Shaping a healthier future
Decision making business case

Executive Summary
1. Executive Summary

Introduction to NHS NW London

The *Shaping a healthier future* programme concerns the health services provided in NW London. Most of these services are currently commissioned by a cluster of eight primary care trusts (PCTs): Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington & Chelsea, and Westminster.

From 1 April 2013, these PCTs will be abolished and many of their responsibilities will be taken on by the eight Clinical Commissioning Groups (CCGs) in NW London, which are led by local GPs. These CCGs played a leading role in the development of the *Shaping a healthier future* proposals and their structure can be seen below.

The majority of patient care in the NHS takes place outside hospitals. Within NW London there are estimated to be over 11 million visits to GP surgeries each year along with almost three million visits to other community settings to receive other types of care. NW London has four community health providers, two mental health trusts, and nine acute and specialist trusts. There are also a number of hospices, rehabilitation centres, residential care homes, and nursing homes.
A wide range of services are provided at the hospital sites in NW London. This number of sites is high relative to the size of the population and geographical area of NW London, and the majority of the acute hospital sites (excluding the specialist trusts) provide a very similar range of services.

**Introduction to Shaping a healthier future and the purpose of this document**

The *Shaping a healthier future* programme was established in November 2011 and builds on significant work previously carried out in NW London by a series of Clinical Working Groups (CWGs) to develop suitable models for clinical services.

The programme is based upon four core principles which are underpinned by the Secretary of State’s four tests for reconfigurations. The principles are that the programme should be

- Clinically led and supported by GP commissioners
- Informed by engagement with the public, patients and local authorities
- Incorporate a robust and transparent process underpinned by a sound clinical evidence base
- Consistent with current and prospective patient choice

The decision-making body for the programme is the Joint Committee of Primary Care Trusts (JCPCT) which comprises the eight PCTs in NW London plus representatives from PCTs in neighbouring boroughs potentially most affected by the changes in NW London – Camden, Richmond, and Wandsworth.
We have worked extensively with clinicians, members of the public, patients and other stakeholders on proposals to transform the health system in NW London and identify recommendations.

**The Case for Change**

The NHS in NW London is facing a number of pressures and challenges. There is increased demand caused by the ageing population and increased prevalence of long term conditions and co-morbidities, for example:

- The population of NW London has risen to 2 million
- Life expectancy is now 80 years for men and 84.5 years for women. This is an increase from 76.8 years for men and 81.9 years for women a decade ago
- Some 300,000 in NW London - nearly one in six - people of all ages - have one of the following five long-term conditions: diabetes, asthma, coronary heart disease (CHD), chronic obstructive pulmonary disease (COPD), and cystic fibrosis disease (CFD).

There are also unacceptable variations in the quality of care provided, evidenced by higher mortality rates for patients who are admitted in hospital at night or during the weekend. However key services in London, such as stroke and major trauma care have been centralised and this has improved patient outcomes. We need to do more to prevent ill health in the first place and improve satisfaction with, and access to, GP and community care.

Doing nothing is not an option. If nothing is done:

- Inequalities would continue and probably get worse
- People would continue to die unnecessarily
- Our dependency on hospital services would continue when this is not the best use of resources
- Existing hospital trusts would be under severe financial pressure.

**Process for identifying a recommendation**

To develop proposals to address the case for change, the programme used a clinically-led, seven-stage process to identify a recommendation for the reconfiguration of healthcare services in NW London. This process was developed with stakeholders. The seven stages are summarised below:
The process was used before consultation in order to identify options to consult on. During consultation, feedback was received about the process and this was used to re-evaluate it. In response to the consultation, 60% agreed that the process we used to decide which hospitals to recommend as major hospitals was the right way to choose between the various possibilities and decide which options to recommend; 28% disagreed. The remaining 11% of people either had ‘no views either way’ or responded ‘not sure/don’t know.

**Consultation, feedback and how we responded**

On 2 July 2012, NHS NW London launched a public consultation on the plans for reconfiguration of services. The consultation covered the proposed clinical standards, clinical service delivery models and three potential options (referred to as A, B and C) for the location of services as well as services outside hospitals. The consultation period ran for 14 weeks and ended on 8 October 2012.

During the consultation, the programme:

- Attended over 200 meetings and met over 5,000 people through road shows, hospital site events, engagement with traditionally ‘hard to reach’ groups and other events such as public debates
- Printed around 100,000 full consultation documents and response forms in ten languages
- Distributed over 555,000 summary leaflets in public buildings and newspapers in NW London
- Recorded over 16,000 visits to our website.
- Produced a wide range of materials which were available at events, on our website and on request through phone, email and letters.

A total of 17,022 responses were received to the consultation in a variety of formats as set out in the table below.

<table>
<thead>
<tr>
<th>Method</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Paper response forms</td>
<td>5,045</td>
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<tr>
<td>Online response forms</td>
<td>11,725</td>
</tr>
<tr>
<td>Written comments (letters and emails)</td>
<td>148</td>
</tr>
<tr>
<td>Voicemails</td>
<td>12</td>
</tr>
<tr>
<td>Stakeholder responses</td>
<td>74</td>
</tr>
<tr>
<td>Petitions</td>
<td>18</td>
</tr>
<tr>
<td><strong>TOTAL RESPONSES</strong></td>
<td><strong>17,022</strong></td>
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Ipsos MORI conducted an independent analysis of the responses. A number of themes emerged from the feedback. These included:

- The impact of the proposals on accessing services (journey times and public transport accessibility)
- Some respondents expressed opposition to some or any services closing
- The capacity and ability of hospital and out-of-hospital services to meet demand and support change
- Some respondents criticised the consultation process itself.

These themes were echoed in the feedback received at road shows, hospital site events, GP events and focus groups held during the consultation period.
The Consultation Institute undertook a review of the consultation process and the way that patients, the public and other key stakeholders were engaged. This review was in two parts, the first of which asked for further assurance of a number of factors which we subsequently provided. Following this, the Consultation Institute awarded their compliance certificate and confirmed that the programme had undertaken a satisfactory consultation.

Clinical vision, standards and service models

Three overarching principles form NHS NW London’s vision for care. They are that health services need to be:

- Localised where possible
- Centralised where necessary
- In all settings, care should be integrated across health, social care and local authority providers to improve seamless patient care.

The eight NW London CCGs have agreed a vision to transform out-of-hospital care which will centre on the patient and ensure people receive the right care, in the right place, at the right time. In order to deliver this vision, the CCGs agreed a set of standards covering four areas:

1. Individual empowerment and self-care
2. Access, convenience and responsiveness
3. Care planning and multi-disciplinary care delivery
4. Information and communications.

At the same time, local clinicians supported by patients and their representatives, the public, commissioners and providers have developed visions for emergency and urgent care, maternity and paediatrics. These include patients having quick access to high quality care, regardless of the time or day of the week, and expectant mothers having the choice to deliver their baby at home if appropriate, or with immediate access to supporting services if needed.

To drive the improvements in clinical quality, clinicians developed a set of clinical standards. The work by London Health Programmes to determine the London Quality Standards has been a key driver in developing the standards and we also took into account the latest evidence from Royal Colleges and NICE guidelines.

During consultation, the programme received feedback about the proposed standards for care and responded by updating the acute standards to ensure that 24/7 consultant cover was available in all maternity units and further developing the specification for Urgent Care Centres (UCCs).

Clinicians in NW London have proposed eight settings of care where the vision for in-hospital and out-of-hospital care will be delivered.
Three Clinical Implementation Groups (CIGs) were established in NW London to ensure that the proposals for acute care were sound and included appropriate input from clinicians and patients.

**Out of hospital improvements across NW London**

Pressure on health and care services is increasing, and care closer to home is needed to improve outcomes, with improved prevention, early intervention and increased coordination and integration across services. The eight Clinical Commission Groups (CCGs) in NW London have agreed their plans to transform out of hospital services, setting out the vision for how more care will be delivered at home, at GP practices, in community health centres and at local hospitals.

The new model of care will put the GP practice at the centre, coordinating care, providing routine services and holding accountability for overall patient health.

During the consultation we asked questions about the out-of-hospital proposals. From the responses, quality standards for care outside of hospital were supported by 67% of people who answered the question, whilst 12% were opposed. 43% supported, while 25% opposed the delivery of hospital services locally. Qualitative feedback received from stakeholders also
included comments on out-of-hospital proposals and many people requested more detail on
the plans.

Since consultation, further work has been undertaken and more detail is now available in the
following areas:

- Primary care development
- Impact of out-of-hospital services on carers
- Workforce plans including detail of the additional staff required to deliver these
  services
- Out-of-hospital estate – GP practices and GP ‘hubs’
- UCCs
- Standards of out of hospital care
- Delivering out of hospital services

Feedback from consultation emphasised the need for a consistent UCC specification across
NW London. In response, the Emergency and Urgent Care CIG conducted a significant
programme of stakeholder engagement and considered evidence from a broad range of
sources. This group then made a number of recommendations which have enabled the
programme to outline the key features of a UCC, shown below.

If the recommendations are agreed, nine urgent care centres, all operating 24 hours a day, 7
days a week to consistent standards, will be provided across NW London located at all
proposed major and local hospital sites.

**Decision making analysis**

We used the seven-stage process described earlier to identify options for consultation. The
feedback received during consultation was considered and new analysis was undertaken
based on this feedback (including re-appraisals of the latest evidence, activity and financial
data). The analysis for each stage is defined below.
Stage 1 – Case for Change

Our work before, during and after consultation enabled us to conclude that:

- A robust platform exists for service change
- Improvements and clinical benefits could be delivered by changes
- ‘Doing nothing’ is not an option.

Stage 2 – Vision

Our work before, during and after consultation enabled us to conclude that the vision created by local clinicians for *Shaping a healthier future* will deliver the required improvements and clinical benefits.

Stage 3 – Clinical standards

Our work before, during and after consultation, particularly with the CIGs, confirmed that the clinical standards are based on the latest evidence and clinical thinking, in particular LHP’s London Quality Standards. It also established that if the standards are achieved they will contribute to the improvements outlined in the Case for Change.

Stage 4 – Service models

Our work before, during and after consultation, particularly with the CIGs, confirmed the service models reflect the latest clinical thinking, in particular LHP’s London Quality Standards, and reflect relevant feedback received during consultation. It also established that if the service models are implemented they will contribute to the improvements outlined in the Case for Change.

Stage 5 – Hurdle criteria

The purpose of this stage was to use seven hurdle criteria, developed by clinicians, to establish the right number of major hospitals in the options. Within this stage, there were seven hurdles:

1. The correct care setting model to deliver high quality care
2. Consider the nine existing major hospital sites only and not new locations
3. There should be enough major hospitals to support the population of NW London
4. The number of major hospitals must be viable in the medium term
5. Ensure a good geographical spread of major hospitals across NW London
6. Use sites currently delivering high quality major hospital services
7. Geographic distribution of the remaining sites is proposed to minimise the impact of changes on local residents

The millions of options for the configuration of major hospitals were considered against the hurdle criteria. This enabled us to determine that five major hospitals were needed to balance access with meeting the clinical standards. To ensure a good geographic
distribution of major hospitals across NW London and minimise the impact of changes on local residents, we concluded that:

- For all options, a major hospital should be located at Hillingdon and Northwick Park
- For all options, Central Middlesex should be a local hospital and an elective hospital
- The remaining options should compare the remaining sites in pairs:
  - Either Charing Cross or Chelsea & Westminster
  - Either Ealing or West Middlesex
  - Either Hammersmith or St Mary’s.

This produced a list of eight configuration options, shown below, which we analysed in more detail. Note that Options 5, 6 and 7 were renamed as Options A, B and C for public consultation.

![Configuration options table]

**Stage 6 – Evaluation criteria**

The purpose of the sixth stage was to test in detail the eight options using evaluation criteria agreed by clinicians and the public. We reviewed the feedback from consultation about the evaluation criteria and concluded we should use the same set before and after consultation as shown below:

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Sub-criteria</th>
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<tbody>
<tr>
<td>1. Quality of care</td>
<td>- Clinical quality</td>
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<td></td>
<td>- Patient experience</td>
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<tr>
<td>2. Access to care</td>
<td>- Distance and time to access services</td>
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<td></td>
<td>- Patient choice</td>
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<td>3. Value for money</td>
<td>- Capital cost to system</td>
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<td></td>
<td>- Transition costs</td>
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<td>- Viable Trusts and sites</td>
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<td>- Surplus for acute sector</td>
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<td></td>
<td>- Net Present Value</td>
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<td>4. Deliverability</td>
<td>- Workforce</td>
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<td></td>
<td>- Expected time to deliver</td>
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<td>- Co-dependencies with other strategies</td>
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<tr>
<td>5. Research and Education</td>
<td>- Disruption</td>
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<td></td>
<td>- Support current and developing research and education delivery</td>
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For Quality of care, clinicians have been clear since the start of *Shaping a healthier future* that clinical quality is at the heart of the programme and that it is the driving force behind all the proposals and recommendations. Clinicians agreed that all the eight options under consideration had been designed to achieve the highest levels of clinical quality and that the additional data reviewed at this stage of the evaluation did not provide information that allowed them to differentiate between options on this basis. For the patient experience element, we analysed patient experience data and the quality of the estate. This identified that Options 1 and 5 were stronger and Options 4 and 8 were weaker against this sub-criterion. These evaluations were reviewed post consultation with no change to the results of the evaluation.

For Access to care, we analysed the distance and time to access services based on blue light, off-peak car, peak car and public transport travel times. The analysis showed that that any impact on travel times as a result of the proposed options would be clinically acceptable and that changes in travel times across all options were so similar it did not enable any differentiation between the options so all options are evaluated identically. For patient choice, we considered the reduction in the number of sites delivering emergency care, obstetrics, elective care, outpatients and diagnostics as well as the number of trusts with major hospital sites. This identified that Options 5 and 7 were stronger and Options 2 and 4 were weaker against this sub-criterion. These evaluations were reviewed post consultation with no change to the results of the evaluation.

The Finance and Business Planning (F&BP) group was tasked with overseeing the evaluation of the Value for Money criterion. This covered activity, capacity, estates and finance analyses, including commissioner forecasts, Trust forecasts, the out of hospital forecasts and the capital requirement to deliver the proposed changes. The group was tasked with advising on the value for money of the options consulted upon both relative to each other, and compared to the ‘do nothing’ (i.e. current configuration) situation. The analysis indicates that:

- Commissioner forecasts over the five years involve gross QIPP of £550m with reinvestment in out of hospital services of £190m.
- The acute trust I&E forecast in the ‘do nothing’ is that most sites would move into deficit with no overall net surplus. In the downside scenario there would be an overall deficit of £89m with all bar one acute site in deficit.

The value for money evaluation criteria used to assess the options are:

- Capital costs
- Transition costs
- Site viability
- Total trust surplus/deficit
- Net present value.

The evaluation shows that all three options score less well than in the pre-consultation analysis but that option A remains the highest scoring. Option A requires net capital investment of £206m to implement the major hospital model, results in a positive I&E position of £42m for the acute sector and has a positive net present value. For all three options, the capital investment in out of hospital estates required to deliver the required changes has been assessed at £6m-112m for hubs and up to £74m for GP premises.

For deliverability we considered three sub-criteria. Firstly, analysis of the impact on workforce (done through staff satisfaction data) showed that Options 2 and 6 were weaker with all other options equally strong as each other. Secondly, analysis of the expected time
to deliver the options showed Options 5 and 6 were stronger and that Options 3, 4, 7 and 8 were weaker. Thirdly, we analysed co-dependencies with other strategies – previous Major Trauma designation, previous stroke designation, national initiatives, broader London initiatives and local strategies in place or in development. This identified that Options 5 and 6 were stronger and Options 3 and 4 were weaker against this sub-criterion. These evaluations were reviewed post consultation with no change to the results of the evaluation.

For Research & Education, we considered disruption and support current and developing research and education delivery. Our evaluation of both sub-criteria was reviewed and updated post-consultation. Options 6 and 8 were stronger and Options 1 and 3 were weaker against the disruption sub-criterion. For the second sub-criterion, Options 5 and 7 were stronger followed by Options 6 and 8 followed by the remaining options.

Stage 7 – Sensitivity analysis

At the end of stage 6, we concluded that overall options 5, 6 and 7 were the strongest. Sensitivity analysis was used to test the options to establish whether the ranking changed under testing. Sensitivity analysis supports the conclusion that option 5 is the preferred financial option both before and after consultation. However, as highlighted in the PCBC the programme needs to mitigate against the risk of a number of downside sensitivities happening simultaneously if the overall financial benefits are to be realised.

The proposed future configuration of hospitals in NW London

The evaluation was brought together and a summary is shown below. Note that Options 5, 6 and 7 were renamed as Options A, B and C for public consultation.
## Executive Summary

<table>
<thead>
<tr>
<th>Post-consultation score</th>
<th>Pre-consultation score</th>
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<tr>
<td>-4</td>
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<td>-3</td>
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<td>+3</td>
<td>-</td>
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<td>+4</td>
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### Quality of Care

- Clinical quality: **++ ++ ++ ++ ++ ++ ++ ++**
- Patient experience: **++ + + - ++ + + -**

### Access

- Distance and time to access services: **- - - - - - - -**
- Patient choice: **+ - + - ++ + ++ +**

### Value for Money

- Capital cost to the system: **-- -- -- -- - - - +**
- Transition costs: **-- -- -- -- - - - -**
- Viable Trusts and sites: **+ + -- -- + -- -- --**
- Surplus for acute sector: **+ + - -- + - - --**
- Net Present Value: **- - -- -- + - -- -**

### Deliverability

- Workforce: **+ - + + + - + +**
- Expected time to deliver: **- - -- -- + + -- --**
- Co-dependencies with other strategies: **- - -- -- + + - -**

### Research & Education

- Disruption: **-- - -- - - + - +**
- Support current and developing research and education delivery: **- - - - ++ + ++ +**

### Changes from pre-consultation

- Post-consultation score: **-3 -7 -12 -16 +10 0 -4 -4**
- Pre-consultation score: **-2 -7 -11 -16 +14 +7 +2 -4**

### Locations

- Chelsea & Westminster
- Northwick Park
- Hillingdon
- Ealing
- West Middlesex
- St Mary’s
- Hammersmith
- Charing Cross
- **High evaluation** ++
- **Low evaluation** --
As a result of the decision-making analysis, the Clinical Board agreed that Option 5 (Option A in the table above) was the strongest option. The Finance & Business Planning Working Group agreed that Option 5 was better than the other options.

The Programme Board reviewed the completed evaluation and analysis and considered the recommendations of the Clinical Board and the Finance & Business Planning Working Group. The Board noted the two recommendations and agreed with the assessment that Option A should be the recommended configuration.

The recommended hospital configuration proposes the following service models at each site. At:

- Chelsea & Westminster – a local hospital and a major hospital
- Hillingdon – a local hospital and a major hospital
- Northwick Park – a local hospital and a major hospital
- St Mary’s – a local hospital, a major hospital, a Hyper Acute Stroke Unit (moved from Charing Cross Hospital) and a specialist ophthalmology hospital (moving the Western Eye Hospital onto the site)
- West Middlesex – a local hospital and a major hospital
- Central Middlesex – a local hospital and an elective hospital
- Charing Cross – a local hospital\(^1\)
- Ealing – a local hospital\(^2\)
- Hammersmith – a specialist hospital with obstetric-led maternity unit and a local hospital

This is shown in the map below.

\(^1\) Hammersmith and Fulham CCG is considering whether Charing Cross could be developed into a specialist health and social care hospital. The specialist health and social care hospital model adopts the local hospital model together with enhanced primary and community that reflect Hammersmith and Fulham CCG’s out of hospital strategy. This is not included within the DMBC and is the subject of a separate paper to the JCPCT.

\(^2\) Ealing CCG is considering whether additional services could be provided on the same site. This model adopts the local hospital model together with enhanced primary and community services that reflect Ealing CCG’s out of hospital strategy. This is not included within the DMBC and is the subject of a separate paper to the JCPCT.
Assuring the proposals

Throughout the *Shaping a healthier future* programme there has been ongoing assurance to ensure that proposals are sound, scrutinised and well communicated and considered by all stakeholders. During the pre-consultation phase the programme was assured by an Office of Government Commerce Gateway review and was given an ‘excellent’ rating of Amber/Green. The clinical proposals were assured by the National Clinical Advisory Team (NCAT) firstly pre-consultation in April 2012 and secondly post-consultation in November 2012 and February 2013. The April review highlighted a number of important issues, solutions to which were incorporated into the programme’s plans, and the November review was supportive of the way in which the proposals were developing, recognising there had been good progress made. Further assurance came from external clinical reviews and through our own review of the relevant clinical evidence. NHS London confirmed that the programme met the Four Tests for reconfiguration set out by the Secretary of State in May 2012.

Travel and access implications

Clinicians recognise the importance of access to NHS services for the local population and at the very earliest stages of *Shaping a healthier future* agreed that travel and access would be a key element to the development of the recommendation. 91% of activity is unaffected by the proposals.

The programme undertook a range of travel analysis both during our planned programme of work and in response to feedback we received during consultation. Impacts by borough and site for all modes of transport, including emergency travel times and maximum private journey times to the proposed major hospital sites, were considered. The majority of feedback received during the consultation on travel and access was about general issues that affect the range of NHS services throughout NW London and did not differentiate between the options proposed. The key themes included:

- Improvements to public transport required to support access to all sites
- Potential impact of changes on the accessibility of services by vulnerable groups
• Issues around patients being deterred from attending follow-up appointments due to travel costs
• Requests for further analysis to be undertaken and checks to be made to the accuracy of analysis undertaken
• Potential impact of changes on ambulance journeys
• The need to develop clear transfer pathways
• Potential impact of travel on the quality of care.

The Travel Advisory Group proposed a list of priority areas for further work with regards to patient transport, should the programme be implemented. This included continuing with a Travel Advisory Group during implementation, to establish links with local authority public transport planning liaison groups and local authority transport planners to review strategic transport requirements or changes and to consider prioritising access to health care sites in reviewing transport routes.

Equalities implications

For the work of the programme, NHS NW London has sought to exceed the duty under the Equalities Act 2010. Under the Equality Act 2010, consideration of equality issues must influence the decisions reached by public bodies. Our work assessed the possible impact of the proposals on different protected equalities groups, with whom we carried out significant engagement.

Prior to consultation, the programme commissioned an equalities impact strategic review and established an equality steering group. We also undertook an equalities impact assessment. No disproportionate impact on the protected equalities groups was identified.

Through our engagement programme and the public consultation, some concerns were raised. In order to go beyond the legal duty we have included recommendations and an equalities action plan to show how we intend to continue this work during implementation.

Workforce implications

The programme examined the workforce changes required to support delivery of the service changes and associated clinical standards in acute care (paediatrics, maternity, emergency and urgent care) and out-of-hospital care services. A fundamental part of achieving the clinical standards and clinical service delivery models will be recruiting and retaining an appropriately skilled workforce across NW London. At a high level, our analysis shows that under the preferred recommendation, 81% of the acute workforce would not be affected by the reconfiguration.

We reviewed the impact of the proposals on workforce numbers for emergency care, paediatrics and maternity. This sought to understand more about the activity required to deliver the emergency cover and what impact the recommendation, detailed in this business case, might have on workforce numbers. Further work on this will be carried out during implementation.

The out of hospital workforce strategy is further advanced than the acute strategy as the improvements in service would be required in advance of the acute changes. We have begun to work closely with the emergent NW London Local Education and Training Board (LETB) in developing the workforce requirements including articulating the training requirements for out-of-hospital services for new and existing staff. In discharging its new
responsibilities, the NW London LETB will be instrumental in enabling the delivery of the workforce changes described here and consequently the delivery of the out-of-hospital vision.

**Implementation of proposals for hospital sites**

We outline the likely activity and financial impact of the recommendation on providers in NW London, including the capital investment to increase capacity, which would be required to support the proposed changes in the configuration and delivery of services. For each of the hospitals whose activity would be affected by the changes, we analysed the impact for each of the sites in terms of activity levels, beds, finance and estates.

**Implementation of proposals for CCGs**

As part of the work across NW London, each CCG is making specific improvements to its out-of-hospital services, including the development of hubs, care networks and health centres. Within five years, we will be spending £190 million more on out of hospital services each year. These plans are outlined for each of the eight CCGs.

**Programme implementation arrangements**

We have developed an approach to implementation taking into account feedback we received during consultation. We have analysed the implementation risks of the recommended option and developed mitigations to address these. A set of implementation plans up to March 2018 have been developed, drawing on initial planning work undertaken by acute providers, CCGs and the Clinical Implementation Groups (CIGs). These plans provide a view of the sequence of changes required in both the out of hospital and acute environments. We have continued to develop an assurance process we can use to ensure that safe, high quality care continues to be provided during the transition. There are system wide activities that will be required, including workforce development, communications, equalities and travel. Work will be managed by an Implementation Programme Board, overseen by a Steering Group, comprising the eight CCGs, the NCB and three neighbouring CCGs (Camden, Richmond and Wandsworth).

**Benefits framework**

Building on the Case for Change, a set of clinical, quality and operational benefits we expect to achieve through the implementation of the *Shaping a healthier future* programme have been developed.

The main areas of benefit expected to be delivered by *Shaping a healthier future* are:

- Improved clinical outcomes for patients
- Improved experiences for patients and their carers
- Improved experiences for staff, due to:
  - Improvements in patient care
  - Improved team and multi-disciplinary working
  - Improved integration across primary and secondary care
  - Increased opportunities to maintain and enhance skills
- Operating services with improved financial sustainability.
The implementation of the proposed changes is expected to provide the following high-level benefits for patients:

- Reduced mortality through better access to senior doctors
- Quicker access to treatment by more senior doctors Increased ability to take control of their own health conditions
- Improved access to GPs and other services so patients can be seen quicker and at a time convenient to them
- Reduced complications and poor outcomes for people with long-term conditions by providing more coordinated care and specialist services in the community
- Less time spent in hospital as services are provided in a broader range of settings.

The implementation of the proposed changes is expected to provide the following high-level benefits for staff members:

- Allow doctors to develop their specialist skills through the provision of more opportunities to deal with specialist cases
- Improved access to information about a patient’s health, reducing possible errors and avoiding asking patients to provide the same information multiple times
- Prevent patient’s deterioration in health and reduce admissions to hospital through delivering coordinated care plans and improved multi-disciplinary support.
- Improved job satisfaction due to an increased ability to deliver high quality coordinated care.

The programme has also set out when and how the benefits of the programme are expected to be realised and how their delivery will monitored, including quarterly ‘benefits checkpoints’ and how key performance indicators will show that the NHS locally is ready to implement the next proposed change of the programme.

**Conclusion, final recommendation and resolutions**

The programme has worked extensively with clinicians, the public, patients and other stakeholders on the proposals. The feedback from the public consultation showed a clear mandate for change and broad support for the preferred consultation option. There was also challenge and criticism, which we have taken steps to address.

The recommendation is the strongest option for the future development of health services in NW London. The eight Clinical Commission Groups (CCGs) in NW London have agreed their plans to transform out of hospital services, setting out the vision for how care will be delivered at home, at GP practices, in community health centres and at local hospitals. For acute care, the recommendation is for a local and major hospital on the Chelsea and Westminster, Hillingdon, Northwick Park, St Mary’s and West Middlesex sites, a local and elective hospital at Central Middlesex, a local hospital at Charing Cross and Ealing and a local and specialist hospital with an obstetric-led maternity unit at Hammersmith.

We have assessed the impact of the proposals and have plans for a sequence of changes required in both the out of hospital and acute environments. We have continued to develop an assurance process to ensure that safe, high quality care continues to be provided during the transition.

The Decision Making Business Case (DMBC) has been reviewed by the Programme Board and relevant content has been reviewed by the Clinical Board, Finance and Business
Planning Group and other committees and groups established by the JCPCT to provide it with advice and recommendations.

Taking into account all of the evidence that has been made available to JCPCT members, the JCPCT is recommended to agree the following resolutions on the basis that, taken together, they represent the most effective way of providing high quality healthcare for patients in and residents of NW London:

1. To agree and adopt the NW London acute and out of hospital standards, the NW London service models and clinical specialty interdependencies for major, local, elective and specialist hospitals as described in Chapter 7

2. To agree and adopt the model of acute care based on 5 major hospitals delivering the London hospital standards and the range of services described in Chapters 7 and 9 should be implemented in NW London

3. To agree that the five major hospitals should be as set out in Chapter 10: Northwick Park Hospital, Hillingdon Hospital, West Middlesex Hospital, Chelsea and Westminster Hospital and St Mary’s Hospital

4. To agree that Central Middlesex Hospital should be developed in line with the local and elective hospital models of care including an Urgent Care Centre operating 24 hours a day, 7 days a week as detailed in Chapters 7, 9 and 10

5. To agree that Hammersmith Hospital should be developed in line with the local and specialist hospital models of care including an Urgent Care Centre operating 24 hours a day, 7 days a week as detailed in Chapters 7, 9 and 10

6. To agree that Ealing Hospital be developed in line with the local hospital model of care including an Urgent Care Centre operating 24 hours a day, 7 days a week as detailed in Chapters 7, 9 and 10

7. To agree that Charing Cross Hospital be developed in line with the local hospital model of care including an Urgent Care Centre operating 24 hours a day, 7 days a week as detailed in Chapters 7, 9 and 10

8. To agree that the Hyper Acute Stroke Unit (HASU) currently provided at Charing Cross Hospital be moved to St Mary’s Hospital as part of the implementation of resolutions 1, 2 and 3 above and as described in Chapter 6

9. To agree that the Western Eye Hospital be moved from its current site at 153-173 Marylebone Road to St Mary’s Hospital as set out in Chapter 10

10. To recommend that implementation of resolutions 1-7 should be coordinated with the implementation of the CCG out of hospital strategies, as set out in Chapters 8 and 17

11. To recommend to the NHS Commissioning Board and NW London CCGs that they adopt the implementation plan and governance model in Chapter 17.
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