Director of Contracting & Performance
Summary:	This paper updates the Governing Body on the progress of the MSK service

RECOMMENDATION(S):

This paper is presented to the Governing Body for information only.

CORPORATE IMPLICATIONS:

BCCG Priorities:

The paper has resonance with all of our Corporate Objectives for 2014/15; in particular Objective 1 "Delivering Safe Services" and Objective 2 "Delivering The Bedfordshire Plan for Patients".

IMPACT ASSESSMENTS

Equalities/Human Rights

A more formal review of how the revised service is delivering to protected characteristic groups will be undertaken at a later date and as part of routine contract monitoring.

NHS Constitution

An effective MSK service is needed to improve delivery of Referral to Treatment standards locally.

Financial:

The MSK service is operating within the £26 million budget for 2014/15 previously approved by the Governing Body

Legal:

There are no specific legal implications in this paper.

Risk Management:

The risk registers of the Strategy & Redesign Directorate and Contracting & Performance Directorate reflect risks associated with the MSK service and are escalated to the Corporate Risk register as necessary.

Sustainability:

No direct immediate impact applicable to this paper.

Procurement:

No direct relevance for this paper; the Governing Body of August 2013 received a paper regarding the procurement process.

Conflict of Interest:

There are none to be declared to the Governing Body with respect of this paper.

Background

In August 2013 the Governing Body approved Circle as the preferred bidder to undertake a prime vendor contract for all MSK services in Bedfordshire. This resulted in a contract being finalised in March 2014: the contract is for five years and is for £26 million a year (not allowing for relevant uplifts for population growth agreed within the contract). The Governing Body asked for an update after six months of operation.

Contract Development

The innovative feature of the MSK service commissioned was the adoption of a prime vendor approach – a single organisation that has accountability for managing the entirety of the supply chain to deliver the outcomes specified by commissioners.

It is important therefore the prime vendor has suitable sub contracting arrangements in place to ensure that it has the capacity and capability to deliver the outcomes within the resources allocated.

Circle have formal contracted positions with:

- Horizon Health Choices who deliver all community services including the Integrated Provider Hub that receives and triages all referrals and undertakes relevant onward referrals to secondary care providers
- Luton & Dunstable University Hospital NHS Foundation Trust
- Buckinghamshire Healthcare NHS Trust
- Hinchingbrooke Healthcare NHS Trust
- BMI Healthcare (Three Shires Hospital in Northampton; BMI Saxon in Milton Keynes and BMI Manor in Bedford)
- Spire Healthcare in Harpenden, Hertfordshire
- Nuffield in Cambridge

Contract negotiations are ongoing with:

- Bedford Hospital NHS Trust
- Cambridge Hospitals University NHS Foundation Trust
- East & North Herts Hospitals NHS Trust
- Ramsay Healthcare (due for signature and commencement by 1st December)

The other of BCCG's Top 6 acute providers - Milton Keynes Hospital NHS Foundation Trust – is not in negotiations with Circle for a contract preferring to undertake MSK activity on a non contracted basis.

Bedford Hospital's position to not enter a contract with Circle at present was approved at their Board meeting in November 2014. An extract from that paper is given below:

> *It had previously been agreed that the Trust would continue to contract with the CCG until 30 Sept 14 whilst it negotiated terms with Circle. This is has done and whilst most contractual issues have been resolved the Trust had requested a minimum income guarantee for 2014/15 to safeguard the trauma service. It is intended this was for a fixed period whilst the Trust and the CCG embark on the next stage of the strategic review to set out future hospital models. Neither the CCG nor Circle has to date indicated they are prepared to support the service in this way however the CCG is further considering this stance and a meeting has been arranged in November between the Trust, Circle and CCG. Efforts have been made by all parties to resolve all differences and whilst some risks would inevitably remain the risk to the Trauma service is such that would not be in the Trust's best interests to sign a contract without any mitigation to the consequent impact on Trauma and linked services.*

As recorded above discussions between the CCG, Circle and Bedford Hospital are continuing and it is our aim to seek to support Circle and Bedford Hospital to reach a formally contracted position. The CCG's principle concerns are threefold:

- A minimum income guarantee works against the long established policy of patient choice. If patients choose not to attend a given provider but that provider has certainty of income there is no incentive for that provider to proactively work to change its services and make them more attractive to patients.
- A minimum income guarantee may well be unenforceable – not only because of national rules regarding moving away from national tariffs but also because the CCG does not actually have the money to offer as it will already have been spent at other providers
- The key concern of Bedford Hospital is the reduction in referrals to its secondary care services that effectively help to subsidise the trauma services. Whilst referrals are down from previous years due to the exercise of informed patient choice it is by no means certain that this will be sustained over a long period and as Bedford Hospital's waiting times improve one would expect to see patients choose Bedford Hospital over other local providers such as the Manor Hospital (part of the BMI Group).

The contract with Circle adopts a programme budget approach. This means that from a finance point of view a number of monitoring issues for other hospital services such as new to follow up appointment ratios and growth in activity and cost in secondary care are not an issue for the CCG since this risk is transferred to Circle.

However, because a large amount of T&O activity remains outside of the contract programme budget and is effectively treated as Non Contracted Activity a significant workload is being generated in the finance and contracting teams to reconcile money paid to non contracted providers and then claimed back from Circle. Work is continuing with all providers to make this process much slicker but it will not be resolved until Circle and Bedford Hospital have a formal contracted position.

Patient Choice

As there has been a reduction in referrals to Bedford Hospital, and in discussion with Bedford Hospital management team, BCCG sought clarification from Circle that

choice was being offered appropriately. A Contract Query Notice was issued in June 2014 to Circle so that the matter could be addressed formally and openly.

Circle have confirmed that their patient choice team use a dashboard of information to talk through options with patients – a copy of the typical information is provided at Appendix 1 from July. Circle also offered commissioners the chance to monitor the way choice conversations were handled and this was undertaken in September 2014. Bedford Hospital were also given an open invitation to attend and hear how choice was offered to patients.

BCCG has requested that it be kept informed of the way the patient choice dashboard is developed. Providers within the contracted supply chain are better able to give Circle up to date and detailed information; organisations choosing not to be part of the contract supply chain will only be able to present nationally available data from sites such as NHS Choices or My NHS which is likely to be of a more generic nature and probably less timely and accurate.

Circle have also been requested to implement telephone recording equipment so that they can more easily audit calls and provide assurance that choice is fairly offered to all patients. GP out of hours providers, for example, routinely audit a small percentage of calls each month and feedback training and learning points to both their own staff and to commissioners and this is a model that will be implemented in the MSK service shortly.

Individual cases of patient or referring clinician feedback or complaint regarding choice continue to be addressed as individual cases but there have not been enough to warrant further concern as to the way that patient choice is offered by Circle.

The Contracts Team is satisfied that any movement in referral patterns seen since the development of the new MSK model is as a result of informed patient choice rather than any abuse of the supply chain model. Circle estimate that in October 98% of patients who were referred to secondary had a conversation with a choice advisor.

Service delivery developments

At the heart of the new MSK service delivery model is the Integrated Provider Hub. Whilst it is not legally possible for the CCG to insist that all GP referrals are made via this route it is very heavily encouraged. There is no way for the CCG to currently monitor the levels of referrals to providers but data from Circle suggests that 90% of GP practices now routinely send their MSK referrals to the IPH. Electronic templates to facilitate easy referrals that contain all the relevant information have been developed and are used; 43% of referrals to the IPH in October came via electronic templates this compares well with use of Choose & Book in Bedfordshire which in

2014/15 is running at less than 30%. Recently the IPH has also started accepting self referrals direct from patients for physiotherapy for joint and muscle problems without the need for a GP appointment first.

Orthopaedic consultants from a number of NHS Trusts and private providers are now working within the IPH with more planned in the future. The aim is to create a multidisciplinary team working out of the IPH to share knowledge and enable cases to be discussed and access specialist opinion without the need to see a consultant. This will also enable direct listing to hospital operations from the IPH: this has been happening with some consultants at The Manor Hospital already; with lower limb conditions at Hinchingbrooke with spinal conditions being added from early 2015; L&D consultants should also be working in this way from early 2015 as will consultants working at Spire and Ramsay hospitals.

A mobile MRI scanner is now available at the Enhanced Services Centre in Bedford; this has improved waiting times - of those patients referred to the IPH that accept a referral to the mobile unit 100% are seen within 3 to 6 weeks dependent on patient diary. Patients that choose to attend the Luton and Dunstable Hospital and Bedford Hospital will typically experience longer waits.

Extended Service Practitioner waits have been bought down to 2 to 4 weeks and GP with Special Interest consultations are now seen within 4 weeks down from 8 weeks in April. Pain Consultant waiting times on contract commencement were at 10 weeks and are now operating at 5 weeks and continuing to reduce as the pain nurse becomes more self sufficient and competent to deal with a wider range of patients.

There are 12 physiotherapy providers contracted to Circle. The largest is run by Bedford Hospital at Gilbert Hitchcock House (GHH) and averages 800 referrals each month. There are some referrals still going directly to Bedford Hospital which means patients cannot be offered choice through the IPH to balance workload in physiotherapy providers and reduce overall wait times. Some of the physiotherapy provider contracts have been increased in terms of their capacity in order to keep waiting times as low as possible for patients. Circle have identified high waiting times for physiotherapy treatment at the Luton & Dunstable Hospital and have offered support, advice and to re-distribute patients. Work is ongoing to reduce waiting times further.

Quality & Outcomes

Overall the CCG continues to struggle to meet the 18 week referral to treatment standard (RTT) in all regards for Trauma & Orthopaedics – see the Quality & Performance Report to this Governing Body. Nonetheless some private providers locally are able to offer current referral to treatment times of under 9 weeks and NHS England have let a contract recently with The Manor Hospital for additional RTT activity in T&O.

Penalties for failing to deliver the 18 week RTT standard are applicable within the Circle contract; through national direction these fines have largely been waived in the current financial year with all providers. Individual cases of patients who have waited a long time between GP referral to the IPH and then onward referral to an acute provider are being received – directly from the Trusts concerned and from GPs using the Yellow Inform button – and these are investigated and addressed with Circle on a case by case basis. Circle have recently reported an increase in the number of administrative staff within the IPH and in November are reporting that the clinical triage of all referrals occurs within 24 hours and onward referral to community services within 48 hours of receipt; secondary care referrals are typically made within 5 days of receipt following choice conversations (where a patient does not require any community treatment first).

The Performance Team continue to work with Circle to get appropriate RTT data to ensure reporting is accurate and comes from Circle: the point of a prime vendor contract is that the whole supply chain is managed by the prime contractor and not by the commissioner. Too often currently the position for T&O is ascertained by accessing national data systems rather than direct reporting from Circle.

The monthly Service Quality Performance Report (SQPR) is still being worked on to deliver an MSK specific view rather than a Trust wide or specialty specific view: the Circle service for example excludes children and all trauma so they need to find ways with their suppliers to extrapolate MSK from overall T&O activity. It should be noted that SQPR development is a theme with all of BCCG's contracted providers irrespective of what kind of organisation they are.

The first of a series of quality meetings has been held with Circle to review the service overall. The Quality Team noted that Circle had recognised some limitation in reporting and have revised the number of staff supporting the MSK service and have recruited to three new posts relating to quality, performance and safety. Overall the feedback from the CCG's Quality Team is that more work needs to be done to gain full assurance of the patient experience within community and secondary care clinical settings but that progress is being made and Circle are responding to requests for further information.

A second innovative feature of the MSK service re-design was a move to a more outcomes based service specification. Prior to this work there were no service specifications at all for orthopaedic work in contracts with hospitals; there were some local key performance indicators (KPIs) and CQUIN (Commissioning for Quality and Innovation) schemes related to orthopaedics but not comprehensive description of what outcomes a service should be trying to achieve.

The contract won by Circle has such measures throughout it – a full service specification and description of the CQUIN scheme is attached as Appendix 2.

It should be noted however that reporting on these aspects of the service does not begin until the end of Quarter 1 of the second year of the contract. In part this was to allow for mobilisation but also because a number of measures require services to have been up and running for a period before they can be fully assessed. It is good to report that over 1,000 patient outcome measure questionnaires, using the EQ-5D methodology, have been completed and this will feed into the outcomes reporting developed for Year 2 of the contract.

Conclusion

Circle's MSK service has now been running for almost eight months and has mobilised well.

There are some risks still that need working on such as Bedford Hospital remaining outside of the formal contracted arrangements, difficulties with reporting in sufficient detail to gain a view of RTT performance within the MSK service and financial reconciliation processes.

Nonetheless the prospects of the service improving patient outcomes, reducing waiting times and reducing cost look good. Further updates should be reported to the Patient Safety & Quality Committee once outcome measures are formally reported in the second year of the contract; routine contract monitoring continues.

These are the type of risks that will inevitably arise when new models of commissioning and delivery are attempted for the first time; the risks are being managed and do not amount to a level of risk that would preclude this model from being adopted in other areas of commissioning although there are lessons to be learnt and improved upon.

Diagnostics X-Ray MRI Rheumatology Orthopaedics Knee Hip Ankle Foot Hand Wrist Shoulder Elbow	**Bedford Hospital** 01234 355122 South Wing, Kempston Road, Bedford, Bedfordshire, MK42 9DJ			
	Diagnostic Waits 7 weeks	**Orthopaedic Waits** 8 weeks	**Rheumatology Waits** 10 Weeks	**MRI** 6-8 weeks
	Patient Cleanliness Score 8.62/10	**MRSA Cases in last 3 months** 0	**C.Difficile Infection in last 3 months** 0	**Mortality Rate** As Expected
	297 Car Parking Spaces	**38** Disabled Car Parking Spaces	**£1.33** Average Parking Cost per Hour	**Park & Ride from Elstow** 0600-2300 Mon-Sat 1000-1700 Sun
	Net Promoter Score: 49			

Diagnostics X-Ray Orthopaedics Knee Hip Ankle Foot Hand Wrist Shoulder Elbow	**BMI The Manor Hospital** 01234 364252 Church End, Biddenham, Bedfordshire, MK40 4AW			
	Diagnostic Waits 2 weeks	**Orthopaedic Waits** 5-6 weeks	**Rheumatology Waits** /	**MRI** 2 weeks
	Patient Cleanliness Score	**MRSA Cases in last 3 months** 0	**C.Difficile Infection in last 3 months** 0	**Mortality Rate**
	Up to 50 Car Parking Spaces	**5** Disabled Car Parking Spaces	**£0.00** Car Park Free of Charge	
	Net Promoter Score: 96			

Appendix 1 July 2014 Patient Choice Dashboard

Diagnostics X-Ray Orthopaedics (Day Case Only) Knee Hip Shoulder Hand Wrist Foot Ankle	**Blakelands Hospital** 01908 334200 Smeaton Close, Blakelands, Milton Keynes, Buckinghamshire, MK14 5HR			
	Diagnostic Waits 1 week	**Orthopaedic Waits** 2 weeks	**Rheumatology Waits** /	**MRI** /
	Patient Cleanliness Score /	**MRSA Cases in last 3 months** 0	**C.Difficile Infection in last 3 months** 0	**Mortality Rate**
	- Car Parking Spaces	- Disabled Car Parking Spaces	£0.00 Two Car Parks Free of Charge	Frequent buses from Newport Pagnell & MK Centre
	Net Promoter Score: N/A			

Diagnostics X-Ray MRI Rheumatology Orthopaedics Knee Hip Shoulder Hand Wrist Foot Ankle Spine Elbow	**Luton & Dunstable** 01582 491166 Lewsey Road, Luton, Bedfordshire, LU4 0DZ			
	Diagnostic Waits 5 weeks	**Orthopaedic Waits** 6 weeks	**Rheumatology Waits** 9 weeks	**MRI** 5 weeks
	Patient Cleanliness Score 9.0	**MRSA Cases in last 3 months** 0	**C.Difficile Infection in last 3 months** 0.01	**Mortality Rate** As Expected
	382 Car Parking Spaces	46 Disabled Car Parking Spaces	£1.33 Average Parking Charge per Hour	Arriva or Centrebus (X31) have routes to L&D Hospital
	Net Promoter Score: 76			

Diagnostics X-Ray MRI **Orthopaedics** Knee Hip Hand Wrist Foot Ankle Spine (Minor) Elbow	**Pinehill Hospital** 01462 422822 Benslow Lane, Hitchin, Hertfordshire, SG4 9QZ			
	Diagnostic Waits 1-2 weeks	**Orthopaedic Waits** 4 weeks	**Rheumatology Waits** /	**MRI** 2-3 Weeks
	Patient Cleanliness Score	**MRSA Cases in last 3 months** 0	**C.Difficile Infection in last 3 months** 0	**Mortality Rate** Better than expected
	120 Car Parking Spaces	**8** Disabled Car Parking Spaces	**£0.00** Car Park Free of Charge	5-10 minute walk from Hitchin Train Station
	Net Promoter Score: N/A			

Diagnostics X-Ray MRI **Rheumatology** **Orthopaedics** Knee Hip Shoulder Hand Wrist Foot Ankle Spine Elbow	**Lister Hospital** 01438 314333 Corey's Mill Lane, Stevenage, Hertfordshire, SG1 4AB			
	Diagnostic Waits 6 weeks	**Orthopaedic Waits** 7 Weeks	**Rheumatology Waits** 11 Weeks	**MRI** 6 Weeks
	Patient Cleanliness Score 8.66/10	**MRSA Cases in last 3 months** 0	**C.Difficile Infection in last 3 months** 0.01	**Mortality Rate** Worse than Expected!
	457 Car Parking Spaces	**99** Disabled Car Parking Spaces	**£1.80** Average Parking Charge per Hour	
	Net Promoter Score: 85			

Appendix 1 July 2014 Patient Choice Dashboard

Diagnostics X-Ray MRI Orthopaedics Knee Hip	**Spire Harpenden Hospital** 01582 763191 Ambrose Lane, Harpenden, Hertfordshire, AL5 4BP			
	Diagnostic Waits 1-2 weeks	**Orthopaedic Waits** 1 week – 10 Days	**Rheumatology Waits** /	**MRI** 1 week – 10 Days
	Patient Cleanliness Score	**MRSA Cases in last 3 months** 0	**C.Difficile Infection in last 3 months** 0	**Mortality Rate**
	200 Car Parking Spaces	**12** Disabled Car Parking Spaces	**£0.00** Car Park Free of Charge	10 minute taxi ride from Harpenden Train Station
	Net Promoter Score: 87			

Diagnostics X-Ray MRI Rheumatology Orthopaedics Knee Hip Shoulder Hand Wrist Foot Ankle Spine Elbow	**Hinchingbrooke Hospital** 01480 416416 Hinchingbrooke Park, Huntingdon, Cambridgeshire, PE29 6NT			
	Diagnostic Waits 5 Weeks	**Orthopaedic Waits** 6 weeks	**Rheumatology Waits** 8 Weeks	**MRI** /
	Patient Cleanliness Score 9.13/10	**MRSA Cases in last 3 months** 0	**C.Difficile Infection in last 3 months** 0.01	**Mortality Rate** As Expected
	483 Car Parking Spaces	**43** Disabled Car Parking Spaces	**£0.83** Average Parking Charge per Hour ***Free for Beds Pts***	Stagecoach Buses 30, 65 & 66 connect Ramsey, St Neots & St Ives to Hinchingbrooke
	Net Promoter Score: 86			

Diagnostics X-Ray Orthopaedics Knee Hip Ankle Foot Hand Wrist Shoulder Elbow	**BMI The Saxon Clinic** 01908 665533 The Saxon Clinic, Chadwick Drive, Milton Keynes, MK6 5LR			
	Diagnostic Waits 2 weeks	**Orthopaedic Waits** 4 weeks	**Rheumatology Waits** /	**MRI** /
	Patient Cleanliness Score	**MRSA Cases in last 3 months** 0	**C.Difficile Infection in last 3 months** 0	**Mortality Rate**
	- Car Parking Spaces	- Disabled Car Parking Spaces	**£0.00** Car Park Free of Charge	Directly next to MKGH
	Net Promoter Score: 92			

Diagnostics X-Ray MRI Orthopaedics Knee Hip Ankle Foot Hand Wrist Shoulder Elbow Spinal (Aug)	**BMI Three Shires Hospital** 01604 620311 The Avenue, Cliftonville, Northampton, Northamptonshire, NN1 5DR			
	Diagnostic Waits 1-2 Weeks	**Orthopaedic Waits** 2-3 Weeks	**Rheumatology Waits** /	**MRI Waits** 1-2 weeks
	Patient Cleanliness Score	**MRSA Cases in last 3 months** 0	**C.Difficile Infection in last 3 months** 0	**Mortality Rate**
	- Car Parking Spaces	- Disabled Car Parking Spaces	**£0.00** Car Park Free of Charge	
	Net Promoter Score: 100			

Appendix 1 July 2014 Patient Choice Dashboard

	Milton Keynes General Hospital 01908 660033 Standing Way, Eaglestone, Milton Keynes, Buckinghamshire, MK6 5LD			
Diagnostics X-Ray MRI Rheumatology Orthopaedics Knee Hip Ankle Foot Hand Wrist Shoulder Elbow	**Diagnostic Waits** 7 weeks	**Orthopaedic Waits** 9 Weeks	**Rheumatology Waits** 11 Weeks	**MRI** /
	Patient Cleanliness Score 8.74/10	**MRSA Cases in last 3 months** 1	**C.Difficile Infection in last 3 months** Worse than Average – 0.02 per bed	**Mortality Rate** As Expected
	610 Car Parking Spaces	**65** Disabled Car Parking Spaces	**£0.84** Average Parking Charge per Hour	
	Net Promoter Score: 72			

	Stoke Mandeville Hospital 01296 315000 Mandeville Road, Aylesbury, Buckinghamshire, HP21 8AL			
Diagnostics X-Ray MRI Rheumatology Orthopaedics Knee Hip Ankle Foot Hand Wrist Shoulder Elbow	**Diagnostic Waits** 9 weeks	**Orthopaedic Waits** 14-18 Weeks	**Rheumatology Waits** 12 Weeks	**MRI** /
	Patient Cleanliness Score 8.84/10	**MRSA Cases in last 3 months** 1	**C.Difficile Infection in last 3 months** 0.01	**Mortality Rate** As Expected
	346 Car Parking Spaces	**21** Disabled Car Parking Spaces	**£1.50** Average Parking Charge per Hour	
	Net Promoter Score: Unknown			

Diagnostics X-Ray MRI **Orthopaedics** Knee Hip Shoulder Hand Wrist Foot Ankle Spine Elbow	**Addenbrookes Hospital** 01223 245151 Hills Road, Cambridge, Cambridgeshire, CB2 0QQ			
	Diagnostic Waits 9 weeks	**Orthopaedic Waits** 14-18 Weeks	**Rheumatology Waits** 12 Weeks	**MRI** /
	Patient Cleanliness Score 9.14/10	**MRSA Cases in last 3 months** 1	**C.Difficile Infection in last 3 months** 0.01	**Mortality Rate** As Expected
	3,200 Car Parking Spaces	**68** Disabled Car Parking Spaces	**£2.60** Average Parking Charge per Hour	Park & Ride with free parking (encouraged)
	Net Promoter Score: 50			

Diagnostics X-Ray **Orthopaedics** Knee Hip Shoulder Hand Wrist Foot Ankle Elbow	**Nuffield Cambridge** 01223 303336 4 Trumpington Road, Cambridge, Cambridgeshire, CB2 8AF			
	Diagnostic Waits 1 week – 10 days	**Orthopaedic Waits** 2 Weeks	**Rheumatology Waits** /	**MRI** /
	Patient Cleanliness Score	**MRSA Cases in last 3 months**	**C.Difficile Infection in last 3 months**	**Mortality Rate** As Expected
	108 Car Parking Spaces	**8** Disabled Car Parking Spaces	**£0.00** Average Parking Charge per Hour	
	Net Promoter Score: 100			

A.
Service Specifications

Mandatory headings 1 – 4. Mandatory but detail for local determination and agreement
Optional headings 5-7. Optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

Service Specification No.	0195
Service	**Prime Service Provider Musculoskeletal (MSK) Integrated System of Care**
Commissioner Lead	**Bedfordshire Clinical Commissioning Group, Director of Strategy & System Redesign**
Lead Service Provider Lead	**Circle Clinical Services Limited**
Period	**5 years (01/04/2014 to 31/03/2019)**
Date of Review	**Annual, from date of signatures**

1. Population Needs

1.1 National/local context and evidence base

Introducing Bedfordshire Clinical Commissioning Group

Situated within the NHS Midlands and the East region, NHS Bedfordshire Clinical Commissioning Group (BCCG, "The Commissioner") has taken over from NHS Bedfordshire Primary Care Trust as the main commissioner of local NHS-funded care for the 440,000 population registered with its member practices. It had delegated responsibility in 2012/13 for commissioning services estimated at £478million and has a commissioning budget of £430 million in 2013/14. Its members are 56 general practices organised into five localities based around natural population flows and previously well-established Practice Based Commissioning groups: Bedford, Chiltern Vale, Ivel Valley, Leighton Buzzard and West Mid Bedfordshire. The Bedford locality is coterminous with Bedford Borough Council, and the remaining four localities collectively cover the population of Central Bedfordshire Council. The locality structure is the main vehicle through which the roles and responsibilities of the Clinical Commissioning Group are exercised.

To invigorate change towards better value in healthcare locally, BCCG is adopting a fresh approach to commissioning which focuses on outcomes from both the patient and clinical perspective. Higher quality means better value and less waste, with patients getting the right care in the right place, first time. BCCG's mission is therefore:

To ensure, through innovative, responsive and effective clinical commissioning, that our population has access to the highest quality health care providing the best patient experience possible within available resources.

Our starting point is the health needs of the people of Bedfordshire. With the knowledge of our clinicians and the experience and support of our patients, we build on what works well and change what needs to work better. We do this by:

- WORKING IN PARTNERSHIP with our member practices and localities, with patients, carers and the public, with local councils, and with other healthcare providers

- USING CLINICAL LEADERS to challenge and champion, and to develop new ways of providing care in general practice

- FOCUSING ON OUTCOMES, by using our purchasing power to improve co-ordination of patient care

By working in this way, using clinicians and patients to drive change and focusing on a key set of outcome-based priorities, we believe we can both produce necessary improvements in quality and efficiency and provide financial and reputational 'head room' to invest in future priority areas.

Our commissioning challenge

These are testing times for public services. In Bedfordshire we have a growing population that is getting older and more ethnically diverse, which provides unique health and social care challenges. There are pockets of deprivation primarily in urban areas, alongside a significant number of people living in rural areas, some isolated. That puts greater demand on health and social care services.

Our strategic commissioning plan sets out three key areas of focus for our commissioning, each with a clear outcome-based target:

Care right now: urgent or unscheduled care
We will improve patients' experience of urgent care services, including walk-in centers, GP out of hours services and A&E services, so that more than 85% patients rate their overall experience as good or very good by 2015.

Care for my condition into the future: planned care and long term conditions
We will increase the proportion of people with a long term condition who feel they have had enough support from local services to help manage their condition from 66% (in 2011) to 80% by 2015.

Care when it's just not that simple: addressing complex care needs
We will work with social care to increase to at least 85% the proportion of people aged 65 and over who are still at home three months after leaving hospital for rehabilitation in the community.

Through all our commissioning activities and newly placed contracts, we will be seeking to improve outcomes in these three key areas. (This specification for MSK system of care is no exception, and we will be looking for a prime service provider that can clearly demonstrate how they will help us meet our ambitions in these key areas of focus.)

Our challenge is to continue to improve the health and well-being of our residents through times when we will no longer have the growth in funding of recent years – and indeed may have real terms cuts in

funding. In essence, we need to keep improving quality as we also improve productivity. This has been known in recent years as the QIPP challenge – Quality, Innovation, Productivity and Prevention – and, whether it continues to be known as QIPP or by another name, the need to improve productivity and value in healthcare will remain the main driver for the reform of the local health system overall.

BCCG's Plan for patients for 2013/14 set out the scale of the financial challenge facing the Bedfordshire health economy: BCCG must manage with an estimated £16million funding shortfall next financial year, around 3.5% of the total expected budget. By being innovative in *how* we commission as well as *what* we commission, BCCG will ensure it meets the fiscal responsibilities expected of it by the taxpaying public.

The local population

(from the Joint Strategic Needs Assessments for Bedford Borough and Central Bedfordshire councils)

Local demographics are one of the major factors influencing the use of healthcare resources. The incidence of MSK disorders such as osteoarthritis and osteoporosis is age-related, and in older people, bone and joint diseases are the major cause of the very high prevalence of chronic pain and physical disability. However, women, older people and poorer people are less likely to receive total joint replacement than men and those living in more affluent circumstances. Finally, living in an urban or rural setting can influence not only access to good health-care, but also exposure to environmental factors that might influence the development of musculoskeletal problems. A summary is provided below of the key features of the two parts of the population served by BCCG; further information (including the joint strategic needs assessments) is available on the websites of both local authorities.

Bedford Borough population

In 2010, Bedford Borough was home to an estimated 160,800 people, almost two-thirds of whom live in the urban areas of Bedford and Kempston, with the rest living in the surrounding rural parishes. People aged 65 and over comprise 15.5% of the total population, those aged 75 and over make up 7.5% of the total population. The rural populations tend to be older than the inhabitants of Bedford and Kempston: in the town, only 19.3% of the population are aged over 60, compared to 24.8% in the country. Average life expectancy at birth in Bedford Borough is increasing and is currently 78.9 years for men and 82.6 years for women. Male life expectancy is longer than England but shorter than East of England averages. Female life expectancy is similar to England but shorter than East of England averages. Life expectancy is increasing by about 2.6 years for men and 1.6 years for women every decade.

The numbers of people aged 65 and over are forecast to increase by 15% between 2011 and 2016 and by 26% (from 25,500 to 32,000) between 2011 and 2021. Most significantly, the population aged 85 and over (currently 3,600 people) is forecast to increase by 20% between 2011 and 2016 and by more than 40% from between 2011 and 2021.

Central Bedfordshire population

Central Bedfordshire is classified as predominately rural, and much of the area has either a suburban or rural feel. The largest towns are Leighton Buzzard (population approx. 37,000), Dunstable (population approx. 36,000), Houghton Regis (population approx. 17,000), and Biggleswade (population approx. 16,000). The total population of Central Bedfordshire was 255,200 in 2010, of which 15.3% were aged over 65, and 6.7% aged over 75. Average life expectancy at birth in Central Bedfordshire is increasing and is currently 79.5 years for men and 83.0 years for women. These are similar to East of England and better than the England averages. Life expectancy is increasing at the rate of about 2.5 years for men and 1.5

years for women every decade. The number of people aged 65 and over is expected to increase by 46% (from 37,900 to 55,500) between 2009-2021

Local case for change

BCCG currently commissions a number of different providers offering a variety of services across the whole of the musculoskeletal system. These commissioned services are run in relative isolation from each other, with differences between the model of care in the north of Bedfordshire (which includes a community-based service) and that in the south (which is predominately hospital-orientated). Between general practices, there is significant variation in the rates of referral for predominately secondary care-based specialist care, based at least in part on the knowledge and confidence within each practice to be able to manage patients with MSK conditions. GPs and patients have reported that, as a result of the silo approach to delivery of MSK care between providers; patients are often "ping-ponged" around a number of different providers until finally their problem is resolved. In addition, patients report insufficient support for self-care or shared decision-making.

Spend from all providers on musculoskeletal conditions can be considered together as a single programme budget for all MSK care. Compared with other system-based programme budgets, MSK care is the fourth highest area of spend for BCCG. The BCCG has inherited a commissioning process from its predecessor PCT that relies on having the capacity to plan for, contract with and performance manage each provider separately: this is not sustainable given the significant cut in CCG management allowances from the previous PCT staff budgets.

The evidence from patient feedback, the inefficiency of providers operating in isolation from each other, and the inequity of access to service across Bedfordshire, coupled with a realisation that continued spending on MSK provision and its commissioning is unaffordable, has led BCCG to prioritise MSK as an area for system redesign.

Delivering better outcomes for patients through integrated care

Across the MSK programme budget, there are over 20 different contracts with a number of different providers, with no integrated pathways of care, and evidence of duplication and waste, such as diagnostic tests being undertaken twice in both primary and secondary care. With siloed commissioning and siloed provision, patients can fall into the gaps between each provider.

The Health & Social Care Act 2012 and its associated national policy documents could not be more radical in their approach to healthcare provision and commissioning. Highly regarded think tanks such as the Nuffield Trust and the King's Fund both make the case for clinical commissioners to take responsibility for health outcomes, thereby aligning service planning, development and the commissioning process towards delivering tangible benefits to patients. This is underpinned by the development of the NHS Outcomes Frameworks and significant work in academic institutions to produce disease-specific outcome measures, supported and driven by patient charities such as Arthritis Research UK.

Fundamental to improving patient outcomes is the appreciation that no single provider can really improve outcomes on their own. Rather, providers within a health economy need to collaborate to improve the patient's experience of care and to ensure that, collectively, the patient's needs are met. There is strong agreement within the NHS and across external commentators that the NHS fails many of its patients

because it fails to provide "joined up" or "integrated" care.[1]The failure to provide genuine integrated care leaves most patients who suffer from long term conditions such as MSK with a patient pathway with serious holes in it and, paradoxically, with frequent duplication of care. It is the gaps in most patient pathways that lead to many of the health exacerbations that in turn lead to the hospital beds that are filled with unnecessary emergencies. Therefore one of the paradoxical outcomes from this episodic approach to the patient experience is more, and longer, stays in hospital.

Co-ordinating and managing the budget and supply chain: the prime service provider model

Taking a whole systems approach means moving beyond productive/technical efficiency (i.e. maximising the efficiency of any one institution) towards allocative efficiency (i.e. maximising the efficiency of a pathway served by more than one provider). To incentivise that collaboration and consideration of allocative efficiency, commissioners can align financial incentives for providers into delivery of a single set of outcome measures, shared by all providers within the system of care.

Outcomes-based commissioning is not a new idea: outcomes-based contracts already exist in areas such as substance misuse care and sexual healthcare. However, undertaking an outcomes-based contract for a system as broad as MSK is novel, and BCCG are aware of how innovative this approach currently is. Underpinning our ambition is a firm belief that, without considering the entire MSK system of care and using our financial resources to incentivise the delivery of improved patient outcomes, we will miss the opportunity to systematically encourage providers to identify and remove waste, duplication and poor patient experience from MSK care. A successful MSK system will ensure that the available budget delivers as much benefit to patients as possible, i.e. delivers the highest possible value of care.

Developing a genuinely coordinated care "supply chain" of healthcare for MSK from the complex and varied interactions that are necessary to make that chain work well is a highly complex task. The very different organisations that provide the very distinct aspects of this care are used to working separately, all having different perspectives and paradigms of care. Whilst it is easy to create imperfect but much better relationships between these different organisations, creating a complete interlinked and coordinated supply chain of health and social care is a logistical problem with at least the same complexity in creating the supply chain that exists in the retail trade or the automobile industry. The ' prime service provider' model provides strong power for the integrator, since they have both the clinical and financial accountability (and budget) for the whole programme of care and can create the new integrated incentives that will make integrated care possible.

In this model, BCCG will let a contract for the complete MSK system to a single organisation that will then both provide care and integrate existing and other providers into a programme of care for the Bedfordshire MSK patient population. It is the prime service provider's task to ensure that every part of the overall MSK programme is delivered in a way that joins up with the other parts of the pathway. This provides the prime service provider (with its subcontractors) the ability to construct overall pathways of care and incentives that provide BCCG, as the commissioner, with the outcomes that they want whilst remaining within the available budget.

The prime service provider will, through this contract, take on the accountability for both financial control and the delivery of a high quality MSK system of care. Providers in the supply chain must be managed to ensure each one understands and delivers its part in the delivery overall of an integrated, seamless service and that it does so whilst ensuring maximal quality of care and productive efficiency. Therefore, the prime service provider must be able to (and demonstrate that it can) manage the MSK supply chain: this is as crucial to the overall success of the system as the care delivery itself. The successful prime service provider will demonstrate his ability to marshal reporting, analysis, financial and contract management

[1]Corrigan &Laitner. The Accountable Lead Provider. Developing a powerful disruptive innovator to create integrated and accountable programmes of care.RightCare Casebook series, Department of Health. July 2012

through the supply chain whilst harmonising the overall contract management with the quality of patient care delivery.

Evidence base for change

Publications such as the Department of Health's Musculoskeletal Services Framework[2] (2006) make a strong case for the shift of MSK resources from the acute setting into the community, and delivering integrated multidisciplinary assessment and treatment that ultimately produces better value and improved patient outcomes.

In particular, the Musculoskeletal Service Framework promotes:

- Redesign of services, with full exploitation of skills and new roles for health care professionals, including Consultants trained in Sport and Exercise Medicine (SEM), GPs with special interest (GPwSI), advanced physiotherapy practitioners, and Pain Management Nurse Specialists
- Better outcomes for those with musculoskeletal conditions through more actively managed patient pathways
- Multi-disciplinary interface services – providing a one-stop shop for assessment, diagnosis, treatment or referral to other specialists – in appropriate service setting (e.g. primary/community care)
- Early decision-making through triage that identifies those people who can benefit from rapid access to local services and distinguishing from those who will require hospital referral.
- Facilitating an individual's return to independent living, including return to work or participation in education as appropriate.
- Using capacity in acute settings appropriately
- An *integrated* care pathway for musculoskeletal services that envisages the patient experiencing a seamless service across their entire journey. It places an emphasis on prevention and self-care with the patient as an active agent rather than a passive recipient.

This integrated approach, along with the other key tenants of the Musculoskeletal Service Framework as outlined above, sit at the heart of the BCCG requirement for MSK services in Bedfordshire and therefore the centre of any prime contracting solution.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	Yes
Domain 2	Enhancing quality of life for people with long-term conditions	Yes
Domain 3	Helping people to recover from episodes of ill-health or following injury	Yes
Domain 4	Ensuring people have a positive experience of care	Yes
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	Yes

[2] The Musculoskeletal Services Framework - A joint responsibility: doing it differently. DH July 2006 www.dh.gov.uk/publications

2.2 Local defined outcomes

Key business measures:

1. Number of referrals into MSK system by working day
2. Rates of referrals from general practices into the MSK system, including by BCCG locality
3. Referral triage completion times
4. Referral triage outcomes by disposition (e.g. to community-based service, hospital service, back to general practice with advice, etc)
5. Use of patient decision aids and the choices patients make as a result of using them
6. Use of Choose & Book
7. Waiting times per month against national access targets as per the NHS Constitution (including 95% non-admitted patients starting treatment within 18 weeks from referral
8. Numbers of inpatient activity in hospital (secondary) care
9. Lengths of stay by procedure, and day case rates by procedure
10. Readmission rates, by both elective and non-elective routes within 30 days of discharge
11. Numbers of adverse events, including healthcare acquired infections (HCAIs) such as *Clostridium difficile* and serious incidents and complaints, including within 90 days of planned surgery for an MSK condition (such as cardiovascular events, pneumonia, stroke, ulcers, death, others, MRSA, safeguarding)
12. Proportion of discharge summaries sent to patients and their GPs within one working day of the patient's departure from hospital and that are consistent with the latest recommendations on professional record keeping (e.g. Royal College of Physicians Professional Record Keeping Standards)
13. Financial: evidence of budgetary control. MSK-related activity carried out in line with activity and financial plans
14. Governance: risk register in place and managed

Key outcome measures:

1. Proportion of people with a long term musculoskeletal condition who feel they have had enough support in the last 6 months from local services to help manage their condition.
2. Percentage of patients referred into the MSK system categorised by:
    - Ethnicity
    - Age
    - Gender
    - CCG locality

    and compared with expected percentages based on overall population demographics
3. Patient reported improvements in health related quality of life, using EQ-5D survey pre- and post-intervention
    a. Percentage of patients self-reporting that they have returned to (self-defined) "normality" e.g. self-reported return to work, absence of pain, or self-reported return to domicile
    b. Average and range of time from first symptomatic attendance at GP practice to patients reporting they have returned to (self-defined) "normality" eg. self-reported return to work, absence of pain, or self-reported return to domicile
    c. Improvement in proportion of patients recovering to their previous levels of mobility/walking ability at 30 and 120 days
4. Patient reported improvements in health related quality of life categorised by:
    - Ethnicity
    - Age
    - Gender

- CCG locality

and compared with overall results

5. The proportion of people with rheumatoid arthritis who are diagnosed and treated within the clinically recommended period of three months from the onset of symptoms
6. Patient experience of overall MSK system
7. Proportion of patients who feel they are making an informed decision about their onward management
8. Patient reported improvements in outcomes using most appropriate score (e.g. Oxford Hip Score, Oxford Knee Score)
9. Percentage of total joint replacements (knee or hip) that required reoperation within two years
10. Proportion of older people (65 years and older) who were still at home 91 days after discharge into rehabilitation services from a planned hospital in-patient or day case MSK-related admission

Information schedule

Information requirements to assist commissioners with understanding how the system is working and any subsequent evaluations of its impact. Not performance monitored or rewarded/penalised. Would expect this information to be routinely collated and used by the prime service provider as part of management of the system.

- Number of first, follow-up & self-referral appointments:
  - per speciality, i.e. orthopaedic, rheumatology, pain
  - per clinician, i.e. consultant, ESP, clinical psychologist etc
  - per treatment type i.e. consultation, physiotherapy, joint injection etc
  - per location
- Ratio of first to subsequent outpatient/community clinic appointment
- Waiting times between first attendance at GP practice and first referral for specialist care
- Lengths of hospital stay
- No. of smokers and patients with a BMI >30 referred to the appropriate support services
- Number of all outpatient referrals who receive diagnostics by category (e.g. plain x-ray, MRI, U/S, bloods etc)
- No. of referrals made for diagnostics by type (e.g. x-ray, MRI etc)
- Proportion of referral letters triaged by a clinical member of the MSK community MDT within 1 working day
- Source of new referrals per referral (i.e. GP, secondary care, community service)
- No. of advice & guidance requests received and responded to by phone or e-mail per enquirer type (i.e. GP, patient etc)

3. Scope

3.1 Aims and objectives of service

Aims and Objectives of an integrated MSK system in Bedfordshire

The overall aim of having an integrated MSK system in Bedfordshire is to deliver high quality experiences to patients and improve outcomes, within available resources.

The integrated MSK system will be underpinned with a fixed capitation-based outcomes-incentivised prime contract. The contract holder will be accountable for financial management of MSK care, staying within the total budget made available to the contract holder, and the delivery of high quality clinical MSK care that supports patients to live their lives as fully as possible. This will improve the co-ordination of patient care and the patient experience, and produce better value MSK healthcare for the population served by Bedfordshire Clinical Commissioning Group.

By commissioning an integrated MSK system with a fixed capitation-based and outcomes-incentivised prime contract, BCCG wants to achieve the following:

To improve population health:

- Diagnose MSK conditions quickly and accurately
- Maintain good health by slowing the process of disease using effective and safe treatment and by reducing the incidence of preventable MSK-related problems
- Improve the quality of life of patients with MSK-related conditions
- Minimize the time taken to recover function following flare-ups or surgical interventions

To improve the experience and outcomes of the patients of Bedfordshire

- Improve the quality of life for people living with long term conditions and maximise their ability to live the lives they want to
- Involve patients, both individually and collectively, in their care, including agreeing realistic expectations and encouraging informed decision-making
- Deliver seamlessly integrated care for patients such that they and their carers have a positive experience of care
- Provide evidence-based pathways and service provision commensurate to level of need
- Increase the use of clinically appropriate alternatives to surgery
- Promote and support research that aims to measure and improve outcomes for patients with MSK conditions
- Support the development of staff

To lower per capita costs – delivering better value through better care

- Eliminate treatments with low clinical value from care pathways
- Focus on preventable measures now rather than treatment later as a long term sustainable solution
- Remove duplication and waste from the care pathways
- Ensure resources available are allocated equitably to the different types of MSK condition
- Plan for future increased need for MSK services due to increasing numbers of older people in the local population - without guaranteed proportional increases in funding

To enhance the overall management of the integrated system

- Improve the system of care delivery by capturing and utilising centralised management information to inform operational and strategic decision making
- Improve the current status of supply chain efficiency for MSK within Bedfordshire
- Be able to report annually on the state of MSK care (including the outcomes achieved for the funding available) to the population served

3.2 Service description/care pathway

The key stages of the MSK system delivery

The prime service provider will be responsible for developing and implementing an integrated and coordinated programme of MSK care within Bedfordshire.

The key stages of the MSK system are:

- Stage 1 – Prevention, support for self-care and advice to patients, carers and professionals
- Stage 2 – Primary Care assessment, investigation, management, and onward referral
- Stage 3 – Community-based specialist MSK triage, assessment, investigation & management
    - Stage 3a – 'Discharge'(i.e. transfer) back to support by primary care or supported self-care
    - Stage 3b - Shared decision making, patient choice, surgical listing and fitness for surgery assessment
- Stage 4 – Hospital-based specialist MSK intervention and immediate rehabilitation
    - Stage 4a – 'Discharge' (i.e. transfer) back to support by community-based specialist MSK team, primary care or supported self-care

Though referred to as stages for the purpose of this document, and numbered progressively 1-4, it does not imply that these stages must be followed sequentially once triage has taken place.

[NB: The word "specialist" to describe these stages of the Bedfordshire MSK system is used to distinguish the services from routine generalist or general practice care. They do not refer to those specialist services commissioned directly by the NHS Commissioning Board/NHS England.

Throughout the programme the prime service provider will ensure:

- Integration of care across the providers within the local supply chain
- Contract Management, administration and budget management of the overall MSK system

If at any stage of the system and/or process, there is a suspicion of a cancer diagnosis or life threatening condition, the patient **must** be referred on to the appropriate cancer or urgent care pathway as a matter of utmost urgency, in compliance with rules and procedures in force at the time for dealing with such incidents. The prime service provider will need to set out how the engagement and liaison with secondary care providers would work in practice and to agree the process for handling such urgent cases. These cases will be reported in line with national guidance where applicable.

Expectations of the key stages of MSK care

The following paragraphs set out the expectations of care at each stage by BCCG. They aim not to be didactic about how the services should be structured or run, but instead to describe how the services shall feel and what they shall deliver to users (both patients and other professionals).

The general expectations and specific requirements reflect processes that could sensibly be expected of the system co-ordinator to ensure the system's optimal performance. Not undertaking them, or with results consistently below what might be expected, may trigger investigation by BCCG of the prime service provider's ability to remain within the overall MSK programme budget and deliver a high standard of care across the MSK system.

STAGE 1 – Prevention, support for SELF-CARE and advice to patients, carers and professionals

Description

A successful MSK system of care requires an informed and empowered patient. Effective self-management support means more than telling patients what to do. It means acknowledging the patients' central role in their care, one that fosters a sense of responsibility for their own health. It includes the provision of basic information, emotional support, and strategies for living with a long term musculoskeletal condition, and not limiting available information to a leaflet or one-off class. Using a collaborative approach, providers and patients will work together to define problems, set priorities, establish goals, create treatment plans and solve problems along the way.

The prime service provider will be expected to embed this culture of patient empowerment at every stage across the system, from diagnosis to discharge. They will be responsible for ensuring that the public, patients and carers can access reliable information and support, including health coaching support, about the prevention and self-management of musculoskeletal problems, both acute, self-limiting conditions and long term conditions. In keeping with this culture of empowerment, the MSK system should also include the ability for people to refer themselves directly into the system for physiotherapy and provide local access in a variety of ways (e.g. telephone as well as face-to-face) to physio advice and support.[3]

Often patients will turn for advice early to their local general practice. Therefore, the prime service provider will be expected to ensure that all general practices (a) have appropriate information to support patient self-management (as described above), and (b) are fully aware of and able to appropriately use the new MSK system of care.

Information should be accessible to patients: this includes making it available for those with visual impairments and in the languages most commonly spoken within the Bedfordshire area (e.g. Polish Turkish, Chinese, Romanian, Dari, Urdu, Punjabi and Bengali). The sorts of information and support to be made available by the MSK system (via the prime service provider) should include:

- Information for patients based on symptoms (e.g. back pain, chronic pain) and how to deal with them
- Information for patients on common MSK conditions (e.g. rheumatoid arthritis) including an explanation of the disease to help them understand their condition
- Information for patients about their current MSK-related medication and available treatments, including side effects and the importance of compliance
- Rapid access (including out of standard working hours) to advice and appropriate treatments for patients experiencing flare up of inflammatory conditions
- General wellbeing information (e.g. on healthy diets and physical activity)
- Signposting to local and national resources, including HealthWatch and voluntary organisations
- Appropriate information for employers (e.g. on ergonomics and workplace adjustments)
- Access for health professionals to guidelines and referral protocols – including links to/content within Bedfordshire's GP referral guidance website, GPREF (www.gpref.bedfordshire.nhs.uk)

[3]As per QIPP case study by Chartered Society of Physiotherapy, available at: http://arms.evidence.nhs.uk/resources/qipp/29492/attachment

In addition, the prime service provider should ensure patients have access to timely and appropriate reactive advice should they experience problems or have concerns about how best to self-manage. This should make best use of Information Technology and may take the form of, for example, smartphone apps, a hotline telephone/text number, a dedicated e-mail address or a web-based solution, and the use of appropriate patient self-referral pathways.

STAGE 2 – Primary care assessment, investigation, management, and onward referral

Description

BCCG wants to ensure as much care is provided as close as possible to patients' homes. At the same time, it also wants to improve the overall quality of primary care, and local general practitioners are keen to maintain and develop their MSK-related skills. In this MSK system, the prime service provider will be expected to work with local practices in all localities to ensure timely, high quality and high value assessment and management of musculoskeletal problems within primary care. This will mean the MSK system establishing a *de facto* norm of the level of MSK care that a standard general practice should be able to deliver, and then supporting practices to achieve, maintain and, if possible, exceed that norm.

This should ensure not only that all patients receive straightforward MSK care and support near to their homes regardless of which practice they are registered with, but also that the prime service provider can reduce the volume of patients needing to access more specialist (and more costly) care within the MSK system.

In order to deliver these outcomes, we expect the prime service provider to:

- Support local GPs to make best use of the new MSK system (and the protocols and pathways established by it) by building and maintaining strong professional links with local general practices and localities. This may take the form, for example, of developing protocols in conjunction with GPs, and delivering and participating in education and training sessions using established protected learning time sessions and specific time with individual practices
- Use available information to spot, isolate and re-engineer unwarranted variation and overuse of specialist MSK by local general practices. This information may come from:
    - Numbers of patients on general practice registers for MSK conditions
    - Audits of the number and quality of referrals and requests for relevant investigations from general practice
    - Performance data from QOF, and Directed and Local Enhanced Services
    - Other available data such as rates by practice of first and follow-up outpatient appointments and elective procedures (including day cases), numbers of prescriptions for drugs commonly used in MSK conditions (e.g. BNF Chapter 10), and information from the National Joint Registry
- Work with practices to ensure they all can consistently provide the levels of MSK care expected from primary care. This may require identifying a named MSK lead for each practice to use as a source of advice on management of complex MSK conditions (including pain control) and training on when and how to undertake specific procedures (e.g. joint injections).
- Ensure that MSK care provided in general practice is safe and follows best practice and national guidance. This may entail, for example, supporting the practices or localities with regular audits of the clinical outcomes of MSK procedures undertaken within primary care.

- Equip GPs with the skills and knowledge to support patients who have stable MSK conditions and agreed management plans, including facilitating care shared between the MSK system and the practice
- Make it straightforward for GPs to seek advice and/or refer patients for onward care once all options for local management within the practice have been exhausted
- Ensure that GPs refer promptly for conditions, such as suspected inflammatory arthritis, that require rapid access to treatment
- Help steward the use of NHS resources and reduce patient exposure to harm by eliminating unnecessary investigations including imaging and blood tests, whilst ensuring appropriate access to investigations directly from primary care. This may involve working with BCCG to create indicative practice-based budgets for MSK investigation and management.
- Promote primary and secondary prevention by, for example, ensuring patients are referred for appropriate lifestyle interventions, e.g. smoking cessation, weight management, and supporting practice nurse development in offering self-care and lifestyle management advice
-

STAGE 3 – Community-based specialist MSK triage, assessment, investigation and management

Description

Once a GP has decided that a patient's care would benefit from more specialist MSK advice and management or if a patient makes a self-referral for support, the referral process into the MSK system is triggered. The referral and triage process will feel straightforward to use and minimise the time between the decision to refer and the first patient encounter with the most appropriate specialist for his/her condition.

In particular, this referral and triage process will deliver the following:

- A single electronic referral process for all MSK conditions, including urgent cases, that guides referring professionals to provide all necessary information and therefore ensure onward care is not delayed. It may, on occasions, be necessary to discuss the cases with the referring clinician and/or the patient in order to fully assess the most appropriate care pathway for that patient.
- Referral protocols and/or templates will prompt the referring clinician to seek permission from the patient for their information to be shared, when necessary and in the best interests of their care, with other providers within the MSK system's supply chain
- During triage, referrals are reviewed by an appropriately qualified clinical specialist, familiar with the local MSK system and associated providers, who will assess the appropriateness of the referral, the urgency of the referral and to which pathway to allocate the referral.
- Given the common finding that a significant proportion of serious or urgent cases are never referred as such, there is an expectation that all MSK referrals will be triaged within one working day of receipt.
- The onward care of patients after triage of referrals should be to the specialist that is best placed to address the patient's problem quickly and efficiently, thereby returning the patient to "normality" as quickly as possible. Where appropriate, referrals may be passed straight back to primary care with advice and an on-going management plan. However, in those cases, the practice should be supported to ensure the management plan can be delivered and any learning need is identified and addressed (as per Stage 2).
- Due attention will be paid to the referring clinician's assessment of patient needs and requested clinical management support including clinical letter and/or correspondence attached to the referral

- Patient choice will be respected

This single triage process will not delay the patient journey; the prime service provider will be expected to use opportunities provided by technology and the professional relationships within localities/practices and supply chain providers to be innovative about how triage is undertaken to maintain the straightforward user experience but ensure high quality clinical decision-making.

Should a patient's referral indicate that they have 'red flag' signs or symptoms or suspected cancer, then the prime service provider must ensure that they are fast-tracked to the relevant urgent services.

Routing all referrals through a single process provides the opportunity to:

- Identify trends in patients' conditions
- Identify training and support needs in primary care
- Better plan and map the supply of MSK specialist resources to meet the MSK population demands, thereby providing a system tailored around needs rather than capacity

Once the patient has been referred into the MSK system, the expectation is that the system will provide necessary MSK care and support for the patient until such times as their MSK needs have been resolved to the patient's satisfaction and can be supported within general practice or by self-care. Some patients may be referred into the MSK system with a significant element of diagnostic uncertainty (e.g. those with groin pain). In these instances, the prime service provider should work swiftly to establish any MSK cause for the symptoms/signs or, if no such MSK-related condition can be established, liaise with the referring clinician on further management.

The emphasis will be on patients as partners in their care, which will include:

- Services provided at locations convenient to patients (and taking account of BCCG's locality structures)
- Opportunities taken to shorten the time between the patient entering the MSK system and receiving appropriate care (such as one-stop assessment, diagnosis & treatment clinics)
- Clinicians ensuring that patients have access to sufficient information to enable their understanding of both their condition and the care they are receiving (see stage 1).
- Patient decision aids (e.g. RightCare patient decision aids) used wherever possible
- Long term MSK conditions managed taking into account each patient's particular co-morbidities and circumstances. Personal care plans are developed jointly between clinician and patient, and include patients' personal goals, their choice of options for care and how to best access that care (e.g. through the use of personal health budgets)

The prime service provider will ensure wherever possible, appropriate access to all the necessary diagnostic tests (such as X-ray, MRI, CT, MSK ultrasound, Nerve Conduction Studies and specialist blood tests). All MSK related unbundled diagnostics shall remain the responsibility of BCCG during the first year of the contract. However it is anticipated that they will be incorporated within the scope of the prime service provider contract as soon as deemed appropriate (Year 2 of the contract onwards) subject to a Programme Budget revision.

The expectation is that care for many MSK conditions does not require acute hospital resources. The prime service provider will provide clinical assessment by the most appropriate member of its specialist

multidisciplinary team of patients referred to it (unless another course of action is clinically appropriate and ensured). Treatments and care will include but not be limited to: physiotherapy; podiatry; joint injections; depomedrone injections; biologics; OT; psychological treatments; acupuncture; minor surgery (including Carpal Tunnel Decompression); Podiatric surgery; orthoses; bio-psychosocial pain services; lifestyle advice e.g. smoking weight and alcohol; and appropriate support from voluntary or social care services.

Led by the prime service provider, the MSK system will strive to be a high-value learning organisation, using the lessons from elsewhere to foster a culture of self-study, measurement and oversight. Information on clinical processes and outcomes will be captured, measured and monitored by clinical audit, such that the prime service provider can continue to refine and improve its pathways and infrastructure to best meet the needs of the MSK patient population.[4] As new technologies emerge to support this, the expectation is that the prime service provider will be an early adopter.

STAGE 3a–'Discharge'(i.e. transfer) back to support by primary care or supported self care

Description

Once a patient is referred into the MSK system, it is likely, given the long term nature of their condition, that they will remain known to the system and therefore the term 'discharge' should be used with caution, and the term 'transfer' is preferred. The degree of contact between the patient and the system will be determined by the nature and severity of the patient's MSK condition. It is envisaged that, once a patient has reached a stable clinical MSK state and has a management plan with which they agree, their care may return to be predominately self-care, supported if necessary, by general practice – in effect, returning to stages 1 or 2 as described above.

As part of this transfer back to primary care or self-care, the patient will receive a summary of the key points from their journey through the MSK system, including the on-going management plan. An electronic copy of this summary will be sent to the patient's GP within one working day of the patient's transfer.

Should the patient's condition require further input from the MSK system, the prime service provider will be responsible for ensuring continuity of care from their previous experience with the MSK system and making the process of obtaining necessary expert support and care as seamless as possible. This may entail, for example, allowing direct patient contact with identified MSK system specialists and the ability for patients to self-refer.

It is expected that the prime service provider will continuously monitor the MSK system's processes and outcomes to ensure that patient journeys within and through the system, from point of referral to point of transfer back to self-care, deliver the best outcomes within the resources available.

STAGE 3b – Shared decision making, patient choice, surgical listing and fitness for surgery assessment

Description

[4] Bohmer R. The four habits of high-value healthcare organizations. NEJM 2011; 365: 2045-47

When surgery may be an appropriate clinical intervention, the MSK system providers will help the patient decide whether surgery is appropriate for their personal circumstances at that time. Patients will be given all relevant information, including the nature of the surgical intervention, what to expect during their hospital stay and from their recovery, any potential complications that might happen and what can be done to minimise those risks. Use will be made of decision support information and tools (e.g. Right Care patient decision aids) where these are available.

When the patient wishes to progress to surgical intervention, they will be offered a choice of provider, which may be either NHS or independent sector. Patients will feel able to make an informed choice of provider, and suitable appointments made via the Choose & Book facility where available. Appropriate (based on the individual patient and planned procedure) assessments for fitness for surgery (initial pre-operative assessment) will be undertaken. Opportunities (e.g. direct listing onto a surgical waiting list without the need for additional appointments) will be taken to shorten the time between the patient entering the MSK system and receiving appropriate care.

Forward planning for patients' needs after their hospital stay will be expected, such that hospital discharge planning starts before the admission even occurs. The patient will therefore be aware of their expected length of stay and the support they should expect to receive afterwards.

STAGE 4 – Hospital-based specialist MSK intervention and immediate rehabilitation

Description

The aim in this stage is to provide safe, high quality inpatient or day case care that delivers a positive patient experience, good clinical outcomes, and returns each patient to independence as quickly as possible. Patients will be informed about and prepared for their hospital treatment before their admission starts. Hospital facilities shall only be used when it is not possible to safely undertake the patient's care in a community or home setting (for example, when they require specialist surgical or anaesthetic teams).

The prime service provider will ensure:

- Appropriate protocols and techniques are used, consistent with NICE and other recognised professional guidance, for all MSK surgical procedures
- The hospital and community-based teams work together to move patients out of hospital beds and back into their homes as soon as clinically and safely possible.
- Opportunities will be taken to safely shorten the time between hospital admission and discharge, including, for example, providing rehabilitation care in or close to patients' homes, and ensuring carers feel sufficiently supported to look after their relative.
- Patient experience and outcomes are measured, collated, analysed and acted on as a matter of routine

This close working relationship between hospital-based and community-based teams will require significant trust between professionals and teams to each perform their role to a high clinical standard. The prime service provider will be responsible for fostering and maintaining that trust with the acute hospital facilities and teams most frequently used by the Bedfordshire population. It is expected that the use of clinical audit, appropriate comparisons of key clinical outcome metrics between local providers, and sharing of best practice between local specialist providers will drive up the quality of care overall within these providers.

BCCG remains responsible for any consultations with patients and the public on service reconfiguration. If, during the tenure of this contract, reconfiguration of specialist hospital MSK services is envisaged at one

or more of the local acute hospital trusts within the prime service provider's supply chain, then the prime service provider would be expected to identify this at an early stage to BCCG , and co-operate with BCCG throughout the consultation process, including advising on the impact of such reconfigurations on the quality and safety of MSK care for patients.

STAGE 4a–'Discharge'(i.e. transfer) back to support by community-based specialist MSK team, primary care or supported self care

Description

Once the immediate hospital episode has been completed, patients' care should be discharged (or transferred) to the most appropriate out of hospital support system, i.e. either the community-based specialist MSK team, general practice, or supported self-care. The nature and severity of the patient's MSK condition and the success of the surgical intervention will determine the degree of on-going contact between the patient and the MSK system.

On the day of leaving hospital, the patient will receive sufficient medication to last until their follow-up contact with either general practice or the community-based specialist team. As part of their transfer of care, the patient will also receive a summary of their hospital episode, including the on-going management plan. An electronic copy of this summary will be sent to the patient's GP within one working day of the patient's departure from hospital, including communication with relevant social care services if necessary.

Should the patient's condition require further input from the MSK system, the prime service provider will be responsible for ensuring continuity of care from their previous experience with the MSK system and making the process of obtaining necessary expert support and care as seamless as possible. This may entail, for example, allowing direct patient contact with identified MSK system specialists and the ability for patients to self-refer.

It is expected that the prime service provider will continuously monitor the MSK system's processes and outcomes to ensure that patient journeys within and through the system, from point of referral to point of transfer back to self-care, deliver the best outcomes within the resources available.

3.3 Population covered

This specification refers to an MSK system of care for adults (aged 18 and over) who are either registered with a general practice member of Bedfordshire Clinical Commissioning Group or otherwise the commissioning responsibility of BCCG, and are eligible for NHS care

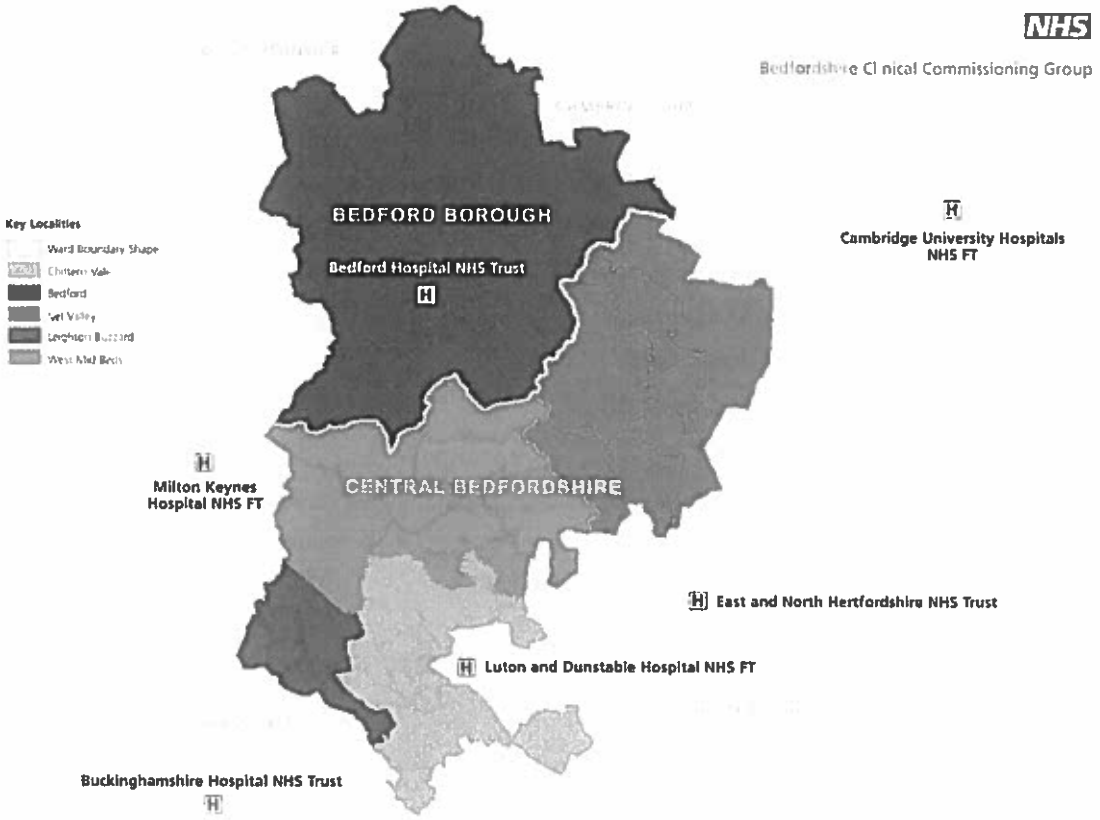
Geographic scope

Bedfordshire Clinical Commissioning Group necessarily operates through its locality structure (see Figure 1), which is based on natural patient flows around Bedfordshire's market towns and larger villages. It is **essential** that MSK services will be delivered across Bedfordshire and within each of the five localities that comprise of BCCG. The delivery of the MSK system will be expected to recognise and reflect the strong locality culture in Bedfordshire, including adapting to the different characteristics of each locality (e.g. the relative urban nature of Bedford Locality compared to the very rural nature of West Mid Bedfordshire).

Five Bedfordshire CCG Localities

- Bedford Locality
- Ivel Valley Locality
- West Mid Beds Locality
- Chiltern Vale Locality
- Leighton Buzzard Locality

Figure 1: Map of Bedfordshire CCG's five localities



3.4 Any acceptance and exclusion criteria and thresholds

IN SCOPE

This specification refers to an MSK system of care for adults (aged 18 and over) who are either registered with a general practice member of Bedfordshire Clinical Commissioning Group or otherwise the commissioning responsibility of BCCG, and are eligible for NHS care. This system of care should encompass the diagnosis, treatment and management of all diseases of the musculoskeletal system and connective tissue as set out in Chapter XIII of the International Statistical Classification of Diseases and Related Health Problems, 10th edition (ICD-10).

By definition, care funded financial MSK programme budget 12/13 scope, as described within this document, is within clinical scope. All MSK related unbundled diagnostics shall be incorporated within scope as soon as adequate data has been collected to enable a reasonable estimate of the total annual MSK

diagnostic spend (assumed to be at least Year 2 of the contract onwards and the budget revised accordingly based upon outturns).

Treatment conditions that are included within the overarching services of this specification are listed in the table below (based on the "A-Z of MSK diseases", The PCR Society Guide to Commissioning Musculoskeletal Services, 2011) and will encompass the diagnosis, treatment and management of all diseases of the musculoskeletal system and connective tissue as set out in Chapter XIII of the International Statistical Classification of Diseases and Related Health Problems, 10th edition (ICD-10).

:

Services	**Treatment conditions (this is not an exhaustive list and other MSK conditions will be expected to be treated)**	
Upper Limb	Repetitive strain injury Shoulder instability Shoulder bursitis Rotator cuff tendonitis Rotator cuff tear	Biceps tendonitis Frozen shoulder Calcific tendonitis/Supraspinatis calcification Acromio-clavicular arthritis Gleno-humeral arthritis
Hand	Skeletal and soft tissue injury to the hand and wrist Work related musculoskeletal disorders Peripheral nerve injury/compression (e.g. carpal tunnel)	Tendon injury Hand/wrist problems related to rheumatic conditions Dupuytren's disease Osteoarthritis
Hip and knee	Hip bursitis Inflammatory hip or knee pain Non-specific hip or knee pain Labral tear Greater trochanteric pain Iliopsoas strain	Pubic bone/abdominal wall related pain Anterior knee/patellar pain & sprain Meniscal condition knee Cruciate ligamentous condition knee Osteoarthritis
Foot and ankle	Heel spur and Plantar Fascitis Ankle sprain/instability Achilles tendonitis Tarsal tunnel syndrome Tibialis posterior/peroneal tendonitis/strain Medial gastrocnemius strain Anterior/posterior ankle impingement	Osteo-chondral defect ankle/foot Metatarsalgia Hallux Valgus/rigidus Hammer toe Sesamoiditis Tailor bunion Osteoarthritis

Back	Chronic lower back pain Non-specific back pain Mechanical back pain Discogenic back pain	Facet syndrome Spinal stenosis Spondylolysis/listhesis	
Rheumatology	Inflammatory arthritis Osteoarthritis Osteoporosis Reactive arthritis	Connective tissue disease Gout Fibromyalgia	
Chronic Pain	Medically unexplained symptoms of pain General musculoskeletal pain Myofascial pain syndromes Post-thoractomy pain Chronic regional pain syndromes Stump and phantom limb pain		
Generic	Managing patients with MSK conditions who are obese or with BMI greater than surgical acceptance limits Osteoporosis assessment and management		
Health Promotion/ Prevention	Falls prevention Facilitate return to work		
Elbow	Tennis/golfer elbow Osteo-arthritis Loose body Nerve entrapment		
Neck	Acute non-specific neck pain Persistent non-specific neck pain		

Areas of specialist interventions and workforce that are in scope include:

- Consultant Services
- Non-consultant career grade staff
- GPwSI
- Advanced physiotherapy practitioners
- Physiotherapists

- Podiatrists
- Clinical Psychologists
- Specialist Nurses
- Acupuncturists
- Hand therapists
- Joint injections
- Management of biologics
- Pain management (to include epidural & nerve root injections)
- Podiatry biomechanics and/or surgery
- MSK related Plastic Surgery
- MSK related unbundled diagnostics (as soon as adequate data has been collected to enable a reasonable estimate of the total annual MSK diagnostic spend (assumed to be at least Year 2 of the contract onwards
- Radiologists/Radiographers (as soon as unbundled diagnostics are incorporated within scope as per above)

OUT OF SCOPE

The expectation is that the Bedfordshire Integrated MSK System of Care will not include the assessment and management of:

- Suspected cancer
- Immediate life threatening conditions
- Acute trauma
- MSK or any other conditions in children (aged 17 and under)
- MSK patients on a maternity or gynaecology (the latter being appropriate to chronic pain only) pathway
- patients subject to Specialist Commissioning in accordance with the prevailing Identifications Rules whom shall be the responsibility of NHS England on a pass through payment with BCCG;
- specialist paediatric rheumatology and specialist paediatric orthopaedic surgery services
- Orthotics
- Unbundled diagnostics in Year 1 (it is anticipated that diagnostics will be incorporated within scope as soon as adequate data has been collected to enable a reasonable estimate of the total annual MSK diagnostic spend (assumed to be at least Year 2 of the contract onwards);
- Primary Care Drugs
- High Cost Drugs
- and
- any non-MSK related conditions;

(Whilst this system specification does not include trauma care pathways, there may be scope for adding, in later phases of the contract, the post-operative care of people who have sustained fractures, subject to planning and negotiation between Bedfordshire CCG and the prime service provider.)

Specialist paediatric rheumatology and specialist paediatric orthopaedic surgery services are out of the scope of this specification and will be commissioned directly by the NHS Commissioning Board/NHS England specialist commissioning teams. However, the prime service provider will be responsible for

working with paediatric MSK specialists to enable a smooth transition from paediatric to adult MSK care of any young persons with MSK conditions as they approach the age of 18. BCCG will, in parallel, work with the NHS Commissioning Board/NHS England specialist commissioners to ensure smooth transition of commissioning responsibilities for this small cohort of patients.

Elective specialist orthopaedic services (adults) are those services not generally provided in local general hospitals and provided by adult specialist orthopaedic centres. They include management of rare conditions and complex procedures only. Specialist spinal services (including the management of spinal cord injury and complex spinal surgery) are those services provided within specialist spinal cord injury or specialist spinal surgery centres, including out-reach. Commissioning of both of these specialist services will be undertaken directly by the NHS Commissioning Board/NHS England and therefore they are excluded from the scope of this specification. However, the prime service provider will be responsible for accepting referrals from the specialist services of any patients who have been discharged after treatment within elective specialist orthopaedic or spinal services but who require on-going general (non-specialist) MSK care. BCCG will, in parallel, work with the NHS Commissioning Board/NHS England specialist commissioners to ensure smooth transition of commissioning responsibilities for this small cohort of patients.

If at any time in the future, the definitions of specialist MSK care commissioned by NHS Commissioning Board/NHS England change, then Bedfordshire CCG reserve the right to amend the scope of this MSK integrated system (and the programme budget) accordingly

Treatments for which restrictions have been recommended by the Bedfordshire and Hertfordshire Priorities Forum will be out of scope of this specification as per the Forum's policy, unless the patient's case has been approved by BCCG through the Individual Funding Request process. It is the prime service provider's responsibility to monitor for changes to the Low Priorities policies; any amendments to the policies are published on the Forum's website.

NHS Bedfordshire CCG will only fund high cost drugs and technologies in line with the East of England High Cost Drugs Commissioning Arrangements 2009-10 (or any arrangements which supersede these). High cost drugs and technologies are defined as those excluded by the Payment By results mandatory tariff.

In addition, any service or activity related to any service that the provider wishes to provide (and is not contained within this service specification) will not be funded by BCCG unless agreed with BCCG.

3.5 Interdependence with other services/providers

Integration: interdependencies with other services

There will be a requirement for the service provider to work with key stakeholders and integrate with other services in the development of accessible, enhanced and actively managed care pathways, taking into account:

- The needs of the local community
- The opportunities of the Bedfordshire infrastructure

- The local agenda of NHS Bedfordshire CCG, which allows for self-care management strategies as part of a responsible service delivery.

In addition to co-ordinating the roles and responsibilities of providers within the MSK system, the prime service provider must also ensure appropriate and constructive relationships with other aspects of the Bedfordshire health and social care economy. Examples of these are:

- Bedford Locality
- Ivel Valley
- West Mid Beds
- Chiltern Vale
- Leighton Buzzard
- Bedford Borough Council
- Central Bedfordshire Council
- Voluntary sector organisations (e.g. Age Concern, Red Cross)
- Providers of diagnostic services, including those providers contracted through 'Any Qualified Provider' to provide non-obstetric ultrasound and MRI services to Bedfordshire patients
- Local acute hospitals providing a range of services beyond MSK, including Emergency Medicine and Trauma
- Community-based services, including community nursing and social care services
- Healthwatch Bedford and Healthwatch Central Bedfordshire, acting as signposts and advocates for patients and the public in the two local authority areas covered by BCCG
- Any relevant local clinical networks and support programmes. (Note: Screening is not an integral part of this service.)

This list is not exhaustive and may increase as the MSK system becomes established.

Promoting a culture of innovation and continual improvement will be sought through:

- Regular dialogue with BCCG to discuss proposed service improvements/enhancements
- Regular dialogue with Bedford Borough Council & Central Bedfordshire Council on community issues and developments.
- Development of education and promotion of self-care management and exercise strategies during intervention time with assigned healthcare professionals in collaboration with other practitioners and organisations
- Continuing liaison with local NHS Trusts and universities to ensure through latest research that interventions continue to be appropriate and sensitive to local ethnic, religious and gender needs
- On-going feedback from questionnaires with a variety of indicators (e.g. service and perceived quality, location of services, responsiveness and waiting times)
- Participating in community events including those with a health promotion focus
- Working with hard to reach groups and carers through community events to reduce inequalities in health and accessing health services
- Running patient participation groups and focus groups to seek views and improvement opportunities
- Training for junior doctors as part of their teaching programme and supporting GPwSI accreditation where appropriate
-

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

- Relevant NICE Guidance regarding MSK conditions (e.g. non-specific back pain, May 2009)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

- The NHS Outcomes Framework 2013/14, which aims to act as a catalyst for driving up quality by encouraging a change in culture and behaviour towards improving patient outcomes from care and experience of care
- The Health & Social Care Act 2012 which requires patients to be involved in decisions relating to their care and promotes far more services being delivered safely and effectively in the community or closer to home.
- Corrigan & Hicks. What organisation is necessary for commissioners to develop outcomes based contracts? The COBIC case study. RightCare Casebook series, Department of Health. October 2012
- Corrigan & Laitner. The Accountable Lead Provider. Developing a powerful disruptive innovator to create integrated and accountable programmes of care. RightCare Casebook series, Department of Health. July 2012
- Chartered Society of Physiotherapy. Integrated Musculoskeletal Services. Guidance for physiotherapy leads – developing a quality service. August 2012
- Briggs T. Getting it right first time. Improving the quality of orthopaedic care within the National health Service in England. (Available at: http://www.timbriggs-gettingitrightfirsttime.com/report/ Last accessed 31 March 2013)
- Corrigan & Nye. Pennine MSK Partnership. A case study of an integrating pathway hub (IPH) "prime contractor". RightCare Casebook series, Department of Health. April 2012
- The PCR Society Guide to Commissioning Musculoskeletal Services. Primary Care Rheumatology Society. September 2011
- National Audit Office. "Services for People with Rheumatoid Arthritis". July 2009.
- Department of Health "Self-referral pilots to musculoskeletal physiotherapy and the implication for improving access to other Allied Health Professional Services" (October 2008)
- Arthritis and Musculoskeletal Alliance (ARMA) Standards of Care (2007-8), including overarching principles of care and specific guidance for osteoarthritis, inflammatory arthritis and back pain in addition to new guidelines published including regional musculoskeletal pain. This series of guidelines is driven by the perspective of the various user groups, focusing on the journey of care as experienced by the patient.
- Relevant NICE Guidance regarding MSK conditions (e.g. non-specific back pain, May 2009)
- Guidance from the British Pain Society, British Society of Rheumatology and the British Orthopaedic Association
- The Map of Medicine or other similar collection of evidence-based, practice-informed care flow diagrams, which connect all the knowledge and services around a clinical condition.

4.3 Applicable local standards

Measuring and monitoring patient experience and outcomes

The ability to systematically measure and monitor patient experience and outcomes is a fundamental part of the MSK system. The prime service provider must ensure the following:

- Data are collected on sufficient numbers of patients to have a representative sample
- Real-time patient feedback is collected at the point of service use about their experiences, and at future points to collect feedback about their outcomes
- National requirements to record patient reported outcome measures (PROMs)are met
- Particular efforts are made to collect patient experience feedback from seldom-heard groups and carers.
- Multiple channels are available for feedback dependent on patient choice, which include qualitative and quantitative methods of engagement.
- A complaints procedure is in operation that complies with legal requirements

- A "learning from complaints and compliments" system is in place for the MSK system that responds appropriately and in a timely manner to issues raised through complaints, Serious Incidents, PALS and patient experience feedback, as they arise.

To achieve this, it is expected that the prime service provider will be innovative in capturing patient experience and outcomes. As BCCG develops its general Patient Experience Programme, the prime service provider will be expected to work with BCCG to share learning.

Contract management, administration and budget management of the MSK system

Sub-contractors

Providers will be able to evidence that any sub-contractors used are appropriately qualified. The provider must also ensure that any subcontractors comply fully with all aspects of the contract.

Outcome and Business Measures

Providers will be required to deliver a suite of data against indicators and outcome measures to provide assurance to BCCG that high quality, safe, high value co-ordinated patient centred care is being delivered within the MSK system..

Quality and Clinical Governance

Service providers will be required to adhere to national standards and service frameworks, as well as a local Clinical Governance policy agreed by BCCG. The prime service provider will ensure the routine use of regular staff, and not be dependent on locums or temporary staffing.

The prime service provider will report concerns of abuse in line with the local Multiagency protocol for Safeguarding Vulnerable Adults.

Staff qualifications and training

The prime service provider must have processes in place for assuring itself and in turn BCCG that staff working within the MSK system are appropriately qualified and maintaining their specialist skills.

This will include:

- Peer review arrangements for consultants
- Performance management of staff using key performance indicators
- Annual appraisal for all staff including 360 feedback, agreeing professional development plan
- Clear training programmes for all staff including mandatory training
- Risk management processes and procedures
- Quarterly audit to review outcomes, patient & customer satisfaction, risks and incidences

Expectations on clinicians will vary depending upon the individual. As a minimum, clinicians will have appropriate qualifications, experience and proof of relevant training. These will include:

Orthopaedic Consultants

- MB ChB or equivalent
- Full and specialist registration with the UK GMC, Certificate of completion of training, Intercollegiate Specialty Exam

Rheumatology Consultants

- MB ChB or equivalent,

- MRCP, Full and specialist registration with GMC, Certificate of completion of training

Rheumatology Registrar

- MBBS or equivalent, MRCP Part 1 (UK) or equivalent, Fitness to Practice

Advanced Practitioner Physiotherapist

- Minimum of 5 years experience in the field of MSK
- Evidence of specialist CPD
- registered with the Health and Care Professions Council (HCPC) MSCP
- Evidence of a relevant Masters module for the ESP role (upper limb or spinal lower limb) – or a requirement to complete this within two years

GPwSI

- Will be expected to be competent to the levels outlined within the Department of Health GPwSI framework document
- The Department of Health publication "Improving Care Closer to Home: Convenient Care for Patients Part 3: The Accreditation of GPs and Pharmacists with Special Interests" requires NHS Bedfordshire CCG to accredit GPwSIs working within the community service in accordance with the guidance. Once accredited, GPwSIs will be required to be reaccredited at least every 3 years.

Nurse Specialist

- 1st level RN with current NMC registration with evidence of competence in clinical examination, assessment and obtaining consent. NMC approved non-medical prescribing qualification.

Clinical Psychologist

- Doctorate in Clinical Psychology with substantial experience or further training in treatment of physical health problems

Physiotherapist

- Degree/diploma in physiotherapy

registered with the Health and Care Professions Council (HCPC)

Podiatric Surgeon

- Podiatry Diploma/degree
- HPC registration
- Local analgesia administration certificate

Acupuncturist

- Membership of AACP, BMAS or BAcC

Cognitive Behavioural Therapist

- Diploma/degree in professional qualification and appropriate registration BABCP

- Recognised CBT qualification to diploma level

Radiographers/Radiologists (in Year 2 onwards)

- Degree/diploma in diagnostic imaging/radiography
- registered with the Health and Care Professions Council (HCPC)

Medicines Management

The prime service provider shall have access to pharmaceutical advice, and shall assure itself and in turn The Commissioner BCCG that providers within the MSK system will ensure effective medicines management by adhering to the following requirements:

- Clinical and cost effective use of medicines at all times.
- Medicines are procured, stored, prescribed, administered, supplied and disposed of within the Clinical Governance Framework.
- Compliance with legislation and NHS regulations in relation to medicines management.

The prime service provider shall assure itself and in turn BCCG that it will be responsible for PBR included drugs

- An element of MSK programme budget will be top sliced, to allow for clinically appropriate community prescribing of MSK medicine working closely with BCCG Medicine Management Team
  - Providers within the MSK system will Adhere to NHS Bedfordshire CCG's localised policies e.g. current shared care guidelines and patient group directions (PGDs), if appropriate to the service, in line with relevant NICE guidance and Department of Health (DH) directives relating to prescribing. The service provider will be responsible for developing and updating PGDs if appropriate for the service.
  - Providers within the MSK system will Apply recommendations from the NHS Bedfordshire and NHS Luton Joint Prescribing Committee or their equivalent body.
  - Providers within the MSK system will Ensure response to and compliance with relevant safety alerts, e.g. National Patient Safety Alerts (NPSA).
  - Providers within the MSK system will Comply with a valid Medicines Management Policy agreed with the PCT and the relevant Drugs and Therapeutics Committee
  - Providers within the MSK system will Comply with Standards for Better Health
  - Providers within the MSK system will Set budgets based on formulary , throughput and case mix
  - Providers within the MSK system will Introduce waste awareness and reduction schemes with clinicians and patients
  - Providers within the MSK system will Carry out quarterly clinical audit to include internal audits of medicines management practice against policy, self-audits of compliance with NPSA alerts collated by the NPSA and external audits conducted by the MHRA and Regional QC.
  - Providers within the MSK system will Carry out action planning with the prescribing team on the appropriate use of medicines
  - Providers within the MSK system will Ordering medicines only from safe sources
  - Providers within the MSK system will Carry out monthly monitoring of prescribing volumes and expenditure per clinician

Patient safety

The prime service provider shall assure itself and in turn BCCG that providers within the MSK system will minimise the risk of healthcare acquired infections by:

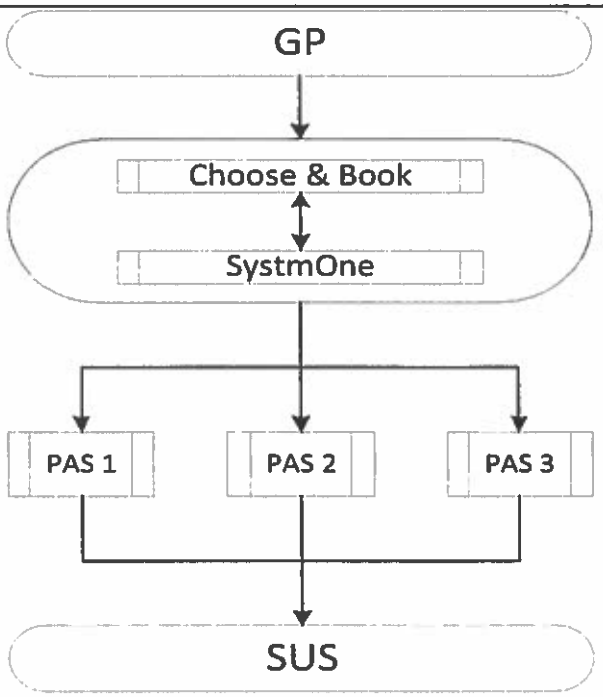
- Having systems in place to ensure that the risk of healthcare acquired infection to patients is reduced with particular emphasis on hygiene and cleanliness ensuring year on year reduction of MRSA.
- Have systems to ensure that all risks associated with the acquisition and use of medical devices are minimized.
- Have systems to ensure that all reusable medical devices are properly decontaminated prior to use and that the risk associated with decontamination processes are well managed
- Employ high standards of infection control including cleaning, domestic and clinical waste disposal and good hygiene including the presence of alcohol gel

Accessibility and acceptability of care

The prime service provider shall assure itself and in turn BCCG that providers within the MSK system will:

- Locate, secure and equip the community service facilities and source all support services (with the exception of diagnostics in Year 1 and the inclusion of all MSK related unbundled diagnostics from years 2 to 5), wherever possible using a "one stop shop" approach.
    - Ensure that all community service facilities comply with Disability Act requirements, and consequently that premises are accessible to patients with disabilities.
    - Ensure there is adequate car parking for patients either on site or nearby
    - Ensure that the provision of the services and the premises used protect and preserve patient dignity, privacy and confidentiality
    - Allow patients to have their personal clinical details discussed with them by a person of the same gender, where required by the patient and if reasonably practicable
    - Provide a chaperone for intimate examinations to preserve patient dignity and respect cultural differences
    - Ensure that provider staff behave professionally and with discretion towards all patients and visitors at all times
    - Not discriminate between patients on the grounds of age, sex, sexuality, ethnicity, disability or any non-medical characteristics
    - Arrange transport for patients when clinically appropriate, and reimburse travel costs to qualifying patients in accordance with NHS guidance
    - Arrange access to an interpreting service for patients for whom English is not their first language when required
    - Ensure that information is available for members of the public; information should be available within all community settings, in Braille, on disk, in large print and in languages other than English which are appropriate to the local community.
    - Comply with and adopt protocols and guidance in relation to safeguarding vulnerable adults & children contained within the policies and procedures put in place and supported by the relevant local safeguarding board.

Information Technology



The provider will be required to use TPP SystmOne or equivalent functionality as the clinical system for the MSK system provision for the purposes of:

- Electronic record keeping
- Appointment booking
- Data and key performance indicator monitoring
- Management reporting

This will also allow for the automatic updating of MSK patient records within primary care.

The provider will demonstrate the use of Connecting for Health (CfH) systems, which must include Choose and Book and PACS, as well as any other CfH systems, which are appropriate for the service provision. For this reason, potential providers must be Approved Service Recipients with a current statement of compliance in order to obtain a direct N3 connection. Workstations must also meet the minimum specification for using CfH applications.

Additional systems requirements include the use of Unify2 in order to monitor and report referral to treatment times and SUS to report CDS information.

The provision of community based clinics will take into account annual leave, training and provision for staff sickness. In addition, the provider will be responsible for keeping full records of all treatment, as agreed with BCCG. All patient information will be managed in accordance with the following legislation and any that supersedes it:

- NHS Code of Confidentiality (2003)
- Data Protection Act (1998)
- Access to Health Records Act (1990)
- Freedom of Information Act (2000)

- Environmental Information Regulations (2006)
- Computer Misuse Act (1990)
- NHS Code of Practice for Records Management (2006)
- Human Rights Act (1998)
- Caldicott Guardian Manual (2006)
- Health and Social Care Act (2001)
- Care Record Guarantee (2009)

Care Pathways

Integrated service user pathways showing access, exit/transfer points, potential routes and relationships with other health and/or social care providers, will be based on the proposals submitted by the chosen provider. Bedfordshire Clinical Commissioning Group and its localities will agree these as part of the mobilisation process once the contract has been awarded.

Premises for Service Delivery

Musculoskeletal services must be delivered in an appropriate environment. Specifications for room sizes are contained in the NHS Estates Health Building note 12 (1994). Any provider will be expected to comply with these guidelines. In addition, equipment requirements include:

- Appropriate equipment to assess and treat potential presented MSK conditions
- The provider must ensure that all equipment is fit for purpose and that all staff are appropriately trained to use the equipment
- The maintenance of equipment will be the responsibility of the service provider

Days/Hours of operation

The service must be responsive to the needs of patients and this will be reflected in the hours that the service is open for business. Therefore, potential providers will provide services outside of usual office hours, with services being available during both evenings and weekends.

Referral criteria & sources

Referrals for triage and assessment or treatment by the Integrated MSK system will be from the following MSK specialties:

- Orthopaedics
- Rheumatology
- MSK related Pain
- MSK related Physiotherapy
- MSK related Podiatry
- MSK related Plastics
- MSK Disorders
- MSK Reconstruction
- MSK Spinal

- MSK related unbundled diagnostics (as soon as adequate data has been collected to enable a reasonable estimate of the total annual MSK diagnostic spend (assumed to be at least Year 2 of the contract onwards)

Clinical practitioners authorised to refer to the community service are as follows:

- Local General Practitioners
- Secondary care clinicians
- Clinicians working within the community service

Equality Delivery Scheme

Ensure the MSK system delivers an equitable system to all:

- To make necessary care easily accessible to all those who require it.
- Eliminating unlawful discrimination and harassment
- Eliminating unlawful racial discrimination
- Promoting equal opportunity and good relations between persons of different racial groups
- Eliminating discrimination that is unlawful under the Disability Discrimination Act
- Eliminating the harassment of disabled person that is related to their disabilities
- Promoting the equality of opportunity between disabled and other persons
- Taking steps to take account of disabled persons' disabilities, even where that involves treating disabled persons more favourably than other persons
- Promoting positive attitudes towards disabled persons
- Encouraging participation by disabled persons in public life
- Ensuring the equity of care and treatment for all patients

Sustainability

To comply with the government strategy "Securing the Future"

Ways of working

It is expected that, to live within available budget, there will need to be emphasis on:

- Prevention and early intervention
- Early introduction of more effective treatments based on emerging clinical evidence
- "Lean" processes within and between providers
- Shared information systems

Response time and prioritisation

Turnaround times expected for each stage of the pathway are as follows:

- Maximum of 3 working days for referral to be submitted by GP, following the decision to refer
- 1 working day for triage to take place following the clinical team's receipt of referral
- Clinical assessment and commencement of treatment is to occur within as short a timeframe as possible and practicable. The wait for the initial appointment should not

exceed 4 weeks and a maximum of 18 weeks should not be exceeded before non-admitted patients commence treatment.

- Patients to be admitted into acute hospitals must be referred on from community services within 8 weeks.

- First line diagnostics to be requested or to occur on the day of clinical assessment
- Results of X-rays and blood tests should be returned to the requester within one working day of the patient having the test
- The results of other investigations should be returned to the requester within 2 weeks for all routine investigations and 2 days for urgent cases.
- Onward referral must occur within 3 working days of that decision being made (subject to patient choice, appropriate work-up etc

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

Quality Incentive 1 Technology

The prime service provider is required to set out how they envisage the use of technology to deliver innovative, efficient, co-ordinated patient centred care.

Quality Incentive 2 Integration

The prime service provider is required to set out how they envisage integrating services to across the system pathway to ensure patients experience a seamless experience across the MSK system and to minimise the patient's time to recovery and time to return to normal activities.

Quality Incentive 3 Patient Outcomes

The prime service provider is required to set out what processes and measures the bidder will employ to gather and evaluate clinical and patient information to continually improve patient outcomes

Quality Incentive 4 Patient Experience

The prime service provider is required to set out what processes and measures the bidder will employ to gather and evaluate patient feedback to continually improve patient experience

Quality Incentive 5 MSK System Annual Report

The prime service provider is required to set out how they envisage gathering data, intelligence and engaging the health and social care system in Bedfordshire, to provide a system wide annual report capturing the points below

- Observed epidemiology of MSK conditions in Bedfordshire and by localities
- Patient outcomes and experience measures, including patient stories
- Independent 360 degree feedback on the MSK system from stakeholders including patients, GPs, commissioners, and internal staff/supply chain providers
- Patient safety outcomes: to include incidence of adverse events, incidence of healthcare acquired infection, incidence of hospital-related venous thromboembolism, incidence of medication errors causing serious harm, and incidence of category 3/4 pressure sores, and serious incidents

- Opportunities to identify unmet need
- Areas of priority for system developments in the subsequent 12 months

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

N/A

6. Location of Provider Premises

The Provider's Premises are located at:

TBC

7. Individual Service User Placement

N/A

Brent CCG Executive November 2013

Proposed support for GP network development

1. Background and Strategic Direction

The development of GP networks in Brent is essential for the successful achievement of "Shaping A Healthier Future" and the creation of hubs, the out of hospital strategy and Brent CCG's corporate objectives in particular to:

- Develop primary care services and commission services to prevent people from dying prematurely
- Develop primary care and commission services to enhance the quality of life for people with long term conditions
- Help people to recover from episodes of ill health or following injury
- Ensure people (patients and carers) have a positive experience of care
- Implement QIPP and investment programme 2014/15 and meet financial duties
- Commission development and collaboration with both capability and capacity across all providers

Bringing together GP practices in this way will ensure the GP community has the optimum opportunity to deliver consistently high quality healthcare to the population of Brent. To achieve Brent CCG's corporate objectives requires:

- a different approach with robust foundations
- strong leadership
- people with the right skill sets working together to optimise capacity and capability.
- partnerships both within GP networks and with all stakeholders including the voluntary sector

This in turn will lead to improving health outcomes via the commissioning of services to enhance the quality of life for people with long term conditions and ensure people (patients and carers) have a positive experience of care across the Borough.

The out of hospital strategy requires all providers across Brent to work differently in the future. The strategy includes a range of initiatives, listed in section 4, aimed at improving patient satisfaction, providing services closer to people's homes and ensuring better value for money in the longer term. The GP network model will provide a robust platform for successful achievement of Brent's out of hospital strategy. The alternative would be for individual practices to deliver the strategy working in silos. The likelihood of success with the existing model would be extremely low. Currently primary care, as a whole, lacks the structures and skill sets to be competitive in the market place as provider organisations and be the vehicle for challenging the delivery of services in new settings. Strong GP

networks with partner organisations will ensure Brent delivers accessible, appropriate first class services to the local population. GP networks will be able to build capability where it's needed the most and ensure clinicians and non-clinicians have the right skill sets to be competitive providers and robust business entities in the future. This programme is likely to take around six months and thus funding will straddle financial years 2013-14 and 2014-15.

In Brent we are working towards an integrated care approach within the networks. This will be facilitated by five multidisciplinary groups (MDGs) made up of local GP practices and providers from community health, mental health, acute hospitals, social care and voluntary sector. Initially these groups will focus on the over 75s, working together, each MDG will identify and review patients at risk of becoming ill, delivering proactive care to keep patients well and out of hospital where possible. This approach makes preventative care across health and social care settings a reality.

The Kings Fund paper on the potential future models for general practice says "a strong and vibrant network of high quality GP Practices should lie at the heart of any transformation agenda for Primary Care in London."

In October NHSE published a document "London – A Call to Action" to support transforming primary care in London. It sets out the need for general practice to move to a new model of service that can meet the changed needs of Londoners for the next fifty years or more, before challenges facing today's model become insurmountable. It recognises that tweaking around the edges will no longer be an option. (http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2013/12/london-call-to-action.pdf) A London-wide summit in November 2013 reiterated the need to enhance leadership and development of delivery networks in order to support the challenging task of meeting the Out of Hospital and Urgent Care agendas. Some 21% of practices in Brent are single-handed and 28% of GPs are aged over 60. Without developed networks there is a real risk that residents in some of areas of Brent will be left with significant gaps in local service provision.

Over the last two years some progress has been made in that all member practices within localities have agreed the following:

- a need to provide more services on a locality basis, particularly with LESs being discontinued, for instance the management of patients with non-complex mental health needs.
- recognised the need for practices to compete collectively to provide some of these services in the future.
- practices should provide services to one another's patients; they have agreed an inter-practice referral protocol
- to reduce costs they should share some back office functions i.e. payroll, patient recalls etc.

- the future of the networks is dependent upon creating robust structures with clear roles and responsibilities. There should be a governance framework with clear lines of accountability for each network. The organisational form requires agreement they need to be able to share information about patients electronically and this will be possible as practices transition to EMIS Web.
- to support the out of hospital strategy with GP practices at the centre of patient care. This may include taking clinical responsibility for OOH care and building on existing work by the STARRS service.
- to support the GP locality services (primary care hubs) by referring patients to this service when they are unable to offer a patient an appointment with a GP within 48 hours at their own practice.
- to work in partnership with a wide range of providers especially social care providers and the voluntary sector in helping overcome issues that are non-health related

All localities have considered options for organisational form including:

- collaboration agreement (inter practice agreement)
- forming a social enterprise or limited company
- establishing a super practice (i.e shared back office functions to full merger).

All localities have received limited legal advice on how these forms would work and three out of the five have made agreements on how to proceed.

- Harness Care is a well established provider.
- Kilburn has agreed a memorandum of understanding.
- Wembley are in the process of agreeing a memorandum of understanding.

Kingsbury and Willesden localities have agreed to work as a single network and plan to agree a memorandum of understanding and form a limited company of member practices by end of March 2014.

In order to further encourage and develop these networks it will be essential to provide sufficient capacity alongside additional skill-sets to enable networks to mature and be ready quickly to take on additional volume and complexity of work, working as partners in the market place in delivery of services.

It should be recognised that GP practices will need to work alongside a growing number of voluntary-sector partners to reach out to groups that statutory bodies cannot. As such this support programme will also be available, where appropriate, to recognised partners sharing the same goals and work streams.

Brent CCG's Primary Care Procurement Panel has evaluated the future commissioning of the existing LESs and recommended that with the exception of phlebotomy that these services be offered to a practice or a network of practices

as the most capable provider of services. It was recommended that phlebotomy be offered on an Any Qualified Provider basis as many providers are capable of providing phlebotomy and indeed do.

2. The Development of GP Networks in London

Tower Hamlets PCT invested substantially in the development of GP networks in 2009 and 8 networks have been running for almost 4 years, enabling the achievement of better patient outcomes through delivery of integrated care packages and comprehensive immunisation programmes. For example, Tower Hamlets GP Networks have rolled out a care package for COPD, resulting in an increase of 9.97% in the recorded prevalence of the disease, and childhood immunisation and vaccination care package has now achieved 95% ('herd immunity') coverage for 1st year vaccinations, and increased coverage from 83% to 92% over a two-year period for all other childhood vaccinations given to the under 5s; this was achieved through practices working together to deliver a systematic, effective call/recall process.

Lewisham CCG has provided facilitated workshops for member practices to explore and then agree their options utilising the Primary Care Commissioning team and Nuffield, along with practice surveys, and this approach is being mirrored with West London CCG.

In Newham, with CCG support, federations of GP practices are forming with. These are formal entities aiming to share resources and take on additional primary care business. The key difference between Newham and Tower Hamlets is that the Newham federations are made up of like-minded GP practices whereas the Tower Hamlets networks comprise all the practices within a specific neighbourhood.

Waltham Forest and Enfield CCGs have provided significant logistical support to the formation of clinical delivery networks, meeting monthly with good attendance, to work on clinical delivery through shared ownership of problems. In addition, all practices across the borough collaborated in clusters to review their performance and development of pathways. In 2011 North Central London, working with five PCTs, placed at their disposal some £12m in order to improve primary care. This money was used to improve physical aspects of practices, provide equipment and training to standardise clinical methods, aid IT infrastructure works and provide effective clinical engagement and leadership. In 2012 Enfield PCT, using some of the 2% top-slice, invited a number of private organisations to put forward proposals for the development of GP networks. PA Consulting was the successful delivery partner and they are currently working

with the locality teams to build the required capability and skill sets. A small number of GPs are also employed on a sessional basis to help develop and deliver services across their localities focusing on care closer to home.

3 Position in Brent

Brent PCT and then Brent CCG have been supporting network development in 2012/13 and 2013/14.

Following approval of a business case in 2012/13, Ian Winstanley led a team managed by Ivan Rudd comprising of 3 network managers and an IT manager:

Progress was made on the following:

- Developing and promoting new LESs including cardiology diagnostics supporting the cardiology procurement
- Supporting practices to develop and implement improvement plans based on their performance in the London Outcomes Framework (LOF)
- Agreeing to move forward with EMIS web and docman
- Supporting practices to become CQC compliant by April 2013
- Provide practices with small premises grants from an agreed budget of £500,000 to support CQC compliance
- Specifying, procuring and deploying essential equipment

Limited progress was made on network organisational form, providing services to one another and appointment of clinical champions in each locality.

As part of budget setting for 2013/14, a network budget of £900k was established and the GP network programme was re-launched with:

- New SRO leadership – Craig Alexander
- Refreshed support team with two network managers, programme manager (June to September), retained IT support (Tony) and a project manager for the locality services (Andrew Round)

The SRO left at the end of May 2013 and Gina Shakespeare was recruited in early June to ensure GP locality services were in place from September 2013 and CSPA was in place from July 2013. Both these objectives were achieved.

Gina Shakespeare's two month stop gap assignment came to an end in mid August and the future of the network team was considered by the primary care development programme board.

The preferred option was as follows:

- To disband the team and allow practices to access bespoke support for further locality network development.
- To retain the IT support (Tony)
- To separate out commissioning and provision elements of the programme
- Jo Ohlson to become the SRO with a supporting primary care transformation project manager and Ethie Kong to continue as CRO.

4 GP Network Development in 2013/14 and 2014/15

The deliverables for GP network development for the remainder of 2013/14 and into 2014/15 have been identified as:

Development Area	Outputs/Deliverables
1. GP Networks to provide a range of services	By April 2014, all networks will provide 100% population coverage of: • Cardiology • Insulin diabetes • Phlebotomy • DMARD • End of Life • Wound care • IAPT & BNP • Supporting carers • Dementia and learning difficulty services
2. Improved GP access	Five GP services have, as a pilot, offered extended hours from September 2013. The scheme is being evaluated in January 2014. In line with commissioner requirements we will develop a robust migration plan for the extended hours model to be provided by networks from April 2014.
3. GP Networks to develop robust organisational forms	Localities to agree their specific/preferred network organisational form by the end of January 2014 with a plan for implementation by March 2014.
4. GP practices and networks securing contracts	Practices and locality networks to be in a position to respond to practice based and network based services from April 2014 onwards to June 2014

Development Area	Outputs/Deliverables
5. Locality GP networks integrated with other providers to provide 24/7 care out of hospital	Each locality network will have determined by the end of February 2014 whether it will participate in one or two of the following whole system integration pilots: i) 24/7 urgent care ii) Supporting vulnerable adults Selected integrated networks will be ready to go live by April 2014
6.GP locality networks estates plan	In conjunction with the Out of Hospital Delivery plan, GP localities to identify and develop business cases for individual practices by the end of April 2014

GP network development is to be supported by a number of programmes across the 8 CCGs, namely:

- Delivering out of hospital strategies (refresh of the OOH strategy and completion of OBC for a hub by end of March
- Primary care transformation
- Whole system integration (GP and provider networks, governance)
- Workforce development.

However in order to move at pace and ensure full member practice buy in, these programmes need to be supported by bespoke work at CCG level.

5. Why should GP network development be funded from CCG transformational funding?

We have created some momentum around establishing GP networks but we need to continue with the six deliverables as set out in the table in section 4 if GP practices and networks are going to be able to provide those services where the CCG deems that a practice or GP network is the "only provider" or "most capable provider" for specified out of hospital services.

In January, it is planned that the CCG Governing Body will be considering recommendations from Brent's Primary Care Procurement Panel on those services currently commissioned through local enhanced services that meet the category of only provider and most capable provider. The Board will be using the toolkit developed by the 8 NWL CCGs with input from NHSE. As part of Brent CCG's commissioning intentions, the CCG may also identify additional out of hospital services that should fall into one of these categories, for example, nursing home provision.

To avoid potential conflicts of interest, the determination of these services will be achieved through using the toolkit that is under pinned by legal advice on procurement, patient choice and competition and the recommendations will be

made by a Board that includes the lay member for audit, COO, deputy CFO, NHSE Head of Primary Care NW London and a member of the NW London Service and Transformation Team. The final decision will lay with the Governing Body and it is proposed that all GP governing body members declare their interest as potential providers and do not participate in the decision. The toolkit is based on the objectives and principles underpinning procurement, patient choice and competition regulations.

The overall objectives are:

- Securing the needs of the people who use the services;
- Improving the quality of the services; and
- Improving efficiency in the provision of the services.

In procuring health services, some of the principles which NHS bodies should adhere to in making decisions are:

- Acting in a transparent and proportionate way;
- Treating providers equally and in a non-discriminatory way;
- Providing best value for money;
- Providing the services in an integrated way;
- Enabling providers to compete to provide the services;
- Allowing patients a choice of provider of the services.

Without GP network development, it is not expected we would achieve 100% population coverage for those services where primary care either as a practice or as a network is deemed the only or most capable provider.

Patient choice and competition for all other out of hospital services will be secured through open procurement competitive tendering where the benefits of procurement exceed the costs. Voluntary sector and independent sector providers and NHS Trusts will have the opportunity to provide services where general practice is not seen to be the only or most capable provider of new or existing services currently commissioned through a LES.

It should be recognised that the CCG will, where appropriate, continue to support other providers where the benefits of doing so can be realised through improved

service delivery. This may take different forms such as workshops and bespoke feedback and subject specific training sessions eg bid-writing skills.

The CCG will regularly act on feedback from patients, carers and stakeholders in terms of service delivery. They will measure access, suitability and outcomes of care seeking providers who can improve the patient experience.

The CCG has also examined models of commissioning carried out by other CCG's, namely Walthamstow Forest and Inner London CCGs seeking to learn from their experiences.

6. Proposed bespoke support

Any support offered to developing networks is required from February 2014 through to June 2014.
Proposed bespoke support will consist of:

a) Backfill time for practices to develop and implement organisational development programmes
b) Seconded staff from within the CCG to help with specific aspects as and when identified, eg analytical support
c) Call off support programme to provide organisational development support to promote team building and agreement on governance/decision making and accountability

6.1 Backfill time support

This will consist of one session per practice per month for five months to ensure:

- The localities have agreed how they will provide 100% coverage of list based services (ie agreement on who will provide services to each other)
- Bids are put forward for out of hospital contracts.

The funding will be obtained by the locality networks/ practices invoicing 50% in March 2014 and the remaining 50% at the end of the financial year with 100% population coverage for services where a GP practice or locality network is deemed the only or most capable provider.

Funding available:
£300 per practice: for 5 sessions £100,500.

6.2 Organisational development support to facilitate above sessions to achieve the following outcomes:

- GP network plans for providing list based services and services for which they will have to compete for

- GP network plans for integrating with other service providers for urgent care and vulnerable adults
- Establishing processes for decision making, governance and business planning including workforce

Three organisational development sessions will be funded for four networks:

Funding available:
£13,200 per session (pre-planning, 3 facilitators, £1800 each plus travel & VAT) - £158,400.

Total CCG cost (max)

Backfill	**£100,500**
OD support	**£158,400**
Total	**£258,900**

7. Proposed Source of Funding

It is proposed that the GP network development work is funded from the transformational fund of £336,000.

8. Value for Money and Probity for proposed GP network development support

In order to achieve value for money, SFIs will be followed for the procurement of external support. The contract for OD will be awarded and held by the CCG. For reimbursement of backfill support, the initial 50% payment to practices will only be made on receipt of a completed proforma from a practice undertaking to attend the three sessions and identifying the individual(s) who will attend. The final payment will only be made by a completed proforma signed off by the locality Clinical Director and Chief Operating Officer and approved by the Finance, Performance and QIPP Committee.

In addition, any agreed support packages could and should be made available to partners in the established and growing voluntary sector.
Moves to engage and develop additional community resources across the primary care delivery arena will help in building the social capital required. It is known that providing a vehicle for change and building capability within communities can itself lead to a positive impact on health and wellbeing. Delivery partners and integration with PPGs would be of great benefit to these processes.

9. Potential Outcomes associated with GP network development

9.1 If we don't fund this work

Implementing the out of hospital strategy is dependent on transforming primary care in respect of:

- Extending the scope of primary care
- GP practices working in networks to provide extended primary care and other out of hospital services.

If we don't fund the above work the following outcomes could be expected:

- We will not have 100% population coverage of services where a GP practice or network is deemed the only or most capable provider
- Locality networks will develop at different speeds in the four localities with some perhaps not developing at all
- Whole system integration with GP networks and other providers may not occur
- GP commissioners may cease to support the out of hospital strategy
- Where GP practices/localities bid for out of hospital work they may fail to win any competitive services as we know from experience their organisational development, business planning and governance arrangements and bid writing is weak even when partnering with established providers.
- Partnerships with voluntary sector providers remain weak.

9.2 If we fund this work

- We are supporting provider development that will promote provider competition as GP practices and voluntary sector do not have this capacity and are unlikely to fund it themselves. Existing NHS Trusts and Independent Sector providers already have dedicated business development and a track record of securing NHS contracts.
- In order to develop the out of hospital market, we may need to consider supporting development of the voluntary sector. This has already started with the pump priming of voluntary agency input to delivering the self-care strategy.
- The support framework can be made available to the voluntary sector and other community providers to bring about synergy and better health outcomes.
- We are more likely to achieve our CCG objectives of improving primary care and delivering out of hospital strategy.
- Other providers will have organised primary care with whom they can partner for whole system integration
- Brent HOSC has already identified primary care as the weakest link for OOH and this will aid meeting that challenging agenda.
- We can expand the support we are giving to the voluntary sector for health and well-being and self-care initiatives to demonstrate we are ensuring there is a level playing field for other undeveloped provider areas. We are also asking the practices to part fund the work.

- GP providers are likely to be deemed the "only" or "most capable provider" for a limited range of services. All other out of hospital services will be open to competitive tendering unless the benefits of procurement are outweighed by the costs.

10. National Moves towards federations or clinical networks

10.1. There is a growing body of literature that considers how the provision of primary care in the NHS in England should best evolve to meet the requirements of NHS commissioners in England over the next ten years, such as integrated care, disease prevention and access to primary care 7 days per week. Studies include:

• General Practice in London, Kings Fund, 2012

• Securing the Future of General Practice, Nuffield Trust, 2013

• Primary Care Federations Toolkit, RCGP, 2010

• 2022; A Vision for General Practice in the Future, RCGP 2013

• Quality in General Practice, Kings Fund, 2011.

10.2. There is a consistent theme running through all of this work - see brief extracts at Appendix 1 – that:

• patients value highly the continuity of care and local access into the NHS that a general practice provides;

• a GP is well placed to 'apply his or her medical expertise to the growing range of long-term conditions; to incorporate this knowledge into 'whole-person' understanding of the patient and their family; to manage risk safely; and to share complex decisions with patients and carers, while adopting an integrated approach to their care; and,

• collaboration between GP practices potentially mitigates the disadvantages inherent in a fragmented system and introduces additional benefits in terms of economies of scale, reduced variation in clinical practice, longer opening hours and the opportunities to deliver new services in primary care.

10.3 In addition a significant number of CCGs nationally have embarked on the processes which are at different levels of development. They have provided varying levels of support from in terms of seconded staff, expert advice and financial help aimed at enabling the network to compete with established providers, responding professionally to invites to tender.

11. Recommendations

The CCG Board is asked:

i) To support the GP network development proposal, with widening its scope as outlined to include involvement with the voluntary sector

ii) To approve the Primary Care Development Board working up the proposed support and seeking expressions of interest from potential providers. Any such proposal to be overseen and agreed by the Independent Procurement Panel to ensure that there is no conflict of interest.

Jo Ohlson & Gary Sired (21 October 2013)
Sean Barnett and Patricia Whelan-Moss (Nov & Dec 2013)
Incorporating comments from Jonathan Wise - Sean Barnett (Jan 2014)

Appendix 1.

Literature Summary supporting Clinical Networks of GPs

2022, A Vision for General Practice in the Future, RCGP 2013
Working in federated organisations (organised networks of teams)

The general practice teams of the future will be working with groups of other practices and providers – as federated or networked organisations. Such organisations permit smaller teams and practices to retain their identity (through the association of localism, personal care, accessibility and familiarity) but combine 'back-office' functions, share organisational learning and co-develop clinical services.

Federated or networked practices are therefore well positioned to act as the provider arm of local communities and can work together to provide extended services (such as those currently defined as 'enhanced services'), as well as providing community nursing services and GPs with extended clinical roles.

Within federations, patients are more than likely to be able to self-refer, if they wish (or be cross- referred within the federation), for physiotherapy, talking therapies and other services provided in community-based clinics. Patients who require routine care will be more than likely to receive this from a range of community-based providers working as a team – including primary care nurses, healthcare assistants, pharmacists, physiotherapists, mental health workers and GPs.

Practices within federations will offer more community services to the population registered within their respective practices – for example, dietetic services, podiatry, and outreach services dependent on GP skills (e.g. minor surgery and complex contraceptive services). Some practices will form large federations, incorporating hospital, third-sector, private and community providers.

The GP of the future is likely to be contracted using a number of arrangements, including, but not exclusively, as a salaried practitioner (either as part of a larger provider organisation, a federation, foundation or equivalent trust, or an employee of a third-sector and/or private- company organisation) and/or as a self-employed practitioner. Federated organisations will be better able to coordinate out-of-hours care and ensure the provision of personalised care for those patients who particularly require continuity with their treating team, both in and out of hours. They will also be better placed to monitor, understand and manage inappropriate variability in clinical performance, through joint learning approaches, audit, peer review and other quality-improvement mechanisms.

General Practice in London, the Kings Fund 2012

Evidence tells us that Londoners, as with patients in other parts of England, value the continuity of relationships and local access that comes with small practices. There are some positive things about small-scale businesses. They are often more personal, conveniently located, and part of the local community. But small businesses today are

harnessing the potential of new technologies to reach more people, work virtually, involve the consumers in co-design and co-production, derive the benefits of scale by networking with other like-minded businesses, and develop social capital within the local community. General practice needs to do the same.

Effective networks of practices can enable practices to retain their identity and knowledge of the population they serve while also enabling them to deliver the new models of care they would find difficult to provide on their own. These networks would also provide opportunities to spread learning between practices for peer review and professional development, create a stronger basis from which to develop partnerships with others beyond general practice, and provide scale to invest in information technology and data analysis to support different ways of working.

The solution is not to 'industrialise' general practice or to introduce larger and more homogenised provision, but for smaller practices to work together to improve care. Group practices, networks, federations and, more recently, super-partnerships have all developed in recent years. There does not appear to be a single organisational model to be applied, but the principle is of shared accountability for patient care rooted in and around primary care practices that act as the hub around which the wider system operates, and these are important features in achieving better outcomes for people in need of care co-ordination.

A strong and vibrant network of high-quality general practices should lie at the heart of any transformation agenda for primary care in London.

Securing the Future of General Practice, Nuffield Trust 2013

New models of care organisation are emerging organically in some areas to meet the challenges facing primary care. The 21 UK and international models examined in this report aim to extend the range of services offered, thereby enhancing the sustainability of practices. They emphasise the need to balance the benefits of organisational scale with preservation of the local nature of general practice. Our review of their development has confirmed that, while the ability to extend the scope and scale of primary care is important, no one organisational model of primary care provision should be advocated. Local context plays an important role in determining organisational form, and the precise mix of functions will likewise depend on the nature and priorities of the local population. When the design principles are combined, fundamental changes to the organisation and delivery of general practice and primary care become necessary. These include the linking together of practices in federations, networks or merged partnerships in order to increase their scale, scope and organisational capacity. This will need to be done while preserving the local small-scale points of access to care that are valued highly by patients. This move towards more networked and larger-scale primary care provision is mirrored in countries such as New Zealand, the Netherlands, Canada and the United States.

To help make this happen, we recommend NHS England work with clinical commissioning groups, GPs, patient groups and professional bodies to create a national framework for primary care. The framework should set out the outcomes and overall vision for primary care, both in relation to service provision and the wider role of primary care in the health and social care system. The vision should be underpinned by design

principles as set out in this report. Alongside the framework, a new alternative contract for primary care is required (in parallel to the current general medical services contract). The contract needs to be crafted by NHS England in a way that encourages groups of practices to take on a collective responsibility for population health (and ideally also social) care across a network of practices, without specifying the detail of implementation – this should be a matter for local determination.

Over time, some federations have evolved into more complex and extensive organisations, using economies of scale to secure senior professional management and clinical leadership support, and develop infrastructure that helps practices manage day-to-day business and extend their reach into new forms of care provision.
[Clinical care design principles which should used by local heath economies to design the model of primary care provision which best meets their local needs]

• A senior clinician, capable of making decisions about the correct course of action, is available to patients as early in the process as possible.

• Patients have access to primary care advice and support that is underpinned by systematic use of the latest electronic communications technology.

• Patients have the minimum number of separate visits and consultations that are necessary, with access to specialist advice in appropriate locations.

• Patients are offered continuity of relationship where this is important, and access at the right time when it is required.

• Care is proactive and population-based where possible, especially in relation to long-term conditions.

• Care for frail people with multi-morbidity is tailored to the individual needs of patients in this group, in particular people in residential or nursing homes.

• Where possible, patients are supported to identify their own goals and manage their own condition and care

• Primary care is delivered by a multidisciplinary team in which full use is made of all the team members, and the form of the clinical encounter is tailored to the need of the patient.

• Primary care practitioners have immediate access to common diagnostics, guided by clinical eligibility criteria.

• There is a single electronic patient record that is accessible by relevant organisations and can be read, and perhaps in future added to, by the patient.

• Primary care organisations make information about the quality and outcomes of care publicly available in real time.

• Primary care has professional and expert management, leadership and organisational support.

NHS
Brent
Clinical Commissioning Group

Frequently Asked Questions

Planned Care Programme: Outpatient Musculoskeletal (MSK) Services Procurement

What is an MSK Service?

- MSK stands for Musculoskeletal. MSK Service is used as shorthand in health for services that diagnose and treat diseases or conditions that affect the muscles, bones or joints.
- Common examples of diseases or conditions include Rheumatoid arthritis, osteoarthritis, osteoporosis, low back pain or limb trauma.
- MSK services are currently provided by hospitals and patients access these services after an initial referral from a GP or another hospital doctor.
- The services typically comprise rheumatology, physiotherapy and orthopaedics and trauma.

Why do we want to change outpatient services for Brent residents?

- Brent residents are living longer with more chronic diseases
- Under our current model of care we can't afford to meet future demand.
- Evidence from across the country, supported by a national MSK framework, shows that we can provide outpatient services in the community that are better quality, achieve better clinical outcomes but more cost effective to deliver through ensuring the right professional input at the right time and in the right setting.
- National, regional and local strategies support NHS Brent CCG's move to change the way in which outpatient care is delivered.
- Current capacity within our acute hospitals is constrained and this is adversely impacting national referral to treatment waiting times
- There is greater scope for providing patient centred, integrated care pathways that reduce patient waiting times for services and the fragmented episodic nature of care that is currently provided.

Why is the CCG conducting a procurement exercise for these services?

- The CCG has taken a decision that making relatively small changes to current services will not achieve the level of change needed to achieve the objectives of; delivering integrated care in the community, providing equity of access for patients, improving patient satisfaction with services and having an affordable and sustainable model of care in place.

- Currently, there is a variance in the quality of services being delivered by providers. For example, waiting times between providers for the services vary and some providers are not meeting the waiting time targets.
- NHS Brent CCG is bound by UK regulations on how it can commission services.
- The way in which we can commission contracts/services is broadly categorised under the following headings:
    - Inherit existing contracts from another organisation
    - Promote an Any Qualified Provider model of care; or
    - Procurement governed by the Public Contract Regulations.
- As it is not possible to achieve the objectives of service improvement through variation of existing contracts and in view of the proposed contract value, the CCG is required to enter into a competitive procurement process.
- To achieve the level of integration and multi-disciplinary input across a range of providers, who all function as separate services at present, a procurement approach called 'competitive dialogue' will be used with a view to stimulating innovation and an integrated care model across multiple providers who may come together to bid to provide this service.
- As with all formal competitive procurement processes, the competitive dialogue approach allows a fair and transparent process to secure the services that we need.
- Furthermore, advantage will be taken of what is called a 'Dialogue Process', which allows the CCG to talk to Bidders about their proposals and use the outputs of these discussions to further clarify the service requirements.
- NHS Brent CCG will work to ensure that robust process is implemented and that the necessary clinical and stakeholder engagement is built into the process.

What is competitive dialogue?

- Competitive dialogue is a stage during a procurement process which is often used to award contracts for complex services.
- Bidders qualify to take part in the procurement by successfully passing a Pre-Qualification Questionnaire process.
- The service specification will then be developed in more detail in discussion with bidders following consultation with service users.
- The aim of the dialogue stage for Wave 2 seeks to enhance innovation and integration in the service delivery model and define strong output measures that providers can be monitored against.

How will the CCG ensure that stakeholders are engaged in the service redesign?

- The CCG is in the process of putting in place a panel of expert clinicians with a deeper understanding of the Wave 2 services. This panel (Clinical Reference Panel)

will help the Project Team scope the services that we commission through the process.

- We are also putting in place a Stakeholder Engagement Group – with service users, carers and patient representatives providing input into the development of services with input from their experience of using services.
- By taking this approach, and then seeking input from the market on how best to deliver the services (in terms of quality, improved outcomes and long term value), NHS Brent CCG is confident that the process will achieve the stated objectives of procurement.
- This will also allow better service continuity for patients and reduce risks related to any transfer.

What are NHS Brent CCG's statutory responsibilities for public consultation and patient involvement in major service redesign?

- As part of the statutory duties, NHS Brent CCG has a legal duty to consult about the proposed changes to the services.
    - Section 242 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) places a statutory duty on commissioners and providers of NHS services to engage and involve the public and service users in:
        - planning the provision of services;
        - the development and consideration of proposals to change the provision of those services; and
        - decisions affecting the operation of services.

      This duty applies to changes that affect the way in which a service is delivered as well as the way in which people access the service.

    - Section 244 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) places a statutory duty on commissioners and providers of NHS services to consult local authority health overview and scrutiny committees (HOSCs) on any proposals for significant development or substantial variation in health services. This is distinctive from the routine engagement and discussion that happens with local authorities as partners and stakeholders.
- The decision to use a competitive process to procure a service is not open to consultation. The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 (the Procurement, Patient Choice and Competition Regulations) put in place regulations to ensure that commissioners:
    - adhere to good practice in relation to the procurement of health care services funded by the NHS;

- protect the rights of patients to make choices with respect to treatment or other health care services funded by the NHS; and
- do not engage in anti-competitive behaviour unless this is in the interests of NHS health care service users.

What will NHS Brent formally consult upon and how?

- NHS Brent will be asking patients and the public to have an input into the service specification to support the development of an appropriate service model.
- This is the opportunity for patients to help design a service that better meets their needs.
- NHS Brent has appointed an independent organisation to conduct the Public Consultation and Impact Assessment – Mott MacDonald.
- Having on board an independent expert to develop a robust and transparent consultation, will support a valid and meaningful effect upon the service redesign in order to get better designed services for patients.

How will the CCG involve patients and the public?

- Your voice counts, which is why we are asking for your views about our plans to improve the provision of outpatient services for the residents of Brent.
- There will be a consultation on Wave 2, which is due to be launched within the next month and will run for twelve weeks. This is your chance to have your say on our plans and to help shape the future design of these services.
- We will give you the opportunity to complete a questionnaire on the proposals, which can be submitted online or through a freepost response form.
- You can also attend one of our public consultation roadshow events being organised across Brent where you will be able to ask any questions you might have, before completing the consultation response form.
- The dates, times and locations of the consultation and events will be finalised in the next few weeks. Please visit the website for future updates.
- There will also be a Stakeholder Engagement Group that will represent patient views. The purpose of the Stakeholder Engagement Group would be to inform the project team in the development of service proposals. The group will also act as representatives of other relevant stakeholder groups
- Information on the procurement and service changes can be found on the NHS Brent CCG website at www.brentcgg.nhs.uk/wave-2-MSK

When will the new services start?

- New services are planned to become available to patients at the beginning of 2015.
- We have reviewed the process to deliver these new services and are confident that allowing the necessary time will result in the best outcome for local services.

What happens if a current provider is not successful in becoming the preferred provider for the restyled community based service?

- The process that we have set up will seek to identify the providers that can best deliver the services for local patients. We will look for additional value that providers can add to services and their proposals for improving outcomes.
- As this is a competitive exercise there is a chance that a current provider will not be selected to deliver the required services. In this instance the new provider and existing provider will plan a transition to ensure that there will be as little disruption to patient care as possible.

Will any services that are currently provided in hospital move to my GP practice? If so how will this be decided?

- As part of the competitive dialogue it is possible that an agreement could be reached in which some services are provided within a GP practice. This would depend on the type of service, the expected clinical outcomes and the availability of facilities.
- NHS Brent believes there is some scope for services to be delivered in primary care by, for example, GP networks.

Will I still be able to choose my hospital for my planned care?

- Yes, patients will still be able to exercise their choice of provider for services.
- The scope of this Planned Care Programme relates to outpatient care only. We will work with patients, expert clinicians and Bidders to develop a service proposal that delivers services in a community setting, and with much greater integration between services.
- Through providing access to services in the North and South of the Brent Borough, we envisage that for a large number of patient visits, travel time for appointments should be reduced. This will be further examined as part of the impact assessment that we have commissioned from Mott McDonald.
- Currently the provision of outpatient services, for example, Musculoskeletal services, is very fragmented. Patients often need treatment or consultation with one or more specialities (e.g. an orthopaedics consultant and physiotherapy) and the patient interface between these services need to change to ensure the most appropriate care is provided in a timely way.
- It is likely that the new services will serve as a 'one point of care' service for patients. Most patients will benefit from using these services. However, we accept there will be times, for example, where treatment is already ongoing for specific complex disease or conditions, where the patient's choice of provider will not be the

integrated MSK Service. The patient can make this decision with the right advice from their GP.

What analysis has been done on the performance of current services?

- A performance management regime is in place for all services that are delivered for Brent patients.
- Performance data for the providers of the Wave 2 services shows variability and in some cases significant shortfall in, for example, waiting time data.
- Anecdotal evidence from GPs and other professionals in the region also points to dissatisfaction with some services – including the waiting times for physiotherapy services.
- It is important for all of our stakeholders to be aware that although current variability in performance of services is a driver for this programme, one of the major drivers is to ensure that we put in place services that are sustainable and provide an effective model of care for future needs.

What are the projected savings from the process?

- Efficiencies from the procurement of MSK Services will come from a reduction in costs resulting from providing services in a community setting as opposed to under defined hospital tariffs and using different multidisciplinary professionals to meet the varying needs of patients accessing MSK services.
- Furthermore, we expect additional savings from the right care being provided to patients in a timely manner and greater integration of services meaning that different service specialities (and clinicians) can communicate more effectively with each other and any inappropriate referral be reduced.
- The Business Case planning process for NHS Brent CCG has been based around scenario planning – this is a commonly used tool for financial planning.
- Further analysis will be undertaken on the projected financial gains from the Wave 2 programme as the scope of services becomes clearer.
- NHS Brent CCG is committed to only commission services if they meet our objective of delivering high quality, affordable and sustainable NHS outpatient services.

Will the service requirement for MSK services include the requirement for a Clinical Assessment and Treatment Service (CATS)?

- Brent CCG is in the process of developing further details on the proposed scope of the MSK Services Procurement. This information will be made available to stakeholders and interested parties.

- At this stage we have not limited the service scope by defining whether a CATS service is required as part of the integrated MSK services. It maybe that alternative ways of delivering integration between services is determined to offer higher quality and better value. This will be explored as part of the dialogue phase of procurement.

How will NHS Brent CCG ensure the conflicts of interest are managed?

- Brent CCG has in place a Conflicts of Interest policy. This policy requires that all actual or potential conflicts of interest are made known to the Governing Body so that any necessary and appropriate mitigation action can be taken. All conflicts of interest (actual or potential) that are made know to the Board are register on the Conflicts of Interest register.

Where can I go for information on the MSK Services Procurement?

NHS Brent CCG is committed to running an open and transparent process for the Wave 2 programme. Web pages for Wave 2 have been published for interested parties. The website will post key published documents and updates on the programme.

The website for Wave 2 Planned Care Programme is: www.brentcgg.nhs.uk/wave-2-MSK

How do I make contact with the Project Team?

If you need to contact the team please email wave2plannedcare@brent-harrowspcts.nhs.uk with details of the nature of your enquiry and a member of the team will be in touch soon.

Topic Guides for the IIA Strategic Consultations

Current providers:

Current Provision
Q1: Please describe the provision of current outpatient services for these 4 specialties, including the location from which they are current provided?
Trauma and Orthopaedics: **Rheumatology: For Brent – outpatients in CMH and NPH** **MSK:** **Gynaecology:**
Q2: Please describe typical activity for these specialties?
Outpatient clinics provided by NWLHNHST. Presently provided by consultants supported by specialty trainees, specialist nurses, physiotherapists, GP trainees. ***Management can supply exact number of clinics.*** **Clinics include a variety of sub specialist clinics. At CMH this includes the SLE clinic. At NPH these comprise the Hypermobility clinic, connective tissue disease clinic, metabolic bone disease clinic, Spondyloarthropathy clinic, early arthritis clinic, biologics clinic. There are also specialist nurse specialist clinics in connective tissue disease, early arthritis, subcutaneous methotrexate, biologics, and TB testing.** **I am uncertain how the application ongoing to supply Highly specialised adult rheumatology services for these clinics will dovetail with the procurement.**
Q3: Operationally, how are services currently delivered and what resources do they utilise?
Staffing (incl. sessions/pa): *Management please supply* **Equipment/ access to diagnostics: Injection. TB testing. Radiology including MSK ultrasound, XR CT MRI DEXA, nuclear medicine scans, and PET. Biochem, immunology, microbiology, virology, haematology, cytopathology for synovial fluid analysis .Lung function (rheumatology request more than resp department), echo.** **Clinical Inter-dependencies. Multiple. For example, in the CTD clinic, care is shared with a wide variety of specialists including in no particular order** **Infectious diseases in cases of PUO, high TB risk, immunosuppression** **Neurophysiology** **Dermatology** **Ophthalmology** **ENT and Max Fax** **Haematology** **Renal – local and Hammersmith** **Resp medicine (MDT meeting monthly for interstitial lung disease)** **Cardiology** **Gastro – often St Marks for complex gut disease**

Neurology

Orthopaedics

Vascular surgery

Wider tertiary networks – eg Royal Free Scleroderma service, Royal Free Pulmonary Hypertension tertiary service, Imperial renal Lupus centre, St Thomas SLE centre; Queen Charlotte's obstetric medicine department; RNTNE and Charing cross subspecialised ENT services; UCL/Queen's Square myopathology and muscle unit – this is not an exhaustive list!

Orthopaedics for general clinics.

OT, hand therapy, physiotherapy, podiatry, hydrotherapy,

We are currently missing a spinal service, and make limited use of Stanmore, Saint Mary's, Hillingdon.

We make limited use of chronic pain services and psychology, but would welcome more provision.

Space: 9 dedicated clinic rooms and waiting area; secretarial and admin staff, offices

Q4: What do you feel are the challenges and issues with the current provision of the four outpatient specialties under review? (4 specialties)

Instability/morale – it has been difficult to grow and innovate in the current climate since the decommissioning notices.

Capacity – I am under the impression demand has grown over the past year – management will have referral figures. Rheumatology lost a consultant (to CIP) 2 years ago which has increased strain on remaining consultants. Trainees spend more time in acute and general medicine reducing clinic capacity. Nurse helpline remains unfunded, which threatens our ability to continue the local enhanced service for DMARD monitoring.

Lack of integration – the CCGs refusal to allow consultant to consultant referrals for non-threatening consitions results in needless delays to some patients care (those at the interface between rheum and orthopaedics for example).

Nicholson challenge.

Rising use of complex (and extremely effective) drug regimens requiring close monitoring..

Need to expedite referrals for inflammatory disease – as per Best Practice Tariff – 3 week target. This is made almost impossible by delays in referral introduced by Referral Management systems, and contributed by Choose and Book – (figures available if wanted)

Need to upskill primary care to ensure best use of our services. An effective triage service would help – the RMS services are not providing this at present – perhaps because they have no specialist input.

More effective measurement of patient outcomes – we keep high quality local data (eg for early arthritis, ank spond), and contribute to national data (HQUIP early arthritis, BSR biologics registry) but need more robust data capture and more PROMs.

Impact of newly commissioned outpatient provision on current provider, assuming they are successful in the competitive procurement process

Q5: How will the hospital and Trust be impacted should they be successful in the competitive procurement to provide these outpatient services in line with the new specification?

I find this very difficult to answer in the absence of a specification.

One could hypothesise that there is a risk of over activity and requirement for additional personnel. There may be challenges in changing the shape and design services. There may also

be challenges in developing community services. Information technology may need development.

Impact of newly commissioned outpatient provision on providers, assuming they are unsuccessful in the competitive procurement process
Q6: How will the clinically interdependent services you retain (e.g. the inpatient component of these specialties) be impacted should a new provider provide the outpatient component of care?

Difficult to say confidently in the absence of a specification.

Disintegration of care. We have seen locally how the involvement of a private provider in Harrow has disintegrated rheumatology care. Patients have occasionally been referred to both services at once, have passed from one service to the other without complete information, and the feedback from the secondary care consultants has been negative about the community service. Procuring community musculoskeletal and rheumatology services from a different organisation to that providing complex care in secondary care risks creating further 'silos' at a time when integration is what is required to minimise costs and improve services for patients.

GIM and acute medicine. Rheumatology provides 5 day a week input into the medical admissions unit, ambulatory care, and A+E/ITU if needed. Reduced rheumatology staffing will imperil that. Similarly delayed inpatient reviews (often discharge dependent) will result. This will prolong lengths of stay.

Specialist registrar training. If outpatients are lost, there is a significant risk of losing the trainees (SpRs) who provide the bulk of inpatient care (acute medicine, GIM and rheumatology). This would have a significant impact on acute medicine provision (3 SpRs on the on call rota-extremely difficult to replace). Also the lengths of stay would increase as they perform a significant part of Ward referrals.

Specialist registrar funding. Loss of SPRs will result in loss of the 50% of their funding that comes centrally from higher education England. SPRs are cheaper providers of patient care.

Daycare. Daycare provides high cost (and high risk) drugs, and needs an onsite team. There will be governance issues if the hospital are asked to administer these drugs by a different provider without local clinician input.

Sub specialist work. Specialised clinics will not be sustainable without a 'critical mass' – this will adversely impact on the trust if they continue to run (costs) or on patients (both within and outside Brent) if they are stopped. This may change dependent on whether the trust is authorised by NHS England as providing highly specialised adult rheumatology services.

Increased costs per patient-if only complex work is left, the tariff will no longer support the costs associated with each patient's needs.

Local enhanced services. Both Brent and Harrow have local enhanced services for monitoring disease modifying antirheumatic drugs that rely on a functioning well staffed rheumatology service. This may be imperilled by loss of income and loss of staff.

Continuity of care – it is unclear to me what will be proposed for our long term patients (>70%). If their care is moved that will represent a significant clinical risk, and will cause a great deal of upset for the patients. If not, the new provider will be taking on a significant financial risk if patients choose not to move across.

Employment costs associated with re-procurement. Brent work is <50% of our total work – I suspect TUPE will not apply (certainly not in the case of Northwick Park, possibly at Central Middlesex Hospital (if all of the service for outpatients is moved-not if specialised services are excluded as per the application to supply adult highly specialised rheumatology services as part of National commissioning.) This may leave the trust with costs of personnel who are underemployed.

Income loss. This may destabilise the secondary care trust.

Reputational damage-both to staff and patients. Removing the service will significantly damage the reputation of NWLH. This may make in future recruitment and service development significantly more difficult.

Overemployment or underemployment. There must also be a risk that the NWLH service shrinks, members of staff are transferred, and in fact most patients choose to have their care with the current provider and there is a staff shortage at NWLH and staff under employment at the new provider

Loss of work for the associated health professionals-occupational therapy, hand therapy, physiotherapy, orthotics particularly.

Loss of a complete training scheme for those associated health professionals.

Q7: What will be the wider impacts on the Trust?

Research and development. The commissioners may not be aware that the rheumatology department recruited more patients into clinical local research network studies them the entirety of Imperial over the last financial year. This work is predicated on specialist clinics, and having a sufficient catchment area. Splitting the outpatient services will have **a poorer outcome** for patients in the long term from loss of research, and the financial cost to the trust of **lost income** from commercial work.

Education. NWLH gets consistently good feedback from Imperial undergraduate education. Removal of outpatient services to an alternative provider would result in loss of educational opportunities and loss of income.

Management time. No resources have been allocated to clinicians involved in this process.

Legal fees & other costs-particularly during any hand over period. NB shaping a healthier future review specifies that hospital services will not close until the community services are running. This implies there will be a period of double provision.

Reduced income.

Q8: Will any of these wider impacts be increased further through other changes planned by neighbouring CCGs or Trusts?

Harrow CCG presently plan to put rheumatology services out to any qualified provider. There is a risk of loss of activity further destabilising the arthritis centre at Northwick Park Hospital associated with this. I also remain concerned that it will increase this integration within current services, and make clearly defined clinical pathways harder to achieve.

A worst-case scenario would be that 75% of the outpatient rheumatology activity in Northwick Park Hospital is lost (all of Brent and Harrow). This would clearly be catastrophic for the organisation, and also an extremely difficult for the remaining patients who attend the arthritis centre.

Q9: What do you consider to be the key challenges in implementing the re-procured services?

This again is extremely difficult to answer in the absence of a detailed specification.

Change enablement.

Reorganising services to ensure clinical safety.

Reorganising services to ensure integration.

Reorganising services to ensure the right patient is seen by the right time-effective triage.

Upskilling primary care to ensure appropriate referrals. Triage feedback.

Engaging more multidisciplinary team members to reduce overall costs.

Integrating services previously regarded as peripheral-clinical psychology, pain management, spinal services.

Maintaining a safe, effective and timely emergency and inpatient service.

Wider Impacts

Q10: What do you think are the potential benefits of the re-procured services likely to be on patients and the health economy?

For patients and the public: This again is extremely difficult to answer in the absence of a detailed specification.

Shaping a healthier future suggests more localism. Better access (if that has been perceived as a problem). Better integration.

For the health economy: This again is extremely difficult to answer in the absence of a detailed specification.

Lower costs.

Q11: Do you think the benefits you have identified are dependent on other factors, and how important are these factors to the successful delivery of services in the future?

Q12: What do you think the potential negative impacts of the re-procured services could be?

For patients and the public: as listed above under question six, seven, eight.

For the health economy: as listed above under question six, seven, eight.

Q13: Do you think that the proposed change to services will provide particular benefits or disbenefits to any groups within the local population?
I worry about the long stay patients with chronic diseases under the current service. They will be at risk if the procurement/commissioners insist their care is moved to a new provider. I would hope any new provision would include a high-quality interface with primary care to try to identify patients who need to be seen urgently by rheumatologists. It should also provide better care for patients currently poorly provided for-back pain services, chronic pain.
Q14: How do you feel that the proposed change to services will help to address existing health inequalities?
See question 13. There may be an opportunity to change geographical provision, although my personal feeling is that is not a significant part of the inequalities within Brent, where no one is more than a couple of miles from the hospital.
Q15: Are there any ways in which some of the negative impacts that have been identified can be mitigated?
I think a procurement exercise and change of service will have to be managed extremely carefully. I think the timeline presently proposed is too short to be able to do that.
Q16: Do you feel that the changes could be improved in any way? If so, how?
I am uncertain which changes this question refers to.
Q17: Are there any key individuals / stakeholders that we should be talking to as part of this impact assessment?
Heads of service of the four services. Director of strategy and providers. Commissioners, and managers at the CCG. Patients. It is not clear to me that this consultation has been advertised to the users of the arthritis centre. I worry that as such, this consultation will not reach the hard to reach users, particularly those with English as a second language, and those who attend infrequently but for many years.
Q18: Is there any specific evidence or local work that you are aware of which we should consider as part of the impact assessment?
I have a lot of data about clinical outcomes. I do not believe the CCG do. I think that a benchmarking exercise of clinical and financial outcomes is required, as without this, the CCG will not know whether a future service is of higher or lower quality than the current clinical service.
Q19: Do you have any other comments?
I remain unconvinced that a strong argument has been made for the use of competitive dialogue for this tender process.

I have not been approached by the CCG on any points of concern about the clinical service.

The Department has tried to be innovative over the past few years, and am engaged with Brent CCG at present in developing a local enhanced service for disease modifying drugs.

I am concerned the commissioners do not understand the pathways, interdependencies, and service currently provided. As such I am not sure they are in a good position to understand the ways in which the service could be improved.

I remain concerned that they do not have good data about activity within the Department, case mix, and clinical outcomes.

I also have slight concern about the data with regards to activity in outpatients, as when I last looked at this year ago the figures seemed approximately 10% lower than the number of appointments I was given to understand were provided by the trust data.

I also remain concerned that national specialist commissioning may have a significant impact.

Topic Guides for the IIA Strategic Consultations

Current providers:

Current Provision
Q1: Please describe the provision of current outpatient services for these 4 specialties, including the location from which they are current provided?
Gynaecology: This service is provided on both sites namely – NPH and CMH. Our Gynaecology provision includes secondary and tertiary care in General Gynaecology, Cancer/RAC gynaecology, Colposocopy, Fertility, Menopause, Psycho-sexual, NND Clinic (Neonnatal Death), recurrent miscarriage, endometriosis, Prolapse, Urogynaecology & Ambulatory. Gynaecology Direct Referral (GDR) is also available for women with early pregnancy issues/complications and gynaecological emergencies (acute vaginal bleeding other gynaecological emergencies, complications arising from gynaecological conditions or management thereof). Recently we have established outpatient Hysteroscopy clinic to reduce day cases in Theatres.
Q2: Please describe typical activity for these specialties?
NPH • **General Gynaecology – Consultation, possible diagnostic tests and treatment plan** • **Cancer - Baseline investigations, consultation, diagnosis and treatment plan/breaking bad news** • **Colposocopy – Consultation and diagnostic test and then treatment plan** • **Fertility – Consultation, baseline investigations, inpatient surgical diagnostics and treatment plan** • **Menopause – Consultation and treatment plan** • **Psycho-Sexual – Consultation and treatment plan** • **NND – Post-mortem results, blood results, consultation and discussion of future pregnancies** • **Recurrent miscarriage – blood results and consultation and discussion of future pregnancies** • **Endometriosis – Consultation and treatment plan** • **Prolapse – Consultation and treatment plan** • **Urogynaecology – Consultation and diagnostic test and then treatment plan** • **Ambulatory Care – Diagnostic test and treatment plan** • **Gynaecology Direct Referral – Scan, bloods, consultation and treatment plan/Emergency admission/medical and/or operative management** • **Outpatient Hysteroscopy – Surgical diagnostic within an outpatient setting and treatment plan** **CMH** • **General Gynaecology – Consultation, possible diagnostic tests and treatment plan** • **Cancer - Baseline investigations, consultation, diagnosis and treatment plan/breaking bad news** • **Fertility – Consultation, baseline investigations, inpatient surgical diagnostics and treatment plan** • **Endometriosis – Consultation and treatment plan** **Standard Template** **NPH** • **General Gynaecology/Fertility/Prolapse – 15 News and 15 Follow ups** • **Cancer/RAC – 15 News and 15 Follow ups but is generally overbooked depending on need to meet cancer target**

- **Menopause – 30 News and 35 Follow ups (to include young, normal, breast combined, medication management and counselling clinics)**
- **Psycho-Sexual – 2 News and 2 follow ups**
- **NND – 4 Follow ups**
- **Recurrent Miscarriage – 4 News and 2 Follow ups**
- **Endometriosis – 12 News and 12 Follow ups**
- **Urogynaecology – 16 News and 16 Follow ups**
- **Outpatient Hysteroscopy – 6 News**
- **Colposocopy – 40 News and 40 Follow ups**
- **Ambulatory Care – 4 News and 2 Follow ups**

CMH

- **General Gynaecology/Cancer/RAC/Fertility/ – 15 News and 15 Follow ups**
- **Cancer/RAC – 15 News and 15 Follow ups but is generally overbooked depending on need to meet cancer target**
- **Endometeriosis – 6 News**
- **Cancer – 16 News and 16 Follow ups**
- **GDR – 50 News**

Activity during 2012-2013 was as follows:

NPH – 16,950 Attendances

CMH – 4258 Attendances

Q3: Operationally, how are services currently delivered and what resources do they utilise?

Staffing (incl. sessions/pa): Consultant/Associate Specialist, Registrar, SHO, Nurses, HCAs, Admin which equates to 19.25 consultant PA sessions. Each PA session consists of a consultant, an RSO, a nurse, HCA and Admin staff

Equipment/ access to diagnostics: Ultrasound Scan, Fertility Scan, MRI scan, CT scan, Bone Density Scan, Urogynaecology, Ambulatory, Colposcopy, Hysteroscopy equipment, IT Systems to access results

Clinical Inter-dependencies – Pharmacy, Pathology (cytology and histopathology) haematology, biochemistry, microbiology and virology, Radiology, Theatres, Obstetrics

Space: Adequate within outpatient setting

Q4: What do you feel are the challenges and issues with the current provision of the four outpatient specialties under review? (4 specialties)

We have previously undertaken community outreach clinics in gynaecology and would be happy to re-establish this service if there is a perceived need

Impact of newly commissioned outpatient provision on current provider, assuming they are successful in the competitive procurement process

Q5: How will the hospital and Trust be impacted should they be successful in the competitive procurement to provide these outpatient services in line with the new specification?

Provision of services likely to be provided at a greater number of sites which may require an increase in personnel to deliver

Potential loss of income if tariff is reduced

Impact of newly commissioned outpatient provision on providers, assuming they are unsuccessful in the competitive procurement process

Q6: How will the clinically interdependent services you retain (e.g. the inpatient component of these specialties) be impacted should a new provider provide the outpatient component of care?

- **Many of the gynaecologists support obstetrics**
- **It is inappropriate to undertake operative treatment for patients without their having been first counselled by the operating team prior to admission. This will therefore lead to duplication of service with cost implication for the Commissioners**
- **If we retain emergency gynae services, we need a core group of consultants to support this service. It is not affordable to provide emergency cover if we lose our outpatient work, as the cost of maintaining emergency services and cover would be unsustainable. This would have a negative impact on our training contracts with the London Deanery and Imperial College with the risk of withdrawal of trainees with the resultant destabilisation of both gynaecology and obstetric service**
- **The Trust contract for undergraduate training would be put at risk with loss of outpatient work**

Q7: What will be the wider impacts on the Trust?

Severe difficulty in maintaining the emergency gynaecology pathway, obstetric care/ante natal clinics and elective gynaecology and obstetrics operative management

Q8: Will any of these wider impacts be increased further through other changes planned by neighbouring CCGs or Trusts?

- **Impending merger with Ealing and transfer of all emergency and obstetrics services to NPH**
- **Impact of transferring gynaecology outpatient and ante natal clinics from Ealing to NWLH**

Q9: What do you consider to be the key challenges in implementing the re-procured services?

- **Reduction in service agreement tariffs and volumes**
- **Cost of redundancies and relocation of staff (salary protection)**
- **Loss of skilled staff**
- **Increasing level of sickness due to stress resultant from changed working patterns**

Wider Impacts

Q10: What do you think are the potential benefits of the re-procured services likely to be on patients and the health economy?

For patients and the public:

Patients:

- **Local provider services near to patients domicile**
- **Continuity of care**
- **Familiarity and trust of their local hospital**

For the health economy:

- **Maintain and improve services for women locally**

Q11: Do you think the benefits you have identified are dependent on other factors, and how important are these factors to the successful delivery of services in the future?

- Changes in social service provision
- Uncertainty of future levels of primary care support, which are vital to deliver enhanced recovery and discharge planning of treated emergency gynaecology, obstetric and elective treated gynaecology patients

Q12: What do you think the potential negative impacts of the re-procured services could be?

For patients and the public:

Only positive impacts with re-procurement of services

For the health economy:

Positive impact will be to maintain and develop the health of our local population

Q13: Do you think that the proposed change to services will provide particular benefits or disbenefits to any groups within the local population?
Clarity required as to proposed changes to services
Q14: How do you feel that the proposed change to services will help to address existing health inequalities?
Clarity required as to proposed changes to services
Q15: Are there any ways in which some of the negative impacts that have been identified can be mitigated?
In order to mitigate negative impacts, re-procurement of all services is essential
Q16: Do you feel that the changes could be improved in any way? If so, how?
In the past the provision of outreach clinics has not been cost effective as only small numbers of patients could be seen in various Health Centres. Outreach clinics are taken by consultant staff who are therefore unavailable in the hospital to provide immediate care and support of urgent patient issues. This has an impact on the provision of patient care within the hospital
Q17: Are there any key individuals / stakeholders that we should be talking to as part of this impact assessment?
Chief Executive, Clinical Director, Divisional General Manager, General Manager, Consultant leads for services, local Members of Parliament, local council representatives and patient representatives including representatives of minority patient groups
Q18: Is there any specific evidence or local work that you are aware of which we should consider as part of the impact assessment?
Patient satisfaction audits
Q19: Do you have any other comments?
Both services are interdependent and it would be best practice for delivery by the same single provider

Topic Guides for the IIA Strategic Consultations

Current providers:

Current Provision

Q1: Please describe the provision of current outpatient services for these 4 specialties, including the location from which they are current provided?

Trauma and Orthopaedics:

At the North West London NHS Trust, Orthopaedics is a cross site service delivering a trauma service on the Northwick Park (NWP) site and the majority of elective surgery offered on the Central Middlesex site (CMH) through the BECAD and ACAD wings.

In addition the service delivers a range of outpatient services from the Pinn Medical Centre.

Q2: Please describe typical activity for these specialties?

	Day Case	Elective	Emergency	Total
April 2012-March 2013	1611	1439	1496	4546
April 2013-Dec 2013	1665	1513	1248	4426

Out-patient comparison of new and follow-up

		Attend
April 2012-March 2013	Trauma	6968
	New Referrals	5242
	Trauma f-ups	9773
	Review patients	10131
April 2013-Dec 2013	Trauma	7079
	New Referrals	4917
	Trauma f-ups	9985
	Review patients	10553

Q3: Operationally, how are services currently delivered and what resources do they utilise?

Consultant staff – Orthopaedics

Mr. L. Freedman	Knee Surgery
Mr. S Jennings	Revision surgery, hips and knees
Mr. J. Murphy	General Orthopaedic
Mr. M. Sala	Shoulder surgery
Mr. G Allardice	Lead for Trauma /Foot surgery
Mr. J Perez	Upper Limb
Mr. M Bartlett	Lower Limb
Mr. J. Hollingdale	Lower limb surgery
Mr. M. Pearse	Revision surgery, foot and ankle
Mr. K Lehndorff	General Orthopaedic surgery
Mr Al-Yassari	Upper Limb
Mr Holloway	Lower Limb
Mr Gupta	General Orthopaedic
Mr Bhattee (Locum)	General Orthopaedic

Orthopaedic Middle and Junior Medical Staff
Northwick Park and Central Middlesex Hospitals
8 x WTE Specialist Registrars
2 Associate Specialists
4 Trust Specialist Doctors
5 Senior Clinical Fellows
6 x FY2 & 2 x FY1

Equipment/ access to diagnostics:

Access to a full range of diagnostic imaging facilities including plain film, ultrasound, CT and MRI

Clinical Inter-dependencies

All acute medical and surgical services available 24/7
(Theatres, A&E, HDU, ITU, beds) UCC - therapists

Space:

At CMH the BECAD was opened in April 2006 and has state of the art laminar flow theatres and a dedicated elective surgery ward (Abbey Ward). ACAD accommodates the minor and intermediate surgery with day case and step down beds.

On the Northwick site, there are ring fenced elective orthopaedic beds in Evelyn ward and the theatre admission unit with a dedicated new specialist theatre opening in January 2014.

In addition clinical and management offices are collocated to provide an integrated service.

Q4: What do you feel are the challenges and issues with the current provision of the four outpatient specialties under review? (4 specialties)

- Meeting 18 week standards has been an issue, however this is being resolved through the implementation of three session days
- lack of available out-patient accommodation at both sites (NPH/CMH)
- Recovery space post operatively has been an issue, however this is being resolved through the opening of additional theatre capacity.

Impact of newly commissioned outpatient provision on current provider, assuming they are successful in the competitive procurement process

Q5: How will the hospital and Trust be impacted should they be successful in the competitive procurement to provide these outpatient services in line with the new specification?

This is difficult to answer without sight of the clinical specification.

Impact of newly commissioned outpatient provision on providers, assuming they are unsuccessful in the competitive procurement process
Q6: How will the clinically interdependent services you retain (e.g. the inpatient component of these specialties) be impacted should a new provider provide the outpatient component of care?
Decommissioning the elective element of the service would destabilise the emergency care pathway and significantly compromise the delivery of trauma care. Leading to: • Reduced clinical outcomes • Reduction in patient satisfaction • Loss of market share and income • Redundancy • Loss of experienced staff
Q7: What will be the wider impacts on the Trust?
• Out of hours cover in A&E and support to other specialities • Poor overall patient care
Q8: Will any of these wider impacts be increased further through other changes planned by neighbouring CCGs or Trusts?
• Shaping a healthier future • Merger with Ealing NHS Trust
Q9: What do you consider to be the key challenges in implementing the re-procured services?
This is difficult to answer without sight of the clinical specification.
Wider Impacts
Q10: What do you think are the potential benefits of the re-procured services likely to be on patients and the health economy?
This depends on the clinical model and specification. Benefits of locally provided services would be offset by lacl of access to support services
Q11: Do you think the benefits you have identified are dependent on other factors, and how important are these factors to the successful delivery of services in the future?
Dependant on the engagement of CCGs/GP practices
Q12: What do you think the potential negative impacts of the re-procured services could be?
For patients and the public: Out of hours resource reduced with compromised emergency care pathway **For the health economy:** Overall a more expensive orthopaedic model

Q13: Do you think that the proposed change to services will provide particular benefits or disbenefits to any groups within the local population?
This is difficult to answer without sight of the clinical specification.
Q14: How do you feel that the proposed change to services will help to address existing health inequalities?
Please identify the health inequalities alluded to ?
Q15: Are there any ways in which some of the negative impacts that have been identified can be mitigated?
This is difficult to answer without sight of the clinical specification.
Q16: Do you feel that the changes could be improved in any way? If so, how?
-
Q17: Are there any key individuals / stakeholders that we should be talking to as part of this impact assessment?
GPs – UCC – A&E (out of hours)
Q18: Is there any specific evidence or local work that you are aware of which we should consider as part of the impact assessment?
No
Q19: Do you have any other comments?
Responding to the IIa would have been made easier with sight of the proposed specification

From: Gaynor Lloyd [mailto:gaynor@gaynorlloyd.co.uk]
Sent: 02 October 2014 17:39
To: ccg foi
Subject: RE: FOI CCG/0961 RE: FOI CCG/0755a RE: FOI CCG/0755 RE: Freedom of Information Request NHS Brent CCG - Property costs Sudbury and Willesden - RE: Follow up from EDEN Committee meeting on 26 March 2014

Dear Dominic,
Please see my comments in red. I am sorry that I still do not understand why there is no subsidy or effect on the bid. I hope the comments make it clearer- or that a reply analysing why there was no potential for prejudice can be given. Perhaps details on the scoring.
Regards
Gaynor

From: ccg foi [mailto:ccgfoi@nw.london.nhs.uk]
Sent: 02 October 2014 17:00
To: Gaynor Lloyd
Cc: ccg foi
Subject: RE: FOI CCG/0961 RE: FOI CCG/0755a RE: FOI CCG/0755 RE: Freedom of Information Request NHS Brent CCG - Property costs Sudbury and Willesden - RE: Follow up from EDEN Committee meeting on 26 March 2014

Dear Ms Lloyd,

I am writing further to your follow-up query to a previous Freedom of Information request. I apologise for the delay in responding to your query.

Please see Brent CCG's response below.

- Can you please let me know when the bid spec changed from the provisions in 7.3 of the Bid Spec (cardiology - but similar in ophthalmology) on the website? http://www.brentccg.nhs.uk/en/publications/plans-and-strategies/cat_view/1-publications/12-plans-and-strategies/22-out-of-hospital-plans/166-wave-1-ophthalmology-and-cardiology.
  The CCG is unable to establish what change is being referred to other than in respect of the cost of premises which were clearly designated as *'Indicative Sessional Costs for NHS Brent Venues'*

1 ***But on what basis was the bid done? Put simplistically, if a provider did not need the CCG's premises because it had its own, how were the bids adjusted? Your earlier reply "*** We do not believe there is any difference between the rent payable by the CCG and the rent to be paid by BMI. There is, however a cost difference between the amount we told potential bidders for ophthalmology community services to assume in their prices and the actual cost of the clinical rooms. This later difference is what we are making an adjustment in the contract for." shows an adjustment in the contract price. Can you please explain in terms how/why there was no disadvantage to any bidder whose bid was found less "attractive", say on a financial evaluation basis?

"

- It appears clear that the spec was that the Provider will do what you outline below as the contract obligation on the commissioner? Was this simply changed in the contract.

2 **The CCG is unable to respond to this as it is not clear precisely what the question refers to. Make the premises fit for purpose in the alterations. Was not all this for the Provider to do in**

the spec? Has the commissioner not done this work/part of it for this provider? If so, please state in terms how/why there was no disadvantage to any bidder whose bid was found less "attractive", say on a financial evaluation basis?

- Can you please let me know what the actual premises costs are as opposed to the quoted figures in the Bid Spec, as the bid spec says that the bidders will use these figures for the contract pricing?
  The rent costs for ophthalmology for Willesden is £52,498 as advised by NHS Property Services and Sudbury is £102,569 per annum as advised by Community Health Partnerships. The position in respect of cardiology remains to be finalised once specific premises requirements have been agreed.

3 **The annual costs per clinical room at Willesden and Sudbury were respectively £2,010 and £6,509 in the spec - OK, this was indicative but therefore the bid assessments have to be adjusted. Again,** please explain in terms how/why there was no disadvantage to any bidder whose bid was found less "attractive", say on a financial evaluation basis?

- Again - re point 3 below - on page 9 of the ophthalmology bid spec, it said that the Provider would be responsible for all the IT costs, so when did the bid spec change? How much has been spent on the IT generated alterations?
  Having reviewed the contract the CCG is unable to establish that there has been any departure from this requirement.

In your point 3 response below, you said " The commissioner has funded a minor works alteration on the Willesden site relating to IT." So how is this not funding IT?

- In each case, were all the prospective providers informed of the revised budgetary considerations?

4 **Only the preferred bidder was notified of the cost changes to the premises at Sudbury and Willesden on the basis that it made no material change to the bid. I do not understand how this can be, if other bidders had their own premises. Perhaps all costs were factored out but then if the CCG is paying any difference in rent, surely this is a subsidy. Again,** please explain in terms how/why there was no disadvantage to any bidder whose bid was found less "attractive", say on a financial evaluation basis?

Regards Dominic

If you are dissatisfied with how your request has been handled or the response you have received, you can write outlining your complaint by emailing ccgfoi@nw.london.uk. If you remain dissatisfied, you can request an Internal Review of your response by emailing ccgfoi@nw.london.nhs.uk. This would be conducted by a member of staff not originally involved in the FOI. The outcome would be reported back to you. Where you feel your request has still not been dealt with properly, you can refer your compliant to the Information Commissioner by writing to: *The Information Commissioner, Wycliffe House, Water Lane, Wilmslow SK9 5AF* which can investigate the matter.

Further information on the Freedom of Information Act is available at: http://www.ico.gov.uk.

Regards Dominic

Dominic Mallinder
Freedom of Information Manager
North West London Clinical Commissioning Groups
ccgfoi@nw.london.nhs.uk

2nd Floor, 15 Marylebone Road, London NW1 5JD

NHS

North West London Collaboration of
Clinical Commissioning Groups

Brent PPG Chairs Submission of Evidence to Mansfield Enquiry

Appendix 3 – Correspondence between PPG Chairs and Imperial College Healthcare NHS Trust about the A&E situation at the Trust.

1. PPG Chairs to Dr T Batten 11 Nov 2014
2. Dr Batten to PPG Chairs 13 Nov 2014
3. PPG Chairs to Dr Batten 18 Nov (plus tables as attachment)
4. Dr Batten to PPG Chairs 1 Dec 2014
5. PPG Chairs to Dr Batten (and D McVittie) 15 Dec 2014
6. Steve McManus to PPG Chairs (via Robin Sharp) 14 Jan 2015

Address for reply:
Robin Sharp CB
30 Windermere Avenue
London NW6 6LN
robisharp@googlemail.com
tel: 02089690381

11 November 2014

Tracey Batten
Chief Executive
Imperial College NHS Healthcare Trust
The Bays□South Wharf Road
□St Mary's Hospital, □London W2 1NY

Dear Ms Batten,

We write as individual NHS Brent patients and as the chairs of NHS Brent CCG locality Patient Participation Groups to highlight concerns about a sharp dip in performance at St Mary's Paddington A&E, along with serious reported recent delays at Northwick Park Hospital A&E. These have to be seen in the context of the recent NHS NW London corporate decision to implement key elements in *Shaping a Healthier Future* by closing the A&E Departments at Central Middlesex and Hammersmith Hospitals on 10 September last.

The Evening Standard newspaper yesterday reported on page 24 that:

> "Figures from NHS England reveal that the trust that runs Northwick Park and Ealing Hospitals was the worst in the country for A&E performance in the final two weeks of October.
>
> In the week to October 19, it saw only 67.8 % of patients at its main accident and emergency department within four hours, compared with the target of 95%. The next week it was 73.3%. Over the fortnight 1,455 patients waited more than 4 hours to be seen.
>
> Imperial College NHS Trust, which runs St Mary's and Charing Cross, also saw its performance dip last month, in one week to 82 per cent."

When members of the Kilburn Locality Patient Participation Group asked your Deputy Medical Director, Dr Bill Oldfield, to comment on related reports of long waits and overcrowding at St Mary's at its meeting on 5 November 2014, he said that St Mary's (and by implication other hospitals) were being faced with unpredictable surges in demand, not related to the recent closures. However at the Hammersmith Council Health and Social Care etc Committee on 7 October 2014, attended by one of us, you reported that compliance with the 95% waiting time target by Imperial was at 93.5%. An 82% figure in one week in October represents an unacceptable decline. Accordingly we would wish to make a formal complaint about this situation as being unsafe for NHS Brent patients who are served by St Mary's. There must be a huge risk that the situation will become worse as winter weather sets in.

Presumably you are working with NHS Brent CCG and other NW London CCG's who

commission these healthcare services for local patients to monitor and analyse what is happening? Please reply urgently to explain what steps are being taken to remedy the position and when the national 95% target is expected to be achieved. We are making no criticism of hard-pressed and dedicated staff in the Department in raising this concern.

We draw attention to the fact that the A&E closures, which took place on 10 September 2014, were the first main fruits of the highly contested *Shaping a Healthier Future* plan for NW London. Leading up to 10 September Brent CCG led by its Chair was involved in a host of planning meetings and papers running to hundreds of pages giving what the NHS calls "assurances" that all would be well after the A&E closures and that the system would cope. The 100-page report you tabled at the Hammersmith Committee already mentioned is but one example of the assurance process. Manifestly these assurances were not well founded. It is time for a realistic plan to be put in place and for the public to be told the truth about the situation. We look forward to hearing from you.

We are sending copies of this letter to the Chief Executive and the Chief Operating Officer of NHS Brent CCG. We have already written to the Chief Executive of the North West London Healthcare NHS Trust about the Northwick Park situation.

Yours sincerely,

Nan Tewari, Chair Harness locality PPG..
Robin Sharp CB, Chair Kilburn locality PPG.
Irwin Van Colle, Chair Kingsbury locality PPG.
Keith Perrin, Chair Wembley locality PPG.
Peter Latham, Chair Willesden locality PPG .

Chief executive: Dr Tracey Batten
The Office of the Chief Executive
The Bays Building
South Wharf Road
London
W2 1NY

0203 312 5897
tracey.batten@imperial.nhs.uk
www.imperial.nhs.uk

13 November 2014

Chairs of NHS Brent CCG Locality PPGs
c/o Robin Sharp CB
30 Winderwere Avenue
London
NW6 6LN

Dear PPG Chairs

Thank you for your letter of 11 November.

The figures quoted in the Evening Standard article do not show the true picture of what is happening in our Trust's A&E departments. While our A&E departments, along with others throughout London and the rest of the country, are under particular pressure currently, the vast majority of our patients are still treated within the four-hour wait standard, we have an action plan in place to improve our waits further and, categorically, we are maintaining our very high safety standards. We remain one of the safest NHS trusts in the country, according to independent monthly monitoring.

An accurate picture of A&E waits
A significant number of people needing urgent care at our hospitals in fact attend one of our three urgent care centres (UCCs), not an emergency department. At Charing Cross Hospital and St Mary's Hospital, these UCCs and emergency departments are located adjacent to each other so many people are not even aware they are being seen at a UCC instead of an emergency department. Waiting times for UCC patients are recorded separately to waiting times for emergency department patients, and separately also for patients at specialist emergency departments – and it is not always clear in reports in the media and elsewhere which monitoring figures are being used. I have set out a brief explanation of the monitoring system in the box overleaf.

Since we made the changes to our urgent and emergency services in September, our lowest Trust-wide weekly figure for the 4-hour waiting time standard for all types of A&E patients has been 92.06 per cent (week-ending 19 October). In relation to St Mary's A&E department specifically, the lowest weekly figure has been 87.27 per cent (also week-ending 19 October). The latest data available week ending 9 November) shows 93.02 per cent performance for the Trust overall, and 90.73 per cent for St Mary's alone.

Total waiting time in the A&E department: this is measured from the time of arrival and registration on the hospital information system to the time that the patient leaves the department to return home or to be admitted to the ward bed (including the A&E department observation beds).

National waiting time standard: the national minimum threshold is 95 per cent of A&E patients seen in 4 hours.

Types of A&E department and patient categories:
Type 1 A&E department = A consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients; applies to emergency departments at Charing Cross and St Mary's hospitals.

Type 2 A&E department = A consultant led single specialty accident and emergency service (e.g. ophthalmology, dental) with designated accommodation for the reception of patients: applies to emergency department at Western Eye Hospital.

Type 3 A&E department = Other type of department/minor injury units (MIUs)/Urgent Care Centres (UCCs) with designated accommodation for the reception of patients: applies to UCCs at Charing Cross, Hammersmith and St Mary's Hospitals.

Impact of closure of Hammersmith Hospital A&E
The recent changes to urgent and emergency care at Central Middlesex and Hammersmith hospitals are part of the 'Shaping a healthier future' programme. They are intended to ensure we have high quality specialist services where they are most needed. We can provide better emergency and urgent care, more sustainably, by concentrating more resources for seriously ill and injured patients at St Mary's Hospital while ensuring good local access for those with urgent but not life-threatening conditions at our urgent care centres, including the expanded UCC at Hammersmith Hospital.

This important programme of change was implemented in a planned and measured way, working jointly with NHS partners on the safe closure of the two A&Es on 10 September 2014. The closure of the A&E unit at Hammersmith Hospital did not assume or require extra 'out of hospital' services to be in place as we were not assuming a reduction in urgent and emergency capacity but rather a reprovision elsewhere in the sector. To that end, the capacity in the north west London urgent and emergency care system is broadly the same, or higher, than previously.

The UCC at Hammersmith Hospital has been expanded since late June, and is open 24 hours a day, seven days a week. While we 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 A&E, we also expanded our capacity at Charing Cross Hospital's A&E as part of our preparations.

It is still early in the transition and the Trust will continue to monitor activity carefully and work closely with other NHS partners. However, it is clear that attendance and admission numbers at St Mary's and Charing Cross A&Es, and Hammersmith's UCC following the Hammersmith Hospital A&E closure are broadly in line with those expected and prepared for prior to the closure. Attendances and admissions via A&E have increased in line with expectations at St Mary's and at Charing Cross, though there have been unanticipated peaks and troughs in demand throughout the day and from day to day that are creating real challenges.

An action plan is now in place to ensure that we get back on track to meet the 95 per cent standard for 4-hour A&E waiting times as soon as possible, including additional capacity for A&E, increased availability of senior clinical decision makers and improved patient flows through the whole hospital system and through to discharge from hospital, with continuing support wherever needed.

Winter preparedness
In terms of ensuring we are ready for the winter seasonal pressures we have been working closely with NHS and local authority partners and others to make sure we have prepared as much as possible and that we are able to respond flexibly to any new needs, such as a winter virus or a particularly cold and icy spell. This includes additional beds on top of the additional capacity developed as part of the changes to urgent and emergency care. We are also working with partners to help ensure the public know what they need to do to keep well and where to get expert advice.

I hope you find this response helpful and please do keep a watch on our website where we publish our A&E waiting times weekly and will now be adding to this with regular publication of monitoring data to show how we are managing in response to the additional winter pressures.

Yours sincerely

Dr Tracey Batten
Chief Executive

Address for reply:
Robin Sharp CB
30 Windermere Avenue
London NW6 6LN
robisharp@googlemail.com
tel: 02089690381

18 November 2014

Dr Tracey Batten
Chief Executive
Imperial College NHS Healthcare Trust
The Bays□South Wharf Road
□St Mary's Hospital, □London W2 1NY

Dear Dr Batten,

A&E situation at St Mary's Hospital Paddington

Thank you for your reply dated 13 November to our letter of 11 November which raised serious concern about current A&E performance at the Trust in the context of the implementation of plans for *Shaping a Healthier Future*.

Despite what you say in your letter the performance figures for the week ending 9 November on your website (table attached to this letter) and in the national NHS data tables remain extremely worrying. In particular we are concerned about the situation for those patients requiring full A&E facilities (type 1) at St Mary's. We note that, nevertheless, high safety standards are being maintained. This is positive.

There are various ways of presenting the figures concerned but by amalgamating type 1 and type 3 (urgent care centre patient) performance or by consolidating the numbers for all the hospitals in the Trust you have managed to play down the position for type 1 at St Mary's.

The type 1 attendance numbers for St Mary's in the Imperial website table show:

10 weeks 06 July to 07 September : total 11,898 average weekly number 1189.8
9 weeks 14 September to 09 November: total 12,438 average weekly number 1382

This is an average weekly increase of 192.2 type 1 A&E patients at St Mary's since the closure of A&E's elsewhere on 10 September.

The amalgamated performance against the 95% target for types 1 and 3 at St Mary's is 88.3%, while the type 1 performance for the Trust is 85.8%. Since the latter figure includes Charing Cross where performance seems generally better, it follows that the St Mary's performance will be significantly worse.

To be transparent can you please supply us with the performance figures for type 1 cases at St Mary's since w/e 14 September and include this in future on your website?

Can you please supply us with more detail on the action plan you mention at the top of the last page in your letter with expected dates for extra capacity in terms of beds, staff and

flows? The public deserve no less from what sets out to be a world class hospital and is developing very ambitious investment plans for the future.

We look forward to hearing further from you.

We are sending copies of this letter to the Chief Executive and the Chief Operating Officer of NHS Brent CCG.

Yours sincerely,

Nan Tewari, Chair Harness locality PPG..
Robin Sharp CB, Chair Kilburn locality PPG.
Irwin Van Colle, Chair Kingsbury locality PPG.
Keith Perrin, Chair Wembley locality PPG.
Peter Latham, Chair Willesden locality PPG .

From: Robin Sharp <robisharp@googlemail.com>
Subject: Re: A&E at Imperial and LNWHT we 7 Dec 14
Date: 15 December 2014 16:12:51 GMT
To: tracey.batten@imperial.nhs.uk, "Nisar Ginder (LONDON NORTH WEST HEALTHCARE NHS TRUST)" <ginder.nisar@nhs.net>
Cc: Maurice Hoffman <mauricehoffman.uk@gmail.com>, Nan Tewari <nantewari@yahoo.co.uk>, Irwin Van Colle <Irwin@thecopycentre.com>, Peter Latham <peter.latham1@btinternet.com>, "Gallagher Ursula (BHH CCGS)" <ursula.gallagher@nhs.net>, Dominic Mallinder <dominic.mallinder@nw.london.nhs.uk>, "Tom Stevenson (Tom.Stevenson@nw.london.nhs.uk)" <Tom.Stevenson@nw.london.nhs.uk>, William Oldfield <William.oldfield@imperial.nhs.uk>, Michelle Dixon <Michelle.dixon@imperial.nhs.uk>, "Mansuralli Sarah (NHS BRENT CCG)" <sarah.mansuralli@nhs.net>, PerrinCouncillor Keith <Cllr.keith.perrin@brent.gov.uk>, Rob Larkman <rob.larkman@nhs.net, "Benson Tina (LONDON NORTH WEST HEALTHCARE NHS TRUST)" <tina.benson@nhs.net>, Cllr.Kupresh.hirani@brent.gov.uk, Cllr Mary Daly <Cllr.mary.Daly@brent.gov.uk>, Councillor Eleanor Southwood <cllr.eleanor.southwood@brent.gov.uk>, Councillor Claudia Hector <Cllr.Claudia.Hector@brent.gov.uk>, Councillor James Denselow <cllr.james.denselow@brent.gov.uk>, Cllr.neil.nerva@brent.gov.uk

Dear Tracey Batten and David McVittie

As per previous correspondence I am forwarding the latest analysis by our colleague, Cllr Keith Perrin, of the weekly A&E performance at the two trusts which serve most Brent patients. These are for the week ending 7 Dec. In the case of both Trusts the number of patients waiting over for hours and the percentage getting treatment or discharge within that period remain of great concern and no discernible improvements can be identified. Of course you are aware of the numbers but the analysis is useful to show trends before and after the local SAHF closures.

Imperial was 8th lowest in the country and LNWHT was second lowest for percentage performance.

We are aware that the overall NHS performance in A&E has once again been picked up by the media and that there may be national trends at work. However we have to focus on LOCAL PERFORMANCE on behalf of patients and if relative performance within national trends is not improving despite the measures in your various and most recent responses to us - for which we thank you - we cannot simply leave it there.

We have mentioned several times that we would like to take up Dr Mark Spencer's offer at the Brent CCG HPF on 19 November to let us have raw data. (We do appreciate that type 1 performance is shown by hospital on the Imperial website, but not so far elsewhere.) Secondly we were told that an expert had been called in to look at root causes for the deviation from the model used around the 10 September closures and have asked for his/her report

but had no response. We have also asked Sarah Mansuralli for a map showing catchment areas for A&E in Brent, presumably the heart of the deployment of the LAS, so not a state secret.

We continue to appreciate the very dedicated work done by the A&E and UCC staff at our hospitals and by the ambulance staff who work with them. It is vital that they are not over-burdened or subject to burn out which will only make the situation worse.

We look forward to hearing from you on the specifics we have now raised several times and on the prospects for the next few weeks.

With best wishes

Robin Sharp
on behalf of Brent Locality PPG Chairs

On 9 Dec 2014, at 10:05, Mansuralli Sarah (NHS BRENT CCG) wrote:
Dear Robin

Just acknowledging receipt of your email. I am trying to source the information that you are requesting and will forward this to you as soon as possible.

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

On 8 Dec 2014, at 16:50, Robin Sharp <robisharp@googlemail.com> wrote:

Dear Sarah

Thanks for sight of the letter which seems to be advising GP's to do what they are supposed to do in any case in relation to Imperial.

So we can better understand can we please see a map showing the "catchment area" of the Imperial (St Mary's) A&E and how it interfaces with Northwick Park? Presumably GP's and the LAS work to the same map?

In the media simplifications it seemed that Imperial (i.e. St Mary's) was being asked to alleviate the problems at

Northwick Park. I am sure that you are well aware that St Mary's A&E has continuing and seemingly worsening problems (8th poorest in the country on the latest figures). We do not accept that it has been shown that the SAHF closures have had no impact on performance as Ethie's letter implies. We were told at the informal event at the Health Partners Forum that an expert had been drafted in to get at the root cause of recent adverse numbers. If this person has reported may we please see the report?

Mark Spencer also promised that he would let us have raw data for weekly performance for the two trusts, ie broken down by hospital and type. This was on 19 November. We have had NOTHING from him.

Best wishes

Robin

On 7 Dec 2014, at 15:52, Mansuralli Sarah (NHS BRENT CCG) wrote:

Dear Maurice

Thank you for your email. Apologies for the delayed response.

Attached is a copy of the letter which was recently sent to GPs in the Kilburn, Willesden and Harlesden locality about accessing emergency care. To clarify this letter encourages GP practices located in the south of the borough to refer patients to the right place, as special pathways are in place for GP referred patients and, for known patients of Imperial via the patient passport arrangements. This will ensure that patients get to the right speciality bed as quickly as possible.

I hope you find this information useful.

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: Maurice Hoffman [mailto:mauricehoffman.uk@gmail.com]
Sent: 01 December 2014 23:13
To: Mansuralli Sarah (NHS BRENT CCG)
Cc: Nan Tewari; Irwin Van Colle; Peter Latham; Robin Sharp; Keith Perrin; Gaynor Lloyd
Subject: letter to Gps

Dear Sarah

Please can we have a copy of the letter that the CCG has sent to Gps regarding referring patients to NWLHT.

thanks

Maurice Hoffman
33 Meadow Way

Wembley
HA9 7LB

020 8902 3899

07746 372159

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<Accessing Emergency Care GP Direct Referral.pdf>

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If you are not the intended recipient please inform
the
sender that you have received the message in error
before deleting it.
Please do not disclose, copy or distribute
information in this e-mail or take any action in
reliance on its contents:
to do so is strictly prohibited and may be unlawful.

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NHSmail is the secure email and directory service
available for all NHS staff in England and Scotland
NHSmail is approved for exchanging patient data and
other sensitive information with NHSmail and GSi
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NHSmail provides an email address for your career
in the NHS and can be accessed anywhere

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Imperial College Healthcare NHS
NHS Trust

A&E Performance Indicators

ICHT
July – November 2014

innovation respect
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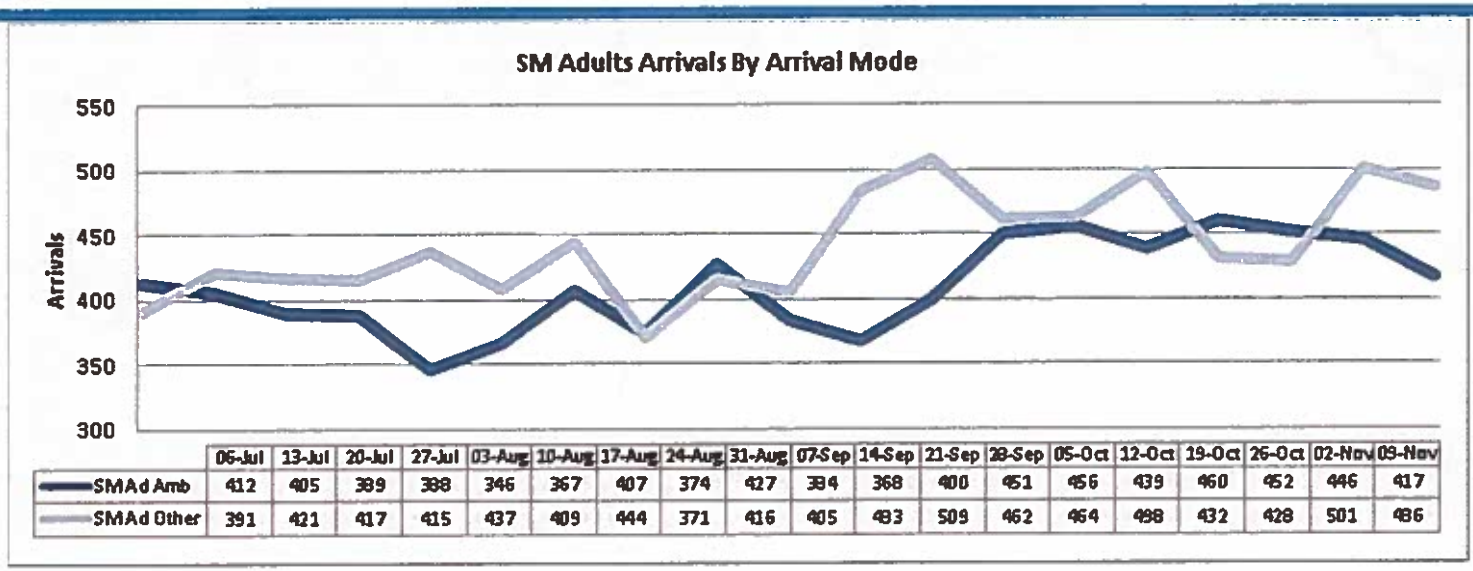
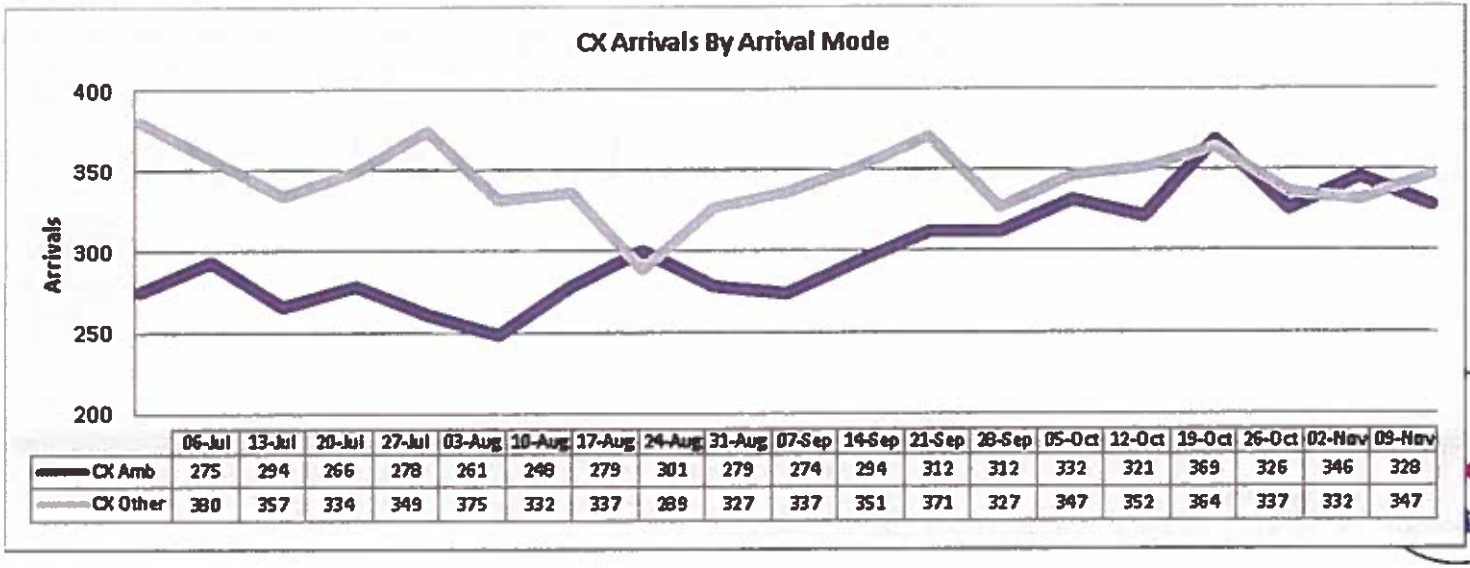
achievement pride

A&E Attendances by Mode of Arrival

Imperial College Healthcare NHS
NHS Trust



	06-Jul	13-Jul	20-Jul	27-Jul	03-Aug	10-Aug	17-Aug	24-Aug	31-Aug	07-Sep	14-Sep	21-Sep	28-Sep	05-Oct	12-Oct	19-Oct	26-Oct	02-Nov	09-Nov
SMAd Amb	412	405	389	388	346	367	407	374	427	394	368	400	451	456	439	460	452	446	417
SMAd Other	391	421	417	415	437	409	444	371	416	405	483	509	462	464	498	432	428	501	486



	06-Jul	13-Jul	20-Jul	27-Jul	03-Aug	10-Aug	17-Aug	24-Aug	31-Aug	07-Sep	14-Sep	21-Sep	28-Sep	05-Oct	12-Oct	19-Oct	26-Oct	02-Nov	09-Nov
CX Amb	275	294	266	278	261	248	279	301	279	274	294	312	312	332	321	369	326	346	328
CX Other	380	357	334	349	375	332	337	289	327	337	351	371	327	347	352	364	337	332	347

1070

Attendances by Type & Site Jul-Oct 2014

Imperial College Healthcare NHS
NHS Trust

Week Ending Sunday	HH T1 Attends	CXH T1 Attends	SMH Total T1 Attends	HH T3 Attends	CXH T3 Attends	SMH Total T3 Attends	Total ICHT Attends
06/07/2014	366	655	1,259	644	899	995	5,742
13/07/2014	393	651	1,279	645	823	919	5,547
20/07/2014	382	600	1,254	686	860	996	5,665
27/07/2014	327	627	1,209	693	870	1,002	5,532
03/08/2014	339	636	1,169	651	826	972	5,427
10/08/2014	360	580	1,117	630	811	1,014	5,364
17/08/2014	343	616	1,199	579	753	927	5,212
24/08/2014	318	590	1,077	562	749	980	5,090
31/08/2014	339	606	1,180	626	881	960	5,305
07/09/2014	345	611	1,155	670	791	1,017	5,418
14/09/2014	86	645	1,280	560	831	983	5,201
21/09/2014	-	683	1,380	580	807	1,038	5,268
28/09/2014	-	639	1,373	577	828	1,013	5,294
05/10/2014	-	679	1,384	587	851	1,045	5,337
12/10/2014	-	673	1,389	615	846	1,001	5,316
19/10/2014	-	733	1,420	627	859	960	5,431
26/10/2014	-	662	1,408	571	808	970	5,228
02/11/2014	-	678	1,443	592	841	950	5,323
09/11/2014	-	674	1,361	625	766	920	5,184

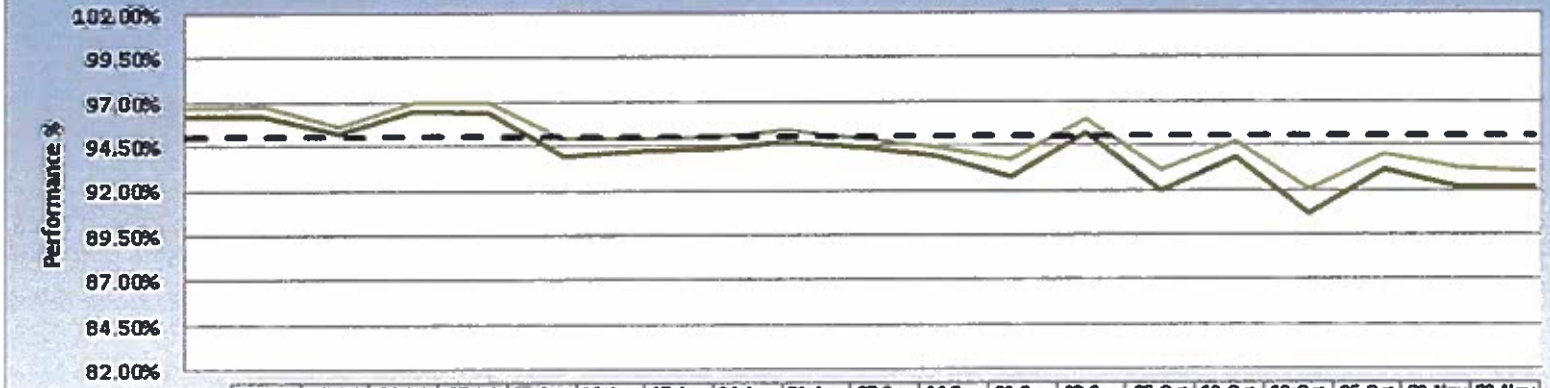
Total ICHT Attends includes WEH

innovation respect care achievement pride

A&E Performance

Imperial College Healthcare NHS
NHS Trust

Total ICHT Performance %



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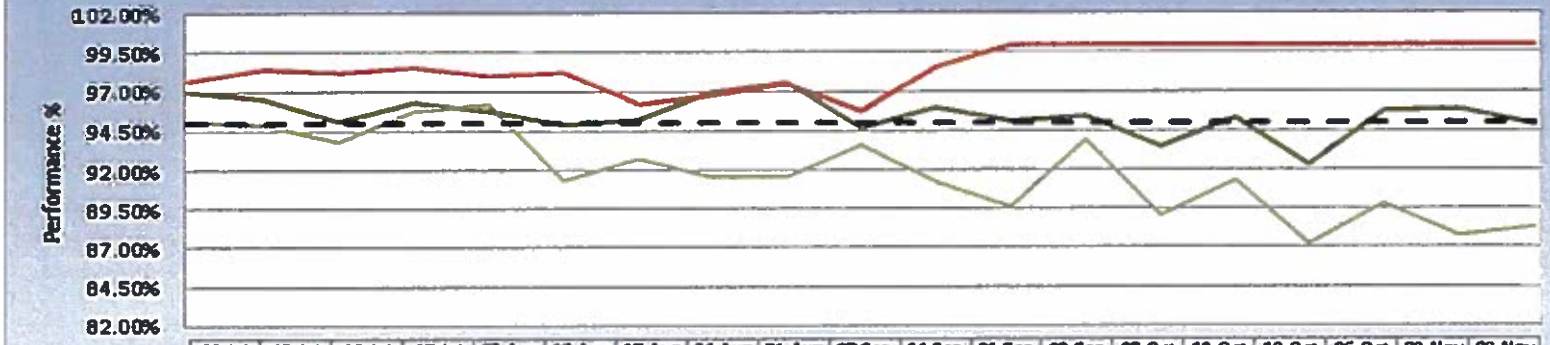
ICHT Exc WEH	96.24%	96.18%	95.19%	96.51%	96.43%	93.95%	94.25%	94.25%	94.75%	94.40%	93.91%	92.80%	95.21%	92.01%	93.85%	90.74%	93.12%	92.14%	92.20%
ICHT Inc WEH	96.69%	96.76%	95.62%	97.00%	96.95%	94.87%	94.92%	94.95%	95.46%	94.96%	94.39%	93.74%	95.96%	93.16%	94.73%	92.06%	94.05%	93.24%	93.02%
Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%

Type 1&3 Performance %



	06-Jul	13-Jul	20-Jul	27-Jul	03-Aug	10-Aug	17-Aug	24-Aug	31-Aug	07-Sep	14-Sep	21-Sep	28-Sep	05-Oct	12-Oct	19-Oct	26-Oct	02-Nov	09-Nov
CX Total	96.93%	96.47%	95.14%	96.26%	95.76%	94.90%	95.25%	96.94%	97.58%	94.72%	96.00%	95.10%	95.43%	93.53%	95.33%	92.27%	95.76%	95.85%	94.93%
HH Total	97.72%	98.46%	98.22%	98.53%	97.99%	98.26%	96.20%	96.70%	97.52%	95.76%	98.63%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
SM Total	95.12%	94.90%	93.76%	95.75%	96.17%	91.32%	92.76%	91.54%	91.54%	93.55%	91.21%	89.66%	93.92%	89.13%	91.34%	87.27%	89.82%	87.94%	88.34%
Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%

Chief executive: Dr Tracey Batten
The Office of the Chief Executive
The Bays Building
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W2 1NY

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tracey.batten@imperial.nhs.uk
www.imperial.nhs.uk

1 December 2014

Chairs of NHS Brent CCG Locality PPGs
c/o Robin Sharp CB
30 Winderwere Avenue
London
NW6 6LN

Dear PPG Chairs

Thank you for your letter of 18 November.

I acknowledge your concerns about current A&E waiting times. Of course, no-one should have to wait more than four hours and we are working very hard to improve performance. It's also important to recognise that those most in need of further care are treated first following initial assessment on arrival at our A&E departments.

The Trust is required to report our A&E performance to our regulator, the NHS Trust Development Authority, for all types of A&E patients. In no way do we seek to present A&E performance figures in a particular way that is favourable to the Trust. I am happy to include a breakdown of our A&E performance by patient type at the end of this letter and we will keep this figures updated on our website.

As your own analysis indicates, the number of extra A&E attendances – and admissions – since the closure of the Hammersmith Hospital emergency unit in September is in line with our modelling. We estimated an increase in daily attendances across St Mary's and Charing Cross A&Es of 37 – the actual increase has been 35, primarily at St Mary's. However, we did not predict the wide variation in attendance, which can be between 275 and 380 attendances daily at St Mary's.

The Trust is taking action to improve performance on A&E waiting times in a number of ways, including:

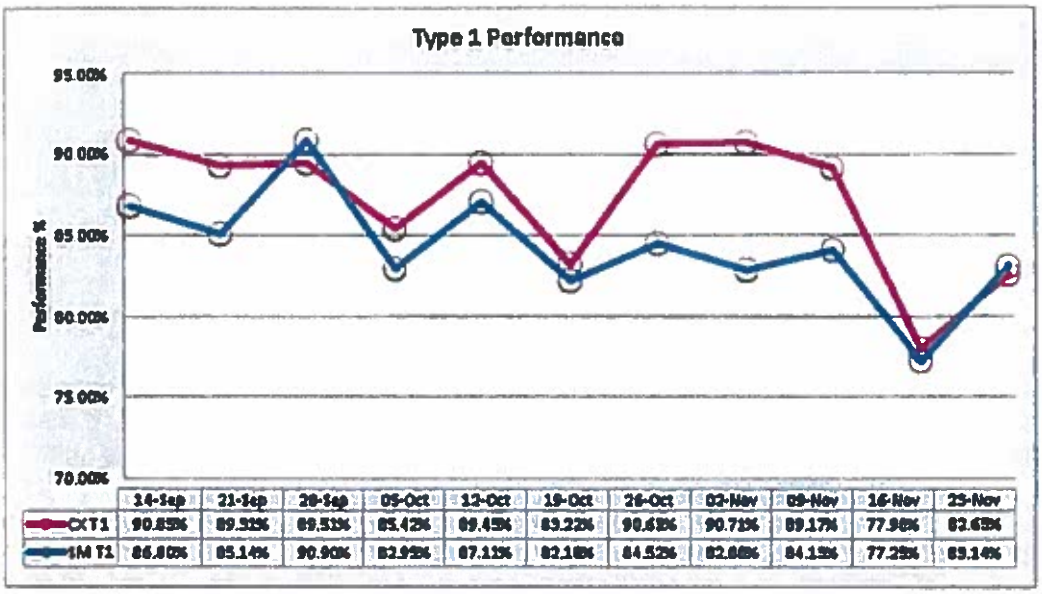
- Staffing: The Trust has put in place additional emergency nurse practitioners, physicians, A&E consultants and nursing and management support, as well as extra GPs in our urgent care centres. This is aimed at improving the pathway within our emergency departments and speeding up clinical decisions on the treatment options for individual patients.
- Capacity: The Trust has opened up extra capacity at St Mary's Hospital to accommodate an increase in medical admissions. As well as the new 15-bed ward opened at the time of the

Hammersmith emergency unit closure, we opened a further three beds last week and will be opening more over the coming weeks. The Trust is also in the process of completing some estates work to accommodate additional ambulatory care and urgent care centre capacity at Charing Cross Hospital, and we will be moving our urgent care centre space at St Mary's to a new area to increase the space in A&E.

- Management of patient flows: A review of information that supports the management of patient flows is helping the earlier identification of potential blockages to patient flows in the hospital system.

These actions and monitoring information are reviewed daily by our senior clinical management teams.

More detailed information on our A&E Type 1 performance follows:



Thank you again for contacting me on these matters and I hope you find this response helpful.

Yours sincerely

Dr Tracey Batten
Chief Executive

Smith Peter

From: Donald McRobbie [redacted]
Sent: 02 February 2015 08:14
To: Smith Peter
Subject: Fwd: Shaping a healthier future
Attachments: Blank 4.pdf; ATT00002.htm

Dear Peter,
I wish the attached to be considered in the hospitals closure enquiry. Shaping a Healthier Future was deliberately misleading in closing that "most medical research is carried out by Hammersmith, St Mary's and Chelsea and Westminster Hospitals."

I challenged Mark Spencer over this at a staff meeting and he conceded verbally that "in terms of the number of trials, publications and grants" that Charing Cross did more research than Chelsea and Westminster. The error in the consultation document was not corrected.

At the time I was working for Imperial NHS Trust, but did not make more of a fuss out of fear of management reprisals- the Trust had a culture of bullying amongst its "turn around" team at the time.

I have since resigned from the NHS, taking early retirement.

Yours sincerely

Dr Donald McRobbie

Begin forwarded message:

> **From:** Donald McRobbie [redacted]
> **Date:** 17 December 2014 21:15:41 GMT+10:30
> **To:** "joshua.neicho@standard.co.uk" <joshua.neicho@standard.co.uk>
> **Subject: Shaping a healthier future**

The closure or downgrading of Imperial College Healthcare NHS Trust's Accident and Emergency services at Hammersmith and Charing Cross Hospitals will see an unprecedented concentration of clinical services to St Mary's in Central London, less than two miles from University College Hospital. Imperial's senior management justify this action citing the Shaping a Healthier Future 'consultation.' However this consultation, conducted by a PR company, was an exercise in spin, portraying several incorrect assertions as fact. One of these 'facts' was the claim that more research was carried out at Chelsea and Westminster Hospital than at the under threat Charing Cross Hospital. This is not true in terms of any of the usual metrics for medical research, e.g. number of clinical trials, research grants and publications, with the result that Shaping a Healthier Future misled the people of NW London. A proper consultation which considers wishes and needs of the local population should be conducted. The planned A and E 'changes' are unsafe and need to be reconsidered urgently.

Dr Donald McRobbie
London SW15.

Smith Peter

From: [redacted] Clara Lowy [redacted]
Sent: 01 February 2015 18:28
To: Smith Peter
Subject: North West London Healthcare.
Attachments: Reorganisation of the NHS.doc; Reorganisation of the NHS.doc

I am retired Diabetic & Endocrine Physician & despite my age have managed to avoid A&E . I do have difficulty contacting my Hillcrest Practise.
I am attaching my comments on the present state of the care Ealing residents are likely to experience currently.
Clara Lowy MD MSc FRCP.

Reorganisation of the North West London Health Care

- Reorganisation per se takes time & time costs. In time of austerity is a major reorganisation without in depth pilot studies not both foolhardy & potentially costly?

For example mixed sex wards & PFI were both introduced over 16 years ago the former regarded now barbaric & punishable, the latter very expensive for the tax payer (BMJ 2010; 1280).

- Medical practise has also undergone massive changes so that surgical conditions are treated on an out patient basis & follow up is often left to the GP who may only receive a brief summary. Without streamlined integration How are outcomes to be monitored & by whom?

A recent Publication (Lancet 2011;377, 127), shows that the UK & Denmark have poorer outcomes for Breast, Colon, Lung and Ovary cancers than Canada, Australia and Sweden & the ranking has not changed over 12 years. The authors infer that much can be attributable to late diagnosis. The GP has the task of considering a cancer diagnosis initiating investigations. However to improve outcome the GP & the expertise of Cancer units have to be integrated & constantly updated and above all, work as a team not in competition.

- How will patients be able to make informed choices? Are we to have league tables for GP and Hospital Consultants?

Besides Cancer & vascular disease, obesity has reached epidemic proportions & with it, Type II diabetes, now prevalent in young people. Outcome for the baby of a diabetic mother is still poor & particularly in Type II diabetic women. These babies may be born with major congenital malformations for example of the heart. Each General practise will only see 1 or 2 a year & will have no overview & in depth experience. A major congenital heart lesion is life long, expensive & preventable in a co-ordinated health service as in East Anglia (Diabetes Care 2010; 33, 2514).

- How can the public judge the skill of the GP? Most ailments get better with time but how will failure to diagnose treatable diseases possibly leading to irreversible complications, be monitored with the new system?

Ultimately Care has to be integrated between community staff involving doctors, nurses, health visitors, social workers and all hospital staff members. Care of Chronic diseases is being devolved from hospital to GPs including psychiatric conditions. The latter require a team of community psychiatric trained nurses. There has been a 17% reduction in hospital psychiatric nurses in England but only a 1% increase in community psychiatric nurses. Devolving the care of patients to the community has not been accompanied with an adequate increase in community trained staff. This is well illustrated by the crisis in North West NHS hospital A &E departments.

- How will the loss of the Ealing Hospital Maternity unit improve Maternity & Neonatal Morbidity and Mortality?

Ealing has both a deprived population with a high incidence of cardiovascular disease & Type II diabetes. The latter now occurs in women of fertile age, approximately 30% of pregnant women presenting at Ealing Hospital develop Gestational diabetes, a group who should be managed by an integrated team currently available at Ealing Hospital. Dispersing the Ealing women to hospitals in neighbouring boroughs on the premise that they will receive better care if the unit has a resident obstetric consultant has not yet been proven to produce better outcome (see Royal college of Midwives submission to the North West Health consortium)

Smith Peter

From: A. Acorn [redacted]
Sent: 01 February 2015 22:13
To: Smith Peter
Subject: NWL Commission Submission
Attachments: Letter to Dr Gill .doc; Memorandum.pdf; Letter to Local Newspaper.pdf; Written Submission to the Commission Eve Acorn.doc

Dear Mr Smith,
Please find attached:

1) My written Submission to the Independent Healthcare Commission for North West London.
2) Letter to the Local Newspaper referred to in my submission.
3) Memorandum from Vic Coe -PCA Chairman of the Perivale Community Centre referred to in my submission.
4) Letter to my GP Dr Gill Friday 17th January 2014 referred to in my submission.

Yours sincerely,

Eve Acorn
Committee Member of the Ealing Save Our NHS Action Group

Written Submission to the Independent Healthcare Commission for North West London by Eve Acorn 28th January 2015

In the text below:
'A&E' means a Type 1 A&E Unit for treating major accidents and emergencies.
'UCC' means Urgent Care Centre for minor injuries and minor ailments.

My understanding is:
1) 'Shaping a Healthier Future' - SAHF - is based on the simplistic premise that by increasing 'Care in the Community', the need for A&Es will be reduced by approximately 50%. The Joint North West London Primary Care Trust agreed with this premise and felt that the closure of 4 out of 9 A&Es was justified.

2) Jeremy Hunt has agreed with this premise and has thus accepted the Independent Review Panel - IRP - proposals which were the same as the SAHF proposals but with slight modifications.
Investment for 'Care in the Community' was promised; but the quality, type and quantity of the care appears not to have been specified.

Care in the Community

It is 2 years since the Joint North West London - JNWL- PCT passed the SAHF proposal, yet there is little sign of this 'Care in the Community' being implemented. Indeed with the Ealing Council having to find £96 million of cuts, organisations such as Solace (which supports people with mental health problems) are under threat or have already been closed. (See attachment - Letter to local newspaper.) Community Centres are also being threatened. (See attachment - 'Memorandum'). Many Exercise Clubs and other clubs which help people's physical and mental health are held in the Community Centres. Many of these clubs are specifically for the elderly whom the Government and SAHF say they want to keep healthy as part of their plans to reform the NHS. It seems that 'Care in the Community' is mainly being **cut or downgraded** rather than being increased and improved.

It should also be born in mind that 'Care in the Community' is concerned with primary care whereas A&Es provide acute care:-
We hear of 7 days a week emergency GP care but this is very patchy. Where it does work, it should help to alleviate the pressure on the walk-in GP Urgent Care Service (UCC). However, it is widely stated that it will help alleviate the demands on the A&E Service. How? The hospital A&E is for acute serious cases which no GPs can deal with - whether they are Urgent Care GPs or GPs working out of hours or at weekends. These serious accident and emergency patients will have to go to the proper A&E whether as walk-in or blue light patients. The part of Emergency Service which is necessary whether there are more GPs or not is the

proper A&E. This unfortunately is the part which has already been cut in the Central Middlesex and Hammersmith hospitals and - if the SAHF plans are implemented - will eventually be cut in the Ealing and Charing Cross hospitals.

As I understand it, Jeremy Hunt assured us that A&Es would not go until 'Care in the Community' is put in place. As stated already 2 hospital A&Es in NWL out of the 4 proposed in SAHF have been cut. If any alternative care has been put in place, it clearly is not working as shown by Colin Stanfield's graphs of week by week % of patients seen in A&Es in NWL within 4 hours. The drop after the 2 hospital A&Es closed is precipitous. (See Colin's graph in his statement).

Another area planned to be cut is the rehabilitation service provided by Clayponds Hospital in South Ealing. The current plan is for Clayponds to be relocated in the new 'Local' Ealing Hospital. If this happens, there will be a great reduction of rehabilitation beds. At present Clayponds has 70 beds (one ward was closed but had to be reopened). The new 'Local' Hospital is to have only 82 beds in total - 30 for Ealing and 52 to be divided between Clayponds patients and Ealing post operative patients from West Middlesex Hospital. (Ealing will not do any operations when SAHF is fully operational.) The Hospital Board cannot tell me at present how many of these 52 beds will be allocated as Clayponds beds.
I cannot see how these planned cuts can provide a 'Healthier Future'.

My recent experiences of the 111 service:

1) On Saturday 3rd January 2015 I had a bad Urinary Tract Infection - UTI. From past experience I knew that I needed antibiotics as soon as possible otherwise if left, I would need more than one course to cure the infection. By Sunday I knew I could not wait until Monday so rang the 111 service. I told the lady that I wanted to see an Out of Hours doctor because I had cystitis and needed some antibiotics. The reply was, "What is cystitis?" I was amazed that someone specifically dealing with patients' symptoms had never heard of cystitis. I had to answer many questions before I could be told where to go to see a GP. However when I got to the GP practice, I was seen promptly and was pleased with the service.

2) On Saturday 10th January 2015, when in West Ealing, I met a retired GP friend. She told me that the spots which I had been scratching were almost certainly shingles; and asked me how long I had had them. On being told that it was 4 or 5 days, she said that I should be seen immediately by a doctor who would prescribe anti-viral tablets. If I delayed until Monday, the tablets wouldn't work. Since my GP surgery is closed every weekend, I rang the 111 service. The lady asked me a couple of questions and then asked me where I was and what was the postcode. As already stated, I was in West Ealing. I knew the postcode started with W13 but I did not know the full postcode so I told her this; and suggested

that she ask the following questions whilst I tried to find out the full postcode from passers-by. She said that the full postcode was necessary in order to get onto the next question - and furthermore the computer would never let her continue to the next question until the current one had been answered; and until every question had been answered she wouldn't be able to tell me where to go for medical advice.
If this is true it is absurd: **Anyone who does not know the postcode for one reason or another cannot get advice from the 111 service nor be told where to go for medical help.**

I asked passers-by but none of them knew the full postcode so I went into Sainsbury's to find out. I just hope I did not infect anyone in doing so. Up to then I had not been in any shops nor in particularly close proximity to any young women. I subsequently learned that whilst shingles per se cannot be caught, someone with shingles can give chickenpox to someone who has not had chickenpox already; and if that person happens to be pregnant, chickenpox can be dangerous.
At the end of all the questions, I was told that there was no Out of Hours GP and I should go to West Middlesex Hospital. I expressed surprise and told the lady that this hospital was at least 2 bus rides away whereas Ealing Hospital was just down the road. She had to go to speak to her manager and then agreed that I could go to Ealing Hospital Urgent Care. The waiting room had been flooded so the UCC had been closed earlier. Since the UCC had just opened, I was lucky and did not have to wait long. The shingles was confirmed and the anti viral tablets given which thankfully worked.

My experience of A&E at Ealing Hospital 16th December 2013

Just over a year ago - 16th December 2013- , I attended A&E at Ealing. As you can see from the attached letter to my GP Dr Gill following my experience, I had to wait well over 4 hours before being taken from the waiting room to a cubicle. This was in spite of my producing a letter from my GP stating that I might have a pulmonary embolism (a serious possibly life-threatening condition) and a prior phone call from my GP to the A&E Registrar on duty. I did not go by ambulance as the GP realised they were overstretched and felt it would be quicker for my husband to drive me to the hospital. In retrospect, had I gone by ambulance at least I would have been monitored for most of the approximate 5 hours that I had to wait. Once I saw the doctor my condition was taken seriously and I was given an injection and blood tests done. If the Ealing A&E was so overstretched a year ago, how could the remaining NWL hospitals possibly cope with all these serious emergency patients if Ealing and Charing Cross A&Es were to close?

Eve Acorn
[redacted]

Letter to Dr Gill from Eve Acorn Friday 17th January 2014

Dear Dr Gill,
I have asked my husband to give this letter to you in person during his appointment. I hope that this is acceptable and proves helpful to you.
I think you should know what happened when you sent me to Ealing Hospital on 16th December for a possible PE.

Just to remind you
My appt was at 4: 20 and you saw me fairly close to that time.
You phoned a doctor at Ealing Hospital to arrange my arrival and gave me a sealed letter addressed to the Registrar. You told me that he was waiting for me. You asked if anyone was able to go with me - I presume to obviate calling an ambulance - I said 'yes' and left.

Subsequently
My husband drove me to the hospital. The traffic was very heavy and slow; so it took quite a time to get there. I didn't note the time when we arrived but would guess between 5:30 and 6:00.
When my husband complained, the receptionist said that I had arrived at 6:30 - which I don't believe but have to accept.

When I arrived, I saw the receptionist for the Urgent Care - who opened your letter and promptly passed it to the A&E receptionist. This lady read your letter and told me to wait. I told her that my GP had phoned and that the Registrar was awaiting my arrival. This met with the response that the doctor only sees everyone in turn and I must await my turn.
To cut a long story short: I wasn't seen by the triage nurse for about 2 hours after my arrival. I then had to wait in the reception area about another 3 hours before I was called through to the A&E some time between 11:00 ~ 11:30. The doctor whom I saw gave me an injection. She also took venous blood and arterial blood to check my oxygen level. The results were not back by mid-night when the doctor decided I should stay overnight and my husband left.

Early the following morning, I was given an oxygen mask based on the arterial blood test result. Later a doctor saw me and ordered a CT scan. This was done in time for the Chest Team to see at the prearranged MDT meeting to discuss my PET scan results and previous CT scan. So it was an amazing coincidence that they were able to compare the earlier CT scan with one taken that day. Their observation was that the lump in my lung which was causing concern had not grown in the interim; and might have even shrunk slightly. They concluded that it is very unlikely to be cancer - which is a great weight off my mind. The conclusion about my breathlessness etc was that it was almost certainly muscular pain. Like wise the low arterial blood-oxygen level was deemed to be due to taking shallow breaths in order to minimise the pain.

Conclusion
In this particular instance 'All that ended well, ended better'.
However, a 5 hour wait to be seen was inexcusable especially if I had had a PE.
My husband & I both complained separately several times to the A&E receptionist without avail.

The suggestion was that your letter was not addressed to a particular doctor. Given that there was unlikely to be more than one Registrar present, this excuse was silly.
I pointed out that you had said I would need blood tests to be carried out - and I asked that they be taken as quickly as possible, in order that the doctor would have the results sooner. The response to this was that it was for the doctor to decide whether or not blood tests were required and I must wait until I am seen.
My feeling is that had the tests been done soon after I arrived, I would have been given the oxygen that night rather than the next day.

My feelings
I think the way I was treated prior to being escorted from the waiting area to the cubicle A&E section was unprofessional and also disrespectful towards you. Your valuable time contacting the Duty Registrar by phone was squandered by the indifference of the A&E Reception; and your letter was either ignored or misunderstood by the triage nurse.

I must say that when I was eventually seen, the doctor acted promptly and took my case very seriously; and I presume that your letter was instrumental in her doing so.

Yours sincerely,

Eve Acorn

TEL. 020 8997 2404 FAX. 020 8998 6417 E-MAIL: PERIVALE_CENTRE@YAHOO.CO.UK

MEMORANDUM

Date: 23.01.15
To: Centre Users
From: Vic Coe - P.C.A. Chairman
Re: Update

Dear Centre User

There are many rumours circulating concerning the future of this centre. The purpose of this interim memo is to tell you of the situation at present.

The London Borough of Ealing has to find savings of some £96 million pounds for the financial year 2015/2016. £302,000 of this will come from community centre budgets. Apparently this will be achieved by removing all subsidiaries paid by the Council to community centres and increasing rents, possibly in line with present day market values.

In a previous letter I explained that part of the staff salaries are paid or by the Council and part are paid by the Centre. The Council part comes under subsidy and will be withdrawn. Community Centres pay a subsidised rent which will possibly be increased to reflect today's true value.

All of the above is subject to consultation between Community Centre Management and the Council, yet to be arranged.

As you can see by the above I cannot produce facts and any figures affecting P.C.C. until after consulatation. When this is completed we will see if there is a way forward and what we can do to achieve it.

What is clear is that P.C.C. faces a large increase in expenditure during the next financial year but until consultation is completed I cannot with any certainty predict the future of this centre. As soon as the situation is clear I will write to you again.

V W Coe
Chair of P.C.C. Management Committee

Smith Peter

From: [redacted]
Sent: 05 January 2015 14:06
To: Smith Peter
Subject: Evidence to Commission
Attachments: MSC SaHF 2 Years On - for 18th.pptx

Dear Sir,

I have been monitoring the progress of the reforms in North West London over the last two years, in particular the effect on A&E services. As a result, I was able to deliver a presentation, attached, to the People's Inquiry and later (and updated by one week's data) to the Ealing Hospital Medical Staff Committee. The crucial slides are numbered 55 and 56.

The graphs in it may stand up on their own but I should be very happy to present it with the necessary oral additions if the Commission would like, and if there is PowerPoint available.

Not much has changed in the intervening couple of weeks because of the perverse and sinister decision not to publish A&E statistics since 14 December, but a continuation of the chaos may be interpolated.

Regards,

Colin Standfield

Shaping a 'Healthier' Future

Two Years On

They Said

- Myth:
- Closing some A&Es will mean that others are overwhelmed

Mythbuster
The truth about proposed changes to NHS services North West London

NHS
North West London

Since the 'Shaping a healthier future' public consultation on proposals to change health services in North West London started on 2 July, we have had lots of questions from local residents about how the proposals could affect them and there has been a lot of discussion about the changes in the local press as well.

Some of this discussion has been well informed, considered and a helpful contribution to our consultation. But some has been inaccurate and speculative. Here we tackle some of the most frequently heard myths and rumours with accurate information about the programme.

If you have other questions or concerns that we have not answered here please do get in touch with the Consultation Response Unit using the contact details below.

They Said

- Myth:
- Closing some A&Es will mean that others are overwhelmed
- Fact:
- ...patients will benefit from improved access to community and local services
- These improvements will be made **before any changes to A&E take place**

(*Mythbuster*.FINAL_.V2.12.08.31)

Dr Spencer Said

- We're investing £138 million across north west London within the next three years which include some building and refurbishing of health centres but mainly on staff. **We can't make any changes to hospitals until this is in place**.

(Interview, *Ealing Gazette*, 21 July 2013)

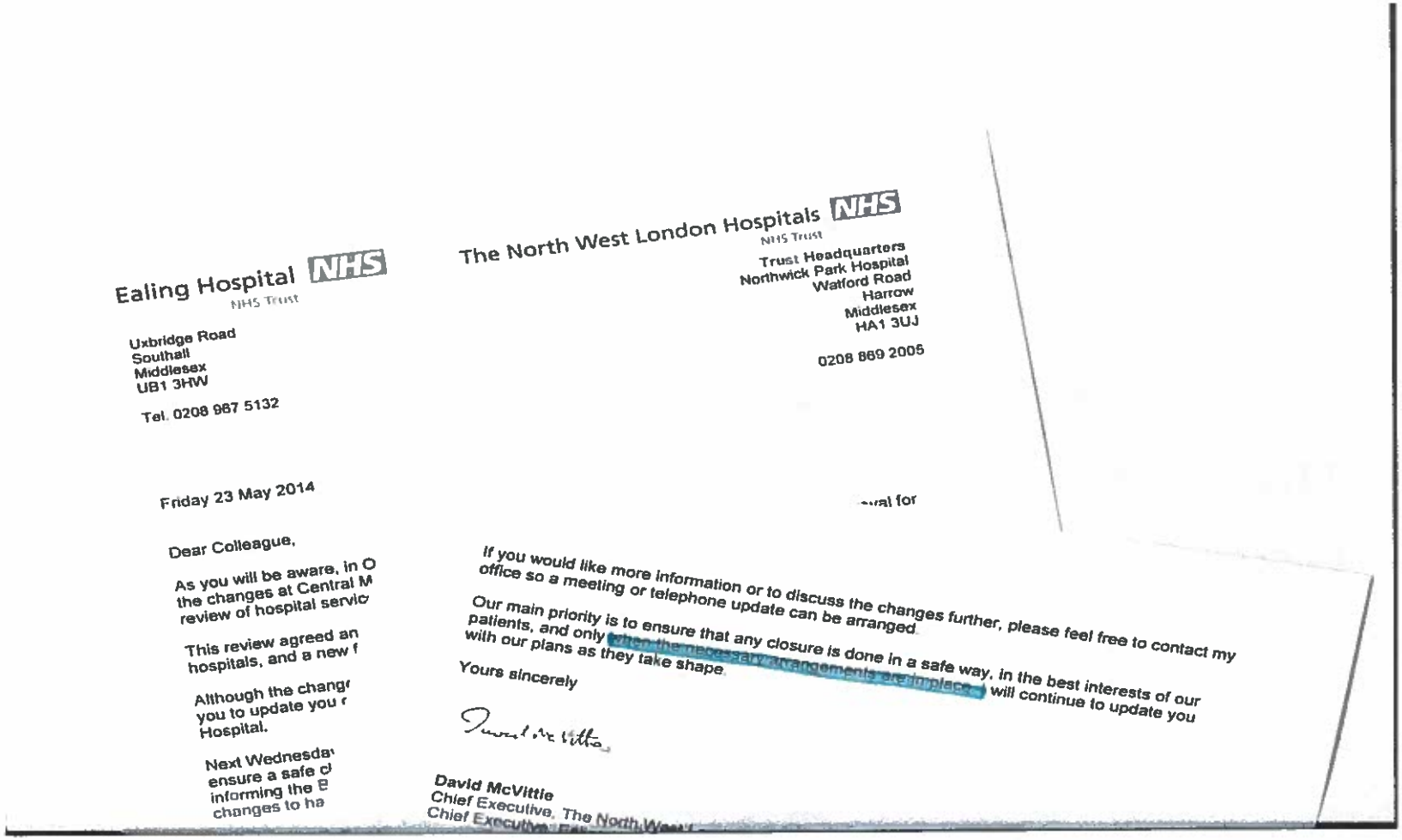
Mr Hunt Said

- None of these changes will take place until NHS England is convinced that the necessary **increases in capacity** in north-west London's hospitals and primary and community services **have taken place**. (*Hansard*, 30 October 2013, col 922)

Mr McVittie Said

- Our main priority is to ensure that any closure is done in a safe way, in the best interests of our patients, and **only when the necessary arrangements are in place**

  (Letter to 'Colleagues', 23 May, re Central Mid closure)



Ealing Hospital NHS
NHS Trust

Uxbridge Road
Southall
Middlesex
UB1 3HW

Tel. 0208 967 5132

Friday 23 May 2014

Dear Colleague,

As you will be aware, in O
the changes at Central M
review of hospital servic

This review agreed an
hospitals, and a new f

Although the change
you to update you r
Hospital.

Next Wednesda
ensure a safe cl
informing the B
changes to ha

The North West London Hospitals NHS
NHS Trust

Trust Headquarters
Northwick Park Hospital
Watford Road
Harrow
Middlesex
HA1 3UJ

0208 869 2005

...ual for

If you would like more information or to discuss the changes further, please feel free to contact my office so a meeting or telephone update can be arranged.

Our main priority is to ensure that any closure is done in a safe way, in the best interests of our patients, and only when the necessary arrangements are in place. I will continue to update you with our plans as they take shape.

Yours sincerely

David McVittie
Chief Executive, The North West
Chief Executive, Ea

We Said

- We submit that the urgent care centre only functions safely with co-localised specialist services on-site and that the investment in community care planned as part of SaHF will not be able to fill the gap created by the major loss of services which will happen on the Ealing site if these plans go through

  (Statement by the Consultants of Ealing Hospital NHS Trust July 2012)

We Also Said

- The implementation of the *SaHF* plans relies on heroic and unsubstantiated assumptions about the availability and effectiveness of 'out-of-hospital services' to cope with much of the displaced A&E demand

  (submission to IRP, p 49 – Colin Standfield, 15 August 2013)

They Now Say

- ...we were advised to close the A&E department at CMH and Emergency Unit at HH **earlier than we had originally planned** (Dr Spencer e-mail, 17 Sept '14)
- ... too early to see the extent of the reductions caused by improved community and primary care which are **still in their early stages** (Ibid)

O-O-H Fantasy Budgets

- Delivering the vision for care outside hospitals will cost up to £120 million.
  (Consultation Document, p 32)
- Up to £120 million will be invested in these services over the next three years

  (Ibid, p 38)
- ...care nearer to patients' homes... we are investing £130m in local services

  (*Sa'H'F Summary*, July '12)

DMBC – More Fantasy

- page xvi: within five years, we will be spending £190 million more on out of hospital services each year
- page 97: we will invest around £190 million *over the next five years*
- page 215: *within five years*, we will be spending £190 million on out of hospital each year

(Decision-Making Business Case, February 2013)

And Dr Spencer Said

- We're investing £138 million across north west London within the next *three years*

  (*Ealing Gazette* Interview, op cit)

I Asked

- I note that the budget for out-of-hospital services [in the DMBC] had increased to £190 million from the £120 million in the PCBC.

  Is there a reason for this?
- (E-mail to SaHF, 24 July 2013)

Sa'H'F Replied

- The investment of £190 million stated in the DMBC is the total annual investment by 2017/18. It will be invested in services that are provided recurrently and so the benefits of the investment will be delivered in every year thereafter.
- (E-mail, 1 August 2013)

I Asked

- Your answer including 'total annual investment by 2017/18' is gibberish - is it total or is it annual?

  (E-mail to sahf@nw.london.nhs.uk, 2 August 2013)

Dr Spencer Rode In

- It's a recurrent investment that will have accumulated to a recurrent £190M by 17/18

  (E-mail reply, 9 August)

I Asked

- How much will really be spent in each of the next 5 years on increased or improved out-of-hospital services? How much in each year will be new money? How will we know if or when it has been spent by the 8 CCGs?

  (E-mail to Dr Spencer, 23 August 2013)

Answer

- I'm sorry you've not a full reply - I know the team are in the process of completing the reply.

  (E-mail from Dr Spencer, 23 August 2013)

Further Answer

- The out of hospital services investment will have accumulated to a recurrent £190M by 17/18. This means that each year new money will be invested. The total invested will increase, and by 2017/18 we will be spending £190M more on out of hospital services each year compared with now.

  (The SaHF Consultation Team, 8 October 2013)

Taking Stock

- I think, far from being 'still in their early stages', **nothing significant has happened to primary and community services**
- **Expenditure: anywhere between £0 and £190m!**

Where Have the Patients Gone?

- Thesis:
- Absence of Primary/Community facilities drives people to A&E

Where Have the Patients Gone?

- Thesis:
- Absence of Primary/Community facilities drives people to A&E
- 2 unplanned A&E closures exacerbate pressure on remaining units

A&E Attendances

- A look at England, London and the NW London Sector from August 2013

A&E Attendances

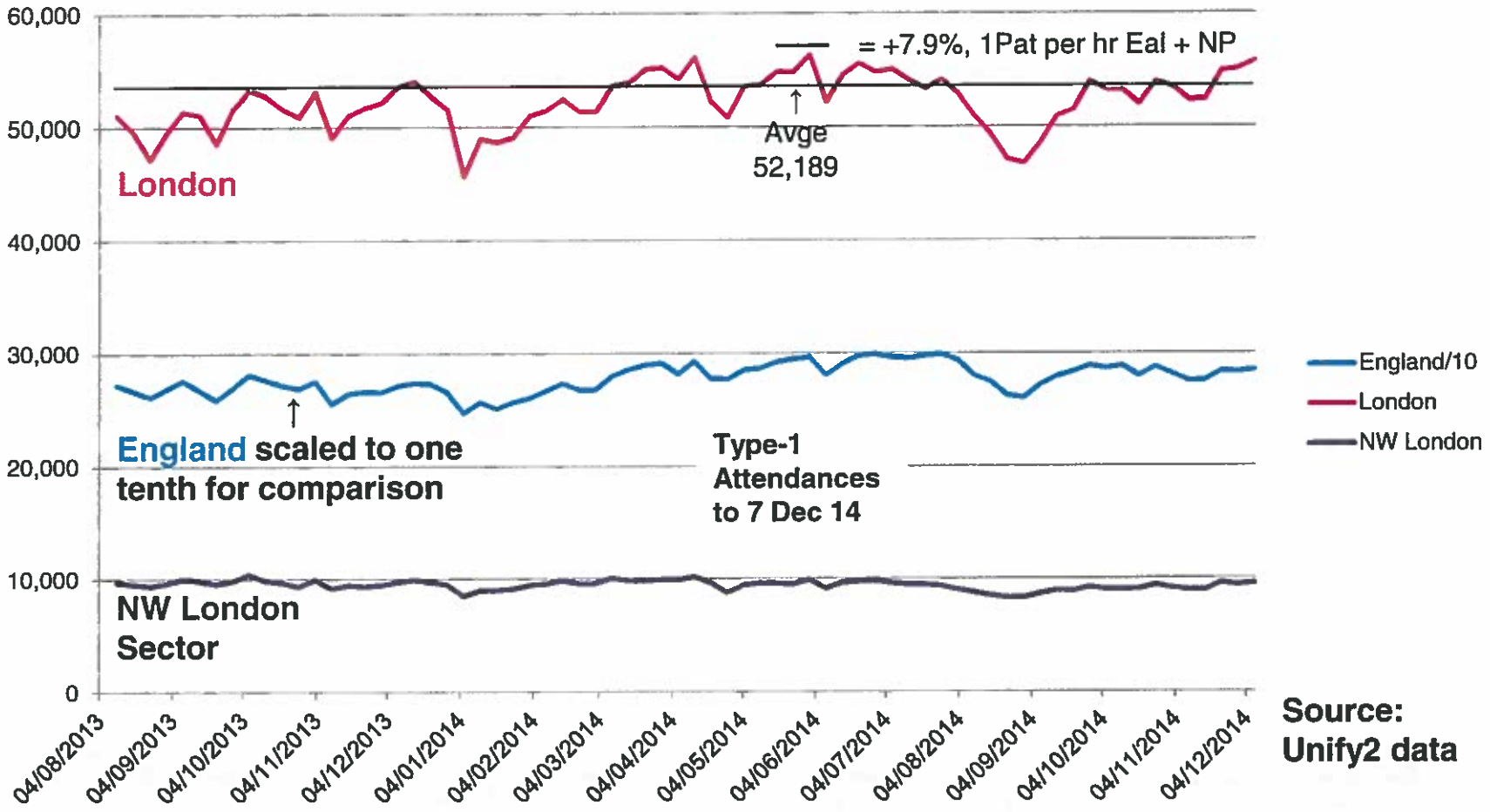
- A look at England, London and the NW London Sector from August 2013
- 'Last week 417,000 patients arrived in A&E, compared with 389,000 the same week last year'

A&E Attendances

- A look at England, London and the NW London Sector from August 2013
- ‘Last week 417,000 patients arrived in A&E, compared with 389,000 the same week last year’
- ‘Some 28,000 extra patients a week are arriving in A&E units compared with this time last year’
- (The Daily Mail, 14 November 2014)

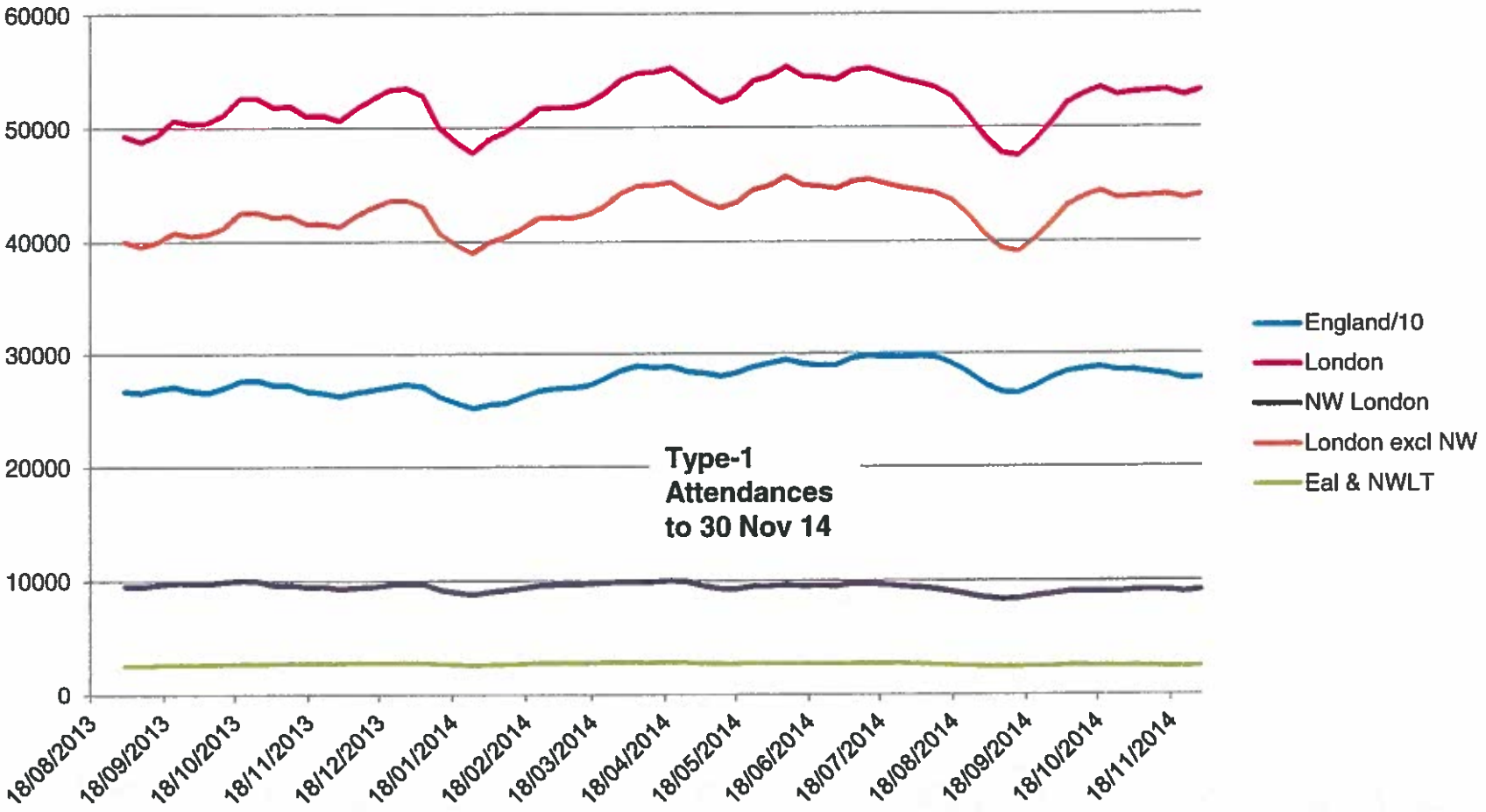
- Oh, really?

Type-1 Attendances Largely Stable



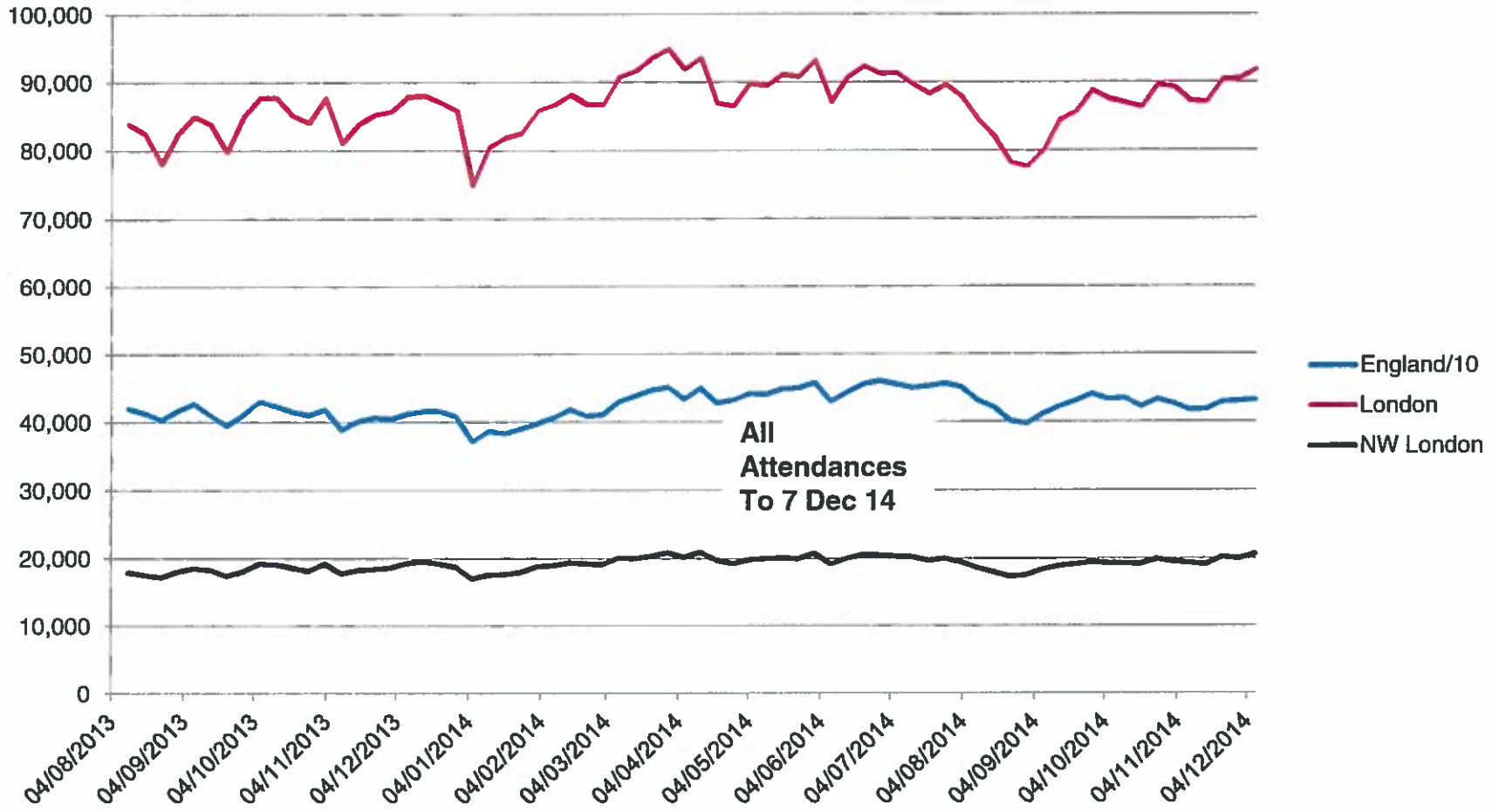
Source: Unify2 data

Type-1 3-Week Moving Average

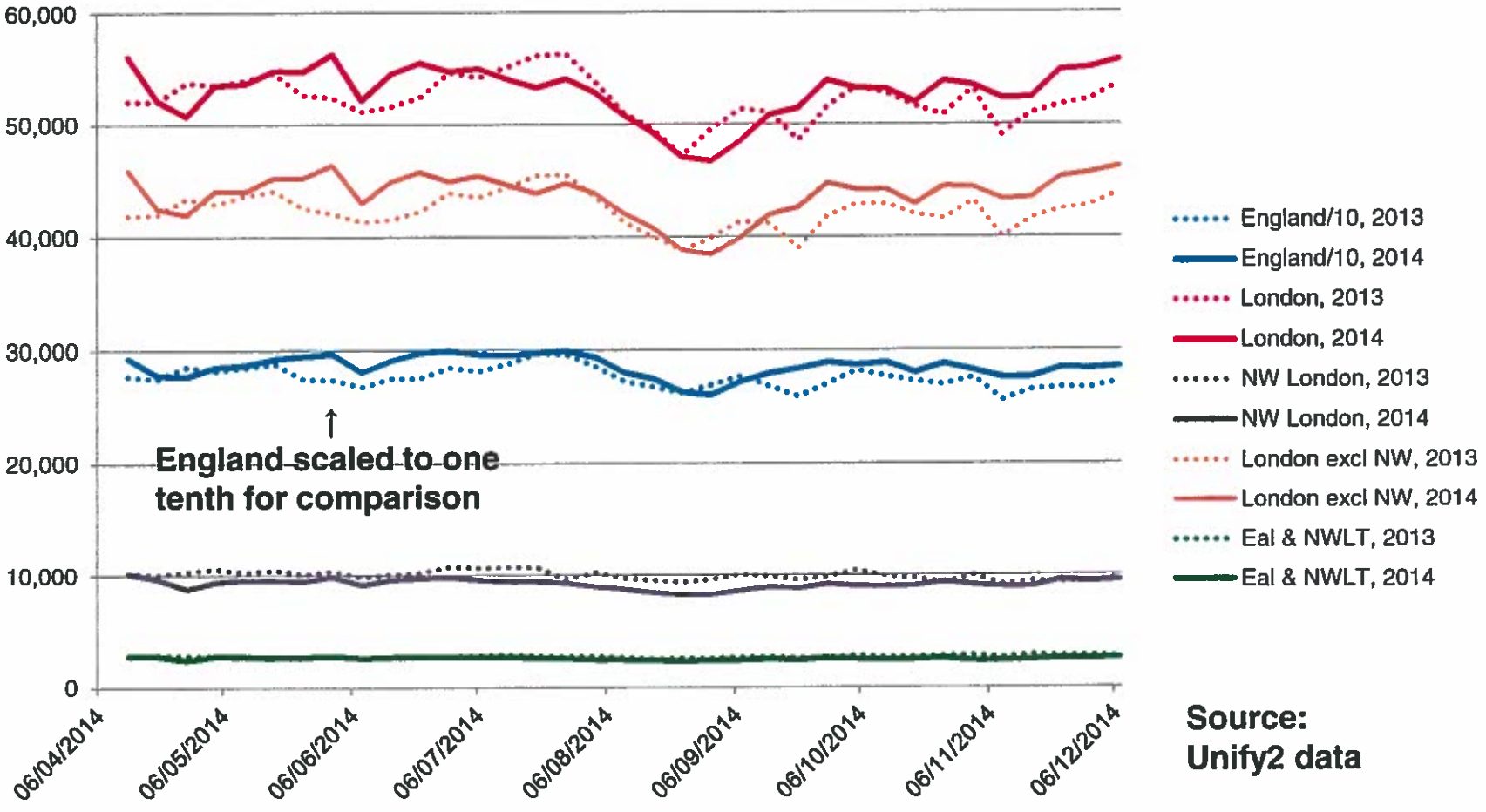


And 'All' Attendances,

esp NW London

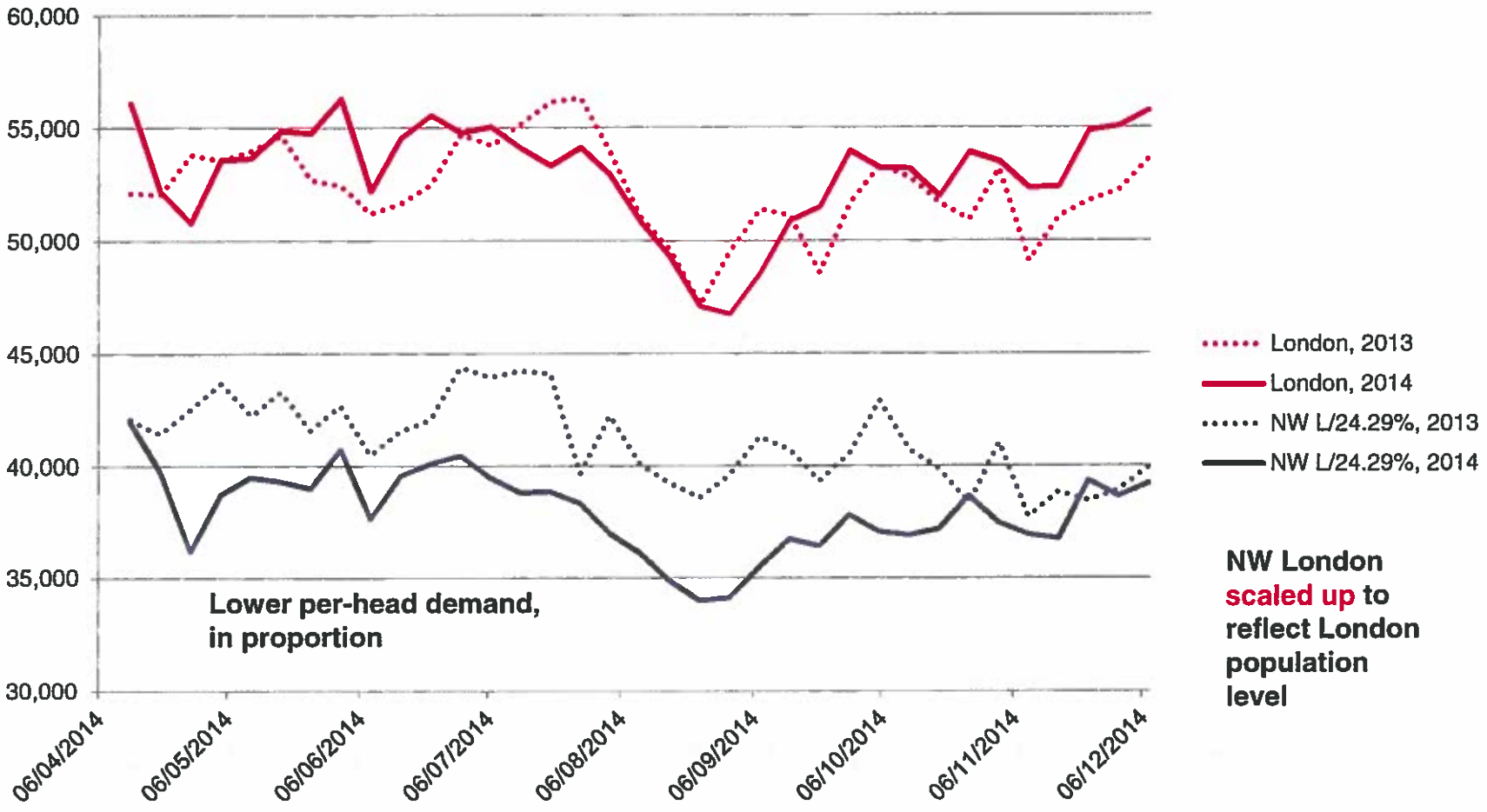


Type-1 Attendances, f/y 2013/14 to date and 2013 Comparison



Source: Unify2 data

Type-1 Attendances across NW London are *below* 2013, YTD



All Attendances are above 2013, showing primary/community pressure

Demand Largely Constant

- Despite NHS claims:

- David Flory, CE of NHS Trust Dev't Auth: 'Many are significantly more crowded than this time last year' (*Mail on Sunday*, 14 Nov)
- David McVittie: 'We saw an increase in emergency activity during September this year' (e-mail, 17 Oct)

- 'The whole of North West London is currently under pressure due to increased demand for emergency care and inpatient beds' (Ealing Hospital internal e-mail, 16 September)

But A&E Performance in Crisis

- Bed reductions inhibit admissions
- Closures at Cent Mid and Hammersmith send 95% performance into nosedive in NW London

Refusal to Believe the Truth

- You promised us that there would be no closures until alternative arrangements were safely in place. You have not done and now, within a week of eviscerating the NW London Hospital estate, you have overseen a crisis

  (e-mail to Dr Spencer, 16 September)

Response

- There is of course no “crisis”. Nor was closing the two smallest units in NWL, whilst increasing capacity at the others, an “evisceration”
- Fluctuations in demand are normal

  (e-mail from Dr Spencer, 17 September)

And...

- A spokeswoman for London North West Hospitals Trust, which runs Northwick Park and Ealing, said: “The challenges we face in our A&E department are similar to those affecting other trusts in London.”

  (*Evening Standard*, 10 November)

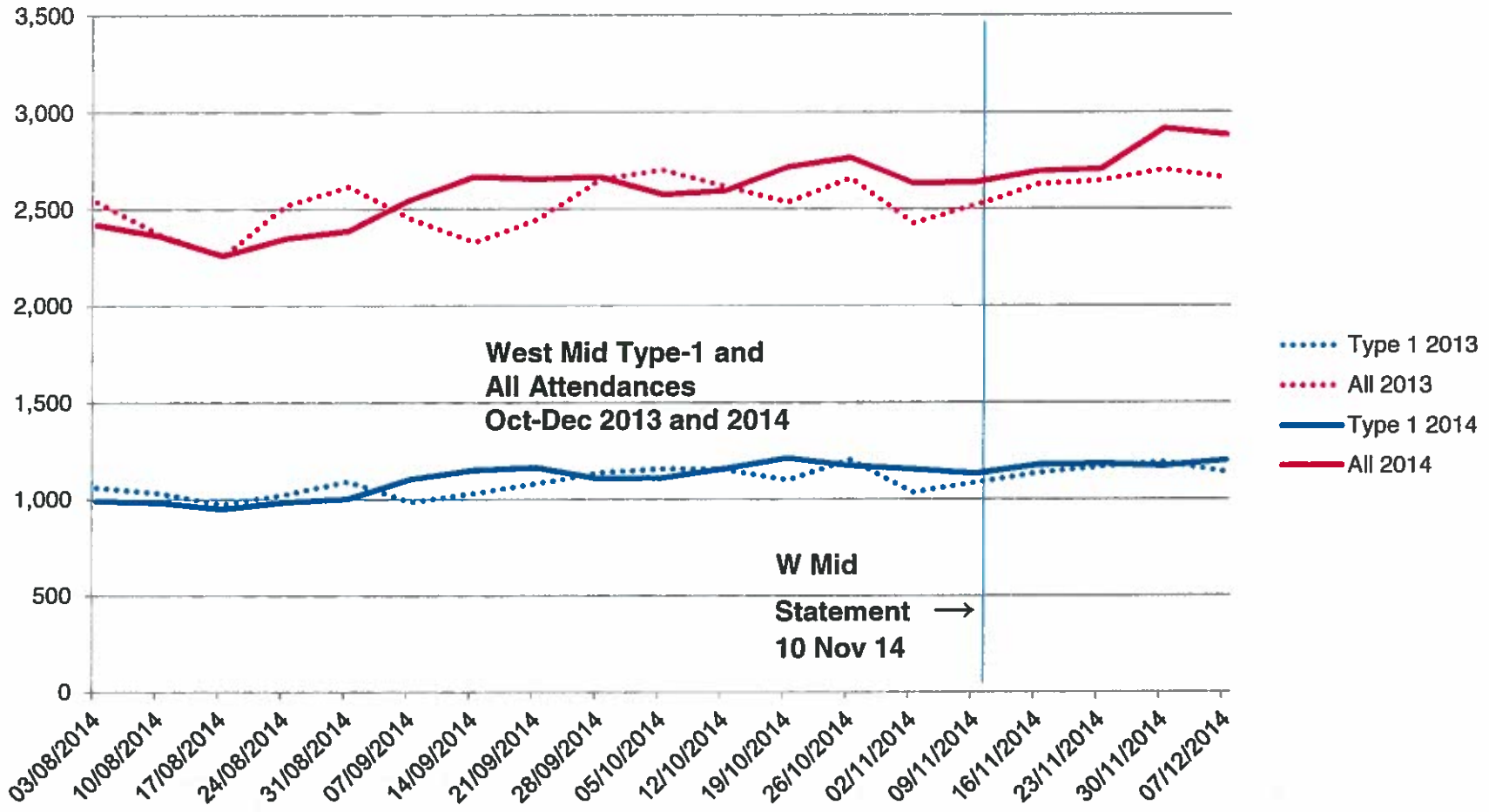
And...

- A West Middlesex hospital spokesman said: “We have seen an overall increase in demand for our emergency services, but we believe this is attributable to a generalised seasonal increase … No direct link with the recent local closures has been established.”

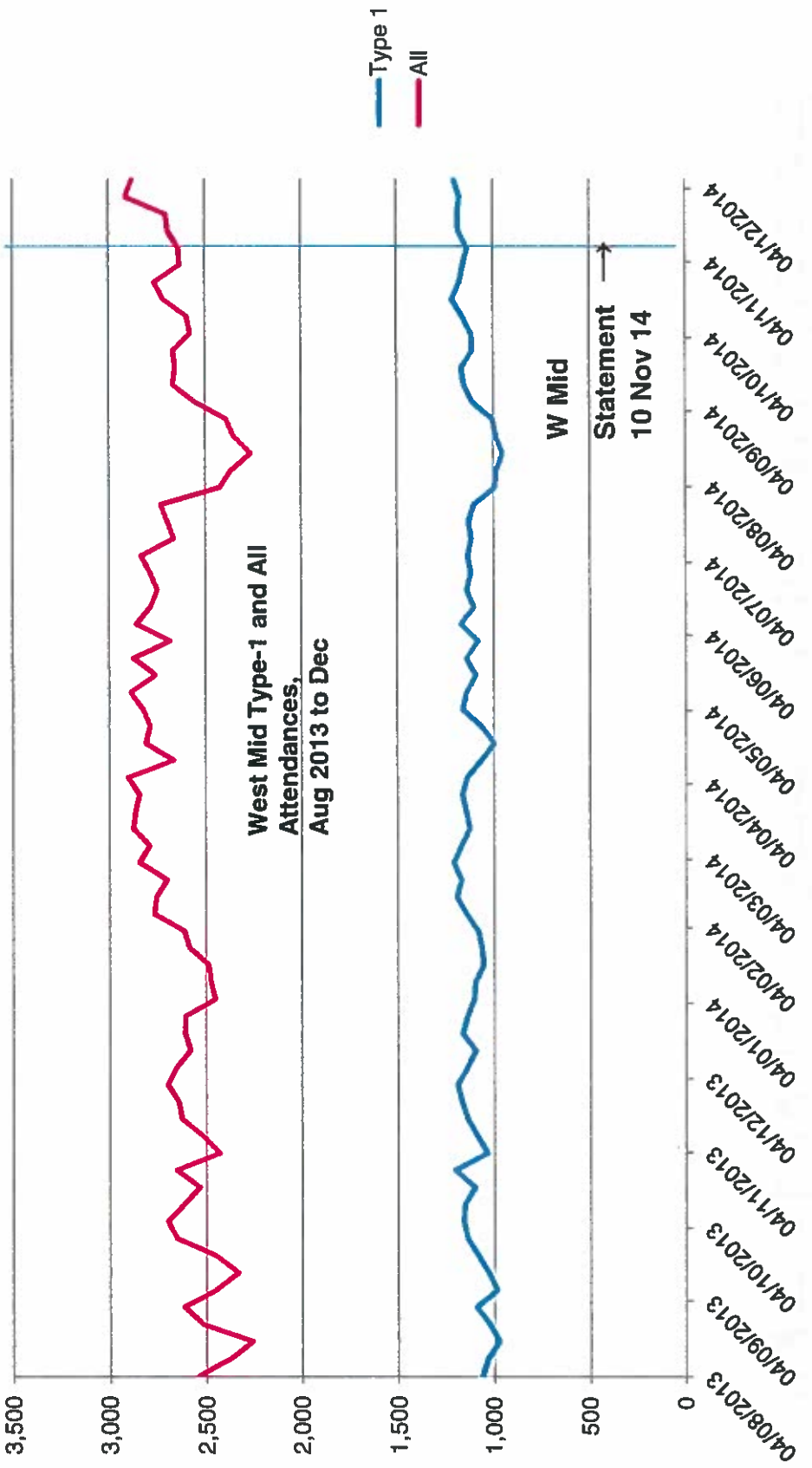
  (*Evening Standard*, 10 November)

- Oh, really?

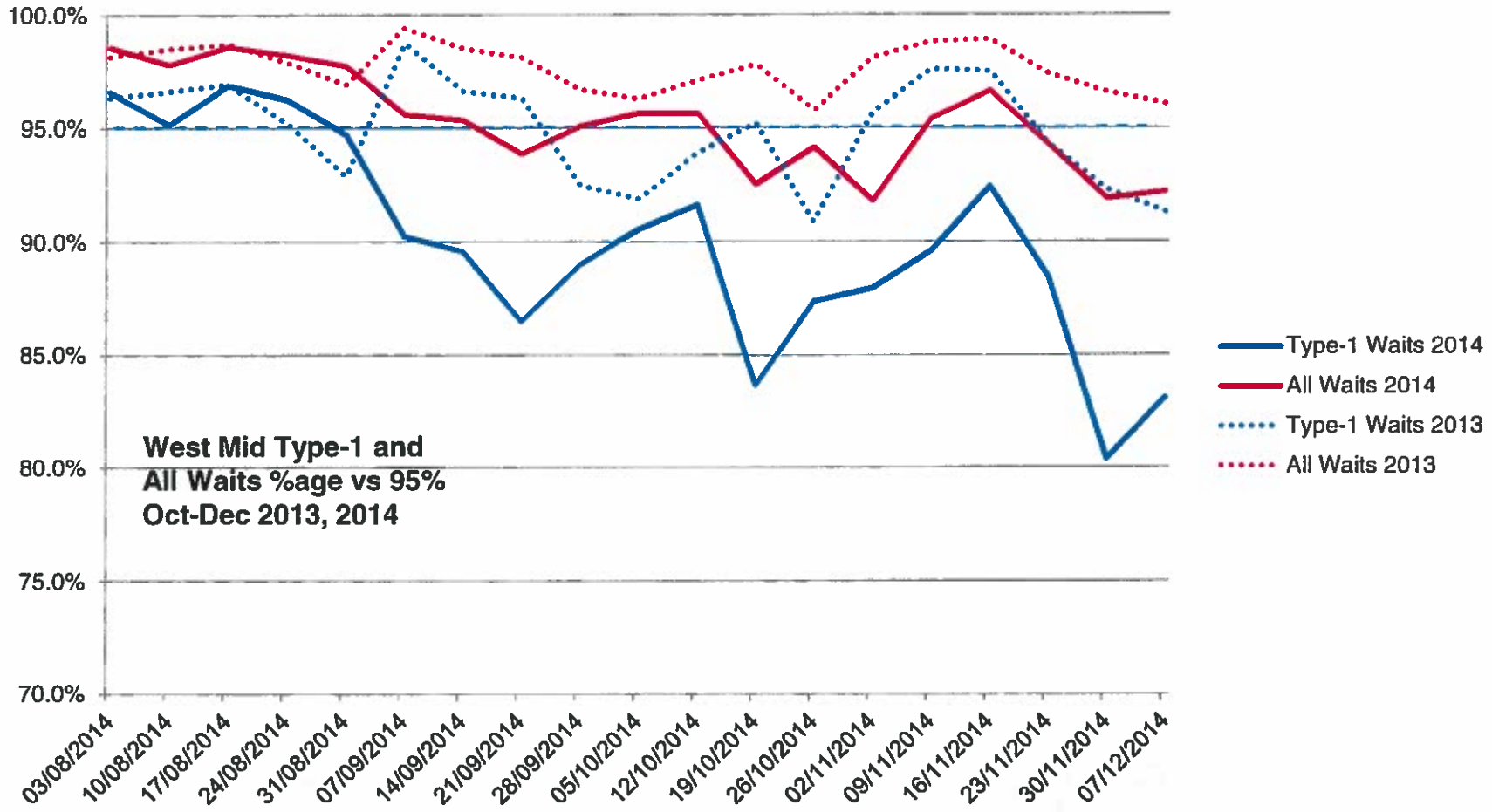
West Mid 'Seasonal Increase'



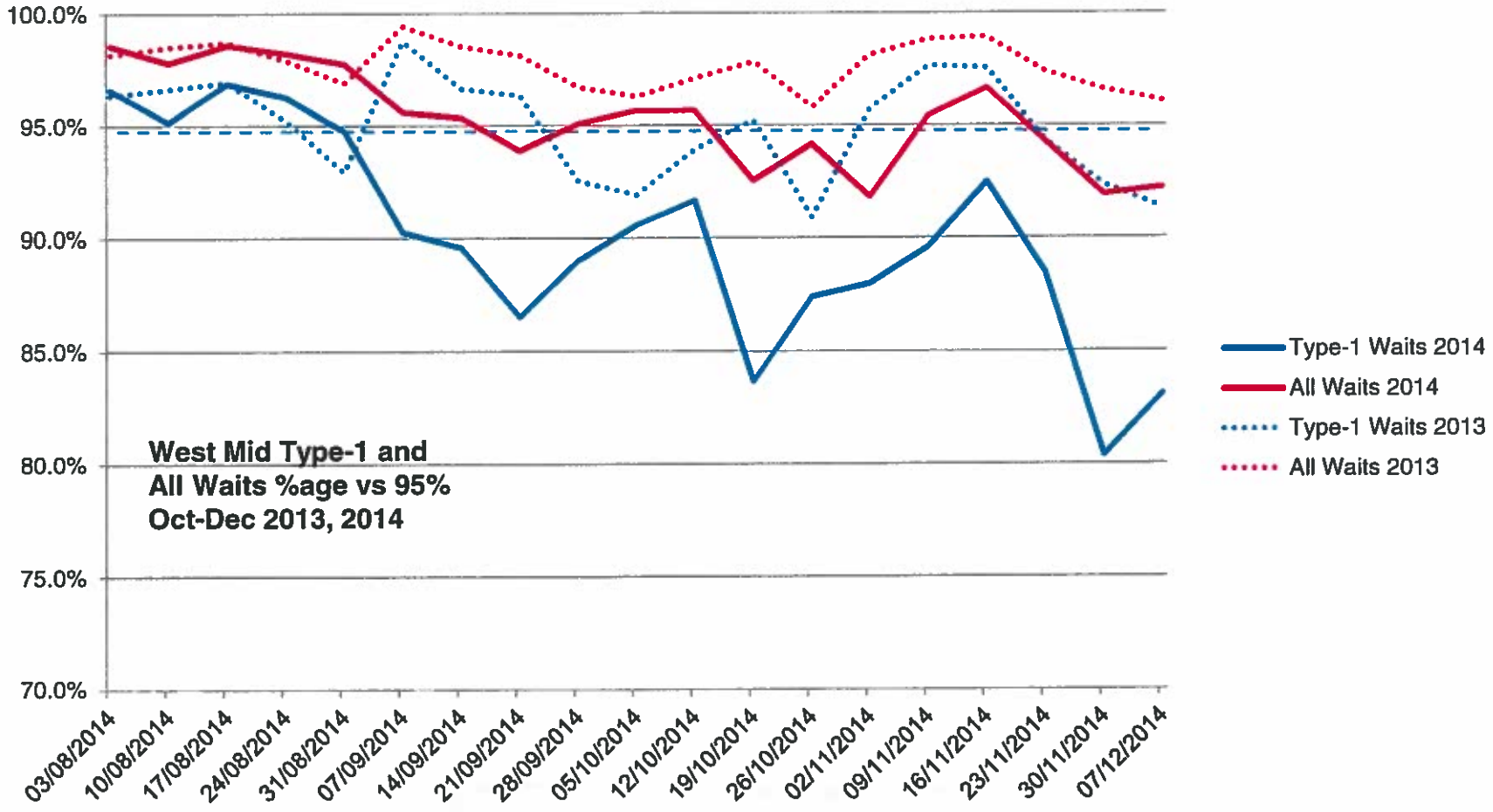
OK, Let's Go Back a Year



West Mid Waits...



...for reasons we can only guess at



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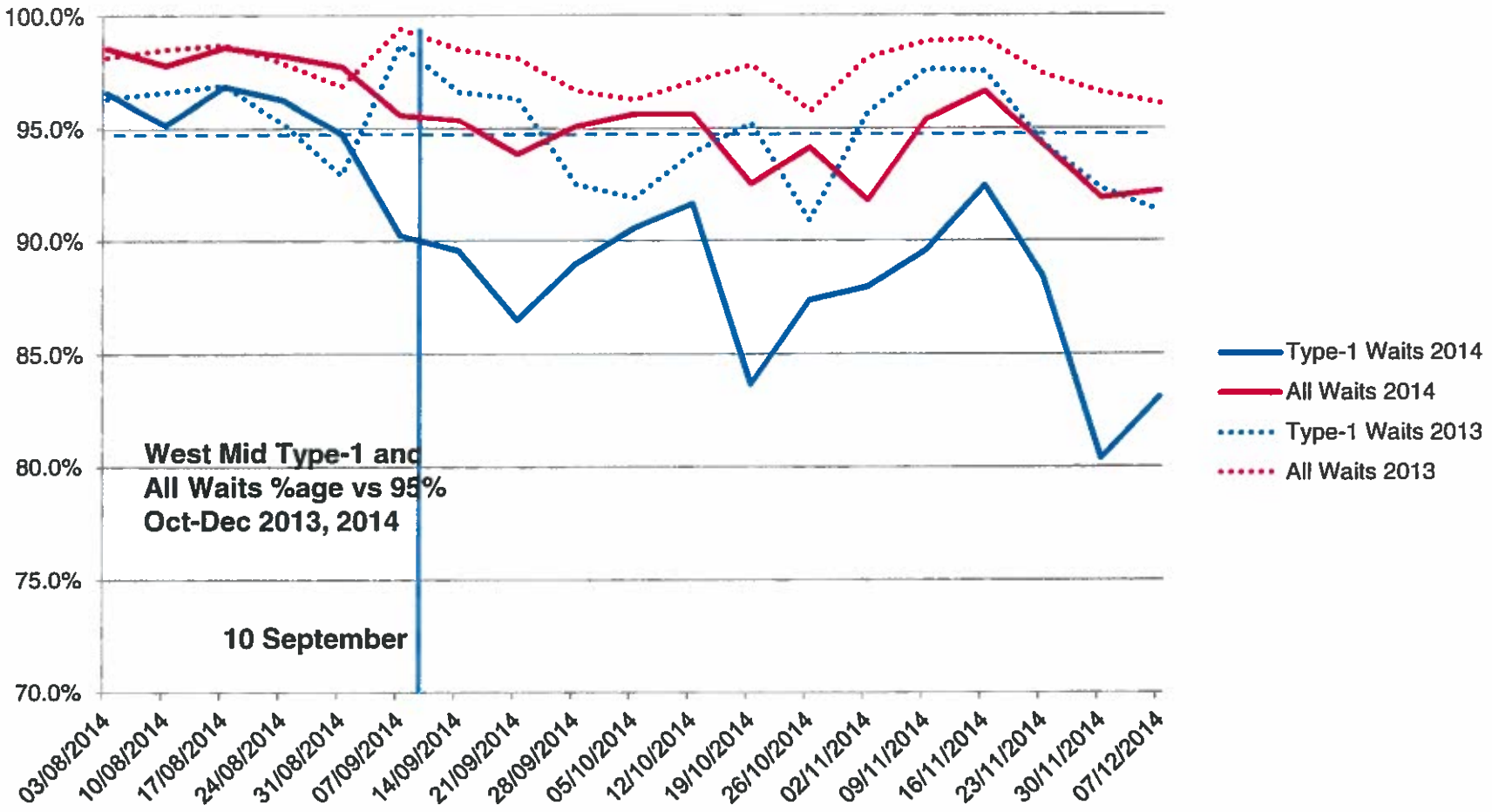

But...

Closure Effect on Type-1 Waits

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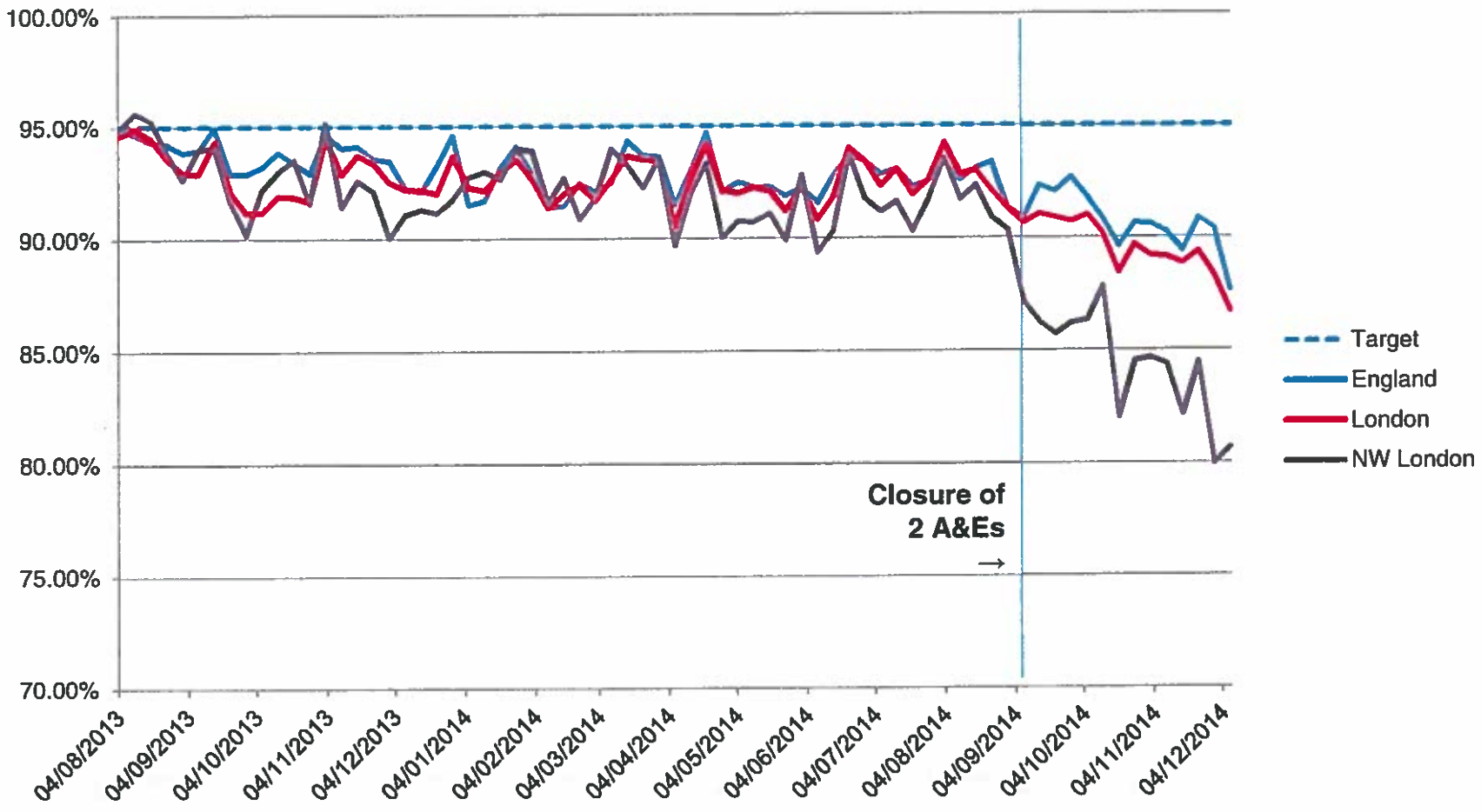

Though London is OK (ish)

- Without the NW Sector, London is on or above England trend

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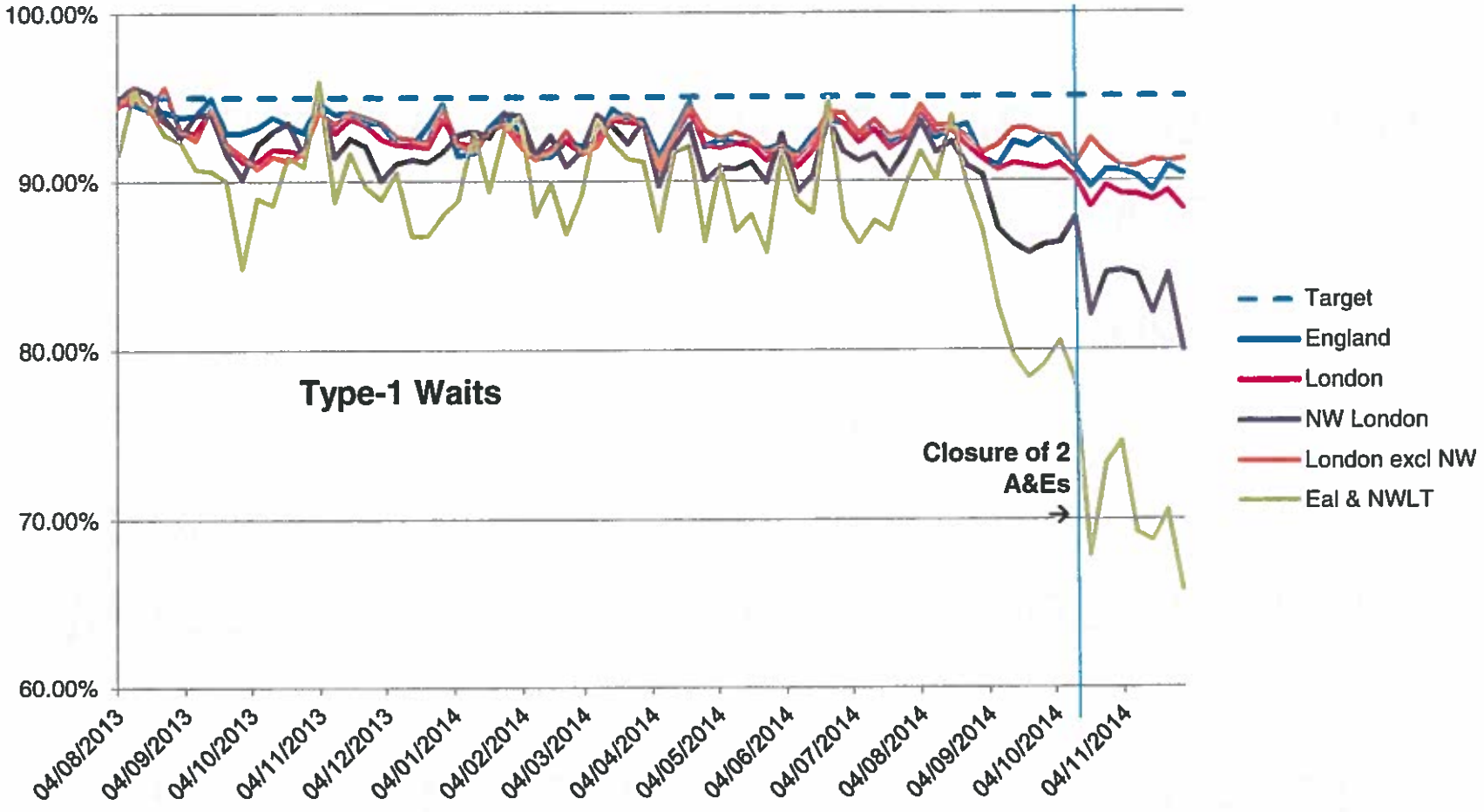
- But the Shaping a 'Healthier' Future Sector drags the London figure down

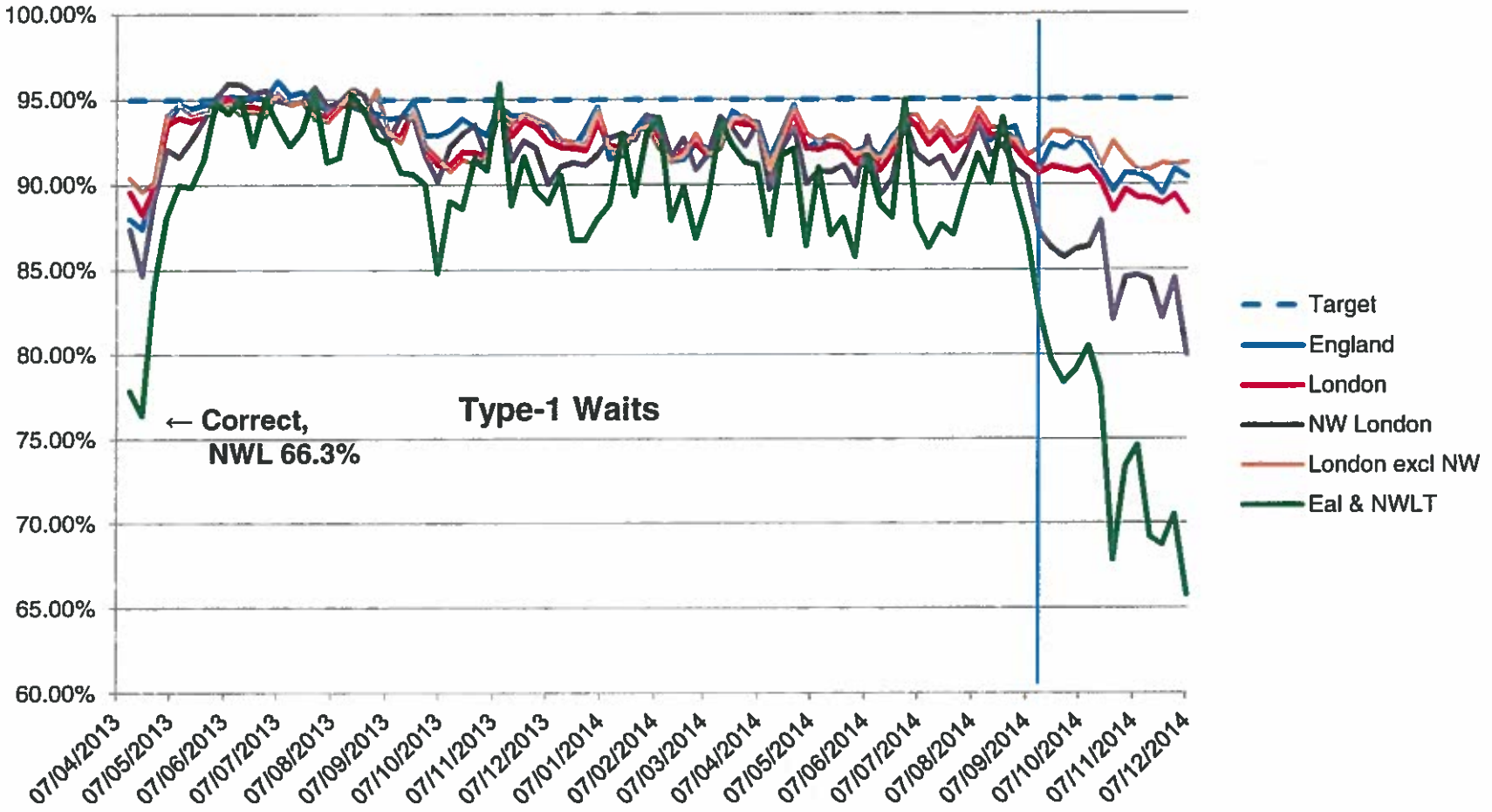
Though London is OK (ish)

- Without the NW Sector, London is on or above England trend
- But the Shaping a 'Healthier' Future Sector drags the London figure down
- Newly-combined London North West Trust is second-worst in England for Type 1 (w/e 7 December 2014)

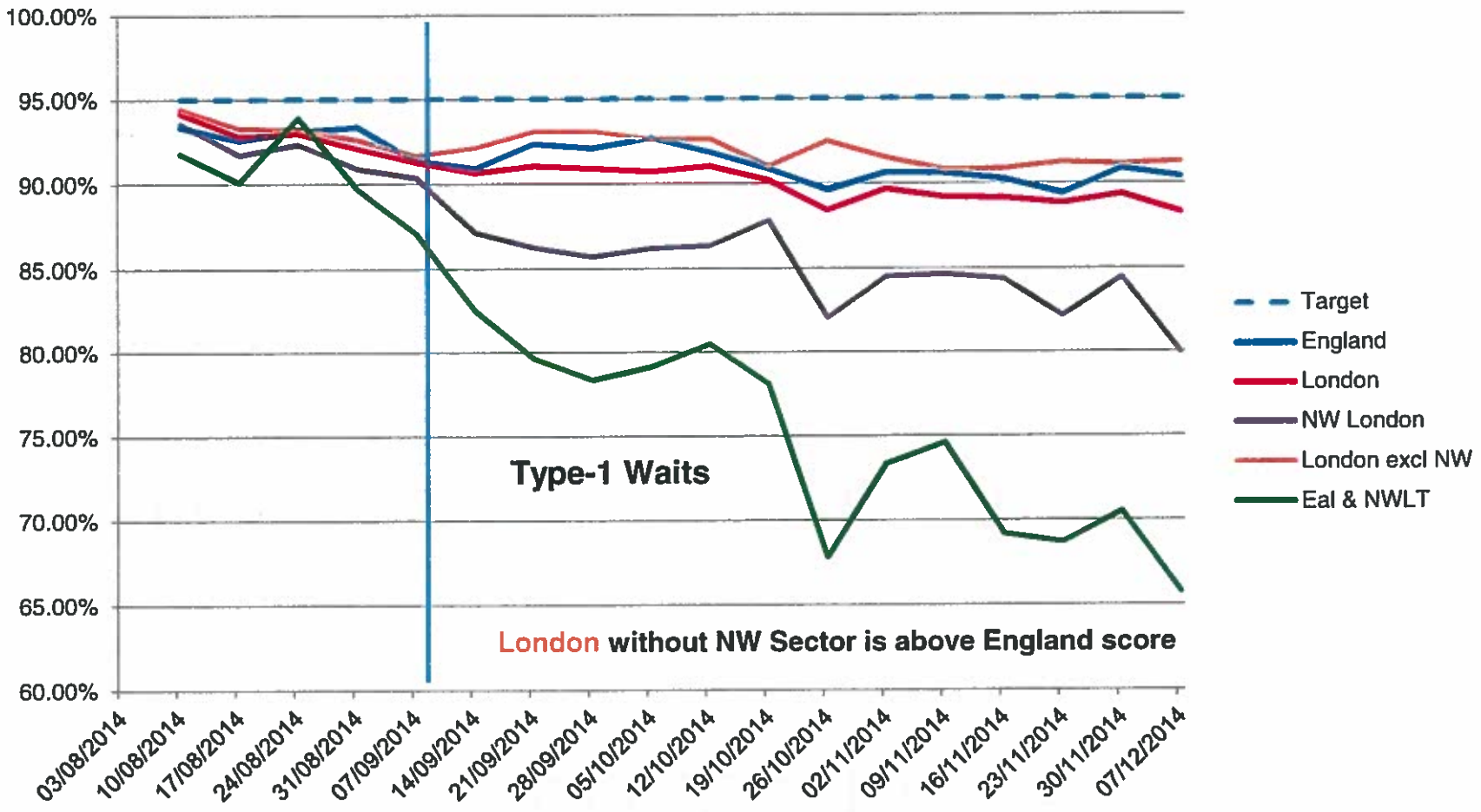
The London NW Trust Effect



The London Effect



Or, from August to date



Separating the Trusts

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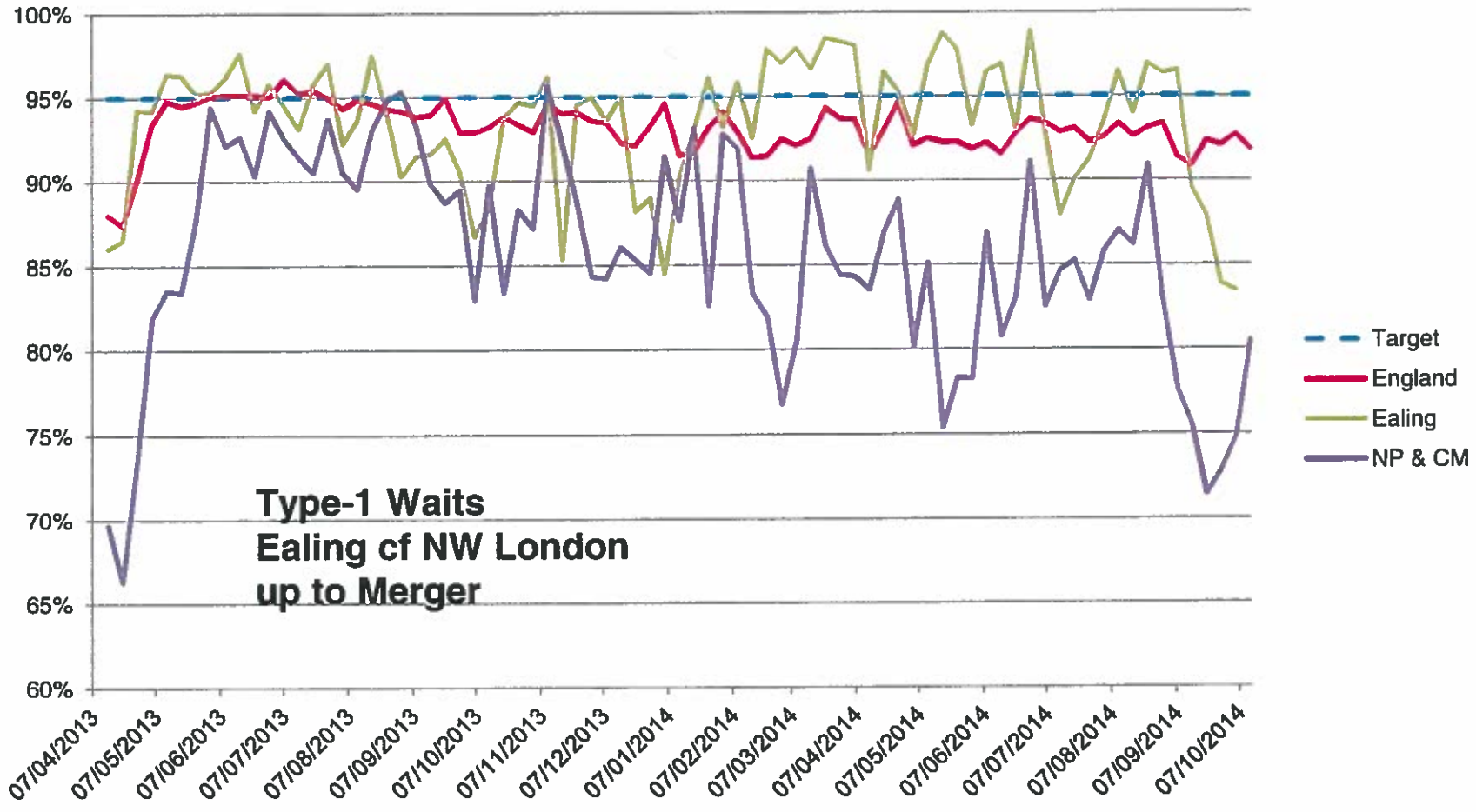
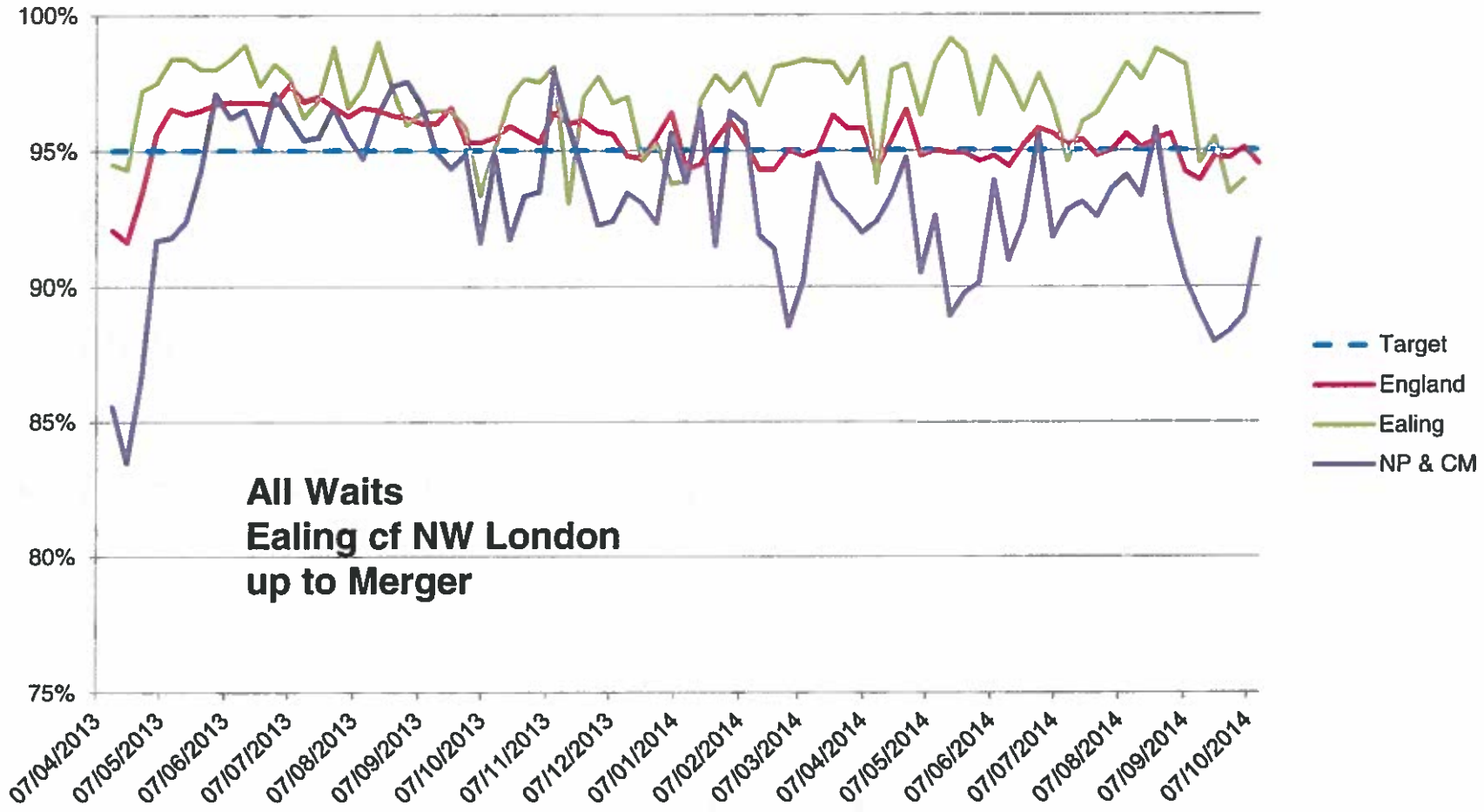



100%
95%
90%
85%
80%
75%
All Waits
Ealing cf NW London
up to Merger
07/04/2013
07/05/2013
07/06/2013
07/07/2013
07/08/2013
07/09/2013
07/10/2013
07/11/2013
07/12/2013
07/01/2014
07/02/2014
07/03/2014
07/04/2014
07/05/2014
07/06/2014
07/07/2014
07/08/2014
07/09/2014
07/10/2014
Target
England
Ealing
NP & CM

The Bottom 5, Type 1

- w/e 7 December :

• Sherwood Forest Hospitals	77.8%
• Hull And East Yorkshire Hospitals	73.2%
• Portsmouth Hospitals	71.6%
• London North West Healthcare	67.3%
• University Hospitals Of North Midlands	65.4%

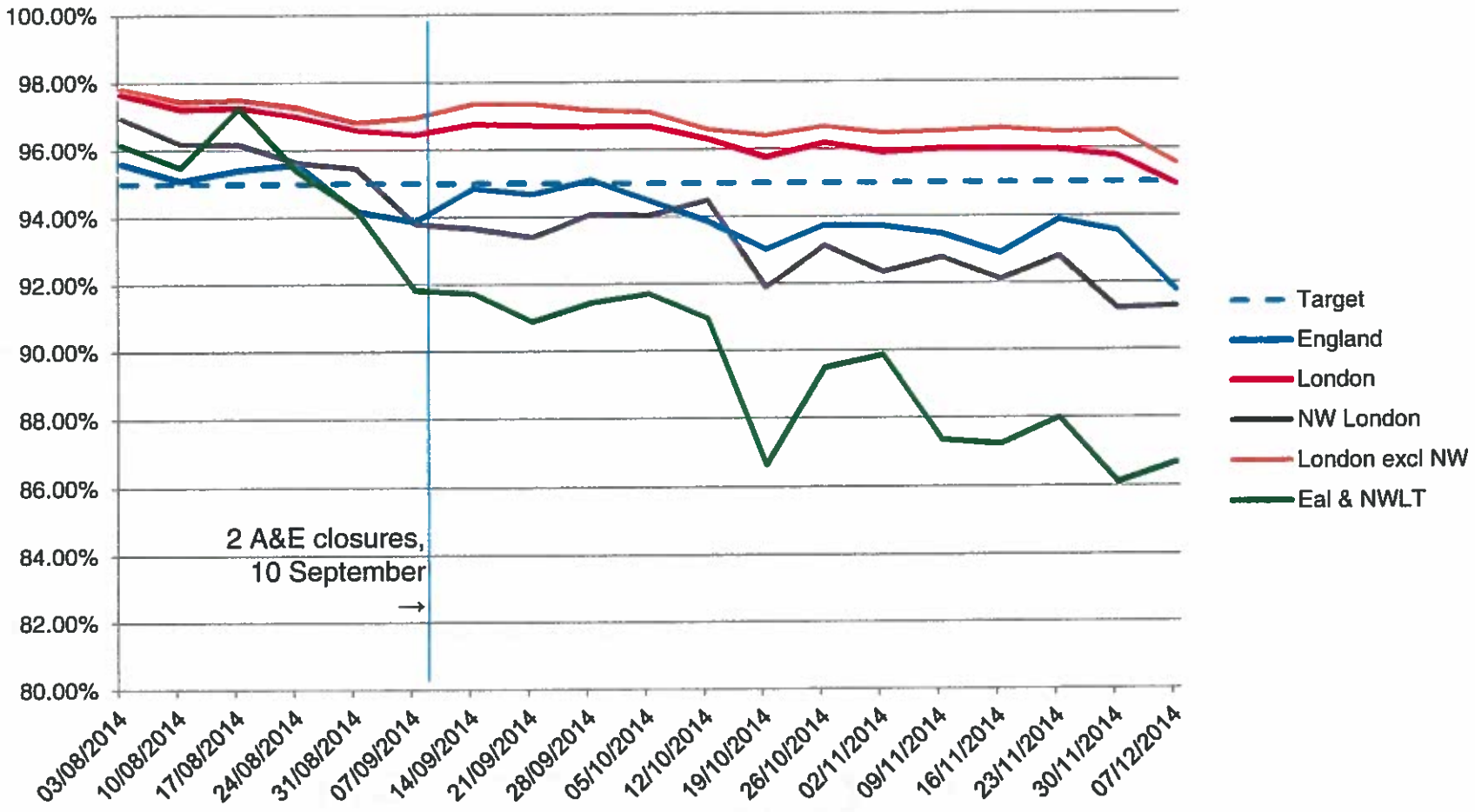
The Bottom 5, Type 1

- w/e 30 November:

• University Hospitals Of North Midlands	78.5%
• Birmingham Children's Hospital	78.2%
• Sherwood Forest Hospitals	77.8%
• Cambridge University Hospitals	70.8%
• London North West Healthcare	65.7%

Collapse in 'All' Waits,

but mostly NW London

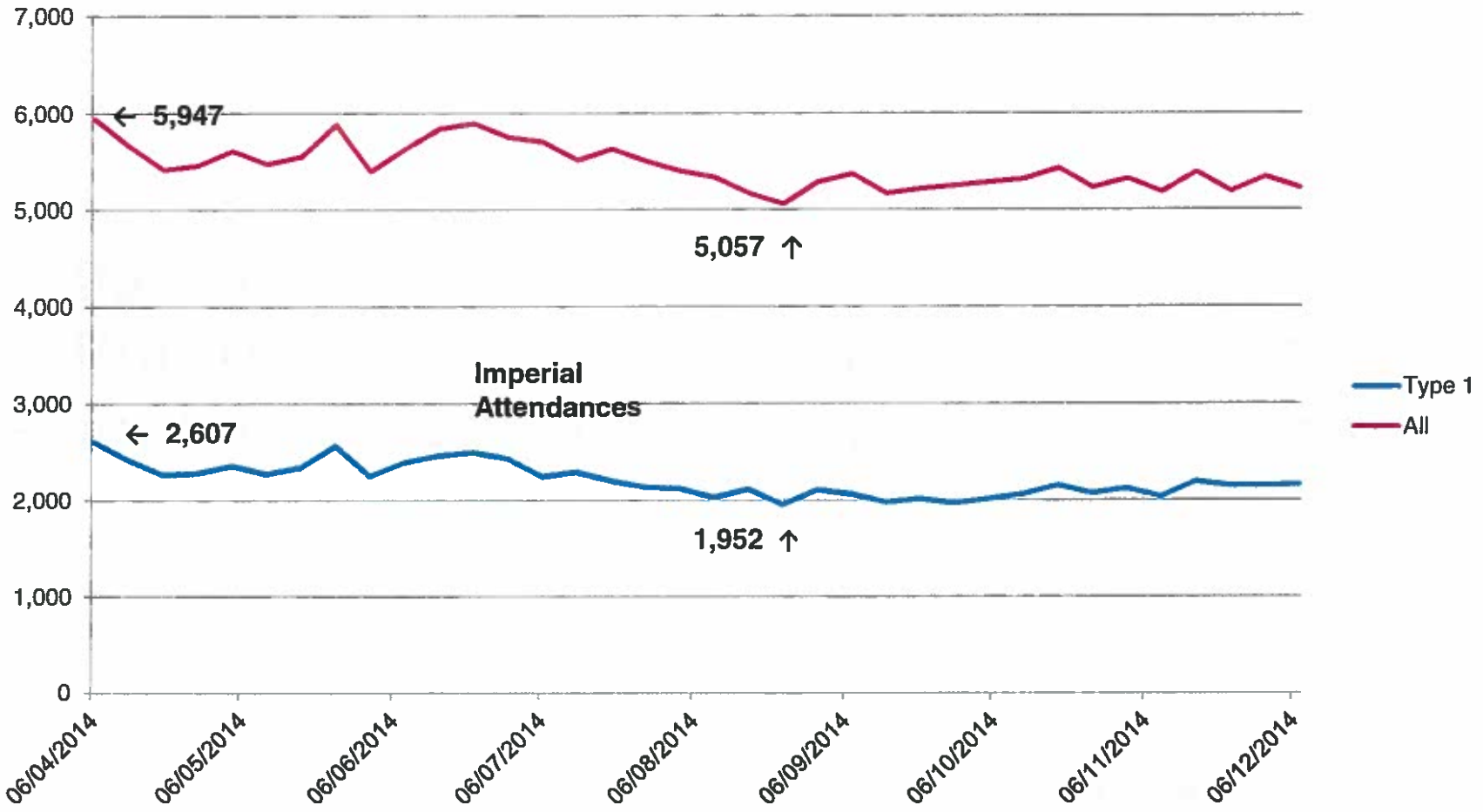


Imperial Mince

- Variations in attendances between days can be as high as 120 and these unprecedented surges in activity have resulted in the Trust failing to meet the 95 per cent four-hour waiting time standard
- (Trust Board: 26 November 2014, Paper Number: 6)

- So, it's a capacity problem?

Imperial, year to date



Calculating Capacity

- **The 80% rule:**

- **theoretical capacity = minimum demand + [(maximum demand - minimum demand) * 80/100]**

The Real Capacity Story

- **theoretical capacity = minimum demand + [(maximum demand - minimum demand) * 80/100]**
- **For Imperial, ytd:**
- **Type-1 = 1,952 + [(2,607 - 1,952)*80/100] = 2,476**
- **All = 5,057 + [5,947 - 5,057)*80/100] = 5,769**
- **(weekly)**

The Real Capacity Story

Imperial f/y 2014			Over Capacity Weeks				November			
	Capacity	06/04	25/05	15/06	22/06	02/11	09/11	16/11	23/11	30/11
Type 1	2,476	2,607	2,564	2,463	2,498	2,121	2,035	2,194	2,152	2,150
All	5,769	5,947	5,884	5,844	5,897	5,323	5,184	5,388	5,191	5,341
%age		91.30%	92.60%	92.0%	92.10%	85.4%	85.80%	77.50%	83.00%	79.20%
%age		96.00%	96.30%	95.9%	95.90%	93.2%	93.00%	90.10%	92.30%	90.80%

Effect on Cancellations

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  38% up on last year
- Partial from C&W – something is 12% up
- 11 Dec re Ealing: conflicting data

Effect on Ambulance Diverts

- Trusts deny knowledge of data
- 'Unfortunately we don't keep records of dates of diverts' (Hillingdon, 9 December e-mail)
- FoI sent to LAS
- Reported they must phone Northwick Pk for access (*Mail on Sunday*, 30 November)

Conclusion

Conclusion

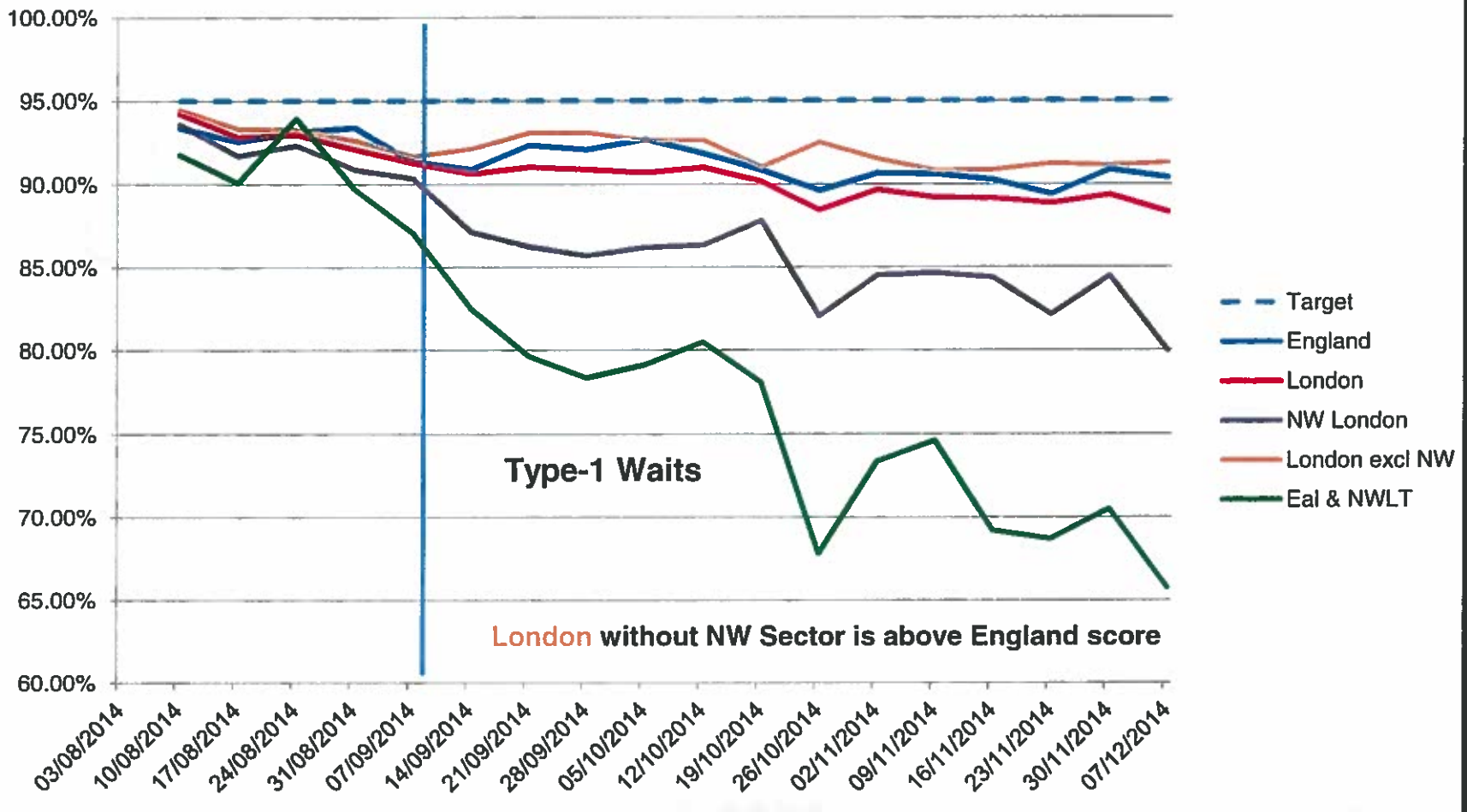
- Unplanned closure of 2 A&Es with no community or primary replacement has caused:
- collapse in A&E 95% performance
- increased waits
- unspecified deterioration in Elective Operation cancellations
- even more pressure on London Ambulance Service

End

Colin Standfield
18 December

ColinStandfield@aol.com

Or, from August to date



End

Colin Standfield
18 December

ColinStandfield@aol.com

Smith Peter

From: [redacted]
Sent: 03 February 2015 17:38
To: Smith Peter
Cc: julian.bell@ealing.gov.uk
Subject: Shaping a 'Healthier' Future - Further Submission

Dear Mr Smith,

Following a meeting on Friday with the Chief Executive, Medical Director and Operations Manager at Northwick Park (along with a small contingent from Brent) I today sent this e-mail to the Operations Manager:

Dear Tina,

Further Follow-Up to the Meeting of 30 January

Type-1 Attendances and Waits

I thought it would be worth sending you the Type-1 Unit graphs I was using on Friday. I had shown you the Attendances and Admissions lines for LNWHT – both virtually flat from August 2013 to 25 January this year.

I had also prepared graphs for LNWHT Type-1 Attendances (using combined Ealing and NWLHT data up to the merger) compared with its average over the period (Graph B i) and for Type-1 Waits, both numerically and as a %age against the 4-hour target.

All 5 graphs except for B i (and now B ii) show: England (divided by 10, to scale it with the local data series), London, North West London Sector, London excluding NW and finally LNWHT.

What Graph E shows quite dramatically is both the collapse at LNWHT since the 2 A&E closures and, more strikingly, that it is the NW London Sector that has performed egregiously badly: take out the Sector blighted by Shaping a 'Healthier' Future and London outperforms the national trend.

If you squint, you can just about detect a slight rise in Attendances over the period, particularly in the Summer and the week before Christmas, now much reduced; but I have now added to the right of each graph a year-on-year comparison (A ii etc) from early August and you can see that this is pretty seasonal. The largest weekly y-o-y increase nationally was not in that Christmas week (w/e 21 December) but in w/e 14 September at 24,472; for that same week, by the way, there were 174 *fewer* T-1 Attendances at Ealing and Northwick Park combined.

24,472 is an average y-o-y increase of 169 Attendances for the 145 Type-1 Trusts in Unify2, or 9.45%, or 1 extra per hour – an exceptional week, but the national Type-1, 4-hour figure was 92.3% compared to 79.6% at LNWHT. The *average* national weekly increase over 2013 for 3 August to 25 January is 9,300 or just 3.49%, or 9 extra per day, rather than that exceptional 9.45%.

All Attendances and Waits

I have added a further graph, A iii, to the right of Graph A ii, showing All Attendances from August to January and comparing 2014 with 2013. This shows a similar pattern to the Type-1s. That is, not much of an increase.

The greatest national year-on-year gap since August was for the week ending 21 December at 37,972 (446,473 against 408,501); that is the equivalent of 21 extra attendances per day for each Trust across the country (Types 1, 2 and 3). In 2013 (w/e 22 December) the 4-hour performance was 95.5% but in 2014 it had fallen to 88.8%. There is clearly something wrong nationally as the 254 Trusts cannot have forgotten how to deal with a 9.3% increase.

The *average* year-on-year weekly difference from the first week of August, 2013 against 2014, is 13,250, or 3.15%, or 7.5 attendances per day per Trust. That is, about one extra every 2 hours if you take out the middle of the night. That should not break the bank, but what would I know?

What I do know is that cancellations of planned operations have rocketed and I have heard that social services are increasingly unable to cope with routine discharges. What I do not know, because the data are not published in the same way as the A&E statistics, is what is happening in Primary and Community Care, the improvements to which were 'still in their early stages' and 'having the expected modest effect' in September last, according to Dr Spencer.

'Care Closer to Home'

"The central plank of the 'Shaping a healthier future' proposals is shifting more investment into primary care and other local healthcare, providing more proactive services in the community closer to patients' homes." (Mott MacDonald Report, Decision-Making Business Case Vol 4, p14 or 3 – the pagination in both 'Business' Cases is chaotic)

The budget for this varies among £120 million, £138 million and £190 million, depending where you look. It is, of course, a fantasy budget and nobody will be able to tell whether it will have ever been spent now that the finance has passed to the CCGs.

But nowhere, in either the Pre-Consultation or the Decision-Making 'Business' Case, is there any evidence that 'care closer to home' results in better health outcomes, still less that it has been the subject of any consultation with the public.

The introduction to the PCBC airily states: "We believe that increasing the amount of care delivered closer to the patient's home will enable better co-ordination of their care, and improve the quality of that care and its value for money," but no evidence is adduced. My suspicion is that this is just a hunch, a hunch based on a guess that it might be cheaper that way.

Mott MacDonald say: "The Case for Change highlights that providing suitable care at community level could result in 20-30% of patients who are currently admitted to hospitals in NWL as emergencies being effectively cared for closer to home.[105]

"[105] NHS North West London (2012) : 'Better Care, Closer to Home: our strategy for coordinated, high quality out of hospital care, 2012-2015' (Ibid, p61 or 50)"

No such calculation has been made in any document resembling that title, especially the one called *PAPER 5_2 PCBC OOH chapter 040512 DRAFT* in the PCBC. Or anywhere else.

And, although the Presidents of the various Royal Colleges say, in their letter which appeared in *The Guardian* on the 28 April 2010 and which is included in the PCBC: "However, at the same time there is also strong evidence to support a large amount of more routine care, currently taking place in hospitals, being carried out closer to where patients live in the community with GPs playing a crucial role in the delivery of services," they do not trouble themselves to cite any.

So, without any evidence in either the PCBC or the DMBC that it is worth doing, 'care closer to home' remains a chimera, a will-o'-the-wisp of healthcare planning. And its budget is even more evanescent.

Like the whole flawed and botched process called Shaping a 'Healthier' Future, it is a busted flush. Those responsible should stop trying to bully the CCGs and Trusts into cooperating with a failed model: the graphs show it to be so.

What is needed is the kind of workable improvements we were beginning to discuss on Friday, not the top-down management-consultant chaos we now have.

I hope this can be considered as part of the Review and am happy to elaborate orally if needed.

Regards,

Colin Standfield

Smith Peter

From: Merril Hammer [redacted]
Sent: 02 February 2015 15:28
To: Smith Peter
Subject: Submission from SOH to the Commission
Attachments: Boroughs Commission - submission.doc; APPENDIX D Graphs showing Type 1 A and E 4h wait time performance stats, NW London v the rest, 16m to 18 01 15.docx; IRP Report.pdf

Dear Peter,

Please find attached 3 papers from Save Our Hospitals:

The first is our submission to the Commission and there are three appendices in this document

The second attachment is a set of graphs – Appendix D – which, for technical reasons I couldn't manage to put into the document above.

The third attachment is a copy of the submission made by SOH to the Independent Reconfiguration Panel last year. We have included this as most of the issues raised even at that time have not been adequately addressed.

I would be more than happy to speak to any of these documents or to answer in whatever format any questions the Commission might have in relation to our submissions.

Best wishes,

Merril Hammer
Chair, Save Our Hospitals: Hammersmith and Charing Cross

SAVE OUR HOSPITALS
HAMMERSMITH & CHARING X

c/o 7 KIMBELL GARDENS, LONDON SW6 6QG

Submission to the Independent Healthcare Commission for North West London
January 2015

Save Our Hospitals (SOH) has been campaigning, together with other groups in NW London, against the proposals in *Shaping a Healthier Future* for over 2 years. As well as campaigning, every week, in the London Borough of Hammersmith and Fulham, we have attended CCG meetings, Imperial Board meetings, Healthwatch and have had two formal meetings of our officers with the CEO of Imperial, Dr Tracey Batten, and several of her senior officers. (We have attached our reports on these meetings to this submission as Appendix A and Appendix B). Week by week we are told of how concerned people are at the proposals and how angry they feel that their needs are not being taken into account.

We are a non-party political campaigning group with supporters from across the political spectrum. We have opposed the reorganisation and closures from the outset, but our current demand is for a moratorium on further closures and reorganisations and for a new consultation on any further reorganisation plans, once there is clear clinical evidence that such changes will be safe and effective. It is interesting to note that, increasingly, other bodies are voicing similar demands e.g. Hammersmith and Fulham Healthwatch (we understand they are also making a submission to the Commission) and, most recently, the Royal College of Nurses in their submission to the Commission (http://www.rcn.org.uk/newsevents/news/article/london/shaping-healthier-future?utm_campaign=ERUSSELL-151625-1301+Shaping+Healthier+Future+Follow+Up&utm_source=emailCampaign&utm_medium=email&utm_content) .

1. *Shaping a Healthier Future (SaHF)*

Shaping a Healthier Future is the most extensive proposed reorganisation that the NHS has experienced and it is feared that it is being seen as a prototype for further massive reorganisations elsewhere in England. Within this quadrant of London it is proposed that 4 A&E departments out of 9 will be closed and that many hospitals will lose services with some hospitals being downgraded. We address many of the issues raised by SaHF in the points following, but it is important to note here some of the history.

The body that drew up SaHF, NHS NW London, no longer exists. SaHF is referred to, by bodies such as the CCG and Imperial College Healthcare Trust, as the 'authority' for the changes, claiming that they are 'trapped' (Dr. Spicer, CCG meeting, 13 Jan '15) inside the proposals and there is nothing they can do about it. For those of us who wish to raise issues/concerns we are faced with a non-existent body used by other organisations to provide a cover for their inability to deal with the core questions we raise. As a result of these *structural* issues, SaHF (whatever it is!) is able to proceed with impunity. This is clearly an undemocratic structure with no accountability.

2. Borough-wide provision

One of the issues which SaHF has ignored, and which has not been dealt with when we have raised it with the CCG or with Imperial, is the discrepancy in health outcomes and health provision between the north of the borough and the south. There is a significant difference in health outcomes - between the poorer north of the borough and the wealthier south. The Joint Strategic Needs Assessment (see http://www.jsna.info/sites/default/files/Hammersmith%20and%20Fulham%20JSNA%20Highlights%20Report%202013-14.pdf) provides figures showing, for example, that men and women living in H&F have a lower life expectancy than in London as a whole. But premature mortality is highest in the poorer wards: Askew, Broadway and Shepherds Bush. Self-reported bad or very bad health is highest in the north: College Park, Old Oak, Hammersmith Broadway and Wormhold and White City wards. There are large health inequalities with a difference between the deprived and the affluent areas in terms of life expectancy of 7.9 years. Yet there are fewer medical facilities in the north, with fewer and smaller GP surgeries there, despite the opening of Parkside (which, with the movement of several practices into a single space, has increased distance from a surgery for many patients), and the Hammersmith A&E has already closed, further reducing services for those in the north. There is a low take-up of patient involvement schemes in the north – although practice across the borough as a whole is patchy.

3. A&E Closures

On September 10th 2014 two A&Es in NW London, at Central Middlesex and Hammersmith Hospitals were prematurely closed – with the claim that each was 'unsafe'. Even the CCG and Imperial Health Trust have admitted that satisfactory alternative provision was not all in place, despite the promises made during the SaHF consultations. Ironically, in the CQC inspection of NW London Hospitals Trust, it was Central Middlesex which obtained a 'good' rating while Northwick Park was found wanting! Since then there have been major consequences in the NW London area for A&E services with major failures at Northwick Park AND within Imperial College Healthcare Trust in meeting the 95% target for seeing patients in A&E. We assume that you have seen the figures for this, but it is worth noting that not only are there major failures in meeting the target but that both *Trusts have fallen significantly in the league tables* of hospitals meeting the target. (Even prior to the 2 closures, St Mary's was reported as being already in 'winter mode' in July 2014.) Any claims that there is a London- or country-wide increase in demand simply cannot explain the landing at the bottom of the league tables. Further, there seems little concern at the knock-on effects on ambulance services when ambulances are left queuing outside hospitals. We are not submitting full details of the issues around waiting times, but the graphs presented in Appendix D (sent as a separate attachment, for technical reasons)

show the deterioration in performance immediately after the closures of Hammersmith and Central Middlesex A&Es.

4. CQC Inspection of Imperial Health Trust

The CQC report on Imperial Health Trust (Dec. 2014) gives no cause for the complacency that Imperial management and the CCGs seem to be showing. Following from the point above for A&E closures, we have a further irony in that Charing Cross A&E was rated 'good' while the A&E at St Mary's was rated 'inadequate' – yet it is Charing Cross that is marked for closure under *SaHF*. While Imperial have said that action has been taken over St Mary's A&E in terms of the hygiene issues, other issues were identified for the St Mary's A&E site, not least the inadequacies of the unloading bay and the access. But Charing Cross has excellent facilities.

SOH is additionally concerned at the failures by Imperial in providing timely and adequate outpatient services and in the very long waiting times etc for elective surgery. Since it has been impossible to find out from Imperial just what services are to be closed/relocated etc in implementing SaHF, we are left with major questions about just what health services will be available locally to Hammersmith and Fulham residents, where they may need to travel to for which services etc. Indeed, since we are unable to get answers to these questions and now have a CQC report raising serious concerns about these areas, we are left wondering whether the management of Imperial is more concerned with seeking foundation trust status, 'keeping in' with NHS England and with local CCGs, and becoming a 'world class' research centre than with ensuring that it provides top-class health services to local people.

5. HASU

It is worth noting here that both Imperial and SaHF claim that the HASU at Charing Cross needs to be co-located with the major trauma centre at St Mary's. SOH has no difficulty in accepting the importance of centralising specialist services where there is clear evidence that this is beneficial to patients. That is, we accept that there is a need for HASUs and for major trauma centres. But no clinical evidence has been provided at any stage to support the contention that the HASU and trauma centre need to be co-located; nor have we heard of moves to co-locate these services elsewhere. There is, for example, a HASU at UCLH – it has no major trauma centre. Why this inconsistency? Further, why move Charing Cross's HASU – according to the CQC report, the 3rd best in the country – to St Mary's when there is one less than 2 miles further down the road at UCLH? This is not just centralisation of specialist services – it is centralisation of key services for NW London into central London itself (the doughnut effect). We have asked for the data that shows that, as a result, no patient in NW London will be more than 30 minutes from a HASU. Imperial has not been able to provide us, as yet, with this evidence and the evidence they say is there is from some 5-6 years ago!

6. Transport

A key issue identified by SOH is that of transport. Again in our meetings with Imperial we have consistently raised concerns about transport. Much of the response

has been about needing to improve inter-hospital transport i.e. the transport service that they provide. Despite repeated questioning over the past 2+ years – and to the CCG – there seems to be little recognition that SaHF will have a major travel impact on patients, carers and families living in Hammersmith and Fulham. Indeed, the chair of the local CCG, laughingly said, in one CCG meeting, that it takes several years to get a change in bus routes! Public transport is key, even more so in the north of the borough than the south because there is significant poverty in the north (including less car ownership) and therefore greater dependence on public transport.

Charing Cross Hospital is superbly located for public transport services for those within and outside the Borough. There are Underground services calling at Hammersmith (4 lines) and at Baron's Court (2 lines); the bus station is a major bus transport hub in west London and, from there, numerous buses run a short 2 stops directly to the hospital, while these routes also provide access for those coming from further south. In contrast, St Mary's is difficult for local people or those living further south or west to access, with multiple public transport changes. For self-referral to A&E, this will be a major problem with the potential for a greater demand for ambulance services or for people not to access A&E services when they need to.

The CQC report on Imperial makes the point that there are too many late night patient discharges. This possibly relates to Out of Hospital care (see below), but is also a major concern in relation to travel. Unless hospital transport is provided – an unlikely outcome! – patients are therefore having to organise their own transport at late hours and at their own expense. This can only be exacerbated if we have further reduced A&E services. Key people who feel they have the need to use A&Es are the homeless, who have little resource to fund travel, low income groups for whom taxi fares would be prohibitive, those with mental health issues, for the elderly, for the disabled and mothers with young children for whom late night public transport travel is less than ideal.

7. Finance

The reorganisation will cost an enormous amount of money – yet another irony at a time when the NHS is under severe financial pressure because of government policies. Imperial's Clinical Strategy paper (July 2014), involving sale of Western Eye Hospital, demolition of Charing Cross with sale of 55% of land and a rebuild of a mini-hospital, the demolition of parts of St Mary's with sale of 45% of that land and a major rebuild, has never been consulted on and the selling of this land was not included in the original SaHF proposals. In all, even after these sales, according to their own clinical strategy paper, they will need to borrow in excess of £400m. While it is a relief to know that they do not plan a PFI arrangement, it remains unclear just how they will finance this and how, with such significant borrowing, they will be able to afford the interest payments (at current interest rates something like £16m p.a.) let alone pay off the capital. What sort of 'efficiency savings' might be necessary for this! And what will be the knock effects on patient care? They admit that they hope to increase revenue by extending the number of private beds. But this also raises a further question about what proportion of the rebuilt hospitals will be for public rather than private provision and how much resource might be diverted to private provision.

The lack of clarity, from both Imperial and the CCG, about the extent of private provision and this might impact on public provision, is another major concern, both in terms of what proportion of beds/provision might be private and how such private

provision may be shaping our health provision. We understand that the CCG is already £2m overspent this year (reported at CCG meeting 13 Jan '13), which is partly ascribed to a failure to recruit permanent staff to CCG services. It is not clear just which staff they are referring to – something the Commission might like to inquire into! There is growing evidence that the commissioning process itself is both expensive and is taking finance away from front-line services. That such large sums are being spent on agency staff exacerbates the situation. With a 10% cut to the overall CCG budget projected for the coming year and rising charges for co-commissioning, the finance of the local NHS looks increasingly bleak.

In terms of finance, privatisation and the CCG, we are deeply concerned at a lack of transparency. Many contracts seem to be awarded on chair's action and, while we do not want to hint at any impropriety, we and the public whose tax pays for services should know which bodies are receiving contracts for public services so that there is public accountability.

8. Out of Hospital Services

SaHF is predicated on there being less need for hospital provision as out of hospital services are developed. Yet plans are going ahead without these services actually being in place, let alone there being clear evidence that they will reduce the need for hospital beds in a situation where there is local population growth and where people are living longer. While Hammersmith and Fulham has a younger population, relatively, with large numbers of working adults, than London as a whole and than England at the same time, older people are living longer and do develop specific needs that will require both in and out of hospital care.

We have followed the reports on Out of Hospital provision, and Healthwatch has provided a number of sessions on this which we have attended. The extent of such services e.g. the virtual ward and Whole Systems Integrated Care is extremely limited. Small pilots, mainly involving the 'frail elderly', show promising results in terms of care for a small number of individuals. However, key question remain unanswered. For example, no prevalence data has been provided so that it is impossible to have any idea as to whether these out of hospital services will actually reduce the numbers of patients needing hospital care in a situation where there is population growth. Beyond the number game, nothing has been said about who will pay for these services as they develop. Will the cost go from the NHS to local borough provision which is NOT free at the point of delivery for all patients but is means tested? Further, local government finances have already been severely cut and are expected to be even more severely cut in the future. People need to know that their health needs will be provided for, as they have been, from NHS services. (It is worth noting here that the Whole Systems Integrated Care package is only available for a 6-week period – with no information on what happens to patients after that.)

One other core element of out of hospital care has to be the district nurse service. Yet this is another service that has been severely cut in recent years in Hammersmith and Fulham – the number of district nurses has be reduced by at least half in the last 10 years) and there is an ongoing failure to recruit district nurses.

GP services in the borough are under considerable strain – as individual GPs will admit to individual patients. We have pointed to the uneven distribution of GPs and GP surgeries elsewhere in this paper. What we have little information on, but which is

key to support for patients outside hospitals, is both the extent to which GP practices are becoming corporatised. We know, from a CCG report at a Healthwatch meeting in November '14, that one such 'corporatised' surgery has been a major cause for concern and that it has experienced a high turnover of GPs. (As this paper was finalised, it has been reported that this practice, the Cassidy Medical Centre, has been rated as 'inadequate' in a CQC inspection just published.) With GPs under pressure and a general shortage across London of GPs, we are concerned that patients will find it increasingly difficult to get appointments and to get continuity of care from their GP practice.

It has just been announced that there will be GP services available on weekends – 9.00am – 4.00pm. Whether this will relieve pressures on hospitals at weekends remains to be seen. However, we would note that of the 5 practices involved, three of these are in the wealthier south of the Borough, with only one in Hammersmith (Brook Green) and only one in the very much poorer north of the Borough at Parkview. This can only add to our concerns about imbalance of health provision across the Borough.

That SaHF and local Health Trusts are willing to push ahead with reorganisation plans while they can provide inadequate evidence for safe, effective and comprehensive out of hospital services which will indeed reduce hospital admissions is truly shocking.

9. Elective Surgery

Much has been made, in SaHF, by the CCG and by the Conservative Party (e.g. Greg Hands, in his most recent enews to his constituents, 18 Jan 2015) of the rebuild of Charing Cross to become a major elective surgery centre. Yet, as with other issues, repeated questioning has failed to provide information about just what elective procedures will be available at a new Charing Cross. Indeed, in Imperial's Clinical Strategy paper the elective provision seems largely to have moved to Central Middlesex Hospital (- with even more difficult travel problems) with Charing Cross mainly providing imaging, radiology and diagnostic services … not elective surgery! This is contrary to promises made after the Independent Review Panel reported and has not been consulted on. Imperial has not been able to clarify this for us, stating, as they do about what emergency services might be onsite, that they are awaiting guidance from NHS England. Indeed, members of the public are left completely in the dark about what services will be available where. SaHF is mysteriously quiet about this! In terms of cancer care, SaHF said outpatient cancer care would remain on the Charing Cross site but the position seems to have changed to one where radiotherapy might be at Hammersmith and outpatient chemotherapy at Charing Cross. The outpatient proposals are increasingly confusing but seem to increase fragmentation which, in turn, leads to poorer outcomes.

10. Medical Education

One of the consequences of the closure of A&Es and of Charing Cross as a major acute hospital, there is a potential significant loss in access for medical students to emergency and acute services – an irony at a time of shortages of emergency specialists. We understand from local medical students that students are already having difficulty in gaining access to the UCC at Central Middlesex (presumably

because this is not currently managed by the hospital) and are not allowed to work in the A&E at Northwick Park.

An additional concern is the training of GPs. Perhaps because Imperial promotes itself as a major research institution, there is a very small proportion of students who take up the option of training as a GP – apparently the 3rd lowest in the country.

10. CCG

In NW London, the CCGs have created an 'informal' consortium to cover some areas, particularly SaHF. For campaigners this creates yet another barrier to having our voice heard as there is no single body to whom we, or anyone else, can make representations.

The H&F CCG has proved unwilling to listen to and answer the issues raised by SOH and others with concerns at the SaHF proposals. Indeed, the local Healthwatch has become so concerned at the failures to provide evidence that the 'reconfiguration' will work that it has recently produced a position statement which 'recommends strongly that no further progress on either project (i.e. SaHF and the Imperial Clinical Strategy) until responses have been provided to the questions and concerns raised in our report' – concerns that reflect our own viz, patient and public engagement, out of hospital strategy, urgent care centre, paediatric services, impact of A&E closures on other services, the future of the A&E at Charing Cross, HASU, elective surgery and travel.

Two further points, unanswered by the CCG, need to be raised. The first is about the initial consultation and the ongoing statements about what will be at Charing Cross after reconfiguration. It is to be a 'local hospital'. BUT, even now, no one can tell us what a local hospital is or what provision we might find there! That is, we were consulted on something which SaHF did not understand and which is still entirely undefined! For Charing Cross the public has been told that there will be some sort of A&E in place yet they are still unable to tell the public what that service will be – and this is more than 2 years after SaHF. If they can't do so, how can the public trust them or believe that any proposals they make are honest? Is this about health care or money?

Finally, the CCG spent the funds it was awarded – Pioneer Funding – for developing out of hospital and integrated care services on a junket to the United States. At the recent CCG meeting (13 Jan '15) there was no report on this trip and the CCG has provided no evidence of how it might improve out of hospital and integrated care. An award of £110,000 seems to have been entirely spent looking at provision in the US, facilitated by a corporation, McKinsey, dedicated to selling public health services to the private sector. I include a copy of email correspondence on this issues (see Appendix C.) The Evening Standard reported (19 Dec '14) that, given the A&E 'crisis' at Northwick Park 'a taskforce of senior managers, medical staff and *consultants from McKinsey* ' (our emphasis) will focus on "decongesting" the A&E over the next three months'. Is this the sort of pay-back McKinsey received for 'facilitating' the junket? A worrying sign of the extent to which private corporations are being given space by CCGs to expand to meet a crisis created, not by a significant increase in patients at A&Es (5%) but by closures of A&Es, of other hospital beds, of cuts to social services provision and inadequate planning.

In summary, the CCG's failure to face up to issues raised by the public – in some cases repeatedly – and to provide any response to current major crises such as the CQC report into Imperial and the A&E/ambulance crisis, indicate a corporate blandness that denies the public both information about OUR health services and input to what is to be provided FOR the public.

11. Mental Health Issues and the West London Mental Health Trust

While mental health issues are not addressed in SaHF in any meaningful way, it has become clear during our campaigning that there are major concerns locally about mental health provision. Our own discussions with Imperial (see Appendix A, 4, and Appendix B, 1) have added to our concerns. A&E services are often used by people with mental health problems when faced with a crisis. Imperial themselves state that some 20-25% of people presenting to Charing Cross A&E have mental health issues. Yet there have been no discussions with the police about how these people can be appropriately cared for once SaHF has been implemented. Of greater concern is the statement by Imperial that WL Mental Health Trust has been 'reluctant' to talk with Imperial. We also understand, from the most recent CCG meeting (13th Jan '15) that the West London Mental Health Trust also refuses to engage with the CCG. Dr McGoldrick, the vice chair of the CCG, reported that the trust was the worst trust they deal with! - that any small moves forward over the last year have been negated by the absence of cooperation, citing as an example the failure to provide a recovery house for young people despite agreeing to act on this. And Healthwatch, in January 2015, has similarly reported that the WLMHT does not engage with them either

At the very least, SaHF can hardly claim to be a comprehensive health plan if there is no engagement with the mental health trust.

In summary, we hope we have provided the Independent Healthcare Commission with evidence to support our opposition to the so-called reconfiguration currently being implemented in NW London. While our focus has been on our local borough, Hammersmith and Fulham, the implications more widely across NW London are deeply concerning and ones we share with other campaign groups such as the Ealing campaign.

Merril Hammer
Chair, Save Our Hospitals: Hammersmith and Charing Cross
[redacted]
SOH, 7 Kimbell Gardens, London SW6 6QG

Appendix A. Report of meeting of SOH Officers with Imperial CEO and officers on Wed. 17th Sept 2014

Chair: Merril Hammer (Chair, SOH)

Other SOH members: Jim Grealy, Una Hodgkins, Anabela Hardwick, Mark Honigsbaum (Note: the latter 2 were brought in when other officers were unable to attend)

Imperial: Tracey Batten (CEO), Prof. Chris Harrison (Medical Director), Steve McManus (Chief Operating Officer and Dep. Chief Executive), Michelle Dixon (Director of Communication), Mick Fisher (Head of Public Affairs)

1. Merril introduced the session, pointing out the strong local opposition to the reorganisations, the poor initial consultation on the reconfiguration of hospital services; and the unexpected extent of the effects of the recently published Clinical Strategy. She noted that the very body that drew up Shaping a Healthier Future, NW London NHS, no longer exists and that the public had been left with a fragmented set of NHS bodies to try to communicate their concerns to.
2. **Why Charing Cross?** Merril asked a detailed question as to why Charing Cross, rather than any other hospital, was chosen for closure when Charing Cross is the only one of the Imperial hospitals to have estate entirely post-1964 and only 4% of the estate as 'non functionally suitable space' for health purposes etc. Imperial's response was that everything was based on SaHF which had always wanted 3 hospitals for Imperial, a major acute, a specialist and a local hospital and that St Mary's was always intended as the major acute hospital. Location and costings were raised and questions asked about how the (limited) options presented to the public for consultation were reached. Imperial responded that it was the NW London NHS then the local CCGs which had made the decision which was then endorsed by Imperial. Imperial did say, however, that they would look at the evidence used at the time and give us a more complete answer in writing.
3. **Urgent Care Centres and A&Es.** Una led on this item asking what the difference between and A&E and an UCC would be. She noted it was not clear what would be treated at a UCC beyond very minor injuries, what diagnostic facilities would be available, what specialists would be available to those presenting at a UCC. She presented a long list of conditions which A&Es currently dealt with but which could not be treated at a UCC. Imperial stated that there would be specially trained GPs on site 24/7 who might be Imperial staff but, if not, would be bank or agency staff who have worked for Imperial before and who will have had appropriate training. When asked about whether concentrating all A&E services in one place would improve treatment for a wide range of emergency conditions (such as appendicitis), Imperial basically ignored the question and answered by referring to concentrating cancer services in one place. When it was pointed out that most cancer cases are not admitted as A&E patients, there was still no answer as to how effectiveness might be improved by concentrating these services at one place.
4. **Specific Health Issues, including Mental Health.** Anabela raised questions about the moving of the HASU (hyper acute stroke unit) to St Mary's. It was explained that it had always been intended to move the HASU to St Mary's which is the major trauma centre for much of London. (It was noted that UCLH does not, in fact, have a major trauma centre.) Anabela asked about

whether there were any areas of NW London which would be more than 30 minutes away from a HASU in the catchment area. Imperial stated that trials had been undertaken at the time of SaHF. They promised to investigate ambulance times etc for stroke patients to check that the 30 minute target would not be breached and to get these figures to us. Imperial stated that modelling for a major event/accident in west London, including Heathrow, had been successfully trialled. We were reassured that dialysis patients would still be treated at Charing Cross and that specialist dialysis services would continue at Hammersmith Hospital. The gender identity surgery would be transferred to Hammersmith Hospital. On mental health issues, Imperial clarified that they did not have responsibility for mental health facilities although these are currently co-located in space the West London NHS Mental Health Trust rents from Imperial. These facilities will remain at Charing Cross under current planning.

5. **Transport.** Jim raised the question of planning for transport arising from the closure of A&Es at Hammersmith and Charing Cross. He asked about the difficulties faced by the frail elderly, parents with one or more children, people with disabilities and reduced mobility etc, having to use more complicated public transport routes to treatment at St Mary's and home from treatment afterwards. What additional transport would be laid on so that such patients would not be disadvantaged? He particularly asked about additional transport for the above groups of people who will have to go to Central Middlesex hospital for elective surgery. He pointed out the poor public transport links and asked what Imperial had planned for such people. The response was that no real planning had taken place on transport issues. Jim also asked whether Imperial had considered the possibility of increased pressure on ambulance services as more people would phone 999 for help. To cover increased demand following the Hammersmith A&E closure, two additional ambulances have been stationed, one at each of Hammersmith and Charing Cross hospitals. Additional ambulance costs would be a matter for the London Ambulance Service not Imperial. Overall, there is clearly an absence of serious planning for transport issues arising from the reorganisations.
6. **Out of Hospital Care**. Jim also led on this item. For SaHF, out of hospital care is supposed to reduce the stress on hospital beds and on inpatient treatment. Jim asked which facilities were in place and which were planned for out of hospital treatments and care. He asked Imperial to provide details of particular sites, recruitment and training of staff, and overall oversight. It was clear that little detailed planning has been undertaken. A small number of pilots are being carried out e.g. one pilot scheme for the over-75s, OPRAC (Older Persons Rapid Assessment Centre). Out of hospital services are essentially the responsibility of the CCG and so not directly a responsibility of Imperial once services move out of the hospitals. Imperial, however, intend to bid for some of these services but CCG may pick other providers. Final accountability and issues of who pays for what are issues that will need further clarification. Tracey Batten stressed that treatment will be 'free at the point of delivery' but we need to clarify whether this will continue to be the case if services go out into the community given that many services provided by Social Services are means tested etc. Jim stressed that the out of hospital care was in danger of further fragmenting our health services with possible dire consequences for patients.
7. **Finance and Privatisation.** At this stage, much of the discussion was curtailed as we were running out of time. Mark pointed out that Imperial already faces some considerable financial difficulties and asked why this was

the case. Imperial answered that they had had heavy losses in the early months of the year but had reduced losses last month. They were paying for unsatisfactory IT systems which had reduces the revenue stream, they were paying for the late closure of winter beds, paying heavily for reliance on agency staff, and had to pay for preparation for the CQC inspection. Mark queried the publicly quoted price for real estate at Charing Cross and St Mary's (£270m) which seems low for London real estate prices. Imperial said this was a conservative figure for their outline business plan and that they will be liaising with the Trust Development Authority. The £400m + extra needed for the rebuilding etc would have to be raised. According to Imperial this might be from a grant from the Treasury, a Treasury approved loan which might have a lower interest rate, or a loan at market rates. When asked how the debt might be serviced, we were told that Imperial would hope to do this by efficiency savings. We were unable, because of time, to pursue this point. Nor was there time to discuss privatisation.

8. Finally, Merril outlined one outstanding issue – our growing concern about how the transition and change process will be managed by Imperial and the absence of any published contingency plans if things go wrong. There was agreement that most issues needed more in depth discussion and that more answers were needed to the questions we had raised. Tracey Batten and her officers all asked that a further meeting – or meetings – take place to address these and any other issues we might want to raise.

Appendix B. Report of meeting of SOH Officers with Imperial CEO and officers on Fri. 28 Nov, 2014

Merril Hammer had prepared the agenda and chaired the meeting. The meeting was a continuation of meeting held on Sept. 17th 2014 where some agenda items had not been reached. Some new items were also raised.

The following issues were discussed:

1. **Mental Health at Charing Cross.**

Imperial pointed out they were not responsible for mental health. These services are the responsibility of Central and North West London Mental Health Trust.

They pointed out that 20-25% of people presenting at Charing Cross A&E have mental health issues. Some of these will be presenting with physical/medical problems. Imperial has not discussed the effects of the proposed closure of the A&E closure with the police in relation to people with mental health issues. Nor are they in ongoing talks with WL Mental Health Trust on the impact of A&E closure on mental health services. It was unclear whether this was because of a reluctance on the part of the mental health trust.

2. **Why Charing Cross?**

At the first meeting and in subsequent correspondence, this question had not been clarified adequately for SOH. We again pointed out that Charing Cross, according to the IRP report, was 95% suitable for health purposes and 100% 'young' according to their criteria, unlike the other Imperial hospitals. We also pointed out that *Hammersmith* Hospital had been discussed, in 2011, as the major hospital for Imperial. We also pointed out that the *evidence* for the proposed reconfiguration of Imperial was not given in the SaHF document. We asked what was the specific evidence that led to the downgrading of Charing Cross. Imperial have said they will try to get more detailed information to us.

3. **HASU and other A&E Services**

SOH queried the moving of a highly praised HASU to St Mary's, not least because of the 'doughnut effect' with the centralisation of HASUs (UCLH is less than 2 miles from St Mary's) and in inconsistency of claiming that a HASU and major trauma centre should be co-located as this does not also apply to UCLH which has a HASU but no major trauma centre.

We pointed out that they had not presented evidence that everybody in NW London to get to St Mary's in 30 minutes. Imperial said there was a report from 2008/9, which we have not seen, and we pointed out that that was some years ago. There have been population and traffic changes since then.

Imperial were unable to provide evidence that the majority of patients using an A&E (i.e. other than stroke and trauma patients) would receive improved treatment in the new configuration. For example, we stressed that for patients with anaphylaxis and acute asthma, speed of treatment is crucial. Imperial did say that there are staffing difficulties, in particular the recruitment of middle grade consultants and junior doctors because of increasing specialisation in medical

training. We pointed out that the same issues would apply to recruitment at St Mary's.

In terms of what emergency services might be at Charing Cross, Dr Batten said that they were still awaiting advice from NHS England. She did say this would go out to consultation (although we remain sceptical!).

4. **Financial Issues**

Imperial were unable to explain how they could service a debt of £400m with interest payments of at least £16m p.a. Efficiency savings were mentioned, but no new revenue streams were identified. They admitted this was a major concern. It was claimed that the revenue from the sale of Charing Cross land would be reinvested in the remaining Charing Cross site.

5. **Issues arising from Board meeting of 26 Nov.**

Closing of beds – Dr Batten says she knows of no beds that can be closed at the moment because 'Imperial hospitals are busy'. She said THAT BEDS WOULD NOT BE CLOSED UNTIL FACILITIES ARE AVAILABLE IN THE COMMUNITY. She agreed that she can be quoted on that. She agreed that Imperial will keep SOH informed of any changes that are happening in the hospitals that might concern the public e.g. bed losses, ward closures.

Dr Batten also said she'd get back to us about what was meant in board papers about identifying non-profitable services and beds that can be closed to save £0.5m.

She agreed when we pointed out that services in the community and social services budgets are being cut.

Dr Batten informed us that she would NOT be going on the CCG-funded tour of America, organised by McKinsey, and recognised that the community disapproved of this.

Dr Batten said that Imperial had not been negotiating with property developers, whatever Dr Spencer had been up to.

6. **Transition and Change**

Dr Batten acknowledged that transition and change is a complex process, even more so given the extent of the SaHF proposals. She said there was no definite 5-year deadline for completing the reorganisation programme. Imperial are very concerned at the A&E waiting time breaches and are looking at contingency plans. Much of the planning seems to depend on the Business Case, which has not yet been agreed and indeed, it is only the Outline Business Case which has been submitted.

She said there is and will be continual review of the process and that she and the Imperial Board would have to take responsibility for anything that went wrong.

7. Moratorium and Reconsultation

We clearly outlined the case for a moratorium and for reconsultation on new proposals and pointed out that the Council and Healthwatch, as well as SOH, support the need for a moratorium.

- The initial consultation on SaHF was badly executed, with many not consulted or knowing about the consultation and with closed options, the rationale for which having never been fully or adequately explained
- The proposals in Imperial's clinical strategy, despite claims by Imperial, do not match up with what we were told following the IRP which include:
- The continuing failure of Imperial, the CCGs or NHS England to tell people what a 'local hospital' actually is. That is, we were consulted on something which SaHF did not understand and which is still entirely undefined!
- For Charing Cross the public has been told that there will be some sort of A&E in place yet you are still unable to tell the public what that service will be – and this is more than 2 years after SaHF. If you can't do so, how can the public trust you or believe that any proposals you make are honest? Is this about health care or money?
- The promised out of hospital services are not in place; the trials are limited and provide no evidence that they will cope with need
- Who pays for out of hospital remains unclear? Social services budgets are being drastically cut and are means tested – hospital services are free. Are you passing costs on to patients?
- The A&E closures have led to major local failures
- The promised greater elective surgery and other electives at Charing Cross seem to have been reduced rather than increased since the IRP. The promise from Dr Spencer of urology services at Charing Cross doesn't seem to be in the plans. We need to be *consulted* on just what will be where. We need to know if people are going to have to travel to Central Midd for elective procedures – or to know just where they will be provided.
- Finally, where is the *evidence* that there will be sufficient *public beds* in the new set up.

When asked whether she supported a moratorium, Dr Batten said this was a question best addressed to the CCG when a new Chief Officer is in post with the CCG as well as with the Secretary of State for Health. She said she wouldn't oppose it, but it was not a matter for her or Imperial.

The meeting closed with agreement that we would not be meeting again for the foreseeable future but that we should keep open lines of communication.

Appendix C. Email communications between SOH chair and Daniel Elkeles about the CCG trip to US in Dec 2014

Dear Merrill

Thank you for your email, am sorry I wasn't able to reply on Friday.

The visit is part of the Whole System Integrated Care programme which is a partnership of 31 health and social care organisations in North West London.

The programme have listened to patient frustrations about difficulties in finding their way through the system and repeating their story multiple times. We want to improve that and provide the best possible care for the residents of NW London so the purpose of the visit is for clinicians in NWL to learn from others and be better informed to lead the improvements to care for our 2 million residents across North West London.

North West London was awarded Integrated Pioneer status last year and each national Pioneer site was given £110,000 by the Department of Health to advance integration in their area. North West London already has a very ambitious programme to improve integrated care which has been cited nationally and internationally. We wanted to learn how we can improve care further by visiting innovative integrated care systems and organisations and meeting one of the requirements of the funding which was to learn about international examples of integration.

It was therefore decided that representatives of our partner organisations, including patient representatives, would go on a study tour of America funded by the award I referred to above. The team will be visiting 9 sites over 5 days and each leader attending will be responsible for studying a different features and writing up what they learn to share within their organisations and across North West London to progress our own improvements in joining up health and social care.

The US was chosen as there are a number of organisations using innovative new care models and performance systems especially in relation to elderly care which is a key focus of the NW London early adopters. I appreciate your point about the US having a private healthcare system but the organisations we are visiting have been specifically chosen because they are providing publicly funded care for elderly people and people who cannot pay for care themselves through the Medicare and Medicaid programmes, where reimbursement levels are broadly similar to those in the NHS. This includes organisations providing care in complex urban areas with high poverty rates like the Bronx and Baltimore.

As Tracey said, and as I have confirmed, McKinsey are not funding the trip. McKinsey were chosen to support the logistics of the trip due to their experience in arrange similar trips within the NHS and for their contacts within the kind of organisations we were keen to visit.

As I mentioned earlier, the trip is being attended by senior representatives of our partner organisations which includes patient representatives, CCGs, Trusts and local authorities. The 22 people who went on the trip yesterday was made up of 2 of our lay partners, 2 Directors of Social Services, 2 psychiatrists, 7 GPs, 2 leaders from community health care providers, 2 clinicians involved in medical and nursing education and 5 managers from the whole systems integrated care programme.

Finally, you referred to an "enquiry" around the A&Es. Dr Spencer as you know is one of our Medical Directors and the review by NHSE is part of the normal course of regular reviews when a change to the system occurs. We are also having regular calls with the acute Trusts and LAS to ensure close monitoring of demand and capacity within A&Es and work together to improve performance.

Hope that this addresses your questions.

Daniel

Daniel Elkeles
Chief Officer
Central London, West London, Hammersmith & Fulham, Hounslow and Ealing CCGs

On 28 Nov 2014, at 15:11, Merril Hammer [redacted] wrote:

Dear Daniel,

Further to my comments of yesterday, Save Our Hospitals has, this morning, had a meeting with Tracey Batten and some of her senior officers. Because of the concerns raised at the Imperial Board meeting by the public at her announcement of her attendance on this study tour, we asked her about these plans. As you will now know, Dr Batten has, because of the concerns of the community - notably SOH campaigners at the meeting - rethought her position on this and decided not to take part in the study tour.

She also apologised for suggesting, at the Board meeting, that McKinsey were funding the tour. However, she did say that, although they are not funding the tour they are organising it. To some extent, this seems like wordplay. McKinsey are only engaged in this because they work help private companies make money from public health provision - something increasingly linked to current commissioning processes. Could you please clarify the role of McKinsey - and any other private corporations and providers - in this tour.

I understand that this 'junket' will cost the NHS £120,000. Can you please justify to me and to Save Our Hospitals campaigners, who can claim to represent a significant section of the local community, how this money can be spent on sending 23 (or is it now 22) NHS staff to America to look at a system, where provision depends on ability to pay and whose values are at variance with those of the NHS? And how can this expenditure be

justified at time when the closure of two small A&Es in NW London has caused huge failures in the system, with Dr Mark Spencer having to call for an enquiry to see what's gone wrong?

Could you also, as it is our NHS money, please inform us as to which NHS staff are taking part in this junket? While participants may be travelling economy class, this does not seem to us to be a necessary cost at the present juncture!

Yours sincerely,

Merril Hammer
Chair, Save Our Hospitals

From: Daniel Elkeles [mailto:Daniel.Elkeles@nw.london.nhs.uk]
Sent: 27 November 2014 18:37
To: Merril Hammer
Cc: Sarah Garrett (now Bellman); Philippa Jones
Subject: Re: Lilyville surgery

Dear Merril

Thank you for your email. I will ask H&F CCG to check all practices to see if they have any misleading information on any websites / newsletters.

With regard to the comments Tracey made at the Board meeting yesterday they are not quite accurate. This is the statement that we have issued today in response which I hope clarifies the position

"The purpose of the visit is for clinicians in NWL to learn about how they can improve care for their patients. They will all gain a better understanding of how others are approaching integrated care, share that with others and be better informed to lead the improvements to care for our 2 million residents across North West London.

"This is part of a national initiative, funded by the Department of Health, to help drive more joined up health and social care. In North West London we have listened to patient frustrations about difficulties in finding their way through the system and repeating their story multiple times. We want to improve that and provide the best possible care for the residents of NW London and beyond. We are therefore using our Pioneer funding to support our already ambitious programme and to learn from international examples of integration."

We have tried to keep costs as low as possible such as flying on a Saturday which is the cheapest day to fly and economy.

There are some amazing integrated care models in operation in the USA and we can learn lots from them to help us deliver the out of hospital care that we aspire to.

Daniel

Daniel Elkeles
Chief Officer
Central London, West London, Hammersmith & Fulham, Hounslow and Ealing CCGs

On 27 Nov 2014, at 14:48, Merril Hammer [redacted] wrote:

Dear Daniel Elkeles,

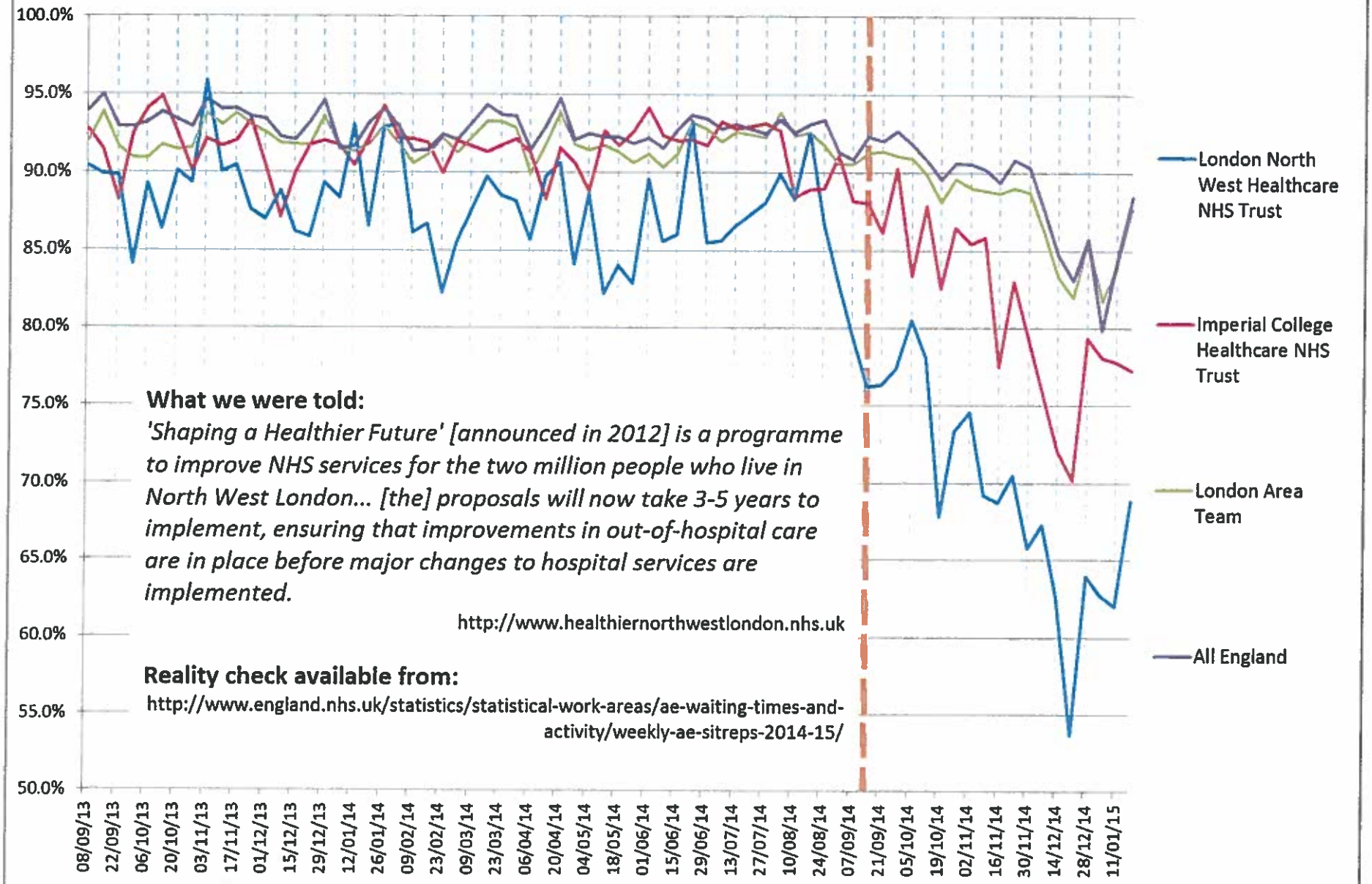
Thank you for responding to my message about the information on A&E services sent around by my GP. I understand from Imperial that they have promised to send a corrective email and to ensure their website carries corrected information. Although I have had an apologetic email from the surgery, I have yet to see the corrective email sent to recipients of the first one.

This issue is so serious - how can a surgery get this information wrong? - that I would, on behalf of Save Our Hospitals, like to know what further steps you are taking not only to correct this misinformation but to ensure that incorrect information is not being propagated by surgeries, GPs and other staff in GP practices. Could you please keep me informed.

Can I also take this opportunity to raise with you another issue which I heard about at the Imperial board meeting yesterday. I am deeply concerned, as were most of the public at the meeting, to learn that the CCG has arranged to send the CEO of Imperial and other NHS officials on a lengthy 'study tour' to America, funded by McKinsey, according to Dr Tracey Batten. Using the privatised, for profit, American system as the basis for looking at out of hospital provision is quite disturbing. That McKinsey should fund this is even more alarming - McKinsey is a company that works to help private corporations gain access to public health sectors and the prime interest is to increase profits from health provision.

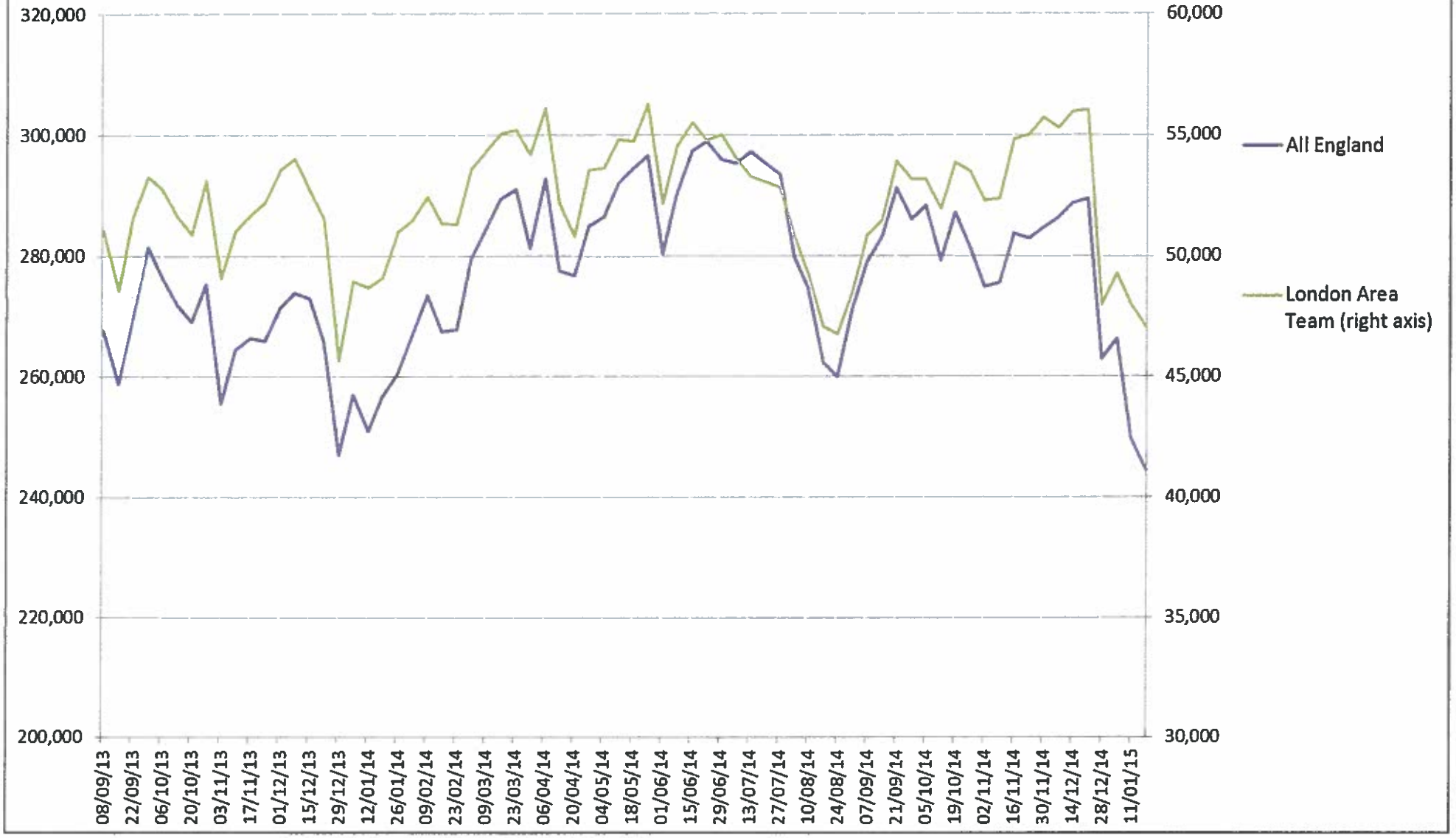
Merril Hammer

Percent of Patients at Type-1 A&Es waiting less than 4 Hours from arrival to admission, transfer or discharge, last 12 months



Type 1 A&E Visits per Week, NW London

Type 1 A&E Visits per Week, All England (left axis) and London (right axis)



BRENT Trade Union Council

375 Willesden High Road

NW10 2JR

President: Pete Firmin. Secretary: Roger Cox

Submission to the West London Health Inquiry

Concerning Brent

Over many years the Brent Trade Union Council has campaigned with other concerned organisations and the local trade union movement about the cuts to the local health service.Our colleagues in the health service unions warned us that the removal of services from Central Middlesex Hospital (CMH) would lead to the eventual closure of A & E.

Central Middlesex Hospital was rebuilt and extensively modernised at a cost of more than £62 million, reopening fully in 2008. This modernisation was funded in large part by PFI and was specifically designed for emergency medicine.

In spite of this, over the intervening years, many services have been moved from CMH to Northwick Park Hospital in a far more prosperous area. Services were transferred without consultation. There was no obligation to consult since the two hospitals were part of the same trust. Staff were often given only a few days' notice that they were required to transfer and eventually Central Middlesex was left without the back up services needed for its A & E to remain viable. So we have a situation where management moved the services, then used it as a justification for saying that A & E was no longer safe or effective as maintaining an A & E service is dependent on the full range of hospital services being available to patients. Yet, right up to the day of its closure the A & E department at CMH was still being sent patients from the overstretched departments at both Northwick Park and St Mary's.

Having moved so many services to Northwick Park and closed the A & E at Central Middlesex, the CCG is now responsible for a splendid modern building which they will have to pay for until the end of the PFI contract and the dilemma of how to make use of it.

Throughout these years, Primary care services have been severely overstretched and continue to be so despite the Shaping a Healthier Future organisation and the local CCG having a "vision" of improving those services by investing to prevent illness, lessen the need for hospital admissions and shorten the length of time patients need to spend in hospital. Of course the BTUC supports improvements in primary care, but promises were

made that these improvements would be in place before radical changes were made to hospital services. However, they remain, to quote the CCG's own documents, "visions" and "aspirations".

There is a crisis in recruitment of GPs, community nurses, health visitors and other staff needed to transform these visions and aspirations into reality, just as there is a crisis of recruitment for hospital staff and an expensive and destabilising reliance on agency staff. BTUC believes that the government's refusal to pay NHS staff even the 1% advised by their own pay review body and the housing crisis which is extreme in Brent, contribute to the recruitment crisis in the NHS, while cuts to the Council's budget threaten the provision of adequate social care, essential if patients' needs are to be met in the community.

The two Brent wards closest to the hospital, Stonebridge and Harlesden, are some of the most deprived in the Borough. The Locality Profile for Harlesden makes for grim reading. Harlesden is ranked in 30s for deprivation for England.

Despite having a young population 32% below the age of 20 years, in Harlesden ward, life expectancy is 13.4 years for men and 9.6 years for women *less* than the highest expectancy rate in Dudden Hill ward. It can be described by a tube train journey. If you take the train from Harlesden station and travel a few station north you will gain a decade in life expectancy.

Chronic Illness is significantly higher when compared to London and England figures, the biggest killers are Cancer, Circulatory and Respiratory diseases.

Mental illness affects one in six residents, TB is the second highest in the Borough and HIV is "considered to be very high" (Locality Profile).

Too many Children are found to be obese in their reception year when starting school and teenage pregnancies are also high.

We have only outlined a few items from the Brent Locality Profile for Harlesden Ward but we want to emphasise how completely unacceptable it is to close the A&E and other services in the middle of a population that so desperately needs a proper A&E and the important the general health services that go with it.

To compound this misery the facilities at Northwick Park which is the A&E that is suppose to replace the CMH facility, cannot cope with the extra load from the CMH and was rated as the worst A&E in the country.

The near impossibility of using public transport to go to Northwick Park. The difficulty of taking a sick child in the middle of the night to the A&E does not bear thinking about. Again the Harlesden and Stonebridge wards have the lowest levels of car ownership and minicab costs are prohibitive for those on low incomes.

Brent Trades Council also want to support and be associated with the submission from The Hammersmith and Charing Cross Save Our Hospital Campaigns.

On behalf of the Brent Trades Union Council please place our submission before Mr Mansfield.

Pete Firmin President

Roger Cox Secretary

Pete Firmin [redacted]

Roger Cox [redacted]

Smith Peter

From: Brent Fightback <brentunited@gmail.com>
Sent: 11 February 2015 14:40
To: Smith Peter
Subject: Submission to the NW London Healthcare commission from Brent Fightback
Attachments: Brent Fightback submission to Health Commission.pdf

Brent Fightback is an organisation set up by BrentTrades Union Council to campaign for public services and against privatisation, cuts and job losses. It aims to bring together service users and workers in our public services and to co operate with local trades unions.

Brent Fightback fully endorses the submission made by Brent Trades Union Council. We would wish our submission to be seen as complementary to it as it focuses on the damage likely to be done to the prospects for effective health care in the community to severe cuts being proposed to the services provided by Brent Council.

Our submission is pasted below and attached.
Pete Firmin (Chair)
Sarah Cox
Sujata Aurora
Martin Francis
Gaynor Lloyd
Anne Drinkell
and others on behalf of Brent Fightback

In addition to the points made in the BTUC submission which Brent Fightback endorses, we would like to add that effective out of hospital care, care in the community, cannot be provided if social care provided by the Council is slashed.

Brent Council's funding has been drastically cut and among their proposals to achieve a balanced budget are many cuts which will severely damage the quality of care available - in particular the reduction in time from 30 to 15 minutes for carers' visits which has been widely criticised by elderly peoples' charities as ineffective and dehumanising. Also the closure of the (ironically titled New Millenium Day Centre which caters for 80 plus people with complex mental and physical needs - the group SAHF proposals are supposed to focus on.

Also the withdrawal of any provision for rough sleepers who have a high level of unmet health needs and already a disproportionately high level of A&E attendances because they lack alternative means of care.

At the other end of their residents' lives, Brent Council proposes to close ten of its seventeen children's centres. As well as providing facilities for play and education, children's centres often host health services for under-fives including baby and child clinics and advice on health and diet for parents and their small children. Brent has a very poor record on child immunisation, dental

health, child mental health and obesity. If these facilities are lost, the NHS primary care services will be put under even more strain.

[redacted]

Peter Smith, Clerk to the Commission,
Hammersmith & Fulham Council.
Room 39,
Hammersmith Town Hall,
London W6 9JU

January 2015

To Peter Smith Clerk to the Commission and
Michael Mansfield QC Chair of the Commission

Inquiry Notes "Shaping a Healthier Future" **Judy Breens**

Evidence on Shaping a Healthier Future (SaHF) proposals NHS NWL

My Background
I have lived in Ealing since 1966
I was a teacher, then a Careers Adviser for Ealing, Hounslow and Richmond Boroughs
Later the service became Connexions and I was a Specialist Personal Adviser for Young People with Special Needs in Ealing.
I have worked in many schools in these boroughs, latterly in L B of Ealing Special Schools: St Ann's, Springhallow, Belvue and John Chilton Schools.
I retired in 2006. I am married and was a foster carer for over 10 years.

Health Service Experience.
I have used most North West London Hospitals at different times. I remember Ealing Hospital being built. I had Rheumatoid Arthritis over 20 years ago and have been excellently treated by Ealing Hospital so that the disease is under control and officially "non active". Our family GP (Dr Evans) is excellent. Our foster children always had excellent care. One had a "club foot" (sorry don't know the proper medical term!) that was successfully operated on in Ealing in the 90s.....Another is now married and her husband was operated on in Ealing for an appendectomy very recently. We, or the children must have attended A & E over the years many times. We've had no complaints. From my work with young people, some with multiple disabilities and health needs, I know how much Ealing citizens appreciate local services.
I have also attended Western Eye Hospital over years and received excellent treatment. This January (2015) I had a successful cataract operation.

Pre-Consultation Process and present situation
I heard about Shaping a Healthier Future and attended many meetings at Lords Cricket Ground and other venues. To start with, the idea that A & E should be in fewer hospitals with 24/7 full specialist cover was plausible. The proposals purported to be Doctor led. It also sounded reasonable that more services should be "in the community" until we asked what services and where? Then it appeared there was no clear answer. As time went on it became obvious that the whole exercise is for cost cutting and privatisation arising from the Health and Social Care Act. When the "preferred option" was unveiled we saw clearly how, if these plans go ahead, it was the hospitals in areas of deprivation that will be down graded (Charing Cross, Ealing/Southall, Central Middx) and that three boroughs of around 300,000 residents each would have no major hospital with A & E. Further, it was obvious that Ealing and Charing Cross hospitals could be "picked off" as they were fully paid for (rather than having PFI contracts) and stood on land that could be profitably sold for a lot of money.

Consultation
This was a most appalling process. Only those who are well educated and used to such

material could negotiate the large consultation documents on line or in paper form. Other language versions were few. It was therefore biased against less able and/or non-English speakers. Ealing is one of the most multi-ethnic boroughs and has the largest Sikh population in UK. Many were not aware the consultation existed. What was worse, there was no ent for the respondent's name and address so replies were open to fraud. The document shamelessly exploited nimbyism, setting one hospital against another. Many in Ealing refused to enter this game and "choose" hospitals because they wanted no closures.
They did not want other boroughs to lose their hospitals. Some hospitals had no such scruples and heavily promoted their cause. There was an issue of "cards " supporting one hospital being signed instead of the whole document and these were accepted and counted! In Ealing a very large Petition was presented, in a process similar process to these "cards" but they were not counted! Hard-to-reach groups missed out.
The claimed response to the Consultation of 17,022 was proved incorrect. Colin Stanfield was later told by Jeff Zitron of SAHF that the figure was 4,500. However, when the "votes" were added up the result favoured unsurprisingly the favoured option! The "rigged" consultation was complete!

Misrepresentation.
The plan was presented as losing A & E in some hospitals. Only if you read the document carefully did you realise that Ealing would be demolished, land sold off and a polyclinic with a few beds would replace it. Neither did the consultation document mention Clayponds Hospital. This is a much-loved provision. It is a purpose built single storey rehabiltation hospital in a quiet part of South Ealing with gardens and easy parking for visitors. An example of the "community settings" that were suggested I thought. We now learn that Clayponds too will be demolished, the land sold and the service relocated in the "new" Ealing hospital. So much for provision in the community!

Finance driven Cuts
Although SAHF presents the changes as improved care, it is obvious this reorganisation is driven by finance and is simply cuts in service. There was also eagerness to let the dying NWLNHS do the dirty work before the CCGs took over on April 1st 2013. Dr John Lister in "Under the Knife" 2012 exposes this. His research showed that 5,600 jobs in NW London would go by 2015 if the plan goes ahead. The "efficiency savings" are in reality a reduction in the availability of services. He concludes "There is not a shred of evidence that the plan will improve care or that the resulting level of services will be sufficient to meet the health needs in NW London or accessible to those ...communities that need them most." (P.27) The BMA said on August 8th 2013 responding to the £500,000 the Government pledge to improve A & E services "**With cuts of £20 billion** planned across the UK it's just "papering over the cracks".

How will Ealing cope?

- Getting to other hospitals A & E will result in longer journeys. This is possibly OK if you have a car (depending on parking) but public transport will lengthen journeys and raise the travel cost for others, particularly vulnerable groups (other respondents have explained this in detail)
- How will the ambulance service cope? Either to take more people further or to transfer them from Ealing Urgent Care Centre to "real" A & E as needed.
- How will the other A & E's cope? Two nearby were already closed in 2014. Northwick Park often diverts patients (to Ealing!) Rarely do you wait less than 2 hours in any A & E. Since SAHF was presented similar plans have been put in place across the UK. Now the media is full of stories of "overstretched" and understaffed A & E services nationally and rising death figures where A & Es have been How can it make sense to close more A &E services?
- Much is said about "unnecessary" A & E visits. This is a nonsense. Everyone goes to their GP as first port of call but out of Surgery hours they go to A & E. What is wrong with that? Should we call a Dr out from the "Out of Hours" service? How could that be more cost effective for the NHS.... even if the service was adequate. There have been grave concerns about this privatised service anyway.

- Community Settings. Where are these? One excellent one is planned for closure (Clayponds) Where are the plans, sites, funds, staff? Why is it cheaper to outsource services from an already functioning site to a new one?
- How will people know if they should go to the local Urgent Care Centre and not the "real" A & E? Ealing's UCC is currently backed up with A &E so this is no problem. Once A & E closes, moving on as necessary would take more time and trouble and the Ambulance Service would get extra work. How would that service cope? What if patients got worse or died in the process?
- Removing Ealing (327 beds) and Charing Cross (498 beds) as General Hospitals will result in a loss of 825 beds. All Paediatrics, Maternity, Surgery, Intensive Care would go. In a new Ealing Hospital 100 beds may be installed replacing Clayponds and for other (observation/care?) functions. But this loss of acute beds is astonishing. Hospital bed closures are proposed in other hospitals too. How will there be enough beds?
- How can we possibly get an equal service under SAHF, let alone a better one? In addition, Foundation Hospitals can have up to 50% private income and the freedom to do what they like. Is this the new NHS? If it is not available free on the NHS you can pay for it.
- The UK population is rising. NHS UK predict (Aug 8th) from the rising birth rate, that the 2010 figure of 62.26 million will rise to 71.39 million by 2030 The population of London is rising. In Ealing birth rates are rising. The approved 2026 Council Local Development Plan (LDF) mandates building 12,000 new homes, many on the "Uxbridge Road Corridor" ie on the 207 bus route to Ealing Hospital! This would house 25,000 new residents by 2026. On one "Gas Works" site in Southall (very near Ealing Hospital) 4,300 new homes are planned for 9,000 new residents. Surely we will need more facilities not less?
- Mental Health is another big concern. I am told there are 80,000+ mental patients in the Ealing borough. Cuts to the NHS NWL mental health spending will be £43 to £54 million by 2015. 450 fulltime posts at the West London Mental Health Trust (WLMHT) will be lost 2010 to 2013. Recently there has been talk of services withdrawn and patients to be covered by their GPs. But GPs are already over stretched. This is all incredibly alarming. None of this featured in SAHF. Why not?
- I am seriously concerned that SAHF recommends demolition of the excellent Western Eye Hospital building, land sold and a new unit built as part of St Mary's Paddington. Can this really be cost effective or sensible?
- The extraordinary thing is that in 2013 the media reported that in a world league table of Healthcare Performance by the Commonwealth Fund, UK was 2nd, after Netherlands (1st) and above Australia (3rd) and Germany (4th) We know the NHS is near the top of the world league table for cost efficiency. Yet we hear nothing but doom and gloom stories undermining the NHS in the press! We must applaud and improve our NHS not demolish it

Conclusion

Shaping A Healthier Future is a cruel deception. It simply seeks to cut services. Those of us who value the NHS and are also getting older (like me!) are becoming fearful. What on earth is happening to our beloved NHS? We realise there are money issues. Yet there are ways of raising money. Recovering tax avoided and if necessary putting up personal taxes for example. Also, how can privatisation save money when firms need to make a profit? Most of us realise the profit would come by cutting staff wages, terms and conditions, reducing the service and of course "cherry picking" the easy work leaving the expensive and difficult to the NHS. We need a co-ordinated publicly run and publicly funded National Health Service. We realise sometimes things need to change. But this is basically a programme of cuts. There is no assurance that it will work. Once Dr Mark Spencer told the Evening Standard that 200 would die if this plan was not implemented. Later he admitted this was an unsupported assumption by him. Why should we trust this person? This is a dangerous plan. It must be changed.

I am very concerned and frightened. If these cuts (along with so many more) go through my own future health would be threatened. The health of everyone in UK will be threatened. And our once great publicly run and publicly funded NHS will be wrecked. **Page 3 of 3** (1975 words)

[redacted]

Peter Smith, Clerk to the Commission,
Hammersmith & Fulham Council.
Room 39,
Hammersmith Town Hall,
London W6 9JU

January 2015

To Peter Smith Clerk to the Commission and
Michael Mansfield QC Chair of the Commission

Inquiry Notes "Shaping a Healthier Future" **Arthur Breens**

Evidence on Shaping a Healthier Future (SaHF) proposals NHS NWL

Background

- I attended 2 meetings at Lords, at Wembley, at the Hilton and at Central Hall Westminster to find out more about these SaHF proposals. We know now that similar schemes have been introduced in other parts of the country involving these hospitals:- Frenchay, Newark, Wickham, Lewisham and Chase Farm to mention just a few.
- I am a veteran of numerous consultations CPZ, Tram, Parks, Traffic and Police estate schemes.
- I am a critic of "tablets of stone" proposals and in good company. "Shaping Neighbourhoods" London Plan Foreword Boris Johnson 2013 "One Nation Labour" A voice for Everyone Ed Miliband 2013
- My experience is that schemes fail or cause major dispute when the public are not involved at the formative stage. The "Primrose Hill" CPZ decision gives guidance that the public should be involved at the formative stage.
- What was the brief guiding the management consultancy McKinsey? Was it to improve the health of the population of NWL? Or was it to reduce beds and service and make money by selling off sites for much needed housing
- At the first two meetings run by NHS NWL I listened and "went along" with the medical arguments. The presentations were by three medics and not by estate agents. At Wembley I sat next to a GP. He was incandescent. "They are closing hospitals in poor areas." For me that was the Damascus Road moment.

A flawed consultation

- Most people are and were unaware of the proposed changes. This indicates that the SaHF team set about this in a random, expensive and poorly planned way. The process was taken to JR but the judge accepted this chaos. We were not privy to the case or the proceedings.
- As a consultee one began to realise that this was not about medicine it was selling off hospital sites for housing

Problems with the plan

- Why were we not told about the closure of Clayponds Hospital at the beginning?
- There were documents about car journey times to hospitals but no comparison with times to present facilities and no mention of parking charges or availability at difficult to reach hospitals.
- Did NHS NWL ever engage with the LDF or Local Plan that in Ealing was designed to facilitate the building of thousands of new homes along the Uxbridge Road corridor. It is along and near to this corridor that NHS NWL wants to remove facilities. I sat in Ealing

LDF meetings and NHS NWL over the same period. The arrogance of both groups of planners was that they were not prepared to talk to each other while taking very different geographical views of their area its potential and its present and future needs

- The Uxbridge Road is one of the busiest bus routes in London. This is why Ken Livingstone chose it for the tram route. One Tube journey takes us to Charing Cross. Why is NHS NWL wanting to expand and retain hospitals that are difficult to get to and not on that major east west bus route? You wonder if McKinsey has a geographer on board or if his whizz-kids had ever tried the Tube system outside central London. Here the standard is stairs not lifts. If you are to concentrate hospital services in fewer sites then plans must be made to facilitate travel. My niece is a GP in Cumbria. She jokes about hospital performance and patient choice when she finds most of her patients chose the hospital where it is easiest and cheapest to park.

- In any consultation the public are asked to make a decision; in this case say to close Ealing Hospital. Some will want it some will not. I saw much evidence of protest and lobbying to keep it and Charing Cross open and no evidence at all of pressure groups wanting to close it to improve health care. Dr Mark Spencer and his small medical team (paid) supported these proposals. And now the Ealing CCG (paid) seem to have adopted them unquestioning. Where is the public lobby and the Medical lobby supporting these changes?

- In Aug 2013 Jeremy Hunt announced £500million extra to be spent on A&E because of fears during the winter period but in this area we are discussing A&E closures. Now we are in the winter of 2014/15 and we are in the same A&E crisis in. Meanwhile the BMA are talking cuts of £20billion to the NHS. Is that where the Estate Sell-off comes in.
- These plans are the final solution. There is no reconsidering them by Ealing CCG. There are no plans to mothball hospital sites to reopen them if the population rises rapidly. There is no humility, no doubt. No way for the public to question McKinsey, the shoot and run consultants.
- The title "Shaping a Healthier Future" is fraudulent. It should be "Estate sell off to fund £20 billion cuts" . We've been lied to as well. We were told that there would be no changes to hospital provision unless the alternative "care in the community" was in place. That has not happened. I noted that the SaHF team at the few round table discussions we had seemed unable to explain how "care in the community" would greatly affect hospital admissions.

- If these proposals are valid then it would be dangerous to complete them without large contingency funds and an enormous expansion of "care in the community" These changes are being introduced with shrinking funds and shrinking care provision and as such they are destined to fail to shape my healthier future.

- Now there is in NWL a crisis in A&E provision that is to do with a crisis in GP service, loss of two A&E units and shortage of beds. McKinsey proposals are to reduce beds in NWL by 600. We have a baby boom and McKinsey proposals are to close our Local Maternity hospital.

Arthur Breens BA Hons Keele Biology and Geography 1965–69
I am happy to speak if asked.
Other references:

"The Case for Hospital Reconfiguration- Not Proven" Byrne and Ruane Mar 2007
"The Sham of NHS Consultation on Service Provision" Boyle and Steer 2008?
"Ealing Local Plan" Planning Policy Team LBE contact Steve Barton LBE

Smith Peter

From: RHering [redacted]
Sent: 17 February 2015 07:26
To: Smith Peter
Subject: NHS enquiry. Ealing hospital's future.

P Smith Esq.

FAO M Mansfield Esq. QC

Dear Mr Mansfield,

So much already written. Hard to add more.

I speak as an Ealing hospital patient. Being 6 monthly monitored for 6 ailments. Have been an inpatient 4 times in last 3 years. Last inpatient visit April 2014. Access all via A&E and transported by ambulance. There were no delays as regards target timescales in the ward; and no remarkable delays to the care ward. Overall I was satisfied.

RECENT KING'S FUND REPORT
The evaluation by the King's Fund think tank says the coalition government's changes had wasted three years, failed patients, caused financial distress and left a strategic vacuum.

As regards "failed" that is particularly in regard to all the A&Es in W. London. "Failed" because there are now not enough of them; and what remains cannot now deliver- or only at a slow pace which is beneath what is acceptable.

Unpopular for some and hard on reputations, but it would seem most appropriate now that the Ealing A&E service should be enlarged and expanded; and certainly not reduced to urgent care status.

GEOGRAPHIC PROXIMITY
All my issues needed consultant experience. But for the presence of a consultant last time I understand I might have died in a few hours through considerable blood loss. When I purchased my home decades ago (in perfect health) a factor was to live near a hospital. I see Ealing hospital from my garden.

IMPACT OF CLOSURE
It would be a disaster to cut back the A&E services. Both locally and nationally the country is just not ready for it. The waiting times in West London have gone up significantly. The very senior local NHS management are incompetent in that they have not provided extra facilities either on time, nor enough of them in remaining local A&E services. Northwick is an example! In particular this is a hospital which had not been made ready before other A&Es had been closed. That is a matter of deep shame and scandal. I could not possibly support the closure of a single further A&E until new facilities are in place to meet documented increased numbers of patients. That would be many years off based on past performance and would need a new consultation. It would be a nonsense to believe "we have learnt by our mistakes". It is now proved beyond doubt that a different strategy has to be adopted. One that is easier for mortals to handle. One that is balanced, serves the people, and is as measured as it is mature.

GREED VERSUS ENGLISHMEN

It is incredibly difficult to believe those who argue in favour of closure - because so much seems driven by finance and politics. I've yet to meet a doctor, nurse, ambulance driver (all with whom I chat) who supports reducing Ealing's A&E. Those categories and people are enough to tell even a nincompoop that the present plan is wrong. The whole idea of our care system is that it has always been seen as service to which capitalism and self interest have to be subordinated. Providing for the common good and for the poorer sick is one of the key identifiers of what it is to be English - i.e. being fair minded. It would be astonishing if this precept does not run deeply through the process of your investigation and decision making. The qualifications of you very well educated three leading investigators familiarise you in particular with dignity and humanity; and if you are good leaders, then also with high morals. The finances must, in your reports, be seen to play second fiddle to these masters. With a million NHS employees please don't conclude that there are insufficient resources to improve NHS management very significantly.

SPECIALISATION IN TWO OR MORE SUPER HOSPITALS DISADVANTAGES PATIENTS WITH MULTIPLE HEALTH ISSUES.

So while I accept the theory that a phalanx of liver specialist consultants housed in one location is seductive, not a soul knows how this ideology this will work long term. As money gets tighter will staff numbers be reduced? Will senior consultants lull themselves into thinking the departmental expertise has become good enough, thereby tempting them to do even more private work; and thus putting more pressure on remaining less experienced consultants? I believe barriers should be established to guarantee against or make it harder for the authorities to extend super hospitals at the expense of continuing closures. We know from the last three years that the NHS is too powerful and isolated from the public to pay regard to our wishes. The local CCG has refused to engage with the public except at bare minimum level: this is completely ineffective. Will politicians, as they already are trying to do, allow a GP to graduate to consultancy status in less than 10 years. A defective liver can affect the functionality of so many other organs. If these are being treated by a specialist in another hospital then the two consultants need to discuss the patient's health strategy. Near impossible if A&E closures lead to separately located super centres of specialism. All know that the computer systems with patient records are disastrous when two hospitals need to know about a patient. It is worth checking whether the completely paranoid policy that the NHS have over electronic data transmission will add to delays in patient care when more than one hospital or GP is involved. Even the legal profession is not that stupid over the electronic exchange of sensitive information. There are of course other ways of training experienced practitioners to higher standards. As professionals you know what they are. Also I expect a group of different specialists to be housed under one roof, because they keep and develop some of their general medical knowledge. As with lawyers, specialisation has become so great in our lifetime that it is nigh impossible to treat patients with multiple issues unless we have more hospitals with super standard specialists trained in a variety of fields. Holistic treatment continues to recede which puts more pressure on a sick patient in managing his health and also upon the GP who is becoming remoter and even more so.

INFRASTRUCTURE SUPPORT MISSING

TFL have refused to lay on new bus routes because there is insufficient demand to make such services sustainable. HOD Transport Department Ealing Council can advise. The impact on people having to struggle to more distant hospitals is positively appalling. Especially when accounting for extensive deprivation in many areas. Savings made from closures need to be ploughed back into additional transport, by a grant perhaps.

The risks attendant with ambulance patients being in ambulances for longer on the way to more distant A&E units makes it the default position that a fully qualified doctor must be on the vehicle for serious emergencies. He can also do some triage work to speed up the process in hospital. Ambulance crews should also be trained to do more triage work. Fascinating to listen to the barriers faced by bed allocation managers.

A&E DELAYS

It suits some politicians and NHS England chiefs to say that bad weather has contributed much to delays in target times. Reference to the Met Office will show this is nonsense in London 2014; particularly as the targets were not being met already in the warm Autumn.

WITHOUT LONG TERM PLANNING
WORDS AND FIGURES WILL NOT AGREE.
None of the investigations have satisfied anyone that the forecast rapid population expansion will have enough hospitals to meet demand. It is complete madness and utterly irrational to redevelop old hospital sites for housing - leaving no space in twenty five years time for new hospitals. Births in London are nearly 3 times deaths. We read that perhaps 30% of people could live to 100+. Where on earth will they be hospitalised? I suggest you have no option but to place much more emphasis on long term planning. That also includes making provision now for the rapid forecast population increase and the average age which everyone knows is rising.

CARE PROVIDED THROUGH THE COUNCIL
Almost impossible to avoid the politics. Personal care is available from most Councils generally only if one meets the highest category of need. The Councils do not appear to publish waiting lists but anecdotally the delays are quite unacceptable. When I used to apply for care for clients a mere decade ago the expectation was that the client would get a Freudian hour of help at home. Not a mere smear 15 minutes. Do you really know how long it takes for an old person to answer the front door and then get undressed, be washed and re-dressed. Put your arm in a sling and try it out yourself. Despite your education, respectfully, you need practical experience and not imagination. Try, and be surprised. And just as the carer is leaving what about at tin or jam jar lid which at nearly 70 I, enraged, can barely open. It's the difference between supper or a desolate serving of dried toast. The cut backs in care are shameful and demonstrate a deep lack of understanding concerning vulnerability.

Councils will play politics with and prioritise, or not, money for Social Services. The government has said there are further massive cuts coming in the next term. If we close more A&Es in West London the remainder will fall into becoming a major special measures incident for years, due partly to a shortage of carers. If all the care services were statutory or driven by the DOH we would all have clarity. We don't. Councils do their own thing. With imagination, even bye laws could/should be made to be useful. Ergo no more A&E closures or reduced A&E services are appropriate.

AMBULANCES WILL TRAVEL LONGER BEFORE REACHING A&E.
The perceived bed blocking is impacting inter alia on the ambulance service. In 2012 I waited in the middle of the night nearly two hours to get into Ealing. The ambulance station is 8 minutes walk from my home. I truly was screaming and shouting in pain. I am sure the wait is more commonplace now. The queues of ambulances on the A&E approach are commonly nowadays alarmingly long. The common good in one of the most civilised and richest countries demands that patients are not treated this way. To close further A&E's is the same as saying that the state will try to rescue you from dying if it gets to you and then onto hospital in time - and also provided there are not too many other patients in the A&E ward who are dying; otherwise you can lie in pain till we collect you - or worse.

CHANGE OF CIRCUMSTANCES
A new factor is the risk from terrorism which was at a lower level earlier in the life of this Parliament. Surely the higher risk is reason enough to revise previous decisions and retain a greater number of spread out A&E departments in W London. Another changed factor - the government expected to reduce immigration. It did not. So a greater number of dwellers in W London need more A&E beds. Your stats will illustrate if the delays have changed for the worse in just the last 24 months.
We have just received latest GLA forecast population figures. These should now underpin more strongly the argument to keep Ealing as it is and build its resources gradually up to 2039.

The volume of A&E beds and facilities presumably is calculated to cope with the most demanding period of the year, i.e. winter. Surely the claim that the flu vaccination this winter is just 3% effective (because the virus has mutated so extensively) is a WAKE up call telling you that we just cannot afford to risk the lives of so many people in the face of viruses whose properties cannot be predicted. What has happened with this year's flu virus is reported as being unusual. Was the average of normal demand the only figure which was

used to decide closing so many A&E units? If so then that would be another change in circumstance, i.e. the risk norm would need to be increased to match our new and more realistic understanding about virus behaviours.

MAJOR EMERGENCY IN EALING

The major emergency planning is utterly inept in Ealing Council. With the bad crowding in the W London hospitals a major event would be unsustainable with fewer Hospitals. I consider this has to be factored in - and to include a contingency to meet an unexpected and sudden demand for medical care. A plane crash, a more extensive failure of antibiotics protection, noxious chemicals, a plague, terrorism.

UNDERMINING EALING HOSPITAL

http://www.bbc.co.uk/news/health-25055444

Shows Ealing hospitals' A&E figures are getting worse. I know from my outpatient visits that staff are already being moved to Northwick. This is jumping the gun before we know the future of Ealing Hospital. In my opinion the drift is down to appalling and inequitable management. It completely ignores the fact that many in Ealing will use WestMid hospital which is so much more convenient, closer and accessible and has a much better reputation. So I want to see a stop to this drift until final decisions are made. Jumping the gun is forcing an unwanted change on huge numbers of Ealing residents without their consent and against their wishes. It is a sneaky device to making Ealing hospitals' figures and care standards and reputation look worse than they should be.

It may well be appropriate to satisfy the enquiry that the local CCG is also not in league with the plan to accelerate the demise of Ealing Hospital by unfairly diverting services and goods to other locations; that is when no reasonable person would have done that at this stage of the process. Perhaps a review of the CEOs diaries would be helpful in understanding more about current changes of processes and attitude.

We live in one of the richest countries in the world and we are blessed with the benefits of advances in medical science. That will continue.

If we have wait an extra few years in a life span of 200 years, (our parents, spouses and siblings, children and their children), before the deficit is sorted out, then wait we must.

When a government says I can no longer have what is almost a staple of life which I have enjoyed up to now, it almost seems as if they are perpetrating a vile personal abuse.

It is up to you - please - to stop that.

Thank you.

With respect,

Richard Hering
W7

RH