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Foreword

Dr Mark Spencer

The Clinical Board, which includes the North West London medical directors of all the acute and mental health trusts and the chairs of all the Clinical Commissioning Groups, has led the Shaping a healthier future programme in considering the challenges facing the local health system. As chair of the board I commend the work on this Decision-Making Business Care which reflects the recommendations of the Clinical Board and trust that the Joint Committee of Primary Care Trusts will consider this carefully.

It is clear that there are examples of great care within the NHS in North West London, in hospitals, the community and general practice - but this is not consistent. More importantly the current way of working in the NHS is not going to be able to meet the future challenges. We need to develop new ways of providing care and support to an ageing population, often with multiple chronic illnesses.

Having examined this in depth as clinical leaders we have proposed changes to create fewer, more comprehensive and better staffed hospitals, able to provide the best quality care throughout the whole week, whilst developing out of hospital services to allow co-ordinated integrated care for people with less severe acute illness and those with chronic conditions. We are clear that these proposals would help us meet the challenge of the NHS mandate, save lives and improve clinical outcomes.

I do also want to take the opportunity to thank the large number of clinicians who have played a part in developing this work, GPs from all the commissioning groups, specialists and nurses from all North West London’s hospitals, as well as from around the country who have given input. I particularly want to thank Dr Susan LaBrooy, Dr Mike Anderson and Dr Tim Spicer who have helped lead the clinical work. We have also benefitted from the many members of public, patients and carers, clinical colleges and other organisations who have taken part in the discussions, shared their concerns, and allowed us to improve the proposals and make them more robust.

As a Clinical Board we look forward to ensuring, whatever decisions are made, that we implement any changes carefully and safely so that we can continue to be proud of the care and treatments we deliver to the people of North West London.

Mark Spencer (PEC Chair) on behalf of the full Executive Committee
1. Executive Summary

This section provides a summary of the decision making business case (DMBC).

2. Introduction to NHS NW London

This chapter describes the shape and structure of the NHS in North West (NW) London and how the local commissioners ensure that the two million people who live here receive the community, acute, mental health and specialist services they need.

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

This chapter describes the work that preceded the Shaping a healthier future programme and how the programme was established. It discusses the underlying principles of the programme and how the programme’s governance and timeline were established to support those principles. The programme has worked extensively with clinicians, the public, patients and other stakeholders on proposals to transform the health system in NW London and select a recommendation. The chapter concludes with a description of how this business case provides the information necessary for the Joint Committee of Primary Care Trusts (JCPCT) to make an informed decision about reconfiguration in NW London.

4. The Case for Change

This chapter describes why change is necessary and why it must start now. The NHS in NW London is facing a range of pressures and challenges. From a clinical view, there is increased demand caused by the ageing population and increased prevalence of long term conditions and co-morbidities. There are also unacceptable variations in the quality of care provided, evidenced by higher mortality rates for patients who are treated in hospital at night or during the weekend. Alongside this, there are financial pressures which require the NHS to deliver efficiency savings for reinvestment. As such, doing nothing is not an option. The Case for Change was developed by clinicians, who looked at the current and future demands on the NHS in NW London, and showed that a new configuration of services was necessary to deliver high quality care within the financial constraints on the system.

5. Process for identifying a recommended option

This chapter describes how we identified a recommendation for reconfiguration of hospital services in NW London using a seven stage process. There are millions of options for the configuration of services if all the combinations are considered. Therefore we developed a process that uses seven stages to consider all the available options systematically, to develop a shortlist of options and to enable us to carry out in depth analysis on that shortlist. We used the process before consultation to identify options to consult on. During consultation we received feedback about the process and we used this feedback to re-evaluate the process. We then reconfirmed with our stakeholders that the process remained appropriate for use to identify the recommended reconfiguration option.
6. Consultation, feedback and how we have responded

This chapter describes how we consulted on the proposals and the engagement activities carried out. On 2 July 2012, NHS NW London launched a public consultation on the plans for reconfiguration of services as outlined in the pre-consultation business case. We consulted on the proposed clinical standards, clinical service delivery models and options for location of services. The consultation period ran for 14 weeks and ended on 8 October 2012. The feedback from consultation showed a clear mandate for change and broad support for the preferred consultation option. There was also challenge and criticism. We responded to this feedback, carrying out significant additional work on the analysis, in particular the clinical recommendations, options evaluation (including finance), travel, equalities and implementation planning.

7. Clinical proposals, vision, standards and service models

This chapter describes how patients in NW London will be treated in the future to ensure they receive the highest standards of care. Services will be provided locally where possible and centralised where necessary. Services will also be integrated across organisational boundaries to provide a seamless experience of care in a range of care settings. This chapter sets out the vision for improving services in out of hospital settings and how these services will be delivered, as well as the vision for urgent and emergency care, maternity and paediatric services. Clinicians have developed a set of clinical standards for each of these areas and these standards will underpin quality within any future configuration of acute services. The clinical standards have been brought together into a set of eight service models that are used as the building blocks of the recommended option for the future of healthcare provision in NW London.

8. Out of hospital improvements across NW London

This chapter gives an overview of the work being undertaken by NW London to improve out of hospital care. 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. Within five years, we will be spending £190 million more a year on out of hospital services, building on improvements already being made to out of hospital care across NW London.

9. Decision making analysis

The four parts of this chapter describe the analysis undertaken to identify a recommended option for reconfiguration. Using the seven stage process for identifying options for consultation we explain the analysis undertaken at each stage of the process. We describe how we have considered the feedback received during consultation and undertaken new analysis based on this feedback (including re-appraisals of the latest evidence, activity and financial data) to enable the programme to review options at each stage in order to come to the final recommendation. The case for change, vision and clinical standards were reconfirmed. These were used in conjunction with agreed clinical dependencies to develop
the service models. Options for the configuration of major hospitals were assessed using hurdle criteria to determine that five were needed and to produce a list of eight configuration options. These eight options were evaluated using criteria (covering quality of care, access to care, value for money, deliverability and research & education) developed before and after consultation. This evaluation enabled us to determine a preferred option. We confirmed that this remained the best option if our modelling assumptions changed through the sensitivity analysis.

10. The proposed future configuration of hospitals in NW London

This chapter summarises the results of the decision making analysis and sets out the programme’s proposed future configuration of hospitals in NW London. This is based on Option A in the consultation and has been refined following feedback from the consultation and the analysis in response to this feedback. The recommendation is for a local hospital (including an Urgent Care Centre operating 24 hours a day, 7 days a week) and major hospital (24/7 A&E with co-located obstetrics and maternity unit and inpatient paediatrics) 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.

11. Assuring the proposals

This chapter shows that there has been ongoing assurance and scrutiny to verify that proposals are sound and well communicated to and considered by all stakeholders throughout the programme. During the pre-consultation phase the programme was assured by an Office of Government Commerce Gateway review. The clinical proposals were assured by the National Clinical Advisory Team (NCAT), 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. During and following the consultation, the programme has continued to work to meet the Four Tests and sought further assurance from NCAT and external clinical reviews. This includes a detailed literature review of recent clinical evidence and a review of clinically relevant feedback from the consultation.

12. Travel and access implications

This chapter describes the expected travel and access impacts of the recommendation, by borough and site, for all modes of transport, including emergency travel times and maximum journey times to the proposed major hospital sites. This chapter also considers the impact of public transport options. The programme established a Travel Advisory Group bringing together representatives from local authorities, Transport for London, London Ambulance Service and public and patient representatives. 91% of activity will be unaffected by the proposals. Changes to travel times will be greatest in Ealing, Brent and Hammersmith and Fulham. Evidence shows that travelling to the right location for the right care has a greater impact on outcomes than distance travelled.
13. Equalities implications

This chapter explains how NHS NW London has met 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. No disproportionate impact on the protected equalities groups was identified. We intend to go beyond the legal duty, and have included recommendations and an action plan to continue this work as part of the implementation programme.

14. Workforce implications

This chapter describes the workforce implications of the recommendation. Workforce changes will be required to support delivery of the clinical standards in acute care (paediatrics, maternity, emergency and urgent care) and we have identified further analysis required as part of the implementation. For out of hospital care, an estimated additional 250 whole time equivalent (WTE) staff will be required to deliver the reactive and proactive care services across NW London, filling a range of new and enhanced roles that have been identified. This is only a part of the additional 800 WTE staff we expect to be working in out of hospital settings.

15. Implementation of proposals for hospital sites

This chapter outlines the likely activity and financial impact of the activity forecasts on providers in NW London, including the capital investment which will be required to support the proposed changes in the configuration and delivery of services in NW London.

16. Implementation of proposals across the CCGs

This chapter sets out, for each CCG, initiatives being introduced to improve out of hospital care, achievements in delivery of out of hospital care to date, and further out of hospital work planned for the future. It describes the planned investment in local hospitals, hubs, primary care estate and out of hospital services across each borough.

17. Programme implementation arrangements

This chapter describes our proposed approach to implementing the recommendation and how we have developed this approach taking into account feedback we received during consultation. The chapter also includes an analysis of the implementation risks of the recommended option and proposals for managing 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. The chapter also includes discussion of the 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).
18. Benefits framework

This chapter builds on the Case for Change by describing the benefits that are expected to be achieved as a result of implementing the recommendation. The benefits include improvements to patient outcomes and patient experience, as well as improved experiences for staff through advanced patient care, improved ways of working and opportunities to enhance skills. The benefits have been developed by clinicians in line with the clinical standards that underpin the proposals for clinical change and have been discussed with patient representatives. The chapter also sets out how the progress against the benefits would be monitored and the set of measures that the programme would focus on.

19. Conclusion, final recommendation and resolutions

This chapter outlines the decisions that need to be taken by the JCPCT about the future shape of services in NW London.
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.
The overall programme timeline is broken down into five phases as shown:

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:
Continue expanding out of hospital services
All specialist services will remain as they are
Located with, or independent of major hospitals
All 9 sites with an A&E to provide local hospital services and a UCC

Out of hospital:

Case for change
• Provides platform for service change
• Defines improvements and clinical benefits
• Confirm ‘do nothing’ is not an option

Vision
1 Localising
2 Centralising
3 Integrating

Standards
Acute:
• Urgent and emergency care
• Maternity
• Paediatrics

Service models
Correct care setting to deliver high quality care
Use existing sites
Enough major hosp. to support population of 1.9 million
Number of major hosp. must be viable in medium term
Ensure good geographical spread
Use sites currently delivering major hospital services
Minimise access impacts for residents

Hurdle criteria
Evaluation criteria
1 Quality of care
2 Access to care
3 Value for money
4 Deliverability
5 Research and education
Criteria include sub-criteria

Sensitivity analysis
• Tests 22 underlying assumptions

Recommended option

Number of options: MILLIONS
< 20
~ 3
~ 3
1

Executive summary
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>
</tr>
</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>
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<tr>
<td>Written comments (letters and emails)</td>
<td>148</td>
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<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>
</tr>
</tbody>
</table>

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
Executive summary

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.

| 1 Primary care led | • Started by at least one GP at all times
|                   | • Started by multi-disciplinary teams including GPs, nurses, emergency care practitioners |
| 2 24/7 service model | • Service available 24/7
|                  | • This includes 24/7 availability of dispensing and diagnostic services with X-ray either on site (or where not available on-site, e.g. during periods of low activity, patients should be transferred to an alternative site within 30 minutes if necessary) |
| 3 Ability to treat minor injuries | • Able to treat minor injuries (including minor fractures) in addition to minor illness
|                       | • 24/7 access to (and ability to interpret) X-rays and 'rapid (30 minute) diagnostics
| 4 Integration with General Practice | • Positive re-direction of patients to a service appropriate to their needs (e.g. OP, pharmacy)
|                             | • Unregistered patients supported to register with a local GP |
| 5 Integration with ED | • Secure, clinically safe transfer of patients from UCC to ED, access to specialist advice from ED consultant and others (e.g. orthopaedics)
| 6 Integration with community services | • Close integration with Rapid Response teams, Psychiatric Liaison Team
|                       | • Well defined pathways for onward referral of patients into the care of community, social care and mental health services
| 7 Facilities for paediatric patients | • Appropriate training and competences to provide suitable care for paediatric patients
|                       | • Dedicated paediatric waiting area
| 8 Integration with GP out of hours services | • Aspiration to co-locate with GP OH services where feasible
|                       | • Integrated with advice services (e.g. cold calls – e.g. 111)

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.

<table>
<thead>
<tr>
<th>Site</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
<th>Option 4</th>
<th>Option 5 (A)</th>
<th>Option 6 (B)</th>
<th>Option 7 (C)</th>
<th>Option 8</th>
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<tbody>
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<td>St Mary’s</td>
<td>Local hospital</td>
<td>Local hospital</td>
<td>Local hospital</td>
<td>Local hospital</td>
<td>Major hospital</td>
<td>Major hospital</td>
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<tr>
<td>Hammersmith</td>
<td>Major hospital</td>
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<td>Specialised hospital</td>
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<td>Specialist hospital</td>
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<td>Charing Cross</td>
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### 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:

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<th>Criteria</th>
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<td>Quality of care</td>
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<td>Access to care</td>
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<td>Value for money</td>
<td>• Capital cost to system&lt;br&gt;• Transition costs&lt;br&gt;• Viable Trusts and sites&lt;br&gt;• Surplus for acute sector&lt;br&gt;• Net Present Value</td>
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<td>Deliverability</td>
<td>• Workforce&lt;br&gt;• Expected time to deliver&lt;br&gt;• Co-dependencies with other strategies</td>
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<td>Research and Education</td>
<td>• Disruption&lt;br&gt;• 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.
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### Changes from pre-consultation

- West Middlesex
- Hammersmith
- Chelsea & Westminster
- Northwick Park
- Hillingdon

### Pre-consultation score

-2 -7 -11 -16 +14 +7 +2 -4

### Post-consultation score

-3 -7 -12 -16 +10 0 -4 -4
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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Chapter 2

Introduction to NHS NW London
2. Introduction to the NHS in NW London

This chapter describes the shape and structure of the NHS in North West (NW) London and how the local commissioners ensure that the two million people who live here receive the community, acute, mental health and specialist services they need.

2.1 Commissioning arrangements in NW London

Primary Care Trusts (PCTs) are currently responsible for commissioning the majority of NHS services in England on behalf of the residents of their area. PCTs in London are grouped into six ‘clusters’, one of which is the NW London Cluster. Figure 2.1 shows the different NHS clusters in London.

Figure 2.1: PCT Clusters in London

The scope of Shaping a healthier future covers the services provided in NW London which serves all residents of NW London and some residents of neighbouring boroughs and PCTs who access services provided by NW London trusts. The NW London PCT Cluster comprises eight PCTs: Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea and Westminster, as shown in Figure 2.2.
Each of the eight PCTs is governed by a board. The membership of each of the eight boards is the same and they meet ‘in common’ (i.e. at the same time).

Following the passage of the Health and Social Care Act 2012, PCTs are to be abolished and from 1 April 2013 many of their commissioning responsibilities will be taken on by Clinical Commissioning Groups (CCGs), led by local General Practitioners (GPs). In NW London there will be eight Clinical Commissioning Groups (CCGs), as shown in Figure 2.3. The remainder of PCT’s commissioning responsibilities are transferring to the NHS Commissioning Board (NHSCB) and Local Authorities.
The responsibility for commissioning health services in NW London is in the process of being transferred from the NW London Cluster to the eight CCGs.

All eight NW London CCGs have been established and are progressing through the authorisation process. Seven NWL CCGs in Wave 2 of the authorisation process have been authorised with or without conditions by the NHSCB. Hillingdon CCG is progressing through Wave 4 of the authorisation process and is on track to be authorised by 1 April 2013. They are operating in shadow form, taking decisions within authority delegated by the PCTs, and are working to ensure a seamless transition of responsibilities on 1 April 2013. Because the CCGs will take on responsibility for implementing any agreed changes, they have played a leading role in developing the *Shaping a healthier future* proposal.

To ensure an appropriate balance between economies of scale and the necessary local focus on the commissioning of health services, the eight CCGs manage their operations in two groups of four:

- **BEHH Federation of CCGs**, covering the CCGs of Brent, Ealing, Harrow and Hillingdon

### 2.2 Out of hospital service provision in NW London

The very great majority of the care of patients in the NHS takes place outside of hospitals. Within NW London there are estimated to be over 11 million attendances at GP surgeries.
annually along with almost 3 million other community attendances\(^1\). Out of hospital settings include:

- GP practices and health centres
- Community health services
- Dental practices
- Pharmacies
- Opticians
- Walk-in centres
- Mental and community health services
- Patient’s homes.

NW London has four main community health providers that deliver community nursing and therapy services. These include:

- Central London Community Healthcare Trust (CLCH), covering Hammersmith and Fulham, Kensington and Chelsea and Westminster
- Hounslow and Richmond Community Healthcare (HRCH), covering Hounslow
- Central and North West London NHS Foundation Trust, incorporating Hillingdon Community service provider, covering Hillingdon
- Ealing Hospital Trust, incorporating Ealing Integrated Care Organisation, covering Brent, Ealing and Harrow.

There are two mental health trusts that provide out of hospital mental health services across NW London:

- West London Mental Health NHS Trust, covering Ealing, Hammersmith and Fulham and Hounslow
- Central and North West London NHS Foundation Trust, covering Brent, Kensington and Chelsea, Harrow, Hillingdon and Westminster.

There are also a number of hospices, rehabilitation centres and residential care homes and nursing homes.

2.3 Hospital services in NW London

Within NW London there are nine acute and specialist trusts:

- Chelsea and Westminster Hospital NHS Foundation Trust
- Imperial College Healthcare NHS Trust. This includes Charing Cross Hospital, Hammersmith Hospital (including Queen Charlotte’s Hospital), St Mary’s Hospital and Western Eye Hospital
- The Hillingdon Hospitals NHS Foundation Trust. This includes Hillingdon Hospital and Mount Vernon Hospital\(^2\)
- The North West London Hospitals NHS Trust. This includes Central Middlesex Hospital and Northwick Park Hospital

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\(^1\) Reference costs 2009/10 - District Nursing, Health Visitor (HV) Post natal visits, specialist palliative care, GP practice list size (Quality and Outcomes Framework 2010/11). National average GP visits per person (Qresearch 2009), Reference costs 2009/10, other community activity (including HV activity other than post-natal visit)

\(^2\) Mount Vernon is the site for some services that are not part of The Hillingdon Hospitals NHS Foundation Trust. These services include: East and North Hertfordshire Trust (cancer services), Lynda Jackson Macmillan Centre, The Royal Free (plastic surgery). All of the services provided from the site have been excluded from the scope of Shaping a healthier future.
- West Middlesex University Hospital NHS Trust
- Ealing Hospital NHS Trust
- The Royal Marsden NHS Foundation Trust
- The Royal Brompton and Harefield NHS Foundation Trust. This includes Royal Brompton Hospital and Harefield Hospital
- The Royal National Orthopaedic Hospital NHS Trust.

In addition to commissioning services from these trusts, the PCTs commission some services from hospitals outside of NW London, often in central London and for highly specialised services.³

Figure 2.4 shows the position of the hospital sites in NW London and those in neighbouring areas.

**Figure 2.4: Hospital sites in NW London and surrounding areas**

A wide range of services are provided at the hospital sites in NW London. The number of sites is relatively high for the size of population and geographical area, and the majority of the acute hospital sites (excluding the specialist trusts) provide very similar ranges of services. Figure 2.5 sets out the services provided by each of the acute trusts in NW London. These are grouped according to hospital service delivery models (local hospital, ³ For example Guy’s and St Thomas’ NHS Foundation Trust and University College London Hospitals NHS Foundation Trust
Figure 2.5: Current services provided at acute hospital sites in NW London

<table>
<thead>
<tr>
<th>Core services</th>
<th>Acute Hospital</th>
<th>Elective</th>
<th>Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urgent care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outpatient and</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>diagnostic</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>24/7 A&amp;E</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ICU level 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychiatric</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>liaison</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complex</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Elective</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Major Trauma</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Paediatric</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Neonatal</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Obstetrics &amp;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maternity Unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HASU</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Heart Attack</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Elective</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ITU/HDU</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cardiac</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Thoracic</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Neurosurgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vascular</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cancer Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central Middlesex</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
</tr>
<tr>
<td>Charing Cross</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
</tr>
<tr>
<td>Chelsea &amp; Westminster</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
</tr>
<tr>
<td>Ealing</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
</tr>
<tr>
<td>Hammersmith (incl. QCCH)</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
</tr>
<tr>
<td>Northwick Park</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
</tr>
<tr>
<td>St Mary’s</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
</tr>
<tr>
<td>West Middlesex</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
</tr>
<tr>
<td>Mount Vernon</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
</tr>
<tr>
<td>Royal Marsden²</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
</tr>
<tr>
<td>Royal Brompton³</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
</tr>
<tr>
<td>RNOH⁴</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
</tr>
<tr>
<td>Western Eye⁵</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
</tr>
<tr>
<td>Harefield</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
</tr>
</tbody>
</table>

¹ This Figure has been advised by Medical Directors from each site. Due to variations in services, not all categories are strictly comparable. Notes from Figure 2.5:
1. These services are grouped as services that are likely to be delivered in these types of hospital settings, although it does not necessarily mean that the services are provided in the same way across all sites.
2. All services relate to cancer patients.
3. Relates to heart and lung services.
4. Relates to trauma and orthopaedic.
5. Relates to eye care services.
7. Not all specialist tumour types at each site.
8. Only a selection of specialist services shown in this table.
major hospital, elective centre and specialist centre), which have been defined by local clinicians. These models are explained further in Chapter 7.

### 2.3.1 Acute hospital activity levels

Across the nine acute hospital sites (this excludes the specialist hospitals of Royal Brompton, Royal Marsden and Royal National Orthopaedic Hospital) in NW London there are approximately 4,060 acute beds of which 3,450 are adult and 610 paediatric or maternity. A summary of activity in NW London hospitals is described in Figure 2.6.

**Figure 2.6: Current activity levels and beds by site (2012 / 2013)**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Eating</th>
<th>Charing Cross</th>
<th>Central Middlesex</th>
<th>Chelsea &amp; Westminster</th>
<th>Northwick Park &amp; St. Mark’s</th>
<th>West Middlesex</th>
<th>Hillingdon</th>
<th>Hammersmith</th>
<th>St. Mary’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective</td>
<td>14,650</td>
<td>44,936</td>
<td>14,779</td>
<td>33,131</td>
<td>28,742</td>
<td>12,187</td>
<td>15,008</td>
<td>157,073</td>
<td>29,293</td>
</tr>
<tr>
<td>Non-Elective</td>
<td>15,305</td>
<td>32,819</td>
<td>11,563</td>
<td>28,892</td>
<td>43,102</td>
<td>16,819</td>
<td>21,308</td>
<td>165,335</td>
<td>31,757</td>
</tr>
<tr>
<td>Maternity (Births)</td>
<td>3,141</td>
<td>-</td>
<td>5,561</td>
<td>5,042</td>
<td>4,728</td>
<td>4,239</td>
<td>4,938</td>
<td>3,851</td>
<td></td>
</tr>
<tr>
<td>Maternity (General)</td>
<td>2,573</td>
<td>5</td>
<td>41</td>
<td>14,073</td>
<td>8,376</td>
<td>1,239</td>
<td>1,574</td>
<td>22,406</td>
<td>18,061</td>
</tr>
<tr>
<td>Neonates</td>
<td>4,219</td>
<td>-</td>
<td>20,967</td>
<td>5,419</td>
<td>5,451</td>
<td>833</td>
<td>6,880</td>
<td>5,107</td>
<td></td>
</tr>
<tr>
<td>Paediatrics</td>
<td>3,052</td>
<td>7</td>
<td>1,205</td>
<td>15,193</td>
<td>11,405</td>
<td>3,571</td>
<td>2,447</td>
<td>266</td>
<td>6,966</td>
</tr>
<tr>
<td>Critical Care</td>
<td>3,151</td>
<td>1,576</td>
<td>1,541</td>
<td>4,056</td>
<td>8,628</td>
<td>4,902</td>
<td>736</td>
<td>32,383</td>
<td>4,270</td>
</tr>
<tr>
<td>Outpatient</td>
<td>158,396</td>
<td>202,647</td>
<td>125,112</td>
<td>491,651</td>
<td>251,578</td>
<td>235,821</td>
<td>299,410</td>
<td>174,027</td>
<td>326,064</td>
</tr>
<tr>
<td>A&amp;E (major &amp; sta.)</td>
<td>26,246</td>
<td>25,439</td>
<td>11,957</td>
<td>28,927</td>
<td>37,209</td>
<td>39,399</td>
<td>52,206</td>
<td>15,591</td>
<td>41,621</td>
</tr>
<tr>
<td>A&amp;E (minor)</td>
<td>19,832</td>
<td>8,113</td>
<td>2,784</td>
<td>14,006</td>
<td>37,039</td>
<td>20,756</td>
<td>32,986</td>
<td>5,657</td>
<td>100,977</td>
</tr>
<tr>
<td>UCC</td>
<td>71,540</td>
<td>49,612</td>
<td>53,602</td>
<td>70,328</td>
<td>74,964</td>
<td>80,430</td>
<td>29,033</td>
<td>32,016</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>-</td>
<td>-</td>
<td>1,729</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>312</strong></td>
<td><strong>443</strong></td>
<td><strong>197</strong></td>
<td><strong>498</strong></td>
<td><strong>739</strong></td>
<td><strong>420</strong></td>
<td><strong>508</strong></td>
<td><strong>373</strong></td>
<td><strong>418</strong></td>
</tr>
</tbody>
</table>

| Elective            | 14,650          | 44,936        | 14,779            | 33,131                | 28,742                      | 12,187         | 15,008     | 157,073     | 29,293     |
| Paediatrics         | 3,052           | 7             | 1,205             | 15,193                | 11,405                      | 3,571          | 2,447      | 266         | 6,966      |
| Critical Care       | 3,151           | 1,576         | 1,541             | 4,056                 | 8,628                       | 4,902          | 736        | 32,383      | 4,270      |
| Outpatient          | 158,396         | 202,647       | 125,112           | 491,651               | 251,578                     | 235,821        | 299,410    | 174,027     | 326,064    |
| A&E (major & sta.)  | 26,246          | 25,439        | 11,957            | 28,927                | 37,209                      | 39,399         | 52,206     | 15,591      | 41,621     |
| A&E (minor)         | 19,832          | 8,113         | 2,784             | 14,006                | 37,039                      | 20,756         | 32,986     | 5,657       | 100,977    |
| UCC                 | 71,540          | 49,612        | 53,602            | 70,328                | 74,964                      | 80,430         | 29,033     | 32,016      |            |
| Other               | -               | -             | 1,729             | -                     | -                           | -              | -          | -           | 2          |
| **Total**           | **312**         | **443**       | **197**           | **498**               | **739**                     | **420**        | **508**    | **373**     | **418**    |

5 Source: Trust data. Central Middlesex A&E is only open restricted hours.

### 2.3.2 Acute hospital cross-border flows

Some hospitals in NW London provide significant levels of activity for non-NW London patients, as demonstrated in Figure 2.7.
Figure 2.7: Hospital activity delivered by NWL providers for non-NWL patients

<table>
<thead>
<tr>
<th>Hospital sites</th>
<th>Inpatients 2011/12 % of all spells</th>
<th>Outpatients 2011/12 % of all attendances</th>
<th>A&amp;E 2011/12 % of all attendances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chelsea &amp; Westminster</td>
<td>34.1</td>
<td>25.7</td>
<td>30.9</td>
</tr>
<tr>
<td>St Mark’s</td>
<td>33.4</td>
<td>33.4</td>
<td>21.4</td>
</tr>
<tr>
<td>West Middlesex</td>
<td>24.8</td>
<td>23.0</td>
<td>17.6</td>
</tr>
<tr>
<td>Charing Cross</td>
<td>21.4</td>
<td>16.4</td>
<td>10.5</td>
</tr>
<tr>
<td>Hammersmith</td>
<td>19.2</td>
<td>16.4</td>
<td>17.6</td>
</tr>
<tr>
<td>St Mary’s</td>
<td>17.3</td>
<td>16.4</td>
<td>10.5</td>
</tr>
<tr>
<td>Western Eye</td>
<td>13.6</td>
<td>16.4</td>
<td>17.1</td>
</tr>
<tr>
<td>Mount Vernon</td>
<td>11.1</td>
<td>15.8</td>
<td>5.8</td>
</tr>
<tr>
<td>Northwick Park</td>
<td>9.6</td>
<td>6.9</td>
<td>17.3</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>6.1</td>
<td>4.5</td>
<td></td>
</tr>
<tr>
<td>Central Middlesex</td>
<td>5.8</td>
<td>3.6</td>
<td>10.5</td>
</tr>
<tr>
<td>Ealing</td>
<td>2.7</td>
<td>1.8</td>
<td></td>
</tr>
<tr>
<td>NWL average</td>
<td>17.1</td>
<td>15.6</td>
<td></td>
</tr>
</tbody>
</table>

The majority of this cross-boundary activity is from neighbouring regions in South West London, North Central London as well as the surrounding Home Counties, as shown in Figure 2.8

Figure 2.8: Top 10 non-NW London PCT regions referring to NW London acute trusts (total activity)

<table>
<thead>
<tr>
<th>PCTs</th>
<th>Inpatients 2011/12 Spells</th>
<th>Outpatients 2011/12 Attendances</th>
<th>A&amp;E 2011/12 Attendances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Richmond and Twickenham</td>
<td>14,559</td>
<td>73,448</td>
<td>21,959</td>
</tr>
<tr>
<td>Wandsworth</td>
<td>13,940</td>
<td>63,995</td>
<td>22,693</td>
</tr>
<tr>
<td>Hertfordshire</td>
<td>6,395</td>
<td>31,172</td>
<td>12,368</td>
</tr>
<tr>
<td>Barnet</td>
<td>6,007</td>
<td>20,335</td>
<td>12,459</td>
</tr>
<tr>
<td>Camden</td>
<td>3,513</td>
<td>20,803</td>
<td>7,606</td>
</tr>
<tr>
<td>Surrey</td>
<td>3,114</td>
<td>16,374</td>
<td>4,475</td>
</tr>
<tr>
<td>Buckinghamshire</td>
<td>2,471</td>
<td>12,334</td>
<td>3,918</td>
</tr>
<tr>
<td>Berkshire East</td>
<td>2,462</td>
<td>9,338</td>
<td>2,641</td>
</tr>
<tr>
<td>Lambeth</td>
<td>1,671</td>
<td>15,376</td>
<td>4,672</td>
</tr>
<tr>
<td>Sutton and Merton</td>
<td>1,182</td>
<td>8,040</td>
<td>2,286</td>
</tr>
</tbody>
</table>

Notes from Figure 2.7:
1. Outpatients activity for Imperial is not split by site (16.4% represents the share for the Trust overall)
2. A&E activity for NWLHT is not split by site (10.5% represents the share for the Trust overall)

Notes from Figure 2.8:
1. 2011/12 HES inpatient spells
Chapter 3

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

This chapter describes the work that preceded the Shaping a healthier future programme and how the programme was established. It discusses the underlying principles of the programme and how the programme’s governance and timeline were established to support those principles. The programme has worked extensively with clinicians, the public, patients and other stakeholders on proposals to transform the health system in NW London and select a recommendation. The chapter concludes with a description of how this business case provides the information necessary for the Joint Committee of Primary Care Trusts (JCPCT) to make an informed decision about reconfiguration in NW London.

3.1 Overview of the Shaping a healthier future programme

Shaping a healthier future builds on significant previous work undertaken in NW London, including work conducted by a series of Clinical Working Groups (CWGs) between 2009-11 to develop suitable models for clinical services, which culminated in some of the key elements of the 2011 Commissioning Strategy Plan, including:

- The definition of a case for change for NW London
- The definition of a detailed strategy to localise care close to patients’ homes, to centralise specialist care and to integrate care for people with long term conditions and the elderly
- New clinical quality standards for NW London
- Proposals for the establishment of a service change programme.

As a result, the Shaping a healthier future programme was established in November 2011 to develop proposals for service change across NW London, encompassing acute services and out of hospital care.

There are a number of other planned activities to improve services as part of the Commissioning Strategic Plan (CSP), for example, the development of integrated care systems across NW London. These will support Shaping a healthier future in achieving its goals but are outside the direct scope of the programme.

3.2 Principles underpinning the programme’s approach

To enable the CCGs to identify the optimal design for the future services required in NW London, Shaping a healthier future has followed an approach based upon four core principles (which are based on the Secretary of State’s four tests for reconfigurations):

- Clinically led and supported by GP commissioners: At all stages of the development of the proposals, local clinicians have led the work to ensure that any proposals improve the quality and safety of care and patient experience. The work is led by four Medical Directors – two representing hospital care and two representing out of hospital care. Together they have ensured that the development of options has been clinically-led and that the recommendations identified are clinically appropriate and viable. CCGs have been involved directly in development of proposals and are part of the programme approval process. The Clinical Board (see Section 3.3) has been responsible for requesting, reviewing and testing analysis that supports the recommendations that they have made to Programme Board. Further detail on those
local clinicians involved in the programme can be found in Appendix A. Additionally, engagement has taken place with wider groups of local clinicians, such as at four public and clinical engagement events (further information in Appendices B and C). Engagement with clinicians has always been led by the senior clinicians involved in the programme.

- **Informed by engagement with the public, patients and local authorities:** Engagement has taken place with local stakeholders at each stage of development to understand the potential impact of any proposals; including direct involvement of NW London’s Patient and Public Advisory Group (PPAG) and engaging with the Health and Wellbeing Boards, and the Joint Health Overview and Scrutiny Committee. The four Medical Directors have been actively involved in a wide variety of engagement events across all the different stakeholder groups identified. Further information on stakeholder engagement undertaken can be found in Section 3.5 and in Appendix B. We undertook formal public consultation, for 14 weeks, during which we explained our proposals, and how they have been developed, to the wider public and listened to their views on the implications of those proposals. Recent guidance from the Cabinet Office is that anything from two to 12 weeks is sufficient – we consulted over 14 weeks so we have gone further than these guidelines suggest. We believe that 14 weeks was plenty of time for people to consider our proposals and fill in a response form, even allowing for summer holidays and other events which took place this summer. This included specific work to understand the implication of proposals on different groups, in particular the nine protected groups defined under the Equality Act 2010 including those communities who are believed to be hardest to reach. Further information on the findings and subsequent responses to the public consultation can be found in Chapter 6.

- **Robust and transparent process underpinned by a sound clinical evidence base:** Our Case for Change and quality standards are already based on sound local and national clinical evidence (details of the clinical evidence base are in Chapter 11, Appendices D and E). We have used a robust, evidence-based process for developing and appraising options for change that we have shared with stakeholders at each stage of its development; working in particular with senior local clinicians and external clinical advisors to ensure any options are clinically sound. This has also included discussing the impact of proposals with staff (including meetings in all of the hospitals in NW London), patients and the public – for residents of each borough, for patients with specific healthcare needs and on patient travel times – and considering impacts on activity, capacity at different sites, and financial and capital implications for providers and commissioners.

- **Consistency with current and prospective patient choice:** The core principles of centralising, localising and integrating will have an impact on the way services are provided, and therefore on the choices available to the public. These three concepts are described in Chapter 7 as part of our vision for care. We believe this impact will be positive and will provide a choice of higher quality services in NW London. We continue to work with local clinicians, our PPAG and Overview and Scrutiny Committees to consider how our proposal for service change may affect other aspects of patient choice (i.e. choice of provider, setting and intervention) as described in the NHS Constitution.

We have sought views from patients, their representatives and other local stakeholders as this work has developed and will continue to do so during implementation of the changes once agreed.
3.3 Programme governance

The Joint Committee of PCTs (JCPCT) is the decision-making body. The JCPCT is constituted of the eight PCTs in NW London plus representatives from Camden, Richmond and Twickenham, and Wandsworth PCTs. The NW London Cluster Board commissioned the programme, setting out the overall scope, aims and timescales. The JCPCT took the decision in June 2012 to proceed to public consultation and will take the final decision on whether to proceed with the proposed service changes described in this document. Figure 3.1 sets out the current governance structure for Shaping a healthier future.
Figure 3.1: Governance structure for Shaping a healthier future (until February 2013)

**Cluster**
- Clinical Executive Committee
- Cluster Executive Team
- Joint Committee of PCTs

**Advisory**
- PPAG
- Travel Advisory Group
- Equalities Steering Group
- Expert Clinical Panel

**Clinical Board**
- Chair: Programme Medical Director(s)
- Members: Nominated Clinical leaders for each NWL provider, nominated CCG representative, PPAG representatives and/or patient experts, NHS NWL Director of Nursing, reps from Camden, Richmond and Wandsworth

**Programme Board**
- Chair: SRO
- Members: NWL Provider CEOs, NHS NWL Directors, sub-cluster, CEOs, CCG Chairs, programme Medical Directors PPAG rep.
- Attendees: NHS London, SWL & NCL Clusters, NHS CB, NHS TDA, Imperial College

**Transformational Group**
- Chair: Cluster CEO
- Members: SRO, Medical Director, SRO programme Delivery, Comms lead, NHS London rep. DSU lead, Other w/s leads

**Programme Executive**

**Emergency & Urgent Care Clinical Implementation Group**
- Chair: Programme medical directors x 2
- Members: Lead clinicians for relevant service, director of public health, local GPs, external clinical experts, PPAG rep/specific patient groups, Mental Health rep.

**Maternity Clinical Implementation Group**
- Chair: Gubby Ayida, Consultant Obstetrician & Gynaecologist and Pippa Nightingale, Head of Midwifery
- Members: Lead clinicians for relevant service, Director of public health, local GPs, external clinical experts, PPAG rep/specific patient groups, Mental Health rep.

**Paediatrics Clinical Implementation Groups**
- Chair: Abbas Khakoo, Consultant Paediatrician
- Members: Lead clinicians for relevant service, Director of public health, local GPs, external clinical experts, PPAG rep/specific patient groups, Mental Health rep.

**Comms & Engagement Working Group**
- Chair: SaHF Communications Lead
- Members: Commissioner & Provider Communication Directors, PPAG rep.

**Finance & Business Planning Working Group**
- Chair: CCG (designate) Director of Finance x 2
- Members: Commissioner and Provider Finance Directors, COOs/Estates leads, PPAG rep where necessary.
The JCPCT is advised by a **Programme Board**, which oversees programme delivery, in particular managing cross-organisational issues, risks and dependencies. The Programme Board consists of:

- NW London Cluster executive team
- All eight NW London CCG Chairs
- CEOs for all NW London (acute, mental health and community) providers
- Representatives from NHS London, South West London PCT cluster, North Central London PCT cluster and the NW London PPAG
- Programme Medical Directors.

The **Clinical Board** has responsibility for providing clinical leadership to the programme, ensuring the programme develops robust clinical proposals and making clinical recommendations to the Programme. The Clinical Board consists of:

- The four Programme Medical Directors
- Nominated clinical leads for all NW London providers (usually Medical Directors)
- Nominated clinical leads for all NW London CCGs (usually CCG chairs)
- NHS NW London Director of Nursing and nursing representatives
- PPAG representative.

The Clinical Board has met fortnightly throughout the programme and has taken the lead in requesting, reviewing and testing different analyses to support the development of the reconfiguration proposals. Local clinicians have asked for wider clinical expertise in certain areas, such as paediatrics, and have stayed in close contact with other clinical working groups, such as the London Health Programme, to ensure that they have the latest advice from those groups and that their proposals align with the latest developments and recommendations to deliver the highest levels of clinical quality and safety.

**Three Clinical Implementation Groups (CIGs)** were established to advise the Clinical Board in the following areas:

- Emergency and urgent care
- Maternity
- Paediatrics.

The purpose of the CIGs is to ensure that:

- The programme develops robust plans for the safe and secure delivery of their affected services
- The implications of any changes are communicated and fully understood at a local level and that there is effective joint working
- The plans for implementing any changes receive appropriate input from clinicians and patients/carers.

The remaining work is managed through working groups, each with commissioning, provider and patient representatives – the out of hospital care Working Group, the Communications and Engagement Working Group and the Finance and Business Planning Working Group. Alongside this structure other external groups, such as the Expert Clinical Panel, have a role in reviewing the work of the programme and strengthening its recommendations through expert advice and challenge.

During the programme timeline, there will be a number of changes in the local NHS including:
Transition of commissioning responsibilities from PCTs to CCGs
Establishment of the NHS Commissioning Board and governance structures established to carry out the Board’s role in London
Changes to the role of Local Involvement Networks (LINks) and the development of Healthwatch
Establishment of Health & Wellbeing Boards and Clinical Senates.

*Shaping a healthier future* has planned for and is responding to these changes as they take place, ensuring an appropriate fit with new arrangements as part of the NW London’s overall response to the changes.

Further detail of programme governance arrangements, including membership of the different Boards is provided in Appendix A

### 3.4 Programme timeline

The overall programme timeline is broken down into five phases as shown in Figure 3.2 and each phase is then the key activities for each phase are then described.

**Figure 3.2: Shaping a healthier future programme phases**

<table>
<thead>
<tr>
<th>Phase</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirm case for change &amp; vision</td>
<td>- during this phase, the programme:</td>
</tr>
<tr>
<td>Pre consultation</td>
<td>• Established governance, resourcing and work streams for programme</td>
</tr>
<tr>
<td></td>
<td>• Agreed the programme plan</td>
</tr>
<tr>
<td></td>
<td>• Published the case for service change</td>
</tr>
<tr>
<td></td>
<td>• Agreed the vision for acute and out of hospital care</td>
</tr>
<tr>
<td></td>
<td>• Developed the benefits framework</td>
</tr>
<tr>
<td></td>
<td>• Began stakeholder engagement with clinicians, commissioners, providers, patients and other local stakeholders.</td>
</tr>
<tr>
<td>Consultation</td>
<td>• Developed acute clinical standards and clinical models</td>
</tr>
<tr>
<td></td>
<td>• Developed options for consultation moving from a long list using hurdle and evaluation criteria and conducting sensitivity analysis</td>
</tr>
<tr>
<td></td>
<td>• Supported CCGs to develop their out of hospital strategies</td>
</tr>
<tr>
<td></td>
<td>• Continued engagement with the full range of stakeholders, including three stakeholder events to inform the work of the programme</td>
</tr>
<tr>
<td></td>
<td>• Developed robust processes that led to successful reviews by NCAT and OGC</td>
</tr>
<tr>
<td></td>
<td>• Evidenced compliance with the “Four Tests”</td>
</tr>
<tr>
<td></td>
<td>• Planned the public consultation and developed consultation documents</td>
</tr>
<tr>
<td></td>
<td>• Developed the pre-consultation business case</td>
</tr>
<tr>
<td></td>
<td>• Carried out pre-consultation elements of equalities review.</td>
</tr>
</tbody>
</table>

3. Introduction to *Shaping a healthier future* and purpose of document
Consultation - during this phase, the programme:

- Supported the delivery of the consultation including:
  - Response to general information enquiries
  - Response to detailed and technical enquiries
  - Producing insights into early consultation themes.
- Developed existing governance structures to prepare for transition to CCGs
- Monitored and reported progress of work stream activities to appropriate stakeholders
- Supported stakeholder management and engagement.

A detailed summary of our approach to consultation is provided in Appendix C.

Post consultation – during this phase, the programme:

- Received an independent Consultation Report
- Developed the Consultation Response document in answer to the Consultation Report
- Finalised relevant clinical standards and models
- Developed local hospital plans
- Developed provisional reconfiguration implementation plans, including workforce considerations, with Clinical Implementation Groups (CIGs)
- Received an independent Equalities Focused Sub-group Review
- Developed the final decision-making papers including Four Tests papers, the business case and the risk assessment
- Supported development of the benefits framework
- Continued to support stakeholder engagement and management.

At the time of issue of this decision making business case, the programme has completed the consultation and decision making phases. It is seeking approval from the JCPCT to transition to implementation.

3.5 Stakeholder engagement strategy

As described in the programme’s principles, developing an inclusive approach to engaging with all stakeholders has been a priority of the programme. This section provides a summary of our stakeholder engagement strategy and principles for stakeholder engagement, supported by further detail of the activities in Appendices B and C. Chapter 6 provides a detailed overview of the formal consultation process, including the full set of activities we undertook and who was involved.

3.5.1 Summary of our stakeholder engagement strategy

The Case for Change was published in February 2012. This set out the desire of local clinicians to transform the way care is delivered in NW London and outlined the basis for the Shaping a healthier future programme. The Case for Change set out the fundamental issues and challenges currently facing the healthcare system and it identified where improvements could be made, particularly to the consistency and quality of clinical outcomes and patient experiences. The Case for Change has provided a basis on which to build engagement with a wide variety of stakeholders across NW London, crucially with patients, the public and clinicians. This engagement has also been used to involve these groups in the development of our proposals and subsequent decision making.
Shaping a healthier future has set out a clear stakeholder engagement strategy that is crucial to the successful delivery of our proposals. We understand that patients, staff and the wider public care deeply about what happens to their local NHS services and it is critical that they are part of the journey we undertake.

Stakeholder engagement work started at the beginning of the Shaping a healthier future programme and built on similar work carried out with Clinical Working Groups and other stakeholders in previous years. The programme carried out a systematic and wide-ranging programme of engagement based on an agreed set of principles and an understanding of who our stakeholders are and how they should be engaged. It is now advising the JCPCT on decisions to be made following consultation.

Figure 3.3: Summary of stakeholder engagement strategy

3.5.2 Stakeholder engagement principles

A set of stakeholder engagement principles to underpin our activity was developed. We committed to:

- Plan and undertake appropriate engagement with relevant stakeholders at each stage of the programme
- Deliver sufficient levels of awareness and understanding about proposed service changes across NW London among key identified stakeholder groups
- Provide regular opportunities for stakeholders to engage with us before, during and post formal consultation to facilitate engagement and consultation through high quality, credible communications channels and messages
- Baseline and monitor support among key stakeholder groups, before, during and after consultation
- Meet statutory requirements to engage stakeholders
• Ensure consistency of communications between commissioners and providers, as part of managing internal communications
• Ensure consistent clinical engagement through regular dialogue between programme Medical Directors and provider/borough clinicians
• Be proactive in identifying existing stakeholder events and meetings to tap into to increase programme awareness and relationship with stakeholders
• Work collaboratively with the media to ensure access to accurate information for the public.

3.5.3 Identification of stakeholders

The programme conducted a robust process that identified a wide range of stakeholders who should be involved in the development of proposals to change the way NHS services are delivered. To identify all the stakeholders, we considered how we could capture the full range of opinions in the development process and how we could incorporate different experiences and learning from similar programmes.

As part of the identification and prioritisation process, the programme developed:

• Stakeholder groupings through an intensive stakeholder workshop
• A stakeholder analysis showing key groups of stakeholders
• A stakeholder prioritisation grid in which stakeholder groups were assessed with respect to specific concerns about the programme and prioritised to ensure those concerns are being discussed, understood and met
• A stakeholder diary in which all external meetings with stakeholders were logged and communication tracked regularly
• A meetings calendar in which all relevant stakeholder meetings were logged to ensure engagement with key stakeholders groups such that meetings were well attended and prepared for.

Figure 3.4 provides a summary of the different stakeholder groups that were identified and the table in Figure 3.5 shows the purpose of engagement with each of the six groups.
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**Figure 3.4: Summary of key stakeholder groups identified in the *Shaping a healthier future* programme**

<table>
<thead>
<tr>
<th>Providers</th>
<th>Public</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs</td>
<td>Members of the public</td>
</tr>
<tr>
<td>NW London acute trusts</td>
<td>Carers</td>
</tr>
<tr>
<td>NW London community services providers</td>
<td></td>
</tr>
<tr>
<td>NW London mental health trusts</td>
<td></td>
</tr>
<tr>
<td>CCGs</td>
<td>LINks</td>
</tr>
<tr>
<td>Royal Colleges</td>
<td>PPAG</td>
</tr>
<tr>
<td>London Deanery</td>
<td>DH</td>
</tr>
<tr>
<td>British Medical Association</td>
<td>DH</td>
</tr>
</tbody>
</table>

**Figure 3.5: Purpose of engagement with each stakeholder group**

<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Individual Stakeholders</th>
<th>Purpose of Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinicians &amp; Staff</td>
<td>CCGs, GPs, Royal Colleges, London Deanery, British Medical Association.</td>
<td>Clinical input such that the options developed reflect the highest levels of clinical quality and benefit to the patient.</td>
</tr>
<tr>
<td>Providers</td>
<td>NW London acute trusts, NW London community services providers, NW London mental health trusts, London Ambulance Service.</td>
<td>Providers along each care pathway are able to input into proposals by providing knowledge and understanding of their population and patients, such that this enables a better outcome for patients.</td>
</tr>
<tr>
<td>Patient Groups</td>
<td>Public and Patient Advisory Group (PPAG), LINks.</td>
<td>Ensure patient groups are aware of key messages around potential service changes, that these are visible and transparent, allowing patient involvement in shaping the proposals.</td>
</tr>
<tr>
<td>Public</td>
<td>Members of the public.</td>
<td>The public are aware of potential changes to the way their healthcare services are delivered, what is being considered and how the possible changes might affect them.</td>
</tr>
</tbody>
</table>

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1 In addition, since January 2013 we have been formally engaging with the NHS NCB and NHS Trust Development Authority (NTDA).
3.6 Stakeholder involvement in developing the proposals

The programme has engaged extensively with clinicians, the public, patient representatives, providers and political stakeholders to develop the recommended option. Progress against the plan was regularly reviewed at Programme Executive and Programme Board meetings and the plan was refreshed based on feedback from these groups to ensure the appropriate focus was directed at each group. Input has been provided from all stakeholder groups to the Case for Change, detailed options development, testing and finalisation of options for consultation, the formal consultation, the programme’s response to consultation and the development of the recommended option.

A range of methods have been used as part of our stakeholder engagement activities above and beyond meetings with individuals and groups. Different types of stakeholder engagement activities have included:

- Newsletters being issued monthly to internal staff, patients, the public and GPs. The newsletters provided regular updates on programme progress as well as details of the options development process (internally and externally)
- The Shaping a healthier future website which provides information on the programme to all online users, including key documentation from the programme and materials from stakeholder events, which can be downloaded
- Social media mechanisms such as Twitter to deliver programme news
- Four large stakeholder events to engage with public, patients and clinicians, allowing questions to be asked, input into the development of the proposals, and further information given to attendees. These were held on 15 February, 23 March, 15 May and 28 November 2012. Over 200 people attended each event, including around 80-100 clinicians at each one.

Full details of all stakeholder engagement that has taken place in the pre-consultation phase of the programme can be found in Appendix B of this document. This includes four engagement event reports, newsletters and details of all meetings attended. Chapter 6 explains in detail the consultation process, the engagement activities that were undertaken during this period and the feedback from key events.

Testing and refinement has taken place throughout the development of the proposals, starting from the setting out of the Case for Change. This has included reviews by NCAT and the Expert Clinical Panel, discussions with patient and public groups and their representatives. NHS NW London also pays due regard to the aims of the general equality duty and the public sector equality duty, and complies with both its general equality duty and its public sector duty when making decisions. We have endeavoured to understand the
potential effect of our practices and policies on our staff and communities, particularly those with protected characteristics as defined in Section 149 of the Equality Act 2010. Consideration and understanding of the potential effects of our proposals on different people has been an additional component of review and refinement.

An overview of the activities for clinical, provider, public and political engagement is described below.

### 3.6.1 Clinical engagement activities

Clinicians have led the programme throughout, working with key stakeholders to:

- Set out the case for service change in NW London
- Develop the vision for NHS services in NW London, including standards for both primary and secondary care and a set of service delivery models
- Identify options for change
- Analyse and evaluate these options to identify proposals to take to public consultation
- Inform the response to findings from the public consultation
- Support the analysis to develop the recommended option for the DMBC.

Enabling widespread clinical engagement was essential in developing a preferred option for reconfiguration. The Programme Medical Directors worked closely with the Clinical Board (which consists of medical directors from each provider in NW London and clinical representatives from each CCG) to develop the main programme deliverables. In addition, the Programme Medical Directors have been continuously committed to supporting stakeholder engagement by attending and presenting at meetings to enable the clinical messages to be given accurately to other clinicians and for audience feedback to be gathered and considered throughout the proposals development process.

To ensure wider clinical engagement, additional direct engagement was focused on two core groups: senior provider clinicians and local GP practice staff. This was delivered through a series of local clinical engagement events during March – May 2012. The first area of focus was on the quality standards, service models and influencing the options development process. The second area of focus has been on the NCAT review, refining the options for consultation and understanding the site-specific implications in more detail.

### 3.6.2 Provider engagement activities

The programme has engaged with clinicians and managers across the providers in NW London, with the main focus on acute providers and community care providers. The record of engagement with these providers can be found in Appendix B. These have included:

- **Events focussed on a wider group of clinicians** - the programme was aware whilst there was strong clinical engagement through the Clinical Board and regular Programme meetings, local clinicians wanted to supplement this through engagement with the wider clinical community. This was done by Programme Medical Directors using standing events such as regular consultant meetings and GP forums to present the progress of the programme and to answer questions.

- **Clinicians representing every NW London service provider** - including hospitals and community health services and GPs attended four stakeholder events where they were able to discuss and inform the programme’s work on:
  
  o The Case for Change
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- Rationale for options development
- Out of hospital visions and strategies
- Consultation options
- Plans for consultation
- Estate reconfiguration discussions.

- Programme newsletters have been shared with all GPs.

In addition to these activities, the programme runs a monthly Communications and Engagement working group. This consists of programme communications staff and directors of communications from each of the providers. This enabled us to ensure alignment of activities between the programme and providers and gave the opportunity to share progress and gain feedback on considerations for the programme. It enabled us to disseminate material and messages and also for the provider teams to request tailored material from the programme. Between each meeting we shared relevant materials including the development of options, post event reports and newsletters that provider communications leads have then been able to distribute to provider staff. This has resulted in wider stakeholder engagement.

### 3.6.3 Patient groups engagement activities

The main engagement activities to engage with patient groups have been the four large stakeholder events, where half a day was given to discussing the work of the programme with patient and public representatives. Further detail of events is in Appendices B and C.

Throughout the development of the recommended proposals, meetings and briefings have also been held with the Patient Public Advisory Group (PPAG) and its members. This has allowed for the direct input of patient representatives into the programme. The programme has taken PPAG through all stages of the programme including the Case for Change and the options development and refinement process.

LINks members were present at the four large stakeholder engagement events. In addition, PPAG representatives ensured LINks members are aware of programme objectives and progress. The programme attended LINks meetings and further formal engagement with LINks took place during consultation.

### 3.6.4 Public engagement activities

The main focus of our engagement with the wider public has been through four large stakeholder events (three during consultation and one post consultation), as described in Appendices B and C and Chapter 6. In addition to these events and other regular meetings with patient groups, the programme has proactively sought opportunities to speak at open, public events to raise awareness of the work of the programme prior to the full public consultation.

As part of the wider consultation and engagement work for *Shaping a healthier future*, the communications and engagement team have undertaken work to engage and consult groups, communities that are seen as seldom heard and traditionally under represented. This includes groups such as refugee communities, the elderly, faith groups, BME communities and women from within these communities. This element of the work ensures that these groups are aware of the possible changes to NHS services within their local area and how these may affect them as an individual or as a community. We have also sought to ensure that any concerns or views they have on the reconfiguration of services are captured and used to help determine the future provision of NHS services. This engagement also links with equalities work that has been undertaken (described in Chapter 13) which will help to
ensure that the impact of changes to services accentuates the positives, as well as minimises the impact on people as a result of their protected characteristics.

It has been important for the programme to link with existing networks and forums within the eight boroughs. This has included working with local authority colleagues who support voluntary and community sector networks, voluntary sector organisations, including the CVS network, and small community organisations who work with the key target groups and meeting with faith groups who are able to access a large number of community members through the work they undertake.

### 3.6.5 Engagement with ‘hard to reach’ groups

We wanted to ensure engagement with stakeholders from ‘hard to reach’ communities and protected groups who may have specific healthcare needs and views on our proposals. This was particularly important in cases where opinions would not be heard unless deliberative pro-active engagement was undertaken. We engaged with ‘hard to reach’ communities and protected groups pre-consultation and during consultation. We recognised that NW London Hammersmith and Fulham has the largest Polish community in the UK, Ealing has the largest Somali community in the UK and Black and Minority Ethnic (BME) groups in Brent now make up the majority of the population. Work enabled us to understand the wide range of groups that would form part of our engagement and enabled us to engage them effectively during consultation.

### 3.6.6 Political stakeholder engagement activities

There has been significant engagement with political stakeholders throughout the programme. This has included meetings with councillors, cabinet members and Health and Wellbeing Boards (H&WBs) in NW London. Greater London Assembly Members have been sent the newsletter. A record of meetings with these groups can be found in Appendix C.

The Joint Health Overview and Scrutiny Committee (JHOSC) was formed by bringing together representatives of each Health Overview and Scrutiny Committee (HOSC) in NW London and other potentially affected neighbouring boroughs. It has responsibility for scrutinising the programme and its proposals for service change. The JHOSC provided formal feedback to the consultation and NW London presented a response to the Joint Committee submission a November 2012. Engagement with individual HOSCs has been ongoing in parallel with individual borough HOSCs. There has been regular attendance by the programme at as many HOSC meetings as possible in every borough.

### 3.7 Purpose and scope of the decision making business case

The decision making business case (DMBC) is a technical and analytical document that sets out the information necessary for the JCPCT to make informed decisions for the reconfiguration of healthcare services in NW London. It sets out the robust process of evaluation we have been through to identify our proposals for change, the findings from the public consultation process and how the programme has responded, the final proposal and the implications of this proposal. The document can be considered in two parts; the first part describes the process to identify the recommendation and the second part outlines the implications of that recommendation. The document includes:

- Our vision, supported by clinical standards and proposed clinical service models
- The decision making process we have been through including our response to the consultation findings
The implications of the options in terms of activity by site, equalities, travel and access, finance, capital, estates and workforce
The recommendation for service change
The benefits we believe the reconfiguration will deliver
What we believe the next steps are to support planning for implementation and how we plan to maintain clinical safety in the transition period.

The DMBC will be published by NHS NW London but it is not intended to be the main mechanism through which reconfiguration is explained to the public. It will be made available through the website address detailed below.

Other programme documentation can be found on the Shaping a healthier future website at www.healthiernorthwestlondon.nhs.uk
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Chapter 4
The Case for Change
4. The Case for Change

This chapter describes why change is necessary and why it must start now. The NHS in NW London is facing a range of pressures and challenges. From a clinical view, there is increased demand caused by the ageing population and increased prevalence of long term conditions and co-morbidities. 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. Alongside this, there are financial pressures which require the NHS to deliver efficiency savings for reinvestment. As such, doing nothing is not an option. The Case for Change was developed by clinicians, who looked at the current and future demands on the NHS in NW London, and showed that a new configuration of services was necessary to deliver high quality care within the financial constraints on the system.

4.1 The clinical Case for Change

The Case for Change was developed by local clinicians with involvement from providers, CCGs and representatives of patient groups and the public. It builds upon the Case for Change set out in the 2011 Commissioning Strategic Plan, but represents the specific case for service change in NW London. The key elements of the Case for Change are set out below. Further detail is available in our full Case for Change, which was approved by the Programme Board in January 2012 and published as a standalone document which is available on our website www.healthiernorthwestlondon.nhs.uk, it can also be found in Appendix D. Further detail on clinical evidence can be found in Appendix E. Since the approval of the Case for Change in early 2012, the financial analysis has been updated. Further detail on the financial analysis can be found in Chapter 9d.

4.1.1 The demands on the NHS in NW London are changing

The population of NW London is growing and life expectancy is improving. NW London population is forecast to increase by approximately 141,000 people (7%) growing from circa 2 million to circa 2.15 million over the period to 2018 (see Appendix N for further details about ONS). Ten years ago life expectancy in NW London was 76.8 years for men and 81.9 years for women, but it is now about three years longer: 80 years for men and 84.5 years for women, particularly due to early diagnosis and improved treatments resulting in fewer people dying prematurely from diseases such as cancer, heart disease and strokes.

For the NHS, this is hugely significant because older people are more likely to develop long-term conditions such as diabetes, heart disease and breathing difficulties and are more at risk of strokes, cancer and other health problems. Three out of every five people aged over 60 in England suffer from these kinds of conditions and as the population ages there will be more people with age-related diseases. In NW London some 300,000 people, nearly one in six, of people all ages have one of the following five long-term conditions: diabetes, asthma, coronary heart disease (CHD), chronic obstructive pulmonary disease (COPD), and congestive heart failure.

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1 Some of the references included in this chapter have been truncated. For full references, please refer to the full case for change.
2 GP registered population figures used to calculate population weightings of each NW London PCT. Life expectancies associated with each NW London PCT then multiplied by weightings to produce “average” life expectancy for NW London
3 Source: QOF, Proportion of GP registered population in NW London who are on the CHD, COPD, CHF, diabetes and asthma registers
Fortunately, our ability to prevent, diagnose and treat medical conditions is constantly improving. Much of this advanced medical treatment depends on better technology and equipment, operated by more specialised clinicians. Surgeons now specialise in different conditions and different parts of the body; until recently cardiology did not even exist as a speciality but now it is a major clinical speciality with a number of sub-specialities.

This in turn means the traditional ways of organising care in the NHS have had to change. A recent report by the King’s Fund has underlined how advances in medicine and surgery have led clinical staff and equipment to become more specialised, leading to specialist teams brought together in fewer, larger hospital sites so that skills can be maximised and patient outcomes improved.

Medical advances also mean fewer hospital beds are needed. Most routine surgery is now done in just one day (“day surgery”) and 80% of all patients have stays in hospital of fewer than three days. Not surprisingly therefore, the number of hospital beds in NW London has fallen by about 9% over the last five years. As medicine and surgery continue to become more specialised, and new techniques allow people to go home even earlier, or avoid going to hospital at all, the number of hospital beds will reduce even more.

The rise of the internet, mobile communications, and “telehealth” all provide other ways for patients to access advice about their health and communicate with health and social care professionals. This creates more opportunities to support patients in their own homes and receive services, traditionally based in a hospital, through more local facilities such as GP surgeries. This results in services being moved closer to patients’ own homes.

In financial terms, analysis suggests that Government expenditure on health will only be increasing very slightly in real terms in the years up to 2015. Alongside this, the financial pressures caused by the changing demographic profile and maintaining pace of new technologies are likely to exceed this, unless we change the way services are delivered. Services also need to be redesigned and ensure that we are spending money in the best way to deliver the best clinical outcomes for patients.

4.1.2 The NHS in NW London has also been changing

The doctors, nurses, other clinicians, managers and staff of the NHS in NW London have been working hard to constantly improve healthcare delivery across hospital, primary care and in local communities.

Critical services have started to be centralised where necessary to deliver high quality care:

- **Major Trauma**: People who suffer a serious injury or major trauma need high quality, specialist care to give them the best chances of survival and recovery. From 2010, NW London patients have received new world-class trauma care through the London trauma system. This is made up of four trauma networks, each with a major trauma centre. During the first year the system has saved the lives of an estimated 58 people in London who would otherwise have been expected to die. The network has prevented disability for many more.

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4 Reconfiguring Hospital Services 2011
5 Hospital Episode Statistics
6 Department of Health
7 Using technology such as the internet to remotely monitor and care for people’s conditions
9 London Trauma Office
4. The Case for Change

- **Stroke Services**: The provision of stroke services across London, including NW London, has dramatically improved. Only three years ago, stroke care was fragmented across the capital, being delivered in all of the 31 acute hospitals. Now there is a dedicated network of eight “hyper-acute” stroke units operate across London. This new approach is thought to have prevented an estimated 100 deaths per year in NW London.\(^{10}\)

At the same time the NHS in NW London has improved the way services are delivered in the community so care is delivered as close as possible to where patients live and is integrated with local hospitals:

- **The STARRS scheme (Short Term Assessment, Rehabilitation and Reablement Service) in Brent**: Has improved the transition for patients between acute hospital services and community services, reducing the need for patients to go to hospital and leading to a much better, more independent quality of life.

- **Integrated Care Pilot (ICP)**: Set up to serve patients over 75 or with diabetes overcomes the boundaries between hospitals, community care services, social care and local authorities to allow faster access, streamlined for patients and a stronger focus on their long-term needs. The GP practices involved have initially experienced a 6.6% reduction in non-elective admissions for diabetic and elderly patient groups, compared to 0.3% increase for non-involved GP practices.\(^{11}\). This reduction is likely to increase as the pilot becomes fully operational. (Further information on the evaluation of the ICP can be found in Chapter 8, Section 8.2.3).

4.1.3 **More change is still needed**

To meet the clinical and financial challenges that the NHS faces in NW London, we need to support people to stay healthy and ensure that if they get ill the best community and hospital services are available to them. Significant further change is needed to deliver this to the people of NW London:

**We need to do more to prevent ill health in the first place**

Many people in NW London are not as healthy as they could be. There is currently a difference of up to 17 years in life expectancy in different wards in NW London.\(^{12}\). It is heavily correlated with deprivation and is caused by a number of factors including: living conditions, diet, levels of smoking and drinking, access to sport and leisure activities, social and support networks, as well as barriers to healthcare, including seemingly obvious things like language and literacy.

More needs to be done to promote health and stop people of NW London getting ill. Much can be done through successful promotion of public health information and campaigns that assist people to take personal responsibility for their own health. Also, more proactive primary care and better integrated working needs to happen so that the whole system – from schools, to GPs, from community nurses to hospital doctors – works seamlessly to support everyone to lead healthier lives.

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\(^{10}\) NHS press article: “Specialist stroke centres save lives across capital”

\(^{11}\) NW London Integrated Care Pilot preliminary performance assessment (presented at NW London JCPCT 10th April 2012)

\(^{12}\) Greater London Authority (London.gov.uk)
We need to do more to provide easy access to high quality GPs and their teams

If a basic level of access to GP care is not provided, it can result in more people resorting to using A&E services. These services are more costly to deliver and are also “episodic” as they lack the continuity and historical knowledge that a GP practice can provide, resulting in poorer care for the patient.

Despite many GP practices in NW London offering a good quality service, many patients still find it too hard to access good quality care. Patient satisfaction in primary care is low in all eight NW London boroughs when compared with national levels, as seen in the table below:

- The majority (79%) of GP practices in NW London have below national average satisfaction scores. This could, in part, lead to the higher than average use of A&Es, particularly in outer NW London, for example, emergency admissions are much higher in Ealing and Hounslow compared to the national average.
- Similarly, one in four patients in NW London do not feel that they are being treated by their GP with care and concern.
- In terms of communication and access (such as communications by the doctor, level of empathy, satisfaction with the out-of-hours service), five of the NW London boroughs rank in the bottom 10% nationally.

Figure 4.1: Primary care patient satisfaction scores for communication and access in NW London (percentages of patients reporting satisfaction during 2010/11)

The effectiveness of the delivery of GP services is highly variable and often below national averages. This variation means we are not consistently delivering the kind of high quality primary care we should be.

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13 GP Patient survey 2010/11
We need to do more to support patients with long term conditions and to enable older people to live more independently

In NW London there are big differences in the level of care given to people with long term conditions and the specialist services available to them out of hospital, for example leading to significant variations in the specialist support given to diabetic patients and the level of amputation rates suffered by them\(^{14}\). Figures 4.2 and 4.3 show the variations in funding levels across the different PCTs in NW London for different settings of care and on long-term conditions.

**Figure 4.2: Funding by PCTs for each setting of care\(^{15}\) (percentage of 2010/11 PCT programme budget spent on setting of care)**

<table>
<thead>
<tr>
<th>Prevention &amp; Health Promotion</th>
<th>Community Care</th>
<th>Health and Social Care Provided in Other Settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hammersmith &amp; Fulham</td>
<td>4.3</td>
<td></td>
</tr>
<tr>
<td>Westminster PCT</td>
<td>4.1</td>
<td></td>
</tr>
<tr>
<td>Kensington and Chelsea PCT</td>
<td>5.7</td>
<td></td>
</tr>
<tr>
<td>Brent PCT</td>
<td>5.7</td>
<td></td>
</tr>
<tr>
<td>Ealing PCT</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td>Harrow PCT</td>
<td>4.4</td>
<td></td>
</tr>
<tr>
<td>Hillingdon PCT</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td>Hounslow PCT</td>
<td>0.4</td>
<td></td>
</tr>
</tbody>
</table>

\(^{14}\) Total lower limb amputation rates per 1,000 adults with diabetes vary in NW London (Yorkshire & Humber Public Health Observatory)

\(^{15}\) Source: 2010-11 Programme Budgeting Benchmarking Tool Version 1.0.14.12.11.xls
If people with long-term conditions are not cared for well enough in the community, they create a heavy burden for our hospitals. NW London currently estimates people living with such conditions account for 67% of all hospital bed days\(^\text{17}\).

Some solutions, such as the Integrated Care Pilot, have been developed within NW London (further information on the successes of the ICP can be found in Chapter 8.20.4). Elsewhere, a pilot project in Ipswich has helped 107 patients to better manage their own conditions with a resulting 75% reduction in GP visits and 75% reduction in bed days in hospital over a six-month period. Staff are being trained to become “health coaches” to their patients.

For older people, receiving co-ordinated and effective support from social care, the NHS and the local community delivered together enables independent living. When this works well it can keep people out of hospital and healthier for longer. In hospital older people are often at risk of developing further conditions that complicate or worsen their health.

Currently, too many older people are admitted to hospital when, with appropriate out of hospital care, they could be treated in the community and looked after in their own home. Equally, at the end of people’s lives, more want to die at home rather than in hospital, and more needs to be done to enable this. In NW London only 18% of people are dying at home versus a national average of 23% and in contrast to the wishes of 54% of patients\(^\text{18}\).

**4.1.4 Hospitals also need to change to improve the quality of care**

While the NHS must focus on keeping people healthy and treating them, where possible, in the community or their own homes, there will always be the need to treat some patients in hospitals.

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\(^{16}\) Source: Expenditure from 2009-10 programme budget. Number of patients with each LTC - QOF 2009-10

\(^{17}\) Based on Department of Health methodology

\(^{18}\) [www.londonhp.nhs.uk/services/end-of-life/case-for-change/](http://www.londonhp.nhs.uk/services/end-of-life/case-for-change/)
In NW London, however, the NHS is struggling to deliver consistent, high quality hospital care:

- Patient experience across NW London hospitals is low compared to other regions
- Many staff would not be comfortable sending their own relatives to hospitals in NW London
- There is marked variation in the quality of acute hospital services in NW London.

**To improve patient and staff satisfaction**

Patients are regularly surveyed on their experience of hospital services and in NW London these results are mixed. Only the three specialist hospital trusts in NW London have scores substantially higher than the national average when it comes to overall patient experience. Across the other five measures collected by the Care Quality Commission (CQC) non-specialist hospitals scored about the same or lower than the national average. Staff are also regularly surveyed and worryingly in some NW London hospitals a significant number of staff do not “agree” or “agree strongly” that they would recommend their hospital as a place to work or to be treated\(^\text{19}\).

**To make high quality more consistent**

In general, the clinical quality of hospitals in NW London compares well to the national average in terms of mortality rates. But there remain significant variations in mortality, for example, standardised mortality rates at Imperial are significantly lower than the other hospitals in NW London\(^\text{20}\).

**Figure 4.4: Mortality rates across London Trusts**\(^\text{21}\)

A pan-London study in 2011 established that there is a greater than 10% higher mortality rate in London for emergency admissions at the weekend compared to weekdays. We believe this could be addressed by improved consultant cover and access to diagnostics at weekends. Data for London shows that patients admitted at the weekend are more likely to die from an emergency admission compared to a weekday. It is estimated that around 130 lives could be saved across NW London every year if mortality rates for admissions at the weekend were the same as during the week\(^\text{22}\).

\(^{19}\) National NHS Staff Survey 2010  
\(^{20}\) AES Case for Change September 2011; Dr Foster Ltd  
\(^{21}\) Source: AES-Case-for-change-September-2011; Dr. Foster Ltd.  
\(^{22}\) High Quality Hospital Provision in London – an Analysis: Quotes 520 lives could be saved across London, NW London estimated to account for 25% of these
Other areas of care also demonstrate variations in quality, for example the proportion of patients who need to be readmitted after receiving a number of procedures varies considerably from one hospital to another.

For example, readmissions for cholecystectomy (the surgical removal of the gallbladder) vary substantially. This can be due to multiple reasons, but one reason is differences in the way in which patients are cared for which results in complications after surgery.

**Figure 4.5: Readmissions for cholecystectomies, April to September 2011**

<table>
<thead>
<tr>
<th>% of all cholecystectomies performed by each provider readmitted within 30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imperial College Healthcare</td>
</tr>
<tr>
<td>Hillingdon</td>
</tr>
<tr>
<td>Chelsea and Westminster</td>
</tr>
<tr>
<td>Ealing</td>
</tr>
<tr>
<td>North West London Hospitals</td>
</tr>
<tr>
<td>West Middlesex</td>
</tr>
<tr>
<td>ALL LONDON</td>
</tr>
</tbody>
</table>

By providing 24/7 access to specialist emergency care

Clinical evidence compiled has highlighted that for emergency care services, early involvement of senior medical personnel in the assessment and subsequent management of many acutely ill patients improves outcomes, including fewer complications and lower mortality rates. A self-reported survey of London trusts undertaken in 2011 demonstrated that there is considerable variation in the availability of senior experienced staff to care for patients between hospitals and between the services provided on weekdays compared to that at weekends: Findings included:

- Senior doctors availability in acute medicine and emergency general surgery at the weekends is more than halved at many sites compared to cover during the week
- Patients admitted on a Sunday have a 16% greater chance of dying than if admitted on a weekday, with a corresponding figure of 11% on a Saturday
- This is a group that has the least access to senior clinicians and diagnostics when they most need it.

Figure 4.6 shows the significant reduction in review of emergency surgery admissions by senior doctors at weekends compared to weekdays.

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23 NW London Performance team
4. The Case for Change

It is known that in NW London, four hospitals are not always meeting the best practice guidelines of emergency general surgery admissions seeing a consultant within 12 hours.

The Royal Colleges have recommended increased consultant presence, in particular to cover emergency and maternity services. Achieving such increased coverage is a huge challenge nationally as well as in NW London:

- Units need to serve a sufficiently large population so that they are busy enough out-of-hours for staff to maintain their skills in dealing with complications. This is a particular issue for senior staff who must also spend time fulfilling other responsibilities
- Only larger units can afford to employ an increased number of senior staff, with many smaller units already being on the margins of economic viability due to junior doctors now working fewer hours
- There is insufficient staff available to provide such increased cover across all units, even if it could be afforded and skills could be maintained.

Just as staff need to maintain their skills, so specialist teams gain skills because of the increased numbers they treat. It is well established that the more specialised doctors and other professional staff become, the better the results for patients. For example, patients treated by a specialist surgeon are at a lower risk of death, are likely to have fewer complications and are likely to benefit from shorter stays in hospital. Specialists become proficient by dealing with large numbers of similar cases. By being located in specialist centres and working as part of a network of specialist staff, specialists can access the best equipment and develop their skills by working alongside other specialists.

There are some excellent specialist centres and networks already benefitting patients and carers in NW London. However there are other areas of clinical practice which would also benefit by being centralised in a few centres of excellence, such as specialist laparoscopic (keyhole) surgery. Laparoscopic surgery is associated with faster recovery times and

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26 Source: Survey of London acute trusts (2011)
29 NHS London, Adult emergency services: acute medicine and emergency general surgery, 2011
can improve patient outcomes, yet at Ealing hospital only a third of surgeons providing emergency care are able to perform laparoscopic surgery.

However, other very specialist services, for example, cardiology, oncology (cancer), vascular surgery and neurosurgery, need to be delivered in larger centres of excellence with specialist staff, equipment and facilities. With increasing specialisation and guidelines setting standards for the degree of experience staff need to get to be sufficiently qualified, it is becoming increasingly difficult for the NHS in NW London to sustain the specialist surgical and other teams needed and ensure they see the volume of cases to enable specialists to maintain and develop new skills and sub-specialise across all our current sites.

With NW London's growing population it is increasingly hard to provide a broad range of services around the clock at the existing nine acute hospital sites to the standards we believe our patients should expect. We have more A&E departments per head of population than other parts of the country and this makes it harder to ensure enough senior staff are available. Currently only one trust in NW London is currently providing the level of consultant cover recommended by the College of Emergency Medicine.

Even with the current configuration of A&E services nationally, four NW London hospitals have a catchment population smaller than average, as shown in Figure 4.7. In addition, all but one (Northwick Park) have a catchment population smaller than the Royal College of Surgeons preferred level.

Figure 4.7: Catchment population of A&E provision in NW London31 (‘000 population per A&E)

<table>
<thead>
<tr>
<th>Catchment population per A&amp;E department1</th>
<th>‘000 population/A&amp;E</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>259</td>
</tr>
<tr>
<td>Average NWL</td>
<td>238</td>
</tr>
<tr>
<td>Headingon</td>
<td></td>
</tr>
<tr>
<td>West Middlesex</td>
<td></td>
</tr>
<tr>
<td>Northwick Park</td>
<td></td>
</tr>
<tr>
<td>Hammersmith and St Mary’s (incl WEH)</td>
<td></td>
</tr>
<tr>
<td>Charing Cross</td>
<td>Above average</td>
</tr>
<tr>
<td>Ealing</td>
<td>Below average</td>
</tr>
<tr>
<td>Chelsea &amp; Westminster</td>
<td></td>
</tr>
<tr>
<td>Central Middlesex</td>
<td></td>
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</tbody>
</table>

Residents in NW London currently enjoy excellent access to acute services, with travel times between hospitals being relatively short in comparison to other areas of the UK. However, medical evidence clearly indicates that for life-threatening conditions, for example a heart attack, stroke or major trauma, the clinical outcome is far more dependent on getting to the right specialist service than it is on small differences in travel times. Indeed, NHS London has already implemented pathways of care that take patients with major trauma, acute heart

31 Estates Return Information Collection, 2010/11; ONS. Assumes 200 A&Es in England; Includes small, medium, large, teaching and multi-service acute Trusts, excludes specialist Trusts; sites with over 10,000 admissions; Assumes Hammersmith catchment travels to St. Mary's; Estimated catchment populations for individual trusts in NW London; England populations ONS mid-2009 estimates.
attack or stroke to designated centres, even if that means going past another acute hospital. The clinical benefit, in terms of improved survival and reduced disability from the implementation of these pathways, has been proven. If high quality hospital care is to be delivered, there is a clear need to consolidate some services in NW London.

4.1.5  **The NHS in NW London can face the challenge and use reconfiguration to change the way our services are provided – across hospitals and in the community**

In order to meet these challenges and improve the quality of care provided across NW London, we believe we need to "reconfigure" our services and change the way they are currently provided across our hospitals, GP practices and other community care sites. This will mean we will need to review the current pattern of hospitals in NW London.

We need to ensure that people in NW London have access to the right care in the right places. Higher quality, more effective treatments for patients need to be provided more consistently where they are needed, within higher quality, more up-to-date, safer places. Care needs to be provided in a more integrated way, in partnership with social services and local government, so that it is clear to patients who is managing their care and that they can seamlessly transition between care settings.

More investment needs to be made in GP services and other local healthcare, so it is more consistent and of a higher standard, bringing better routine treatments closer to home and supporting more services outside hospitals, where they are needed. Alongside this, clinical teams need to be established so patients needing specialist treatment can be certain they will be seen by experienced specialist clinicians, who are familiar with, and who regularly treat, similar patients with their condition.

This also implies more efficient use of NHS buildings and equipment and more targeted investment in both, as well as reduced management costs by planning care across a larger area and achieving savings on a larger scale.

4.1.6  **Significant investment is required to improve NW London’s NHS hospital estate as well as improving primary and community care facilities**

NW London spends more on hospital buildings than the NHS does in other parts of the country and, as a result, spends less in the community. The amount of space per bed is approximately 50% larger than in the rest of the country, and consequently NW London has higher fixed costs and as well as having hospitals that are more expensive to run and maintain than average.
The physical condition of much of the NHS estate in NW London is poor:

- Three quarters of hospitals require significant investment and refurbishment to meet modern standards, at an estimated cost of approximately £150 million\(^3\) – we need to prioritise where we invest to maximum effect as capital funding is a scarce resource.
- In addition, primary and community care requires further investment. The details are set out in Chapter 16.

Ealing has 79 GP practices. As Figure 4.9 shows, only 4% of GP practices were meeting statutory requirements and guidance at the time of the last estates review.

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\(^3\) Source: Estates Return Information Collection, 2010/11; ONS (includes small, medium, large, teaching and multi-service acute Trusts; excludes specialist Trusts; sites with over 10,000 admissions). Estimated catchment populations for individual trusts in NW London; England populations ONS mid-2009 estimates

\(^3\) ERIC Site-level data, HEFS, 2010/11
Chapter 8 provides a summary of the work we have undertaken to assess the out of hospital estate across NW London.

4.1.7 Summary

NW London needs to change what services are provided, where they are located and the balance between primary and secondary care providers. Therefore, in providing a recommendation for how services should be configured in the future, this decision making business case sets out how we will address the issues identified in the Case for Change.

4.2 The financial Case for Change

4.2.1 Commissioners and providers face financial pressures

Although the Government's pledge to protect health budgets has meant they fared well compared to some other areas of public spending, expenditure will only be increasing very slightly in real terms in the years up to 2015. Against this, the financial pressures caused by the increasing age of the population, the increased burden of more ill health and the need to keep pace with new technology would need growth each year unless we change the way services are delivered. As a result, the 2010 Spending Review committed the NHS to finding £20bn in productivity improvements by 2015 to reinvest in services to meet increasing demand.

This means the NHS is required to deliver significant efficiency savings. NHS NW London is one of the largest PCT Clusters in England. The total spend in the NW London health economy is £3.7 billion. Without an underpinning strategy, NW London faces significant financial pressure unless we respond to this agenda.

4.2.2 Savings identified by commissioners

Chapter 9 sets out the scale of this challenge and demonstrates that without action, the financial system is likely to move into deficit. In total, Commissioners plan gross QIPP savings of £555 million, with re-investment of £190 million over the next five years.

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34 Ealing Facet Surveys 2008/09 summary findings, Ingleton Wood
4.2.3 **Acute Trusts face challenges to implement QIPP**

With the scale of the financial challenges, under the ‘do nothing’ scenario, most acute sites would move into deficit under the base case with a zero net surplus. In the downside there would be a deficit of £89 million across NW London and all bar one site would be in deficit. Without service reconfiguration, Trust deficits are highly likely to worsen. Further detail is described in Chapter 9.

4.2.4 **The bed capacity base case**

Alongside the impact of Commissioner out of hospital strategies, Trusts also need to deliver their Cost Improvement Programmes (CIPs). A significant component of the CIPs is the need to reduce the average length of stay. The effects of out of hospital changes and the length of stay reductions mean that number of beds needed in the future will be less than the requirement now. The impact of the changes on the need for bed capacity is set out in Chapter 6.

Having this number of beds without reducing the number of sites is an inefficient and expensive use of buildings. The reduction in the number of beds continues a trend that has seen the number of beds in the NHS decrease over the last 30 years as clinical practice changes, as shown in Figure 4.10.

**Figure 4.10: Average daily number of available beds, by sector – England – 1987/88 to 2008/9**

4.3 **What happens if we do nothing?**

The clinical and financial Case for Change explains the challenges facing the NHS. In this section we describe what will happen if we do not address these challenges and why reconfiguration is required.

Even if more money was available, for the reasons described in this chapter, the way services are currently arranged does not produce the best quality care for patients. If nothing is done within the next few years, the following will start to happen within the NHS in NW London:
• **Inequalities would continue and probably get worse:** Currently people in some parts of NW London die on average 17 years earlier than those in nearby areas. This is neither fair nor reasonable and we need to try to reduce those differences.

• **People would continue to die unnecessarily:** A recent study showed patients admitted at weekends and evenings in London hospitals, when fewer senior doctors are available, stand a higher chance of dying than if they are admitted during the week. We need a system that allows all of our hospitals to benefit from having senior clinicians on site at all times, (including appropriate levels of consultant cover in key specialties such as emergency surgery and obstetrics, as evidence is now directing)

• **Our dependency on hospital services would continue when this is not the best use of resources:** Resources which could be better used to help people to stay well in the community. The issue of the current poor state of many of our buildings would not be dealt with – two-thirds of our hospital buildings need upgrading

• **Existing hospital trusts would be under severe financial pressure:** The deeper ‘into the red’ that trusts go, the more difficult it is to keep services running, to keep staff and maintain morale, and to provide high quality patient care. Crucially, this would happen in a disorganised way – meaning a worse effect on patients and staff

• **There would be problems with the NHS workforce:** As it is, some services have already had to be reduced because there are not enough clinicians to provide them safely. Recruiting and keeping clinical staff in London is always a challenge and if we do not offer the best places to work, and the best places to train, we will not attract the best staff. Equally, if there is not enough senior staff, trainee doctors cannot be supervised and are withdrawn from the hospital. All this means patients will not get the best care, and services will be reduced.

While this may sound alarming, it is worth noting that many clinicians working for the NHS in NW London would describe the outcome if we do nothing in even stronger terms. Though many services are providing a good standard of care at the moment, they cannot do so for much longer and it will be patients, and the clinicians who treat them and care for them, who will be the first to feel the consequences.

### 4.4 Feedback received about the Case for Change during consultation

During consultation we sought feedback about the Case for Change. We wanted to understand if people agreed with the case and if people had any suggestions for how it could be improved. We asked people the following question in our consultation response form:

**Q1. Do you agree or disagree that there are convincing reasons to change the way we deliver healthcare in NW London?**

4,951 people answered the question. Of these:

- **64%** of respondents who answered the question agree, including **20%** who strongly agree with the Case for Change
- **29%** disagree, which includes **16%** of respondents who strongly disagree
- The remaining **6%** had no views either way or were not sure/ didn’t know.

In addition to the feedback, we received qualitative responses from organisations addressing the need for change. Over 70 stakeholders submitted written responses to the consultation
by post or email. All of the stakeholders commenting on the Case for Change supported the need for change, with a number making the point that doing nothing is not an option. This feedback is described in Chapter 9, Section 9.3, where an explanation is provided as to how it has informed the decision making process.

4.5 Conclusion

There is a strong clinical and financial Case for Change, conclusions that have been strongly supported throughout the consultation.
Chapter 5

Process for identifying a recommendation
5. Process for identifying a recommendation

This chapter describes how we identified a recommendation for reconfiguration of hospital services in NW London using a seven stage process. There are millions of options for the configuration of services if all the combinations are considered. Therefore we developed a process that uses seven stages to consider all the available options systematically, to develop a shortlist of options and to enable us to carry out in depth analysis on that shortlist. We used the process before consultation to identify options to consult on. During consultation we received feedback about the process and we used this feedback to re-evaluate the process. We then reconfirmed with our stakeholders that the process remained appropriate for use to identify the recommended reconfiguration option.

5.1 Why we developed a process for identifying a recommendation

The Case for Change (Chapter 4) describes why change is necessary and shows that services need to be reconfigured to improve quality and to build a sustainable health economy.

Local clinicians needed to consider how best to reconfigure services to deliver the benefits in clinical quality and financial sustainability. A seven stage process was developed with our stakeholders during pre-consultation (November 2011 to June 2012) to systematically consider all relevant factors in order to recommended option(s) for consultation.

The development of the process was clinically led, with recommendations coming from the Clinical Board (which includes clinical representatives for each provider Trust and for each CCG) and an Expert Clinical Panel, which has provided external challenge to test and refine our proposals. Patients, members of the public, local NHS Trusts, local authorities and local HOSCs and the JHOSC also provided input.

5.2 How we used the process pre-consultation

Prior to consultation, we defined the process, developing and agreeing each stage with our stakeholders, as described in the section above. Then we went through the process, going over each stage in turn and reaching a decision about the outcome of that stage before proceeding to the next. To support this stage by stage decision making we produced any required outputs, for example developing and documenting a service model, or conducting financial analysis of activity data. The production of this work was supported by local clinicians, the Expert Clinical Panel, CCGs, providers, provider finance directors and analysis undertaken by the programme. At each stage the required outputs were presented to the most appropriate group of advisors, including the Clinical Board, Finance and Business Planning group and the Programme Board, who collectively reached a consensus about the outcome of each stage before moving to the next.

Using this process we identified three reconfiguration options for consultation that were recommended to the JCPCT by the Programme Board in our pre-consultation business case (PCBC). The JCPCT took the decision to proceed to consultation with these three options on 25 June 2012.
5.3 Feedback received about the process during consultation

The purpose of consultation has been defined as a process “to winnow out errors in the decision-makers provisional thinking. The JCPCT owes a public law duty to reconsider matters in the light of responses”. Although most consultation responses have focussed on the three service change options proposed, the process which led to their identification is open to critique and the JCPCT should take account of comments on that process in considering what process to adopt in final decision-making stage. In order to elicit this feedback, one consultation question (see Section 5.3.1) sought views on the process. Those who chose not to use the feedback form could also have commented on the process.

5.3.1 Feedback obtained in Consultation Forms

The public consultation ran for 14 weeks from 2 July to 8 October 2012. During consultation the programme received over 17,000 consultation responses from a range of stakeholders and responses from a variety of organisations (see Appendix F).

During consultation we sought feedback about the process we used to identify the consultation options. We wanted to understand if people agreed with the process we used and if people had any suggestions for how it could be improved. For example, we asked people the following question in our response form:

Question 21: Please consider the way we decided which hospitals to recommend as major hospitals, as set out in sections 15 and 16. Do you agree or disagree that this is the right way to choose between the various possibilities in order to decide which options to recommend?’

4,541 people answered this question. Of these respondents:

- 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’.

Figure 5.1 summarises the results.

1 Court of Appeal (19 April 2012)
5.3.2 Feedback obtained from organisations

In addition to the feedback above we received responses from organisations addressing the process itself.

**North West London Joint Health Overview and Scrutiny Committee (JHOSC)**

“We recognise that the development of the proposals have been “clinically-led” and approved by a Board comprising the Medical Directors of the Acute Providers and Chairs of Clinical Commissioning Groups (CCGs) in NW London.

We accept that a clear, logical process of evaluation was used to arrive at the three options presented for consultation”.

**Royal College of Physicians**

The RCP cannot comment on specific service locations or distribution, but the principles and approach adopted in ‘Shaping a healthier future’ resonate with the analysis the RCP has published in its review ["Hospitals on the edge? The time for action”]….Consequently the RCP strongly supports the direction for service re-design as proposed as in the best interests of public and patient services.

**London Borough of Hounslow Health and Adult Care Scrutiny Panel**

“We are supportive of the process and criteria used to designate major hospitals”.

**London Borough of Ealing**

“Fundamentally, the sequential nature of the option identification process does not provide the opportunity for all options to be tested on a truly comparable basis, as some options will

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2 Ipsos MORI. Ipsos MORI was commissioned to provide independent quality assurance of the consultation questionnaire, to establish appropriate response mechanisms for the consultation, and to gather, log and analyse consultation feedback. See Appendix F for further details.
have (or may have) been discounted before a specific element of appraisal is applied, and therefore options that may well have scored well in terms of later elements of the appraisal are dismissed before an assessment can be undertaken. In particular it unnecessarily limits the extent to which options can be tested in terms of quality and access, the criteria ranked most important by patients and clinicians”.

London Borough of Hammersmith & Fulham and Hammersmith & Fulham Health, Housing & Adult Social Care Scrutiny Committee

“The sequential nature of the methodology does not provide the opportunity for all of the options to be tested on a truly comparable basis”.

Brent LINk

“Brent LINk again concurs with the Rideout Report³, seeing SAHF’s decision to only use travel times to determine the location of the five hospitals as inappropriate, given there are other factors such as relative clinical performance, population need and the interdependencies of other services”.

5.3.3 Petitions

We also received 18 petitions and campaign responses. 12 of the petitions opposed the closure of A&E and other departments in hospitals; five were in support of Option A while one supported West Middlesex’s status as a major hospital.

The petitions (some with a large volume of signatories) were generally in support of particular hospitals. These tended to either be in support of a specific option for hospitals set out in the consultation document, or called for specific services (for instance A&E) to be preserved for a particular hospital or hospitals. These petitions did not comment on the specifics of the process. The largest petition with 25,193 signatories was a petition calling for Ealing, Central Middlesex, Charing Cross and Hammersmith Hospitals to retain their status and keep existing services, from Ealing Council. Further details of the petitions can be found in Chapter 6 and Section 16 of Appendix F includes details of the full set of petitions received.

5.3.4 The implications of this feedback for the process

We have considered feedback received about the process. None of the respondents that disagreed with the process we used to identify options presented an alternative process, although some implied that a non-sequential approach would have been more appropriate, or suggested other evaluation criteria. On the question of using a non-sequential process, we believe that approach to be impractical – as it would generate an unmanageable number of options – and, more importantly, it would ignore the process of prioritisation of criteria established in the pre-consultation phase in discussion with the public and other stakeholders. Furthermore the JHOSC supported the process used by the programme and it was commended by the OGC. The suggestion for additional criteria is discussed in Chapter 9, but for completeness in this section, we believe that all have been effectively included in the development of the proposals through the definition of the individual criteria and the Equalities Impact Assessment.

We reached the conclusion that the process used pre-consultation is robust and should be used post-consultation during decision making.

We confirmed this decision, and the process, with the following groups during the post-consultation phase:

- Clinical Board
- Finance and Business Planning
- Programme Board.

5.4 The seven stage process to identify a recommended option

Figure 5.2 provides a summary of the process for identifying a recommended option. The remainder of the chapter describes each stage of the process in detail.
Figure 5.2: Overview of the process for identifying a recommended reconfiguration option

Key principles:
- Continue expanding out of hospital services
- Located with, or independent of major hospitals
- All specialist services will remain as they are
- All 9 sites with an A&E to provide local hospital services and a UCC

1. Case for change
   - Provides platform for service change
   - Defines improvements and clinical benefits
   - Confirm “do nothing” is not an option

2. Vision
   - Localising
   - Centralising
   - Integrating

3. Standards
   - Out of hospital:
     - Case for change
       • Provides platform for service change
       • Defines improvements and clinical benefits
       • Confirm “do nothing” is not an option
     - Vision
       - Localising
       - Centralising
       - Integrating
     - Service models
       - Continue expanding out of hospital services
       - Located with, or independent of major hospitals
       - All specialist services will remain as they are
       - All 9 sites with an A&E to provide local hospital services and a UCC
     - Standards
       - Acute:
         • Urgent and emergency care
         • Maternity
         • Paediatrics
     - Clinical dependencies
       - Correct care setting to deliver high quality care
       - Use existing sites
       - Enough major hosp. to support population of 1.9 million
       - Number of major hosp. must be viable in medium term
       - Ensure good geographical spread
       - Use sites currently delivering major hospital services

4. Hurdle criteria
   - Out of hospital
     - Clinical dependencies
     - Continue expanding out of hospital services
     - Located with, or independent of major hospitals
     - All specialist services will remain as they are
     - All 9 sites with an A&E to provide local hospital services and a UCC
     - Case for change
       • Provides platform for service change
       • Defines improvements and clinical benefits
       • Confirm “do nothing” is not an option
     - Vision
       - Localising
       - Centralising
       - Integrating
     - Standards
       - Acute:
         • Urgent and emergency care
         • Maternity
         • Paediatrics
     - Clinical dependencies
     - Correct care setting to deliver high quality care
     - Use existing sites
     - Enough major hosp. to support population of 1.9 million
     - Number of major hosp. must be viable in medium term
     - Ensure good geographical spread
     - Use sites currently delivering major hospital services

5. Evaluation criteria
   - Quality of care
   - Access to care
   - Value for money
   - Deliverability
   - Research and education
   - Criteria include sub-criteria

6. Sensitivity analysis
   - Tests 22 underlying assumptions

7. Recommended option
   - Number of options: MILLIONS
     - < 20
   - Number of options: ~ 3
     - ~ 3
     - 1

8. Borough level, out of hospital strategies covering:
   - Case for improving OOH services
   - Steps to delivering better care
   - List of initiatives
   - Investment
   - Next steps
5.5 A detailed description of the seven stage process

This section provides a detailed description of the seven stages of the process for identifying the recommended option during decision making.

5.5.1 Stage 1 – The case for change

The first stage of the process for identifying a recommended option is to detail the Case for Change (as described in Chapter 4) and confirm it supports the arguments for reconfiguring services, including confirming that ‘do nothing’ is not an option.

Figure 5.3: Stage 1 – The case for change

<table>
<thead>
<tr>
<th>Stage 1</th>
<th>Purpose</th>
<th>Outcome</th>
</tr>
</thead>
</table>
| 1       | Document the Case for Change and confirm it supports the arguments for reconfiguring services. | • Ensure a robust platform exists for service change  
• Confirm required improvements and clinical benefits  
• Confirming ‘do nothing’ is not an option. |

During consultation we asked people whether they agreed with the Case for Change and this feedback will inform this stage of the process. We also asked for and responded to feedback when it was published in January 2012. See Chapter 9, Section 9.3.

5.5.2 Stage 2 – The vision for change

Local clinicians agree that in order to meet the challenge set out in the Case for Change, Shaping a healthier future will be guided by a vision that sets out how patients will be treated in the future to ensure they receive the highest standards of care. The second stage of the process establishes a foundation from which to design services.

Figure 5.4: Stage 2 – The vision for change

<table>
<thead>
<tr>
<th>Stage 2</th>
<th>Purpose</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Document the vision for achieving the objectives stated in the Case for Change.</td>
<td>• Confirm the vision created by local clinicians for Shaping a healthier future will deliver the required improvements and clinical benefits.</td>
</tr>
</tbody>
</table>

Feedback received during consultation will be used to support this analysis.

5.5.3 Stage 3 – The clinical standards

To deliver the vision and drive the improvements in clinical quality and reduce the variation documented in the Case for Change, local clinicians have developed a set of clinical standards based on the latest evidence, see Chapter 7, Section 7.3, including information and feedback from the Royal Colleges, London Health Programmes, reviews by NHS London, NICE guidelines, NCAT, work by our Clinical Implementation Groups (CIGs), and patient groups. These standards cover out of hospital, urgent and emergency care, maternity and paediatrics.
5. Process for identifying a recommendation

5.5  Stage 3 – The clinical standards

<table>
<thead>
<tr>
<th>Stage 3</th>
<th>Purpose</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standards</td>
<td>Document the clinical standards.</td>
<td>• Establish the clinical standards are in place and are based upon the latest evidence and clinical thinking • Establish that if the standards are achieved they will contribute to the improvements outlined in the Case for Change.</td>
</tr>
</tbody>
</table>

5.5.4  Stage 4 – The service models to deliver change

Clinicians are proposing a range of service models, from care at home to specialist, tertiary care. CCGs have developed a set of service models to deliver better out of hospital care for every borough. These service models are driven by the clinical standards and the clinical dependencies between services.

<table>
<thead>
<tr>
<th>Stage 4</th>
<th>Purpose</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service models</td>
<td>Document the service models for the settings of care required to deliver the clinical standards.</td>
<td>• Confirm the service models reflect the latest clinical thinking and reflect relevant feedback received during consultation • Confirm the service models will contribute to deliver the clinical case required.</td>
</tr>
</tbody>
</table>

5.5.5  Stage 5 – The hurdle criteria

Stage five enables local clinicians to move from an initial possibility of millions of options down to a medium list of approximately 20 options to undergo further detailed analysis in stage 6.
Figure 5.7: Stage 5 – The hurdle criteria

<table>
<thead>
<tr>
<th>Stage 5</th>
<th>Purpose</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hurdle criteria</td>
<td>Use the seven hurdle criteria developed by clinicians to establish the right number of major hospitals in the options.</td>
<td>• A medium list of options to undergo detailed evaluation&lt;br&gt;• Ensure the medium list will deliver the clinical vision and meet clinical need.</td>
</tr>
<tr>
<td>N.B. The hurdle criteria can be applied in any order and are used to identify options that do not meet the agreed set of criteria.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The seven hurdle criteria are described in Figure 5.8.

**Figure 5.8: The seven hurdle criteria**

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 development of the medium list of options was underpinned by four intentions. The outcome of the hurdle criteria was reviewed against these intentions to ensure they would be achieved. The four intentions are:

- Out of hospital services will be expanded and improved in all areas
- All specialist hospitals will stay as they are, including Hammersmith, which would retain its specialist status if not designated as major hospital
- Elective hospitals can be located with, or independent of, major hospitals
- All nine acute sites with an A&E will continue to provide local hospital services with an Urgent Care Centre, so patients will continue to go there for around 70% of the services that they currently access there (outpatients, diagnostics and urgent care centre).
The outcome of the hurdle criteria were reviewed against the key intentions to ensure they would be achieved.

The metrics for each hurdle criteria and the application of each hurdle are described fully in Chapter 9.

5.5.6 Stage 6 – Evaluation criteria and sub criteria

Having established a medium list by employing the hurdle criteria in stage five, further work was required to determine a recommended option for reconfiguration. This section describes the evaluation criteria that have been used for determining a recommended option.

Figure 5.9: Evaluation criteria and sub criteria

<table>
<thead>
<tr>
<th>Stage 6</th>
<th>Purpose</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation criteria</td>
<td>To test in detail the medium list of options using criteria chosen by local clinicians and the public.</td>
<td>• Pre-consultation this stage identified a short list of three options with a relative assessment • Post-consultation this stage identified a single recommended option with the highest relative assessment.</td>
</tr>
</tbody>
</table>

The criteria were developed by clinicians and tested with wider groups and the public. The criteria are focused on quality of care, access to services, value for money, deliverability and the impact on research and education, see Figure 5.10.

Figure 5.10: Final set of evaluation criteria and sub-criteria as agreed by local clinicians

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Sub-criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of care</td>
<td>• Clinical quality • Patient experience</td>
</tr>
<tr>
<td>Access to care</td>
<td>• Distance and time to access services • Patient choice</td>
</tr>
<tr>
<td>Value for money</td>
<td>• Capital cost to system • Transition costs • Viable Trusts and sites • Surplus for acute sector • Net Present Value</td>
</tr>
<tr>
<td>Deliverability</td>
<td>• Workforce • Expected time to deliver • Co-dependencies with other strategies</td>
</tr>
<tr>
<td>Research and Education</td>
<td>• Disruption • Support current and developing research and education delivery</td>
</tr>
</tbody>
</table>

For each criterion, each option on the medium list is given a rating. This relative evaluation is given to differentiate between the options on the medium list. The ratings used are shown in Figure 5.11.
The rankings of each option against the criterion are aggregated to identify the option with the highest relative ranking across all the criteria. This option is identified at this stage as the recommended option, subject to the outcome of sensitivity analysis.

During pre-consultation we selected the three highest ranked options and consulted on these, identifying the highest ranked option as the preferred option. For final decision making we will recommend just the top ranked option unless sensitivity testing shows that the ranking of the ‘best’ two or more options would change in the event of a reasonable change to an assumption or assessment.

5.5.7 Stage 7 – Sensitivity analysis

As a final stage in the evaluation, we conducted further analysis on a shortlist of the most viable options considered to check their sensitivity to changes in the assumptions or assessment.

Figure 5.12: Sensitivity analysis

<table>
<thead>
<tr>
<th>Stage 7</th>
<th>Purpose</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitivity analysis</td>
<td>To test the effect of variation in the underlying assumptions in the modelling.</td>
<td>• To ensure the recommended option remains the recommended option despite variations in the underlying assumptions</td>
</tr>
<tr>
<td></td>
<td>To assess the likelihood that the options being considered for recommendation would withstand the pressures of expected fluctuations and change.</td>
<td></td>
</tr>
</tbody>
</table>

5.6 How we used the process during the post consultation phase

On the basis that the process was valid, during the post-consultation period (October 2012 to February 2013) we went through the process for a second time to establish whether the criteria were right and whether they were applied appropriately. This analysis is detailed in Chapter 9 parts a, b, c and d.
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Chapter 6

Consultation, feedback and how we responded
6. Consultation, feedback and how we responded

This chapter describes how we consulted on the proposals and the engagement activities carried out. On 2 July 2012, NHS NW London launched a public consultation on the plans for reconfiguration of services as outlined in the pre-consultation business case. We consulted on the proposed clinical standards, clinical service delivery models and options for location of services. The consultation period ran for 14 weeks and ended on 8 October 2012. The feedback from consultation showed a clear mandate for change and broad support for the preferred consultation option. There was also challenge and criticism. We responded to this feedback, carrying out significant additional work on the analysis, in particular the clinical recommendations, options evaluation (including finance), travel, equalities and implementation planning.

6.1 The consultation process

The Shaping a healthier future public consultation ran from 2 July 2012 to 8 October 2012. This section describes the consultation process, including consultation methods and engagement activities. During the consultation we:

- Attended over 200 meetings and met over 5,000 people through roadshows, hospital site events, engagement with 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.

6.1.1 Materials developed for consultation

In addition to the consultation document and summary leaflet, a range of additional materials were produced to provide additional publicity and information about the consultation. These included:

- Frequently asked questions (FAQs)
- A standard slide deck for use during engagement events
- Exhibition boards that were used at public events such as roadshows
- Two sets of borough-based factsheets for each borough. The first set summarised how the different options proposed would affect that borough. The second set was produced to provide information specifically on the out of hospital proposals for each borough
- A local hospital factsheet
- Postcards and posters that were distributed across NW London, for example at roadshows, stakeholder meetings and public events
- Three videos, to make information more accessible
- A mythbuster factsheet to address common misconceptions about the programme
- Newsletters.

6.1.2 Stakeholder engagement

People were able to find out about the proposals:
By picking up some of the literature described above in libraries, LINKs and council offices, GP surgeries, hospitals and other health and social care offices

By attending a meeting or roadshow. Our clinicians and managers attended over 200 meetings and met over 5,000 people through roadshows, events at hospitals, meetings with hard to reach groups and other events such as public debates

Through the media. We took out over 50 advertisements in local newspapers, issued 23 press releases and wrote letters for local letters pages. This resulted in over 400 articles in local and national print, broadcast and online media

Through public representatives (such as MPs and local councillors, the Mayor and Assembly Members) who were all offered briefings

Through key stakeholders encouraging participation e.g. hospital trusts, councils and campaign groups

Online – either via our website or by following us or hearing about us via Twitter.

We also had specific targeted discussions (i.e. these opportunities were to a restricted audience or the participation was restricted) with a number of key groups such as Overview and Scrutiny Committees, LINKs, the Joint Overview and Scrutiny Committee, our PPAG and a number of focus groups, which were established to test the proposals with a more representative sample of people in each borough. In addition, a programme was established to meet almost 60 groups traditionally seen as hard to reach covering all nine protected groups as defined in the Equality Act 2010.

Further detail on the consultation process can be found in Appendix C, which was presented to the JC PCT on 6 December 2012.

6.2 Feedback received during consultation

Ipsos MORI was commissioned to provide independent quality assurance of the consultation questionnaire, to establish appropriate response mechanisms for the consultation, and to gather, log and analyse consultation feedback. The following text is taken from the Ipsos MORI final report on consultation which was presented to the JCPCT on 6 December 2012 and is found in Appendix F.

All responses dated and received within the consultation dates were treated as valid responses. In addition, to make allowance for any potential delays within the post or misdirection of emails, paper responses, letters and emails were accepted up until 15 October 2012. Any responses received between 15 October and 2 November were considered, but analysed separately.

Figure 6.1: Number of responses to the public consultation

<table>
<thead>
<tr>
<th>Method</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paper response forms</td>
<td>5,045</td>
</tr>
<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>
</tr>
</tbody>
</table>

421 responses were received in Arabic, Bengali, Hindi, Polish, Punjabi, Somali, Swahili, Tamil and Urdu.
6. Consultation, feedback and how we responded

6.2.1 Key findings from the consultation response forms

The following is a summary of the feedback in the response forms received during consultation:

- 64% of people who responded to the question agree that there are convincing reasons to change the way healthcare is delivered in North West London.
- 67% of respondents support the standards agreed for care both outside hospital and 76% supported the standards for in hospital.
- 83% of respondents agree with continuing provision of urgent care centres and outpatient appointments at acute hospitals, 13% disagree.
- 75% of respondents support all major hospitals having consultant-led maternity units, 5% oppose.
- 68% of respondents support the use of hospital buildings with spare space as elective hospitals, 21% oppose.
- 54% of respondents support all major hospitals having inpatient paediatric units, 28% oppose.
- 43% of respondents agree with delivering some hospital services locally, 25% disagree.
- 41% of respondents agree with plans for urgent care centres, 24% disagree.
- 36% of respondents support delivering different forms of care in different settings, 56% oppose.
- 44% of respondents support plans to improve the range of services delivered outside hospital, 48% oppose.
- 30% of respondents support bringing more healthcare services together on fewer sites, 38% oppose.
- 61% of respondents agree with the recommendation that there should be five major hospitals in NW London.
- 60% of respondents support the way in which NW London chose between the various possibilities to decide which option to recommend.
- Option A received the highest level of support of all three options for organising hospital services, with a majority of respondents supporting this option. Levels of support have been influenced by campaign responses submitted by Chelsea and Westminster Hospital (strongly supporting this option) and West London Citizens (strongly opposing it). If we include these responses in our analysis, support stands at 83% of respondents answering this question. If they are excluded, support for Option A stands at 63%.
- 64% of respondents to the question oppose Option B, while 21% support it. Option C is the second most preferred option, with 31% supporting it, while 59% oppose it.
- While many do not express a view either way, the balance of opinion in favour of the following proposals is positive:
  - 30% of respondents support Central Middlesex Hospital as an elective and local hospital, 19% oppose.
  - 33% of respondents support Hillingdon Hospital as a major hospital, 9% oppose.
  - 33% of respondents support Northwick Park Hospital as a major hospital, 10% oppose.
  - 40% of respondents support Hammersmith Hospital as a specialist hospital with a maternity unit, 17% oppose.

1 It is important to remember that these results are not representative of the population – they only refer to the people and organisations that responded to the consultation.

2 Please note that all percentages in this chapter are based on the number of respondents answering each question.
6. Consultation, feedback and how we responded

6.1 Questionnaire responses

27% of respondents to the question support relocating the Western Eye Hospital to the major hospital at St Mary’s, 22% oppose.

23% of respondents agree about moving the hyper-acute stroke unit from Charing Cross to St Mary’s, 29% disagree.

Further detailed information about all this data can be found in Appendix F.

6.2 Main themes raised in the consultation response forms

6.2.1 The response forms included a number of open-ended questions which enabled respondents to comment on the proposals in their own words. Accessing services was a theme which was raised throughout. Respondents commented on journey times, accessing services using public transport and the impact of the proposals on ambulance journeys.

Some respondents expressed opposition to some or any services closing. The proposed closure of Ealing Hospital A&E received particular attention. Where people live, and the hospital closest to them, is an important determinant of their views.

Quality of services emerged as another theme, with concerns raised about the capacity of both major hospitals and out of hospital services (for instance GPs) to deal with anticipated increases in demand.

Some respondents criticised the consultation process itself, for instance the evidence provided in the consultation document or the response form itself.

These themes were echoed in the roadshows, hospital site events, GP events and focus groups held by NHS NW London during the consultation period. In this strand of the consultation, the need to inform the public about the proposed changes, and how to access services, was frequently raised.

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6.2.3 Petitions

A total of 18 petitions were received both opposing and supporting the proposals. 12 of the petitions opposed the closure of A&E and other departments in hospitals; five were in support of Option A while one supported West Middlesex’s status as a major hospital.

The petitions (some with a large volume of signatories) were generally in support of particular hospitals. These tended to either be in support of a specific option for hospitals set out in the consultation document, or called for specific services (for instance A&E) to be preserved for a particular hospital or hospitals. The largest petition with 25,193 signatories was a petition calling for Ealing, Central Middlesex, Charing Cross and Hammersmith Hospitals to retain their status and keep existing services, from Ealing Council.

Two of the petitions also allowed signatories to post their own comments or respond to specific questions about the proposals. All of these comments have been read by Ipsos MORI and the general themes identified. For example, respondents to Petition T (Petition calling for Secretary of State for Health to stop the closure of Hospital Services in west London, in particular the A&E Departments of Hammersmith and Charing Cross Hospitals) were able to provide a comment to support their signature: 634 of the 1,332 respondents did so. Of those signatories who provided a comment one in three express concerns about the loss of A&E and/or specialised services, while a further one in five say that they believe no services should close. Around one in five people who provided a comment through Petition T express concerns that lives could be lost as a result of the planned changes to services in NW London, while a further one in six state that the plans could results in greater travel.
times (particularly for patients trying to access A&E) and therefore risk worse outcomes for patients.

In addition to forming responses in their own right, it is likely that the petitions and campaigns have influenced responses via other methods by raising awareness and encouraging people to respond to the consultation.

Section 16 of Appendix F details the full set of petitions received.

### 6.2.4 Stakeholder feedback

74 stakeholders submitted a response to the consultation. This feedback followed their own format and very few covered every question asked about in the consultation. Our analysis of this feedback has been qualitative in nature, drawing out the themes and issues stakeholders have commented on.

All of the stakeholders who expressed a view on this supported the need for change. A number of stakeholders expressed overall support for the *Shaping a healthier future* proposals. Several others expressed strong opposition, notably Ealing and Hammersmith and Fulham Councils who both provided detailed criticisms on the way in which the consultation proposals had been determined.

Most stakeholders commenting on the issue expressed support for the out of hospital proposals, although some called for more detailed plans about timing and implementation. The point was made that primary and community services need to be improved before there is any reduction in acute provision.

There were calls for consistent standards across urgent care centres and more detail on the proposals. The need to build public understanding and awareness of UCCs was also mentioned.

The proposal to have five major hospitals in NW London and the criteria for deciding upon these was supported by a number of stakeholders, while some criticised it.

A number of stakeholders, including local authorities, LINks, CCGs and MPs, put on record their support for Option A. Options B and C received fewer comments and only a couple of stakeholders expressed explicit support for either.

Two stakeholders expressed opposition to the proposed closure of services without specifically mentioning any of the options. Among those not supporting any of the options, no alternatives to the status quo were put forward.

Several stakeholders expressed support for Central Middlesex Hospital being an elective and local hospital, while others opposed this because of the impact of the A&E department being closed. There was support for Hillingdon and Northwick Park being major hospitals, although two stakeholders raised concerns about capacity at the latter. The proposal for Hammersmith Hospital to be a specialist hospital was also supported.

Reaction to moving the hyper-acute stroke unit to St Mary’s was mixed, with some stakeholders supporting this while others felt it should stay where it is or would be better located elsewhere. Some stakeholders commented on the need to improve facilities at St Mary’s before either the hyper-acute stroke unit or Western Eye Hospital are moved there.

A number of detailed comments were made about public transport and journey times, with particular concerns raised about vulnerable groups and follow-up appointments. The need
for detailed travel plans and improvements to public transport were highlighted. Some called for more detailed analysis.

A wide range of comments were made about the delivery and implementation of the consultation proposals. A number of stakeholders commented on the potential difficulties and risks in handling the transition. In addition, concerns were raised about timescales, the capacity of both acute and out of hospital services to meet demand and the financial position of hospital trusts. More detailed impact assessments were called for (including equalities analysis), and more information on the workforce strategy was requested. The importance of public information was also stressed by some stakeholders, and the need for effective integration was also highlighted.

While a couple of stakeholders made favourable comments about the consultation itself, others criticised the consultation process and materials.

### 6.2.5 Summary of the consultation findings

Overall, there is support for many of the proposals outlined in the consultation document, and a widespread acceptance of the case for change. Responses to the consultation questionnaire indicate that there is majority support for the proposal that there should be five major hospitals and for Option A. It is also worth noting that there has been clear and vocal opposition to the proposed closure of A&E and other services in some areas, particularly in Ealing and Hammersmith and Fulham.

All the different strands of the consultation highlight some clear concerns about the proposals:

- Their impact on accessing services – in particular journey times and public transport accessibility
- The capacity and ability of both hospital and out of hospital services to meet demand and support the changes in how health services are delivered
- The need for information on what these changes will mean for people in practice, as well as when and how they should access particular services.

Potential changes to services, particularly where closures are involved, understandably cause apprehension among those who may be affected. If the recommendation is approved by the JCPCT, we recognise two key challenges that were raised during the consultation, going forward. The first of these is to implement any agreed changes in a way that addresses these concerns and the second is to explain clearly what the changes will mean for people in practice.

### 6.2.6 Feedback received about the consultation process

During consultation we received feedback from stakeholders about the consultation process itself and from the Consultation Institute. This included:

**North West London Joint Health Overview and Scrutiny Committee (JHOSC)**

“In relation to the consultation process we believe that there has been a clear process based on communication and explanation…..We believe that the consultation has been taken forward according to a clear communication plan. We feel that the website and different written material did get across the main arguments but fell short of actively helping people get to grips with the likely implications for them, their families and communities.”
Westminster City Council, Adult Services and Health Policy and Scrutiny Committee
“We are pleased that the consultation has been led by clinicians who are directly responsible for delivering frontline healthcare in North West London. We have seen no evidence to suggest that there are a significant number of local clinicians that have serious concerns about the proposals and thus do not support the proposed changes, although we noted evidence presented to the JHOSC [Joint Health Overview Scrutiny Committee] that ~10% of GPs in Ealing attended a meeting to oppose the changes recommended in the proposals put forward in the consultation.”

Richmond Clinical Commissioning Group
“The team who developed the supporting consultation documentation should be congratulated as it is very well set out, easy to read and understand.”

Royal Borough of Kensington and Chelsea Health, Environmental Health and Adult Social Care Scrutiny Committee
“Our experience of the consultation process delivered by NHS NWL has been a positive one.”

Ealing Council
“Profound flaws in the approach to public consultation during the development of the proposals and a flawed method of enabling members of the public to submit their views, despite the crucial role of the community in enabling any changes to be successfully delivered.”

Labour Group at Kensington and Chelsea Council
“It has been claimed that GPs in general are on side with this plan although, so far as we are aware, they have not been consulted….Equally, there is little sign that NHS staff have been consulted in a meaningful way and many are taking part in campaigns to save this or that hospital or A&E department. The general public has had little opportunity to have a say in the process…. We see the consultation process as deeply flawed.”

London Borough of Richmond upon Thames’ Health, Housing and Adult Services Overview and Scrutiny Committee
“Periphery boroughs have not been engaged adequately. The fact that Richmond residents have received little information about the consultation, the roadshow in the LBRuT was held 3 weeks before the end of the formal (14 week) consultation period and the presentation by NHS NW London to the Health, Housing and Adult Services Overview and Scrutiny Committee shortly before the consultation closes highlights this point.”

Greg Hands, MP for Chelsea & Fulham
“The opaqueness of much of the consultation material, and the impression it creates of a foregone conclusion, makes the genuineness of this engagement process questionable.”

Kensington and Chelsea LINk
“There has been a lack of information in accessible formats and the questionnaire is wordy and obscure and does not encourage an open thoughtful response.”

Hammersmith and Fulham LINk
“The LINk continues to express concern over the consultation process. The lack of clear information, the length and format of the questionnaire, the delay in the production of accessible formats and the communications strategy have all caused confusion.”

North West London Joint Health Overview and Scrutiny Committee
“We have throughout questioned the wisdom of conducting a consultation over the summer months at the same time as the Olympics, the Paralympics and the holiday season. We
would suggest the consultation has as a result failed to allow local populations sufficient time to digest and engage with the plans and their likely consequences.”

Harrow Council Health and Social Care Scrutiny Sub-Committee
“We appreciate the various means that have been employed to reach out to residents within each borough, for example roadshows, attendance at public meetings, inserts into local newspapers, summary documents in key community venues, as well as online access to the consultation. These are especially important given the complex messages that the programme is aiming to achieve public understanding of. However we also note that consulting over the summer period on changes as substantial as these is never ideal especially given the uniquely busy summer London has experienced in 2012.”

Hammersmith and Fulham Council and its Health, Housing & Adult Social Care Scrutiny Committee (joint response)
“The Council considers that there are several key flaws in the proposals. Broadly, these can be categorised as fundamental problems with the consultation process and methodology, failure to take account of current relative clinical outcomes, and a lack of due regard for the impact on the people who live and work in Hammersmith & Fulham. The proposals are consequently seen as unsafe from the Council’s perspective.”

Kensington and Chelsea LINk
“There is insufficient detail at present about the exact services provide by Urgent Care Centres and Local Hospitals. The leaflets on these arrived very late in the consultation process and it is unclear how standardised the services will be.”

We asked the Consultation Institute to undertake a review of the consultation process and methodologies used with regards to engagement with patients, the public and other key stakeholders.

Throughout the consultation and following this, the Consultation Institute conducted a review of all materials used during the consultation and monitored ongoing programme activities. We provided information on additional work being carried out as part of the programme for example, equalities work.

Mid-review feedback

Mid-review (Early October) the Consultation Institute asked for further assurance including that:

- An equalities study would be undertaken
- There was a clear plan in place to analyse and consider consultation feedback
- That we continue to show willingness to engage
- That stakeholders are reminded of the deadlines by which to respond to the consultation
- We continue post-consultation engagement activities
- We outline how stakeholder engagement will be undertaken during implementation.

We continued to provide assurance as requested by the Institute. In particular we:

- Conducted an equalities review which has been undertaken by an independent supplier, Deloitte (see Appendix G).
6. Consultation, feedback and how we responded

- Analysed and considered consultation feedback (detailed in the independent Ipsos MORI report in Appendix F) in our next steps work, see Section 6.3, and further presented our work at the stakeholder engagement event held on 28 November 2012.
- Demonstrated willingness to continue dialogue with stakeholders with ongoing press releases and newsletters following close of consultation as a reminder that we wish to continue dialogue.
- Stakeholders were reminded of consultation close via a programme newsletter, press advert and on the programme website. Additionally, key stakeholders such as CCG Chairs were personally written to by the programme and urged to respond.
- Post-consultation engagement has continued with the programme engaging with MPs, HOSCs, the JHOSC and other groups. Additionally, a large public engagement event was held by the programme on 28 November.
- A plan has been written for engagement during implementation. In particular to ensure that stakeholders understand the JCPCT decisions, how they can use existing services and new services. This will involve engagement with key groups such as: Councils, HOSCs, the JHOSC, MPs, LINks, PPAG and those people that responded to the consultation or wish to be kept informed.

**End-review feedback**

The Consultation Institute awarded us their compliance certificate in January 2013, having addressed the mid-review feedback and continued engagement. The full letter of compliance is in Appendix I.

**The Consultation Institute**

“As we approach the conclusion of the consultation project undertaken on behalf of the NHS in North-West London, I have pleasure in confirming that the Institute is able to endorse your process…. We examined such activities as you had already undertaken and made a series of recommendations which were discussed with you over an extended period.

We were able to sign-off the Mid-term Review and the Closing Date Review but again subject to recommendations which we delighted to note have acted upon.

As the process culminates in a Final Report, I am now in a position to confirm that despite a number of challenges, the Institute believes that you have conducted a satisfactory consultation process overall”.

**6.2.7 The implications of this feedback on the consultation**

We considered the feedback received about the consultation process as follows:

- Pre-consultation engagement was planned in discussion with stakeholders such as the JHOSC and PPAG included:
  - Formal meetings
  - Focus groups
  - Three public events each attended by several hundred members of the public and local clinicians
  - Engagement with providers, patient groups, hard to reach groups and stakeholders outside of North West London.
- We consulted for 14 weeks, which is in line with previous Cabinet Office guidance and was agreed with the JHOSC. During this time we distributed over 500,000 documents, attended over 200 events and met over 2,000 people from underrepresented groups. We also:
6. Consultation, feedback and how we responded

- Produced **local hospital factsheets** explaining our proposals for these hospital types
- Produced **out of hospital care factsheet** explaining our out of hospital proposals for each NW London borough
- Produced a **travel factsheet** for the JHOSC which explained our travel analysis
- Updated our **website** and online consultation response form in response to user feedback
- Provided consultation materials in all **languages** requested along with additional formats such as large print
- Undertook **additional engagement activities** in response to specific requests (for example, sickle cell community, the Somali community, people with learning disabilities)
- **Answered queries** from members of the public through our **Consultation Response Unit**

Following feedback in the Equality Review we also undertook a gap analysis of our planned engagement with hard to reach groups in the early stages of the consultation and undertook significant additional work as a result including three additional focus groups with mothers with children under two, young people aged 16-18 and those with disabilities

- **We responded to over 1,500 enquiries** both during and after the consultation to help people understand the proposals and respond to their questions
- We wrote to all stakeholders who responded to the consultation providing answers to any queries they had raised
- We developed a borough specific presentation to explain the results of the consultation and offered to attend meetings of OSCs, LINs and other local stakeholders
- The **Consultation Institute** undertook a review of our consultation. We achieved the Institute’s success criteria and was awarded a certificate of compliance.
- We reconsidered the work undertaken during the consultation and undertook **post consultation engagement** which included a further public event held on 28 November with several hundred members of the public and local clinicians, and further engagement with certain hard to reach communities
- **We continued to engage with our stakeholders and sought their views throughout the decision making phase.** This occurred through a variety of mechanisms including:
  - Governance arrangements – including Programme Board, Clinical Board, Clinical Implementation Groups, and the Finance & Business Planning Group
  - Continued engagement with the JHOSC and the PPAG
  - Continued engagement with the Travel Advisory Group
  - Further engagement with local OSCs, local authorities and local politicians on request.

The purpose of consultation has been defined as “one of the functions of a consultation process is to *winnow out errors in the decision-makers provisional thinking. The JCPCT owes a public law duty to reconsider matters in the light of responses*”[^3]. Given the feedback received and our responses to this feedback we consider the consultation undertaken to be sufficient to achieve the purpose outlined above.

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[^3]: The case of R (Brompton and Harefield NHS Foundation Trust) v Joint Committee Of Primary Care Trusts & Anr - Court of Appeal (19 April 2012)
6.3 Our responses to feedback

This section describes how we responded to the remainder of the feedback we received, setting out:

- Actions taken during consultation to address arising issues
- How we considered feedback post consultation as we prepared our proposals for the JCPCT.

The remaining feedback we received during consultation has been categorised into nine themes:

1. Case for change
2. Methodology and process
3. Clinical vision and proposals
4. Proposals for major hospitals
5. Proposals for local hospitals
6. Proposals for specialist hospitals
7. Proposals for out of hospital care
8. Travel and access
9. Equalities and deprivation.

The remaining sections each cover one of the key themes. Information is summarised in tables, describing the feedback, how we responded, and where possible, we indicate the location within this document that our responses can be located. Please note, the ‘Feedback received’ column contains a summary of the key point and not verbatim quotes; this is because in the majority of cases information has been brought together from a number of sources or is a précis of a longer piece of text.
6.3.1 **Theme 1: Case for change**

The case for change describes the rationale for reconfiguration.

**Figure 6.2: Theme 1 – The case for change**

<table>
<thead>
<tr>
<th>Feedback received</th>
<th>Stakeholders who provided this feedback</th>
<th>Our consideration of the feedback</th>
<th>DMBC reference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Will the proposed changes deliver the required benefits and outcomes?</strong></td>
<td>• JHOSC</td>
<td>The proposals were developed to deliver clinical quality improvements and other benefits and we developed a benefits framework pre-consultation to manage the delivery of these benefits.</td>
<td>Benefits realisation tracking: <strong>Chapter 18</strong></td>
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<tr>
<td></td>
<td>• Kensington and Chelsea HOSC</td>
<td>The benefits framework has been further developed post consultation to include more detailed KPIs and proposed data sources.</td>
<td>Implementation tracking: <strong>Chapter 17</strong></td>
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<td></td>
<td>• College of Emergency Medicine</td>
<td>We have developed an ‘Implementation Tracker’ to measure the achievement of the required outcomes of reconfiguration over time. This work will support CCGs as they assume responsibility if implementation is agreed by the JCPCT and responsibility for ensuring benefits are delivered.</td>
<td></td>
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<tr>
<td><strong>Greater clarity required on the clinical evidence base</strong></td>
<td>• College of Emergency Medicine</td>
<td>The proposals are evidence based and were developed jointly with clinicians and in accordance with the latest clinical guidance and evidence base. The Case for Change summarizes key examples of the evidence supporting the case for change (see Chapter 4).</td>
<td>Case for change: <strong>Chapter 4</strong></td>
</tr>
<tr>
<td></td>
<td>• Ealing Council</td>
<td>This document expands upon this work and includes a specific section on the wider clinical evidence base for the proposals (see Chapter 11 section 11.4.3 and Appendix E). Post consultation we undertook a literature review to look at the latest emerging evidence. The Clinical Board, Urgent and Emergency Care (U&amp;EC), Maternity and Paediatric Clinical Implementation Groups (CIGs) all reconsidered the evidence base during their work for the DMBC.</td>
<td>Literature review of latest evidence: <strong>Chapter 7, Chapter 11 and Appendix E</strong></td>
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<td></td>
<td>• Hammersmith Council</td>
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<td></td>
<td>• Hammersmith HOSC</td>
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<td></td>
<td>• Hillingdon LINk.</td>
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<tr>
<td>Feedback received</td>
<td>Stakeholders who provided this feedback</td>
<td>Our consideration of the feedback</td>
<td>DMBC reference</td>
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| What are the implications of the 2011 Census data indicating revised population projections? | • JHOSC  
• Ealing Council  
• Hounslow HOSC  
• Hammersmith & Fulham LInK. | The original model is activity, not population based, so reflects the demand from the actual population of NW London. | Sensitivity analysis: Chapter 9, Section 9.12 |
| Will the final proposals have met key areas required of the four tests? | • College of Emergency Medicine  
• Hillingdon LInK  
• Richmond LInK. | NHS London confirmed in June 2012 that our proposals met the Four Tests and NHS London.  
Post consultation we undertook further work related to the Four Tests, as examples: further work with CCGs to continue supporting GP commissioners during decision making; stakeholder and public meeting on the 28 November to strengthen public engagement; further documentation of the latest clinical evidence base, and further analysis exploring patient choice. | 4 Tests: Chapter 11, Section 11.4 |

### 6.3.2 Theme 2: Methodology and process

Working with local clinicians a seven stage process was developed to identify options for reconfiguration.

**Figure 6.3: Theme 2 – Methodology and process**

<table>
<thead>
<tr>
<th>Feedback received</th>
<th>Stakeholders who provided this feedback</th>
<th>Our consideration of the feedback</th>
<th>DMBC reference</th>
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</thead>
</table>
| Assurances required that relevant capital has been considered and will be available | • JHOSC  
• SaHF (ICHT)  
• Westminster HOSC. | Our Finance and Business Planning (F&BP) group (comprised of CCG Finance Directors and provider FDs) and Programme Board agreed the initial financial modelling work prior to consultation, including all relevant capital costs to support the evaluation of options and the JCPCT’s decision to proceed to consultation on the 26 July.  
The F&B group updated the financial models post consultation and this includes more detailed cost requirements. | Updated capital requirements: Chapter 9, Section 9.13.4 |
<table>
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<tr>
<th>Feedback received</th>
<th>Stakeholders who provided this feedback</th>
<th>Our consideration of the feedback</th>
<th>DMBC reference</th>
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<tr>
<td>Trusts are required to secure capital funds through the standard Department of Health and Treasury processes and the programme is committed to supporting this work.</td>
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</tbody>
</table>
| **Workforce proposals should include greater detail to provide assurance on deliverability** | **Kensington & Chelsea HOSC**  
**Westminster HOSC**  
**Richmond CCG**  
**Hammersmith & Fulham LINk**  
**Hounslow HOSC**  
**JHOSC**. | **The DMBC includes further workforce analysis to the level required for decision making, this includes:**  
- The three CIGs have considered workforce in more detail for their specialties (U&EC, maternity and paediatrics).  
- Out of hospital workforce requirements  
- Consultant staffing requirements for emergency care, maternity and paediatrics specialities  
- A Transformational Workforce Strategy has been developed.  
This work has been included in the DMBC, which will be used by the JCPCT to support their decision making planned for February 2013. | Consultant workforce:  
Chapter 14, Section 14.2 - 14.4  
Urgent care workforce:  
Chapter 14, Section 14.5  
OOH workforce: Chapter 14, Section 14.6 |
| **The linear process for producing consultation options could mean certain options were overlooked** | **Hammersmith & Fulham Council /HOSC**  
**Ealing Council**  
**Brent LINk**  
**Hillingdon LINk**. | **We developed a process that uses seven stages to systematically consider all the available options to identify a recommended option for reconfiguration and enable us to carry out in depth analysis on a manageable number of options. We used the process before consultation to identify options to consult on. During consultation we received feedback about the process and we used this feedback to re-evaluate the process. We then reconfirmed with our stakeholders that the process was appropriate for use after consultation to identify the recommended reconfiguration option.** | Seven stage process to identify a recommended option: Chapter 5 |
### 6.3.3 Theme 3: Clinical vision and proposals

The clinical vision is to improve the standard and consistency of care across North West London.

#### Figure 6.4: Theme 3 – Clinical vision and proposals

<table>
<thead>
<tr>
<th>Feedback received</th>
<th>Stakeholders who provided this feedback</th>
<th>Our consideration of the feedback</th>
<th>DMBC reference</th>
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</table>
| Greater assurances required that planning for home births has been considered     | • Royal College of Midwives  
• Hillingdon LINk.                                                                                       | The maternity working group that met pre-consultation supported the development of proposals for maternity (this included the considerations for home births).  
The maternity CIG proposal is for a sector wide collaboration to increase staff and develop a homebirth service in NW London in line with the national evidence. The national evidence demonstrates that Homebirth is safe and recommended practice. Other regions of London demonstrate much more success in homebirth midwifery led births. NW London will ensure it is a true option for women. The CIG is recommending that there is a Midwifery led homebirth community facility for all women in NW London.  
The midwifery team from the Maternity Network has agreed to form a network to coordinate homebirths and is currently exploring workforce requirements to support this. | Homebirths: Chapter 7d |
| Can six neonatology and five paediatric units be staffed?                          | • NCAT  
• Chelsea & Westminster Hospital.                                                                                       | The proposals were developed with consideration for workforce requirements. The paediatrics working group which met pre-consultation provided assurances that six neonatology and five paediatric sites can be staffed in the short-term. If during implementation it becomes clear that this model of staffing is not sustainable beyond the short term, then the NW London Paediatric Network will need to alert all stakeholders and work with them to provide an alternative suitable model of care on one or more of the sites, for example a short stay paediatric unit.  
The Paediatrics CIG has undertaken work to consider the implications are for both activity and staffing levels and this work is detailed in their report. The CIG is recommending six neonatology and five paediatric units. | Paediatric workforce: Chapter 7c |
### Feedback received

<table>
<thead>
<tr>
<th>Are London Health Programme (LHP) standards consistent with the SaHF clinical standards?</th>
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<tbody>
<tr>
<td><strong>Stakeholders who provided this feedback</strong></td>
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<tr>
<td>• SaHF Clinical Board.</td>
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<tr>
<td><strong>Our consideration of the feedback</strong></td>
</tr>
<tr>
<td>LHP standards were being developed when SaHF went to consultation in July 2012, and proposed standards were reviewed in late 2012. The final standards are due to be published by mid-February.</td>
</tr>
<tr>
<td>During the post-consultation period the Clinical Board, U&amp;EC, Paediatric and Maternity CIGs reviewed the proposed LHP standards against the standards our clinicians proposed pre-consultation to understand alignment. The three CIGs have all recommended adopting the proposed LHP standards.</td>
</tr>
<tr>
<td><strong>DMBC reference</strong></td>
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<td>Clinical standards: Chapter 7</td>
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### Greater consideration needs to be given to social care

<table>
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<th>Greater consideration needs to be given to social care</th>
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<tr>
<td><strong>Stakeholders who provided this feedback</strong></td>
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<tr>
<td>• Harrow HOSC/Council</td>
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<tr>
<td>• Imperial College Healthcare Trust</td>
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<tr>
<td>• Richmond Council</td>
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<td>• Kensington &amp; Chelsea HOSC</td>
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<tr>
<td>• Brent LINk</td>
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<td>• Brent HOSC</td>
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<td>• Hillingdon HOSC</td>
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<td>• JHO SC</td>
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<tr>
<td>• Hillingdon LINk.</td>
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<tr>
<td><strong>Our consideration of the feedback</strong></td>
</tr>
<tr>
<td>We worked with the eight CCGs to develop their out of hospital strategies, and this work considered joint working with social care.</td>
</tr>
<tr>
<td>We continue to support CCGs through the out of hospital work in developing their relationships with social care. This includes engagement with Health and Wellbeing Boards and the expectation is that CCG Commissioning Intentions would be signed off by each Boroughs Health and Wellbeing Board.</td>
</tr>
<tr>
<td>CCGs are also progressing implementation of the integrated care model of local health and social care, working with local authorities to manage care needs of patients in a coordinated way; this includes work by the tri-borough on their community budget programme and whole systems ICP.</td>
</tr>
<tr>
<td>Post consultation we undertook work to explore the impact of the OOH strategies on carers, the outputs of this work are detailed in this document and support the detailed planning of each CCGs OOH initiatives.</td>
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<tr>
<td><strong>DMBC reference</strong></td>
</tr>
<tr>
<td>Carers analysis: Chapter 13, Section 13.6.3</td>
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### Assurances required that UCCs are safe and staff will have necessary competencies including providing junior staff training

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<tr>
<th>Assurances required that UCCs are safe and staff will have necessary competencies including providing junior staff training</th>
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<tr>
<td><strong>Stakeholders who provided this feedback</strong></td>
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<tr>
<td>• College of Emergency Medicine</td>
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<tr>
<td>• Public</td>
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<td>• Ealing Council</td>
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<td>• Ealing HOSC</td>
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<td>• Brent LINk</td>
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<tr>
<td>• Brent HOSC</td>
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<tr>
<td><strong>Our consideration of the feedback</strong></td>
</tr>
<tr>
<td>The CIG is proposing that UCCs operate within a network to provide appropriate clinical governance and that they have a relationship with an A&amp;E at a major hospital to support the safe delivery of emergency services. Where the proposal is for the UCC to be co-located with the major hospital then this would be the ‘partner’ A&amp;E, where the UCC is on a local hospital site or stand alone then a neighbouring major hospital would provide the ‘partner’ A&amp;E.</td>
</tr>
<tr>
<td>The U&amp;EC CIG has developed a common UCC specification which details the services a UCC should provide and the required quality standards. This</td>
</tr>
<tr>
<td><strong>DMBC reference</strong></td>
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<tr>
<td>UCC specifications: Chapter 7, Section 7.6.2 and Chapter 8d</td>
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### Feedback received

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<tr>
<th>Stakeholders who provided this feedback</th>
<th>Our consideration of the feedback</th>
<th>DMBC reference</th>
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<tbody>
<tr>
<td>• Hillingdon LINk</td>
<td>specification is intended to be used across NW London and would ensure UCC services are both safe and consistent.</td>
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<tr>
<td>• JHOSC</td>
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### Clarity required about services provided at UCCs

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<th>Stakeholders who provided this feedback</th>
<th>Our consideration of the feedback</th>
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<tr>
<td>• NHS Central London CCG</td>
<td>Pre-consultation we developed high level descriptions of the services provided at UCCs. Further details were provided during consultation as part of the production of the local hospital factsheet and these were shared at various borough events and put online. The U&amp;EC CIG has developed a common UCC specification which details the conditions that UCCs should follow, those that are excluded, the service models and transfer protocols (i.e. when and how patients will be transferred from a UCC if they need full A&amp;E services), staff competencies, quality standards and governance arrangements. This work is included within this document.</td>
<td>UCC specifications: Chapter 7b and Chapter 8d</td>
</tr>
<tr>
<td>• Ealing Hospital Trust</td>
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<td>• Ealing Council</td>
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<tr>
<td>• College of Emergency Medicine</td>
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<tr>
<td>• Kensington &amp; Chelsea HOSC</td>
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<td>• Kensington &amp; Chelsea LINk</td>
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<td>• JHOSC</td>
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<td>• Public</td>
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<tr>
<td>• Westminster</td>
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<td>• Hounslow</td>
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### How will the lack of consistency between services offered at different UCCs be addressed?

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<tr>
<th>Stakeholders who provided this feedback</th>
<th>Our consideration of the feedback</th>
<th>DMBC reference</th>
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<tbody>
<tr>
<td>• Hammersmith &amp; Fulham LINk</td>
<td>The U&amp;EC CIG has developed a common UCC specification which details the conditions that UCCs should follow, those that are excluded, the service models and transfer protocols, staff competencies, quality standards and governance arrangements. Future tendering of UCC services will reflect this common UCC specification and consistency achieved as contracts are retendered. Existing contracts would be renegotiated where possible.</td>
<td>UCC specifications: Chapter 7b and Chapter 8d</td>
</tr>
<tr>
<td>• Public</td>
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### Is there the required workforce for staffing UCCs?

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<tr>
<th>Stakeholders who provided this feedback</th>
<th>Our consideration of the feedback</th>
<th>DMBC reference</th>
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</thead>
<tbody>
<tr>
<td>• College of Emergency Medicine</td>
<td>We undertook workforce analysis prior to consultation. Our U&amp;EC CIG has undertaken further analysis of staffing requirements for proposed UCCs, including workforce competencies. This work is included in this DMBC.</td>
<td>UCC staffing: Chapters 7 and 16</td>
</tr>
<tr>
<td>• Hounslow HOSC</td>
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<tr>
<td>• JHOSC</td>
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<tr>
<td>Feedback received</td>
<td>Stakeholders who provided this feedback</td>
<td>Our consideration of the feedback</td>
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| Consider proposals for the establishment of freestanding midwife-led units (FMUs). | • Royal College of Midwives  
• Kensington & Chelsea HOSC. | We considered the use of FMUs during pre-consultation and at the time decided not to recommend them.  

The maternity CIG reviewed the proposals post consultation again in the light of RCM feedback. They agree that these can be important elements of maternity provision. However, for Shaping a healthier future, since they are proposing six maternity units with alongside midwife led units, they do not at this stage consider there would be sufficient demand for a standalone or birthing centre for the population of NW London.  

The Maternity CIG will ensure that there is a Midwifery led homebirth community facility for all women in NW London. However, as Shaping a healthier future is implemented, the requirements of pregnant women and mothers will remain at the heart of their approach and should the need for such an unit arise they will ensure it is properly considered.  

To implement this approach the NW London Maternity Network will work with the commissioners and providers, as well as the communities themselves to enable a comprehensive homebirth service is across NW London. | Freestanding midwife led unit: **Chapter 7d** |
| Clinicians need to be central to the development and implementation of clinical proposals | • Harrow HOSC/ Council  
• Kensington & Chelsea HOSC. | We established three CIGs for maternity, paediatrics and U&EC, these groups are comprised of clinicians and they meet regularly to consider feedback received during consultation, develop the clinical standards and consider implementation plans. Proposals are also peer reviewed by a wider community of clinicians, including NCAT and the Clinical Senate. The Clinical Board has continued to lead on making recommendations.  

CCGs are working with the JCPCT through decision making process.  

CCGs have detailed commissioning plans and are already implementing services in their areas as part of their business as usual. We have worked with these CCGs to continue the development of local implementation plans for out of hospital care.  

Over time CCGs will have accountability for the delivery of clinical proposals | Development of proposals: **Chapter 5 and Chapter 9**  
Implementation of proposals: **Chapter 18** |
Feedback received | Stakeholders who provided this feedback | Our consideration of the feedback | DMBC reference
--- | --- | --- | ---
 |  | through their commissioning function and we are supporting this work through the development of proposed system wide implementation tracking mechanisms. |  | 

Assurances required that services can be moved between sites safely and timetable isn’t too short
- Hillingdon HOSC
- Kensington & Chelsea HOSC.
A high level implementation plan was developed pre-consultation. During the post-consultation phase we developed a more detailed implementation planning to ascertain a timetable for the transfer of services between proposed local and major hospital sites. We also developed KPIs for implementation and a framework that ensures that service change would only occur if it was safe to do so.
Safe implementation of proposals: Chapter 17, Section 17.4.5

6.3.4 Theme 4: Proposals for major hospitals

Option A was stated as the preferred option during consultation. Option A designates St Mary’s, Chelsea and Westminster, West Middlesex, Northwick Park and Hillingdon as 'major hospitals'. Option B designates Chelsea and Westminster as a 'local hospital'. Option C designates West Middlesex as a 'local hospital'.

Figure 6.5: Theme 4 – Proposals for major hospitals

Feedback received | Stakeholders who provided this feedback | Our consideration of the feedback | DMBC reference
--- | --- | --- | ---
Objection to closing A&Es
- Public
- Stakeholders in Hammersmith and Fulham and Ealing.
The key issues raised concerned travel, access and capacity. All of which we undertook further work on post consultation. This work is included within the DMBC. | Travel: Chapter 9, Section 9.7.22 and Section 9.7.32 and Chapter 12
Access: Chapter 9, Section 9.7.32, Chapter 11 Section 11.4.4 and Chapter 12 |
<table>
<thead>
<tr>
<th>Feedback received</th>
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<th>Our consideration of the feedback</th>
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<tbody>
<tr>
<td>OPTION A: If option A is selected then reconsider services provided at Charing Cross under this option</td>
<td>Imperial College Healthcare NHS Trust.</td>
<td>The proposals were developed to a level to support the JCPCT’s decision to proceed to consultation with the proposed options. This included initial estates work with potential local hospital sites. Post consultation we have worked with Imperial College Healthcare Trust and Hammersmith and Fulham CCG to develop proposals for services provided at their sites in greater detail to support the decision making process. This detail is included within this document.</td>
<td>Capacity: Chapter 15</td>
</tr>
<tr>
<td>OPTION B: If Chelsea and Westminster is a local hospital St Thomas’s would require significant capital investment to cope with diverted demand</td>
<td>Guy’s and St Thomas’ NHS Foundation Trust.</td>
<td>In addition to the information we provided pre-consultation, we provided additional information to Guys and St Thomas’s during consultation about activity and bed numbers. We also reevaluated Option B during the decision making phase and considered feedback from Guys and St Thomas’s.</td>
<td>Development of the Charing Cross site: Chapter 15, Section 15.5.1 and Chapter 16, Section 16.4.6</td>
</tr>
<tr>
<td>OPTION C: West Middlesex is used by patients living in Richmond and Twickenham, Richmond OSC believe West Middlesex should be a major hospital</td>
<td>Richmond HOSC.</td>
<td>In addition to the information we provided pre-consultation, further details were provided to Richmond OSC during consultation about the travel implications of option C. We also undertook further travel analysis, which can be found in this document. We have reconsidered the impact of Option C on Richmond and Twickenham during decision making.</td>
<td>Identification of the preferred option: Chapter 9c</td>
</tr>
</tbody>
</table>

6. Consultation, feedback and how we responded
6.3.5 **Theme 5: Proposals for local hospitals**

Local hospitals will continue to deliver many services they currently provide.

**Figure 6.6: Theme 5 – Proposals for local hospitals**

<table>
<thead>
<tr>
<th>Feedback received</th>
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</table>
| Greater detail required about the services provided at local hospital sites | • Ealing Council  
• Kensington & Chelsea LINk  
• Hammersmith & Fulham LINk. | We produced a local hospital factsheet outlining the expected services at local hospital sites, including conditions UCCs would treat, during consultation. This can be found on our consultation website (www.healthiernorthwestlondon.nhs.uk).  
We have worked with trusts and CCGs post consultation to develop the service models for local hospitals. This work is detailed in this document. | Local hospital specification: Chapter 7, Section 7.6.1 and Chapter 8, Section 8.11.1 |
| Assurances required that different local hospitals will provide consistent services | • Public  
• Kensington & Chelsea LINk. | Post consultation we worked with trusts and CCGs to develop the service model for local hospitals. Local hospitals are designed to provide services that directly relate to the needs of the local population. Different areas may have different services because the needs of local populations vary – this is one benefit of developing local hospitals. CCGs are working locally to define what the services should be and this would be reflected in commissioning of these hospitals.  
UCCs are an important component of the services proposed to be offered by local hospitals. We have developed a common UCC specification which details the conditions that UCCs should treat, those that would be excluded, the service models and transfer protocols, staff competencies, quality standards and governance arrangements. Any future tendering of UCC services would reflect this common UCC specification and consistency achieved as contracts are retendered. | Local hospitals: Chapter 7, Section 7.6.1 and Chapter 8, Section 8.11.1  
UCCs: Chapter 8d |
| Detail required about the implementation and delivery of local hospitals | • Ealing Council  
• Ealing Hospital  
• Imperial College Healthcare Trust  
• Kensington & | A high level implementation plan was developed pre-consultation and this provided sufficient assurance to the JCPCT to proceed to consultation.  
Post consultation we have developed implementation plans with providers to ascertain how changes could be implemented. CCGs are also developing | Implementation plans: Chapter 17 |
### Feedback received

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<tr>
<th>Stakeholders who provided this feedback</th>
<th>Our consideration of the feedback</th>
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<tbody>
<tr>
<td>Chelsea LINk, Kensington &amp; Chelsea HOSC, Richmond Council, JHOSC.</td>
<td>Implementation plans based on their commissioning intentions for out of hospital care.</td>
</tr>
</tbody>
</table>

**Assurance required that services will only transition/migrate when safe to do so**

- Kensington & Chelsea HOSC
- Public
- Harrow HOSC & Council
- JHOSC.

A high level implementation plan was developed pre-consultation and this provided sufficient assurance to the JCPCT to proceed to consultation.

Service changes would not be implemented until it is safe to do so. As part of our implementation planning we have identified what needs to be in place before potential major changes can be made, including the development of KPIs and a decision making framework that ensures that service change only occurs when it is safe to do so. This framework builds upon existing CCG governance related to the safe commissioning of services.

Safety during implementation: Chapter 17, Section 17.4.5

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### 6.3.6 Theme 6: Proposals for specialist hospitals

Specialist hospitals are where clinicians have specialised in treating certain conditions, for example cancer or heart conditions or lung diseases.

**Figure 6.7: Theme 6 – Proposals for specialist hospitals**

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<thead>
<tr>
<th>Feedback received</th>
<th>Stakeholders who provided this feedback</th>
<th>Our consideration of the feedback</th>
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<tbody>
<tr>
<td>Explore the potential for further concentration of specialist services at Hammersmith</td>
<td>Imperial College Healthcare NHS Trust.</td>
<td>Pre-consultation, the proposals for services delivered at Hammersmith were developed in conjunction with the Trust and approved by the Clinical Board. Post-consultation we have worked with Imperial College Healthcare Trust and Hammersmith and Fulham CCG to develop proposals for services provided at the site. This work is included in this document.</td>
<td>Proposals for Hammersmith Hospital: Chapter 9c and, Chapter 15, Section 15.3.1</td>
</tr>
<tr>
<td>Feedback received</td>
<td>Stakeholders who provided this feedback</td>
<td>Our consideration of the feedback</td>
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| Consider the implications for teaching by Imperial College at Charing Cross      | • Imperial College  
• Imperial College Healthcare NHS Trust.                                                                 | Research and education was considered during the pre-consultation evaluation. As further information has become available about teaching facilities at different sites this has been added to the refreshed modelling undertaken by F&BP during the decision making phase. As part of this work we have worked with Imperial College and the Trust to develop proposals for undergraduate teaching services currently based at Charing Cross. | Proposals for research and education: Chapter 9c  
Proposals for Charing Cross: Chapter 15, Section 15.5.1 and Chapter 16, Section 16.4.6 |
| Consider how more specialist services can be delivered in the community        | • Westminster HOSC  
• Kensington & Chelsea HOSC.                                                                                      | The out of hospital workstream has considered, with each CCG, the activity that could be delivered out of hospital, including reducing non elective admissions, outpatients in the community and some elective treatments. CCGs are responsible for developing services for their local communities and this work will include, where relevant, specialist services. | Out of hospital improvements: Chapter 8 and Chapter 16 |
| Consider locating the HASU nearer areas most at risk (Hounslow and Ealing) and concerns about transport times | • Imperial College Healthcare NHS Trust  
• Richmond CCG  
• Richmond HOSC.                                                                                                  | The previous outcome of the stroke and trauma service configuration review was that commissioners would develop a plan to realise the benefits of future co-location on the St Mary’s Hospital site. Post consultation we have considered consultation responses about the location of the HASU and concluded that the proposals for locating the HASU at St Mary’s are still valid. | Location of HASU: Chapter 9, Section 9.9.40 |
### 6.3.7 Theme 7: Proposals for out of hospital care

There is an ambition to offer more healthcare services out of hospital.

**Figure 6.8: Theme 7 – Proposals for out of hospital care**

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<th>Feedback received</th>
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</table>
| **Assurances required that out of hospital care will be ready and able to meet demand before acute services reconfigure** | • Brent LINk  
• Richmond LINk  
• Kensington & Chelsea LINk  
• Hillingdon LINk  
• Ealing HOSC  
• JHOSC  
• Hammersmith & Fulham HOSC  
• Hounslow HOSC  
• Kensington & Chelsea HOSC. | The Case for Change states that it is essential to ensure that out of hospital services are working well in order to ensure an improvement in the whole healthcare system in NW London. Patient safety is critical and we remain committed to ensuring services continue to be safe when any changes are made. It is also important to remember that CCGs are already commissioning, running and monitoring out of hospital services and these services are safe.  

During implementation we expect some services to be ‘double run’, particularly while capacity in community services is developed; refer to our implementation plans for further details. We have created a monitoring mechanism for key out of hospital initiatives across the eight CCGs and mapping this to actual changes in the system, for example, through monitoring system-wide impact on beds and the use of beds. This ‘implementation tracker’ has been developed for use at CCG and system level.  

We have developed a decision making framework that aims to ensure any service change only occurs when it is safe to do so; this builds upon existing governance structures for commissioning services. | Implementation plans:  
Chapter 17  
Implementation tracker:  
Chapter 17, Section 17.4.6  
Safety during implementation:  
Chapter 17, Section 17.4.5 |
| **Out of hospital plans are not detailed enough to support implementation** | • Harrow HOSC/ Council  
• Ealing Council  
• JHOSC  
• Hillingdon LINk  
• Kensington & Chelsea HOSC. | High level implementation plans were developed pre-consultation and these were sufficient for the JCPCT to decide to proceed to consultation.  

CCGs have developed more detailed out of hospital implementation plans during decision making based upon their 2013/14 CCG commissioning intentions. This work is included in this document. | Out of hospital plans:  
Chapter 16  
Implementation plans:  
Chapter 17 |
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| Is there the necessary workforce to deliver OOH | - Ealing HOSC  
- Westminster HOSC  
- Richmond CCG  
- Hounslow HOSC. | Post consultation the out of hospital workstream has considered the workforce requirements for out of hospital care, building on the work already done to understand the skills and competency requirements of the OOH nursing workforce, the quantity required and the implications on training for the activity shift planned. This work is described in this document.  
We have also established a transformational workforce group, who developed the plans for out of hospital workforce and will provide assurances about deliverability.  
Post consultation the Urgent and Emergency and Maternity CIGs considered their workforce requirements to deliver relevant community and local hospital services to the standards required, this is described in their reports. | Out of hospital workforce: Chapter 8, Section 8.5.3 and Chapter 14  
Urgent and emergency care workforce: Chapter 7, Section 7.17 and Chapter 14 |
| Is the money being made available for out of hospital care? | - Kensington & Chelsea LINk  
- Hillingdon Link  
- Hammersmith & Fulham Link  
- Brent HOSC. | The financial models and out of hospital plans demonstrate that there would be significant investment in out of hospital care for delivering the out of hospital standards and in moving appropriate activity from the acute setting to the out of hospital setting. The DMBC describes the investments. Initial estimates for out of hospital investments for 2013/14 are described in the Commissioning Intentions found in Appendix J. Please note, these Commissioning Intentions are currently being updated and the latest proposals can be found on CCG websites. | Out of hospital investment: Chapter 8, Section 8.20 and Chapter 16  
Commissioning intentions: Appendix J |
| Plans should be produced which set out how all parts of the population will be educated in how to how to access services, in particular urgent care centres | - JHOSC  
- Imperial College Healthcare NHS Trust  
- Hammersmith & Fulham Link  
- Harrow HOSC / Council  
- Central London Community Healthcare | We continued with our stakeholder engagement throughout the post consultation period, and have developed plans for further engagement throughout implementation so that we can communicate with the public about potential service changes during implementation.  
The role of public education is supported by the wider NHS. To inform this work our implementation planning considers the need for public education programmes to ensure the public know how and when to access services such as primary care, out of hospital services, UCCs and hospital care as changes are made. | Stakeholder engagement through post consultation: Chapter 6, Section 6.2.7  
Stakeholder engagement through implementation: Chapter 17, Section 17.5 |
### 6.3.8 Theme 8: Travel and access

Changing the location of services will have an impact on travel and access.

**Figure 6.9: Theme 8 – Travel and access**

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<tr>
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</table>
| **What are the overall implications of the reconfiguration on patient access to services** | • Hillingdon LINk  
• Ealing Council and OSC  
• Kensington & Chelsea OSC  
• Hounslow OSC  
• H&F LINk  
• Brent LINk  
• Richmond Council  
• Wandsworth CCG. | Our proposals are underpinned by a planned movement of work into primary and community care settings and practices and hubs making use of innovative technology (such as telehealth) to improve patient access. The funding for these out of hospital plans is included in Chapters 8 and 16. We have sought to mitigate the impacts on access by ambulance by ensuring an even geographic spread of major hospitals, as described in the hurdle criteria.  
Post consultation we undertook further modelling, supported by our Travel Advisory Group, to address issues raised during consultation and support the decision making process. This work is described in this document.  
We also undertook a further more detailed Equalities review post consultation to consider the specific impacts on protected groups with relation to access on public transport. | Travel analysis: Chapter 12, Section 12.2  
Travel Advisory Group report: Appendix K1  
Equalities review: Chapter 13 and Appendix G |
### Feedback received

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<th>Stakeholders who provided this feedback</th>
<th>Our consideration of the feedback</th>
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<tr>
<td><strong>Detailed modelling is important e.g. what impact will increasing journey times by ambulance have on clinical outcomes</strong></td>
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<tr>
<td>- College of Emergency Medicine</td>
<td>Our options development and short listing process ruled out options that would have a significant impact on journey times.</td>
<td>Option development: Chapter 9, Section 9.9</td>
</tr>
<tr>
<td>- Hounslow OSC</td>
<td>Post consultation we undertook a literature review to examine the latest available evidence about the impacts of journey times on outcomes, this work is described in the documents referred to in the last column.</td>
<td>Literature review: Appendix E, Section E.2.1.1</td>
</tr>
<tr>
<td>- Richmond CCG</td>
<td>Further travel analysis was also undertaken post consultation to address key focus areas. We continued to work with London Ambulance Service (LAS) through this period, as a member of our Travel Advisory Group.</td>
<td>Travel analysis: Chapter 12, Section 12.2</td>
</tr>
<tr>
<td>- Kensington &amp; Chelsea HOSC</td>
<td></td>
<td>Travel Advisory Group report: Appendix K1</td>
</tr>
<tr>
<td>- Kensington &amp; Chelsea Link</td>
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<tr>
<td>- Hammersmith &amp; Fulham Link</td>
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<td>- Westminster HOSC</td>
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<tr>
<td><strong>What are the impacts on walking and cycling?</strong></td>
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<tr>
<td>- Hounslow OSC</td>
<td>Our proposals are underpinned by a move to provide more services locally, improving access. Considerations regarding the location of urgent and emergency care focussed on patient safety, in particular ensuring blue light travel times were safe. Furthermore, patients requiring emergency care should call an ambulance.</td>
<td>Travel Advisory Group report: Appendix K1</td>
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<tr>
<td>- Travel Advisory Group</td>
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<tr>
<td><strong>What are the impacts on patient transport services? Further analysis needed</strong></td>
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<tr>
<td>- Hounslow OSC</td>
<td>Travel analysis was undertaken pre-consolation to a sufficient level to support the JCPCT decision to proceed to consultation.</td>
<td>Travel work on patient transport services: Chapter 12, Section 12.3.5</td>
</tr>
<tr>
<td>- Hillingdon Link</td>
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<tr>
<td>- Kensington &amp; Chelsea HOSC</td>
<td>Further travel analysis was undertaken post consultation and we worked with providers to understand eligibility criteria for travel concessions for patients and whether this can be standardised across NW London. The TAG would continue to examine this issue during implementation.</td>
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### Feedback received

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</table>
| What are the implications on transfer times e.g. Between UCCs and A&Es and inter-hospital transfers? | • Royal College of Midwives  
• Hounslow HOSC  
• Hillingdon LiNk.                                                                 | The Clinical Board agreed that any impact on patient transfer times as a result of the proposed options would be clinically acceptable.  
Further work was undertaken post consultation to consider patient transfer between UCCs and A&Es. We are continuing to work with providers to define how inter hospital transfers would be delivered. We continue to work with LAS and as part of this will explore relevant patient transfer protocols. | Travel work on patient transfer: Chapter 12, Section 12.2  
UCC transfer protocols: Chapter 7, Section 7.15.4 |
| What are the implications for step free access?                                  | • Travel Advisory Group  
• Harrow HOSC / Council.                                                                 | The Travel Advisory Group considered key focus areas such as step free access during the post consultation period and this work is included in their report and has been used to inform the DMBC.  
Further analysis was undertaken post consultation to consider transport times by bus. We have continued to work with Transport for London (TfL) and this work informed our implementation planning. | Bus travel: Chapter 12, Section 12.3 |
| What are the impacts on parking / blue badge holders?                            | • Hounslow OSC  
• Travel Advisory Group.                                                                 | The Travel Advisory Group considered key focus areas such as parking during the post consultation period and this work is included in their report and has been used to inform the DMBC.                                                                                                           | Travel analysis: Chapter 12, Section 12.3  
TAG report: Appendix K |
| How can access by bus be improved?                                               | • Hounslow HOSC  
• Harrow LiNk  
• TAG.                                                                 | We undertook further travel analysis post consultation to understand transport times by bus. We also continued to work with TfL to understand requirements for bus routes and bus stops to inform our implementation planning.                                                                                                         | Bus travel times: Chapter 12  
Travel action plan: Chapter 12, Section 12.4 |

### 6.3.9 Theme 9: Equalities and deprivation

We undertook work to assess the potential equalities implications of the reconfiguration pre and post consultation.

Figure 6.10: Theme 9 – Equalities and deprivation
<table>
<thead>
<tr>
<th>Feedback received</th>
<th>Stakeholders who provided this feedback</th>
<th>Our consideration of the feedback</th>
<th>DMBC reference</th>
</tr>
</thead>
</table>
| Greater clarity required about the specific equalities impacts                   | • Harrow HOSC/ Council • Ealing Council • Hammersmith Council/ HOSC • Hammersmith & Fulham LINk • Hillingdon LINk • Brent LINk • JHOSC.                                                                 | We commissioned an Equalities Review prior to consultation. This work was to the required level to support the JCPCT’s decision to proceed to consultation. This pre-consultation work outlined a number of areas for further consideration.  
We subsequently undertook focused sub-group analysis during the post consultation period to ascertain the specific impacts on protected groups. Out of this work we developed an action plan for the implementation phase. All of this work is described in this document. | Equalities reviews: Chapter 13, Section 13.4 and Appendix G                                                                                                                                                                                                                                                                  |
| Further consideration of deprived population e.g. Is there a link between deprivation and need for proximity of access to acute care | • Ealing Council • Hammersmith Council/ HOSC • SaHF.                                                                                                                                          | We are not aware of evidence to support links between deprivation and the need for additional emergency services. However, the proposals were developed to minimise the impacts on access by ensuring a geographical distribution of the proposed major hospital sites. Critically, work to develop community services (where there is evidence that deprived communities need additional services) will ensure appropriate access for local populations.  
We have developed proposals that seek to minimise access implications.  
Post consultation we undertook a literature review to ascertain the latest available evidence regarding any links between deprivation and need for proximity of access to acute care.  
We also extended the scope of our equalities work to include deprivation. | Equalities reviews: Chapter 13, Section 13.6.1 and Appendix G  
Literature review: Appendix E                                                                                                                                                                                                                                                                                                                                                   |
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Chapter 7
Clinical vision, standards and service models
7a. Clinical, vision, standards and service models

This chapter describes how patients in NW London will be treated in the future to ensure they receive the highest standards of care. Services will be provided locally where possible and centralised where necessary. Services will also be integrated across organisational boundaries to provide a seamless experience of care in a range of care settings. This chapter sets out the vision for improving services in out of hospital settings and how these services will be delivered, as well as the vision for urgent and emergency care, maternity and paediatric services. Clinicians have developed a set of clinical standards for each of these areas and these standards will underpin quality within any future configuration of acute services. The clinical standards have been brought together into a set of eight service models that are used as the building blocks of the recommended option for the future of healthcare provision in NW London.

This chapter builds on our pre-consultation work using feedback received during consultation to refine the proposals. This chapter has four parts; the first part is a summary of the clinical vision, the recommended standards of care to deliver the vision (for out of hospital, emergency and urgent care, paediatrics and maternity) and the recommended service models to deliver the standards of care; the final three sections describe the work undertaken by our Clinical Implementation Groups (CIGs) as they developed our clinical proposals.

7.1 The vision for care in NW London

Prior to consultation clinicians set out their vision for care in NW London. Achieving this vision would address the challenges described in the Case for Change. Clinicians then described the care standards and the settings of care required to deliver the vision and the benefits in the Case for Change. The Department of Health’s National Clinical Advisory Team (NCAT) scrutinised our proposals for in hospital care prior to consultation and made a number of recommendations for further work. We received feedback on our proposals during consultation. London Health Programmes (LHP) developed their Pan London Quality Standards for in hospital care (published early 2013).

To consider the implications of NCAT, consultation feedback and the LHP work on our proposals we:

- Established three Clinical Implementation Groups (CIGs) to refine our clinical proposals for urgent and emergency care, maternity and paediatrics
- Supported the CCGs as they developed their clinical proposals for out of hospital care.

This chapter describes the final vision, standards and service models for in hospital and out of hospital developed by our CIGs and local CCGs and endorsed by our Clinical Board. NCAT provided a final assessment of the proposals prior to JCPCT decision making.

7.1.1 A pledge by local clinicians

Local clinicians want the health system in NW London to be one in which people are cared for in a high quality, consistent, integrated way in the most appropriate setting.

NHS NW London is committed to giving everyone:

- The support needed to take better care of themselves
- A better understanding of where, when and how they can be treated
- The tools and support to better manage their own conditions
- 24/7 access to primary care clinicians like GPs – by phone, email or in person – when they have an urgent health need
- Timely and well-coordinated access to specialists, community and social care providers, managed by their GP
- Properly maintained and up-to-date hospital facilities with highly trained specialists, available all the time.

In addition, NW London’s clinical leaders, the eight CCG Chairs, made the following pledges in the Case for Change (Appendix D):

- “As clinical leaders in North West London, we believe that the case for making changes to how we deliver services in North West London is compelling and places a clear responsibility on us now to deliver better healthcare for our patients in years to come.”
- “We believe that increasing the amount of care delivered closer to patients’ homes will enable better coordination of that care, ensure the patient has access to the right help in the right setting and improve quality of care and value for money”
- “We will take on that challenge. Its scale should not be underestimated but neither should we underestimate the rewards of getting this right – better healthcare, more lives saved, more people supported and a more efficient system”
- “We will listen to our patients and staff throughout the process of change and make sure that we are always working to create a system that works, first and foremost, for them.”

7.1.2 Three overarching principles form the vision for care in NW London

In the 2011 Commissioning Strategic Plan, NHS NW London formulated an overarching strategy which stated that health services need to be localised where possible, centralised where necessary and that in all settings, care should be integrated across health, social care and local authority providers wherever that improves seamless patient care. Figure 7.1 describes the three principles.

Figure 7.1: Three overarching principles that form the NHS NW London vision
Local clinicians agreed that in order to meet the challenge described in the Case for Change, *Shaping a healthier future* will be guided by these three principles. *Shaping a healthier future* is part of a range of NHS NW London initiatives to deliver the Commissioning Strategic Plan, which together are expected to deliver these principles. The agreed principles were then used to develop a vision and a set of clinical standards for both out of hospital care and in hospital care.

### 7.1.3 The vision for out of hospital care

Following on from the Commissioning Strategy Plan and Case for Change, the eight CCGs have set out their vision to transform out of hospital care, Figure 7.2.

**Figure 7.2: Summary of visions for out of hospital**

- We have a clear vision for this future, centred on the patient. At the heart of our vision is providing the right care, in the right place, at the right time to reduce reactive, unscheduled care and do more planned care earlier
- Out of hospital services can help NW London meet the difficult challenge of increasing demand and limited resources - but this will need dramatic transformation in how primary, community and social care works
- We have already started making this change happen and are having an impact across NW London with services such as rapid response in the community, integrated care and use of urgent care centres
- We will make this impact consistent across NW London by putting the GP at the centre of delivering care for patients and coordinating providers
- Local GPs have set high standards of clinical care for all providers and are putting in place a clinician-led system for making sure these standards are met
- Across NW London GP practices are working together to serve the local population and improve how care is provided
- Providers of care will not work in isolation, but will work together in integrated teams, dedicated to serving a population of patients with new ways of working to ensure that care is coordinated
- Across the care system we will invest around £190 million over the next five years in specific services to make these changes a reality*
- We need more than just new services and new ways of working to be effective. We will invest in better information systems, put in place stronger governance structures to hold providers to account and make sure patients have easy ways to tell us what is not working at every stage of care
- We will implement these changes to have them in place to support the proposed hospital reconfiguration in 2014/15

*Funding is recurrent and for investment in services*

By setting out this vision, CCGs have agreed their plans to transform out of hospital care and provide better care, closer to home. As set out in the Case for Change (Chapter 4) there is a clear case for this transformation. Improving out of hospital services, through earlier intervention, better coordinated care, improved community services, and supporting patients at home will improve patient outcomes, satisfaction and provide better value for money. At
present, access to care and the quality of care are variable. Transforming access, quality and the scope of out of hospital services will require innovative ways of coordinating services, more investment, and improved accountability. The NW London integrated care pilots (ICPs) are an example of the benefits that can be delivered through this approach; further information on the ICPs can be found in Chapter 8. Further detail on the individual CCG out of hospital strategies are in Chapter 8 and Appendix L. The out of hospital strategies have been developed based on three year investment figures. It should be noted that the DMBC discusses a five year period.

7.1.4 The vision for care in hospital

From 2009 to 2011, Clinical Working Groups were commissioned to carry out extensive work to develop suitable models for clinical services across NW London. Rather than replicating this work, the Clinical Board of the Shaping a healthier future programme took this work forward to focus on what this means for how services are configured and the dependencies between the different services.

Using the latest evidence and research, clinicians identified that there are significantly improved outcomes for patients and improved patient experiences when certain specialist services are centralised; supporting evidence can be found in Chapter 11. Local clinicians focused on three clinical areas: emergency and urgent care, maternity and paediatrics. Due to the clinical interdependencies between these specialties, they drive the design of the acute clinical service models and therefore the reconfiguration of acute services. Further information on clinical interdependencies and the proposed service delivery models can be found in Section 7.6.

As a first step, local clinicians supported by patients and their representatives, the public, commissioners and providers have developed visions for emergency and urgent care, maternity and paediatrics (described in Figure 7.3). Using the latest evidence from Royal Colleges, reviews by the NHS in London and NICE guidelines, clinicians then developed a set of clinical standards to achieve the visions.

Figure 7.3: Summary of visions for three acute service areas

- Patients that require basic urgent care should be able to access their own GP (if this is not feasible, through a neighbouring GP practice or an Urgent Care Centre)
- If patients need to go to hospital, they should have quick access to high quality urgent care through an A&E backed up by appropriate services, e.g.
  - 24/7 Emergency Surgery and intensive care
  - Diagnostic services needed to assess their condition
- Patients should be able to receive the best quality care delivered by the right person regardless of the time or day of the week
7.1.5 How we considered feedback to refine the vision

During consultation we received feedback about the vision for care in NW London across three areas; choice, A&E size and people with multiple health needs. The feedback received did not include any alternative to the vision. However, it did include areas for further consideration. Full details of the responses can be found in Chapter 9, Section 9.4. We responded to the feedback as follows:

- **Choice**: We undertook further detailed analysis about patient choice during decision making. This work is described in Chapter 11. The analysis in Chapter 11 indicates that for the majority of people patient choice will either be maintained or increased under these proposals as more services are offered in the community and the majority of acute services will remain unchanged. There will be slightly less choice of hospital locations for A&E, maternity and paediatrics, but the quality at all of these facilities will be greatly increased and patients will have greater access to senior staff.

- **A&E size and manageability**: We were unable to find evidence to support the idea that A&Es become ‘unmanageable’ above a certain size. The A&Es in NW London will typically be smaller than other A&Es in London which are currently operating safely. Further detail can be found in Section 9.4.4.

- **Multiple health needs**: Improvements in out of hospital care will result in coordinated individual care planning for patients with co-morbidities. Led by GPs this planning will work across range of specialities and means patients will receive better integrated care. Further work on the equalities can be found in Chapter 13.

For these reasons therefore, the feedback received did not, in the view of the Clinical Board and Programme Board, justify any change to the vision.
7.2 Clinical standards for out of hospital care

Our clinicians agree that the first step to transforming care is to define the standards expected of all providers so that patients and the public can be confident that as changes are made to where and how patients are treated and cared for, high clinical quality is always the priority. Local clinicians have set and agreed standards for the provision of high quality primary and community services across NW London.

Across NW London, the eight CCGs have identified the critical opportunities for delivering high-quality and cost-effective care outside hospitals to improve care for individuals as well as support the wider changes required across the health economy. The Quality Standards support and drive the changes required by:

- Setting our aspirations for the future
- Focussing on the areas that will drive how services are delivered
- Establishing standards that will be equally applicable to all out of hospital providers
- Supporting the shift in care delivery from reactive unplanned care to more proactive planned care
- Emphasising the central role of the GP in the coordination of out of hospital care.

The standards to deliver these changes are set out against the four domains:

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

A summary of the standards agreed by local clinicians for out of hospital care are set out in Figures 7.4-7.7. The standards intentionally go beyond current contractual arrangements. They support and drive the changes required by providing a common set of standards that will be equally applicable to all out of hospital providers, to set out their aspirations for the future in line with the four core themes.

Figure 7.4: Out of hospital quality standards - Individual Empowerment and Self Care

<table>
<thead>
<tr>
<th>#</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals will be provided with up-to-date, evidence-based and accessible information to support them in taking personal responsibility when making decisions about their own health, care and wellbeing.</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Individuals will have access to relevant and comprehensive information, in the right formats to inform choice and decision making</td>
</tr>
<tr>
<td>2</td>
<td>Individuals will be actively involved together with the local community health and care services to support personal goals and care plans.</td>
</tr>
<tr>
<td>3</td>
<td>Information and services will be available for individuals who are able to self-manage their conditions or who need care plan support</td>
</tr>
</tbody>
</table>

Figure 7.5: Out of hospital quality standards - Access, Convenience and Responsiveness

<table>
<thead>
<tr>
<th>#</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of hospital care operates as a seven day a week service. Community health and care services will be accessible, understandable, effective and tailored to meet local needs. Service access arrangements will include face-to-face, telephone, email, SMS texting and video consultation.</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Individuals will have access to telephone advice and triage provided 24 hours a day, seven days a week. This will be either through their General Practice or known care provider’s telephone number or through the telephone single point of access for all community health and</td>
</tr>
</tbody>
</table>
7a. Clinical vision, standards and service models

<table>
<thead>
<tr>
<th>#</th>
<th>Standard</th>
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<tr>
<td>care services (111).</td>
<td></td>
</tr>
<tr>
<td>As a result of the triage process, cases assessed as urgent will be given a timed appointment or visit with the appropriate service provider (including a doctor where required) within 4 hours of the time of calling.</td>
<td></td>
</tr>
<tr>
<td>For cases assessed as not urgent and that cannot be resolved by phone, individuals will be offered the choice of an appointment with the appropriate service provider within 24 hours or an appointment to see a GP in their own practice within 48 hours, or at a subsequent time convenient to them.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>An individual who is clinically assessed to be at risk of an admission to hospital which could be prevented by expert advice, services, diagnostics, or the supply of equipment, will have their needs met in less than 4 hours</td>
</tr>
<tr>
<td>3</td>
<td>Clinical protocols with access times to routine investigations will be made available and followed by service providers. This will include simple radiology, phlebotomy, ECG and spirometry.</td>
</tr>
</tbody>
</table>

Figure 7.6: Out of hospital quality standards - Care Planning and Multidisciplinary Care Delivery

<table>
<thead>
<tr>
<th>#</th>
<th>Standard</th>
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</thead>
<tbody>
<tr>
<td>Individuals using community health and care will experience coordinated, seamless and integrated services using evidence-based care pathways, case management and personalised care planning. Effective care planning and preventative care will anticipate and avoid deterioration of conditions.</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>All individuals who would benefit from a care plan will have one. Care plans will be agreed with individuals (i.e. patients, users, carers) and will:</td>
</tr>
<tr>
<td></td>
<td>• Be co-created, kept up-to-date and monitored by the individual and appropriate professional(s)</td>
</tr>
<tr>
<td></td>
<td>• Include a common approach to assessment covering both health and social care, with an onward package of care in place to meet the individual's needs</td>
</tr>
<tr>
<td></td>
<td>• Include a carer’s assessment where appropriate</td>
</tr>
<tr>
<td></td>
<td>• Be available in the format suited to the individual, with the relevant sections shared amongst those involved in delivery of their care</td>
</tr>
<tr>
<td></td>
<td>• Include sources of further information to help patient’s decision-making and choice about treatment and self-care.</td>
</tr>
<tr>
<td>2</td>
<td>Everyone who has a care plan will have a named “care coordinator” who will work with them to coordinate care across health and social care. The role of the care coordinator will be clearly defined and understood by the individual and those involved in providing care. Clinical accountability will remain with the patient’s GP.</td>
</tr>
<tr>
<td>3</td>
<td>GPs will work within multi-disciplinary groups to manage care delivery, incorporating input from primary, community, social care, mental health and specialists</td>
</tr>
<tr>
<td>4</td>
<td>Pooled funding and resources between health and social care will be included in commissioning plans to ensure that efficient, cost-effective and integrated services are provided</td>
</tr>
</tbody>
</table>

Figure 7.7: Out of hospital quality standards - Information and Communication

<table>
<thead>
<tr>
<th>#</th>
<th>Standard</th>
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<tbody>
<tr>
<td>With an individual's consent, relevant parts of their health and social care record will be shared between care providers. Monitoring will identify any changing needs so that care plans can be reviewed and updated by agreement. By 2015, all patients will have online access to their health records.</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>With the individual’s consent, relevant information will be visible to health and care professionals involved in providing care.</td>
</tr>
<tr>
<td></td>
<td>This should be available electronically and in hard copy.</td>
</tr>
</tbody>
</table>
7a. Clinical vision, standards and service models

<table>
<thead>
<tr>
<th>#</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Any previous or planned contact with a healthcare professional should be visible to all relevant community health and care providers, in particular, when a patient is admitted or discharged from hospital. This should ensure that care providers are aware of any planned or outstanding activities required for the individual.</td>
</tr>
<tr>
<td>3</td>
<td>Following admission to hospital, the patient's GP and relevant providers will be actively involved in coordinating an individual’s discharge plan (including intermediate care and reablement) as well as continuing care needs</td>
</tr>
</tbody>
</table>

All providers will be held to account against these standards during the implementation phase and local GPs in their CCGs are putting in place processes to ensure they are delivered. A clear clinician-led system based around peer review will be critical to ensure that performance is transparent. In addition, a system led by clinicians will be put in place to manage performance so that benefits for patients are delivered. For further details of the implementation governance arrangements refer to Chapter 17.

7.3 Clinical standards for hospital care

To drive the improvements in clinical quality and reduce the variation that has been documented in the Case for Change, clinicians have developed a set of clinical standards. The clinical standards have been defined for the same three clinical areas (emergency and urgent care, maternity and paediatrics) to support the visions. Delivery of the clinical standards creates the need for changes that drive the hospital reconfiguration proposals, ultimately leading to improved clinical outcomes for patients as well as improved experiences for both patients and staff.

Clinicians started to develop the standards in 2011 before the formal launch of *Shaping a healthier future*, this work concluded prior to consultation. These standards were reviewed by NCAT (in April 2012), who endorsed the work. During the decision making phase our three CIGs worked with local clinicians and our CCGs to refine and finalise the standards. These standards include the latest evidence from Royal Colleges, LHP’s London Quality Standards, NCAT feedback, NICE guidelines, evidence from the literature, relevant feedback received during consultation, and input from reviews by the NHS in London. NCAT re-visited the programme in November 2012 and supported the proposals for a second time. Figure 7.8 sets out the process followed by clinicians in developing the standards.
A wide body of evidence was reviewed in determining what clinical standards should apply in NW London. The core documents were:

- London Health Programme Review - Adult Emergency Services: Acute medicine and emergency general surgery (2011)
- NCEPOD (2007) Emergency admissions: A journey in the right direction?
- RCP (2007) The right person in the right setting – first time
- RCS (2011) Emergency Surgery Standards for unscheduled care
- AoMRC (2008) Managing urgent mental health needs in the acute trust
- NCEPOD (1997) Who operates when?
- ASGBI (2010)
- The Royal College of Anaesthetists: Guidelines for the Provision of Anaesthetic Services
- Safer Childbirth - Minimum Standards for the Organisation and Delivery of Care in Labour (2007), RCOG
- Facing the Future: Standards for Paediatric Services, Royal College of Paediatrics and Child Health, April 2011.

A review of recent clinical evidence literature is included in Appendix E.

The work by LHP to determine the London Quality Standards has been a key driver in developing the standards to be adopted as part of this reconfiguration.

### 7.3.1 Shaping a healthier future emergency and urgent care clinical standards

The **Shaping a healthier future emergency and urgent care standards** are detailed in Figures 7.9 – 7.15. For details about the development of the standards and how the
Emergency and Urgent Care CIG considered feedback from stakeholders in their development please refer to Section 7b.

**Figure 7.9: Shaping a healthier future emergency and urgent care standards**

<table>
<thead>
<tr>
<th>#</th>
<th>Standard</th>
<th>Adapted from source</th>
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<tbody>
<tr>
<td>1</td>
<td>A trained and experienced doctor (ST4 and above or doctor of equivalent competencies) in emergency medicine to be present in the emergency department 24 hours a day, seven days a week.</td>
<td>• CEM (2011) Emergency Medicine The Way Ahead. (LHP standard 1)</td>
</tr>
<tr>
<td>2</td>
<td>A consultant in emergency medicine to be scheduled to deliver clinical care in the emergency department for a minimum of 16 hours a day (matched to peak activity), seven days a week. Outside of these 16 hours, a consultant will be on-call and available to attend the hospital for the purposes of senior clinical decision making and patient safety within 30 minutes.</td>
<td>• CEM (2011) Emergency Medicine The Way Ahead. (LHP standard 2)</td>
</tr>
<tr>
<td>3</td>
<td>24/7 access to the minimum key diagnostics:</td>
<td>• CEM (2011) Emergency Medicine The Way Ahead</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• RCR (2009) Standards for providing a 24-hour diagnostic radiology service</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• SaHF pre-consultation standard. (LHP standard 3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• CEM (2011) Emergency Medicine The Way Ahead</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• London quality standards for inter-hospital transfers. (LHP standard 4)</td>
</tr>
<tr>
<td>4</td>
<td>Emergency department patients who have undergone an initial assessment and management by a clinician in the emergency department and who are referred to another team, to have a management plan (including the decision to admit or discharge) within one hour from referral to that team. When the decision is taken to admit a patient to a ward/ unit, actual admission to a ward/ unit to take place within one hour of the decision to admit. If admission is to an alternative facility the decision maker is to ensure the transfer takes place within timeframes specified by the London inter-hospital transfer standards.</td>
<td>• CEM (2011) Emergency Medicine The Way Ahead</td>
</tr>
<tr>
<td>5</td>
<td>A clinical decision/ observation area is to be available to the emergency department for patients under the care of the emergency medicine consultant that require observation, active treatment or further investigation to enable a decision on safe discharge or the need for admission under the care of an inpatient team.</td>
<td>• CEM (2011) Emergency Medicine The Way Ahead. (LHP standard 5)</td>
</tr>
<tr>
<td>6</td>
<td>A designated nursing shift leader (Band 7) to be present in the emergency department 24 hours a day, seven days a week with provision of nursing and clinical support staff in emergency</td>
<td>• CEM (2011) Emergency Medicine The Way Ahead</td>
</tr>
</tbody>
</table>

All hospitals admitting medical and surgical emergencies should have access to all key diagnostic services (e.g. computerised tomography; interventional radiology) in a timely manner 24 hours a day, seven days a week, to support decision making.
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<tr>
<td>7</td>
<td>Streaming to be provided by a qualified healthcare professional and registration is not to delay triage.</td>
<td>- Emergency Nurse Consultant Association (2009) &lt;br&gt; - Royal College of Nursing &amp; Faculty of Emergency Nursing (LHP standard 6)</td>
</tr>
</tbody>
</table>
| 8  | Emergency departments to have a policy in place to access support services seven days a week including:  
  - Alcohol liaison  
  - Mental health  
  - Older people’s care  
  - Safeguarding  
  - Social services.  
  Single call access for mental health referrals should be available 24/7 with a maximum response time of 30 minutes.                                                                                                                                         | - Clinical expert panel consensus. (LHP standard 7) <br> - HM Government (2012) Alcohol Strategy <br> - Clinical expert panel consensus <br> - SaHF pre-consultation standard. (LHP standard 8)                                                                                                                                                  |
| 9  | Timely access 7 days a week to, and support from, onward referral clinics and efficient procedures for discharge from hospital.                                                                                                                                                                                                           | - CEM (2011) Emergency Medicine The Way Ahead. (LHP standard 9)                                                                                                                                                                                                                                                                                      |
| 10 | Timely access 7 days a week to, and support from, physiotherapy and occupational therapy teams to support discharge from hospital.                                                                                                                                                                                                         | - (LHP standard 10)                                                                                                                                                                                                                                                                                                                                |
| 11 | Emergency departments to have an IT system for tracking patients, integrated with order communications.  
  A reception facility with trained administrative capability to accurately record patients into the emergency department to be available 24/7. Patient emergency department attendance record and discharge summaries to be immediately available in case of re-attendance and monitored for data quality. | - CEM (2011) Emergency Medicine The Way Ahead. (LHP standard 11)                                                                                                                                                                                                                                                                                      |
<p>| 12 | The emergency department is to provide a supportive training environment and all staff within the department are to undertake relevant on-going training.                                                                                                                                                                                 | - CEM (2011) Emergency Medicine The Way Ahead. (LHP standard 12)                                                                                                                                                                                                                                                                                      |
| 13 | Consultant-led communication and information to be provided to patients and to include the provision of patient information leaflets.                                                                                                                                                                                                   | - London Health Programmes (2011) Adult emergency services standards. (LHP standard 13)                                                                                                                                                                                                     |
| 14 | Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item on the trust board agenda and findings are disseminated.                                                                                                                                              | - London Health Programmes (2011) Adult emergency services standards. (LHP standard 14)                                                                                                                                                                                                     |
| 15 | Acute medicine inpatients should be seen twice daily by a relevant medical consultant.                                                                                                                                                                                                                                                   | - SaHF pre-consultation standard (LHP standard 15)                                                                                                                                                                                                                                           |</p>
<table>
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<th>Standard</th>
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<tbody>
<tr>
<td>16</td>
<td>When on-take for emergency / acute medicine and surgery, a medical or surgery consultant and their team are to be completely freed from any other clinical duties / elective commitments that would prevent them from being immediately available.</td>
<td>• SaHF pre-consultation standard.</td>
</tr>
<tr>
<td>17</td>
<td>Any surgery conducted at night should meet NCEPOD requirements and be under the direct supervision of a consultant surgeon and consultant anaesthetist.</td>
<td>• SaHF pre-consultation standard.</td>
</tr>
<tr>
<td>18</td>
<td>All hospitals admitting emergency general surgery patients should have access to an emergency theatre immediately and should have an appropriately trained consultant surgeon on site within 30 minutes at any time of the day or night.</td>
<td>• SaHF pre-consultation standard.</td>
</tr>
<tr>
<td>19</td>
<td>The Critical Care Unit should have dedicated senior medical cover (ST4 and above) present in the facility 24 hours per day, 7 days per week.</td>
<td>• SaHF pre-consultation standard.</td>
</tr>
<tr>
<td>20</td>
<td>Prompt screening of all complex needs inpatients should take place by a multi-professional team which has access to pharmacy, psychiatric liaison services and therapy services (including physiotherapy and occupational therapy, 7 days a week with an overnight rota for respiratory physiotherapy).</td>
<td>• SaHF pre-consultation standard.</td>
</tr>
<tr>
<td>21</td>
<td>The majority of emergency general surgery should be done on planned emergency lists on the day that the surgery was originally planned and any surgery delays should be clearly recorded.</td>
<td>• SaHF pre-consultation standard.</td>
</tr>
<tr>
<td>22</td>
<td>On a site without 24/7 emergency general surgery cover, patients must be transferred, following a clear management process, to an Emergency Surgery site if a surgical emergency is suspected without delay.</td>
<td>• SaHF pre-consultation standard.</td>
</tr>
</tbody>
</table>

Please note, the [DN]s in the following tables are from LHP.

**Figure 7.10: Shaping a healthier future urgent care centre standards, governance**

<table>
<thead>
<tr>
<th>No.</th>
<th>Standard</th>
<th>Adapted from source</th>
</tr>
</thead>
</table>
| 1   | Each urgent care service is to have a formal written policy for providing urgent care. This policy is to adhere to the urgent care clinical quality standards. This policy is to be ratified by the service’s provider board and reviewed annually. | • Healthcare for London (2010) A service delivery model for urgent care centres  
• The College of Emergency Medicine (2009) Unscheduled care facilities: minimum requirements for units which see the less seriously ill or injured  
• Royal College of General Practitioners, Royal College of Paediatrics and Child Health, The College of Emergency Medicine (2011) The urgent and emergency care clinical audit tool kit |
| 2   | All urgent care services are to be within an urgent and emergency care network with integrated governance structures.                                                                                       | • Healthcare for London (2010) A service delivery model for urgent care centres  
• The College of Emergency Medicine (2009) Unscheduled care facilities: minimum requirements for units which see the less seriously ill or injured  
• Royal College of General Practitioners, Royal College of Paediatrics and Child Health, The College of Emergency Medicine (2011) The urgent and emergency care clinical audit tool kit |

**Supporting information:**
- Each urgent care service is to be partnered with an emergency department and operate within a common framework of standards and governance structure.
- A joint clinical governance group between the urgent care service and partnered emergency department should foster joint working and drive continuous improvement.
- Integrated governance is to include monitoring, measuring and responding to incidents and complaints jointly.
7a. Clinical vision, standards and service models

Figure 7.11: Shaping a healthier future urgent care centre standards, core service:

<table>
<thead>
<tr>
<th>No.</th>
<th>Standard</th>
<th>Adapted from source</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>During the hours that they are open all urgent care services to be staffed by multidisciplinary teams, including: at least one registered medical practitioner (either a registered GP or doctor with appropriate competencies for primary and emergency care), and at least one other registered healthcare practitioner.</td>
<td>Healthcare for London (2010) A service delivery model for urgent care centres</td>
</tr>
</tbody>
</table>

Supporting information:
- The registered medical practitioner and registered healthcare practitioner should not be staffed using clinical cover from staff working in an emergency department.
- At any time the service is open the team on duty is to have the ability to manage a patient attending for minor injury and illness and complete an episode of care. This requires the team to be competent in the practical skills necessary to identify and manage non-complex soft tissue and bone injuries, such as suturing under local anaesthesia, wound closure, plaster casting and assessment of burns.

| 4   | An escalation protocol is to be in place to ensure that seriously ill/high risk patients presenting to the urgent care service are seen immediately on arrival by a registered healthcare practitioner. |                                                                                      |

Supporting information:
- The escalation protocol is to be understood by all members of staff both clinical and non-clinical at the urgent care service.
- The escalation protocol is to be documented, displayed and reviewed annually.
- For emergency cases an urgent care service is to arrange immediate transfer to an emergency department (by calling 999 if not co-located with an emergency department).
- While waiting for an ambulance to arrive the urgent care service should instigate appropriate clinical management.
- The urgent care service should ensure full integration with the directory of services (e.g. via 111) to assist patients accessing the most appropriate services.


Supporting information:
- Time of arrival at the urgent care service is defined as the time a patient is registered at the point of arriving at the urgent care service.
- Initial assessment includes a pain score and where needed, early pain relief should be initiated during the initial clinical assessment.
- During initial clinical assessment patients should be identified for imaging or diagnostic tests that might be required so these can be initiated early.
- Clinical staff carrying out the initial consultation are to have the necessary skills to complete the majority of cases and are to be able to order relevant diagnostic tests.
- Where possible, when clinically necessary immediate treatment is to be given. ‘See and treat’ is the optimal model of care.
- If inappropriate for urgent care services the patient may need to be transferred to the partnered emergency department.
- Patients attending who do not have urgent care needs should be supported by staff in the urgent care service to access advice and care from their local community pharmacist, or to make an appointment with their own GP practice or an alternative community service. Urgent care service staff to have access to the 111 Directory of Service to support this process.

<p>| 6   | Within 90 minutes of the time of arrival at                                                                                                   | Healthcare for London (2010) A service delivery model for urgent care centres         |</p>
<table>
<thead>
<tr>
<th>No.</th>
<th>Standard</th>
<th>Adapted from source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>the urgent care service 95 per cent all patients are to have a clinical decision made that they will be treated in the urgent care service and discharged, or arrangements made to transfer them to another service.</td>
<td>model for urgent care centres</td>
</tr>
</tbody>
</table>

**Supporting information:**
- Time of arrival at the urgent care service is defined as the time a patient is registered at the point of arriving at the urgent care service.
- Necessary diagnostic testing is to be completed within 90 minutes of the time the patient arrives at the urgent care service.
- If a patient is being transferred to an emergency department after full clinical assessment an agreement should be made that the patient does not have start from the beginning of the emergency department pathway but would be treated the same as a GP referral.
- Where an admission is required this is to be made directly to the specialty concerned.
- The urgent care service will make a clinical decision as to whether a non-emergency patient requires a non-urgent transfer and will arrange transfer where appropriate. [DN: a decision is needed on requirements for transfer for patients not requiring a 999 LAS transfer but that need to be transferred for further examination/treatment/diagnosis and would there be a requirement for patient transfer protocols].

| 7   | At least 95 per cent of patients who present at an urgent care service to be seen, treated if appropriate, and discharged in under 4 hours of the time of arrival at the urgent care service. |                                                                                     |

**Supporting information:**
- Time of arrival at the urgent care service is defined as the time a patient is registered at the point of arriving at the urgent care service.
- Patients to have received a full consultation that is fully documented, including: taking a history, carrying out any necessary examination, diagnosing the case or identifying what diagnostic tests are needed, providing pain relief if needed.
- Patients attending urgent care services are likely to be presenting with less serious illness and injuries than in an emergency department and therefore under 2 hours is optimal.

| 8   | During all hours that the urgent care service is open it is to provide guidance and support on how to register with a local GP. | Healthcare for London (2010) A service delivery model for urgent care centres        |

**Supporting information:**
- Developed by adult patient experience panel

| 9   | The service is to have a clear pathway in place for patients who arrive outside of opening hours to ensure safe care is delivered elsewhere. |                                                                                     |

**Supporting information:**
- The urgent care service is to clearly communicate the pathway to patients.
- The standards do not require urgent care services to be open 24 hours a day, seven days a week.

| 10  | Access to minimum key diagnostics during hours the urgent care service is open, with real time access to images and results:  
Plain film x-ray: immediate on-site access with formal report received by the urgent care service within 24 hours of examination  
Blood testing: immediate on-site access with formal report received by urgent care service within one hour of the sample being taken  
Clinical staff to have the competencies to assess the need for, and order, diagnostics and imaging, and interpret the results. | Healthcare for London (2010) A service delivery model for urgent care centres        |

**Supporting information:**

---

7a. Clinical vision, standards and service models
<table>
<thead>
<tr>
<th>No.</th>
<th>Standard</th>
<th>Adapted from source</th>
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</thead>
<tbody>
<tr>
<td>7a. Clinical vision, standards and service models</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Supporting information:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Urgent care services to have processes in place to ensure patients are contacted as appropriate when results of diagnostics or formal reports are available after they have been discharged from urgent care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● If clinically appropriate diagnostic testing is to be done within the urgent care service rather than referred on to another service.</td>
<td></td>
<td></td>
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</tbody>
</table>
| **11** | Appropriate equipment to be available onsite: a full resuscitation trolley, an automated external defibrillator, oxygen, suction and emergency drugs. All urgent care service to be equipped with a range of medications necessary for immediate treatment. | ● The College of Emergency Medicine (2009) Unscheduled Care Facilities: minimum requirements for units which see the less seriously ill or injured
● 2012 Quality care for older people with urgent and emergency care needs ‘silver book’ |
| **Supporting information:** | |
| ● This is to include an appropriate range of drugs and medication for older people, and children (where accepted). | |
| ● Emergency drugs to include drugs to treat complications of routine care, anaphylaxis, and unexpected deliveries [DN: Include what paramedics have ‘paramedics drug bag’] | |
| ● Advanced life support drugs to be held on site. | |
| **12** | Urgent care services to have appropriate waiting rooms, treatment rooms and equipment according to the workload and patient’s needs. | ● RCPCH (2012) Standards for children and young people in emergency care settings ‘red book’
| **Supporting information:** | |
| ● A separate waiting area is to be provided for paediatric patients. | |
| ● It should be possible for urgent care staff to visually see all patients waiting for their in the waiting rooms. | |
| ● There should be provision for patients to be able to be seated in the waiting rooms. | |
| ● [DN: Do we include ‘Where children are accepted at least one clinical cubicle or trolley space is dedicated to children’?] | |
| **13** | All patients to have an episode of care summary communicated to the patient’s GP practice by 08.00 on the next working day. For children the episode of care to be communicated to their health visitor or school nurse, where known and appropriate, no later than 08.00 on the second working day. | ● Healthcare for London (2010) A service delivery model for urgent care centres
● RCPCH (2012) Standards for children and young people in emergency care settings |
| **Supporting information:** | |
| ● The summary of the episode of care is to include relevant clinical treatment information, medication and any necessary follow-up care. | |
| ● All patients to be provided with a printed summary of their episode of care when discharged. | |
| ● All patients to be provided with appropriate advice and information on where to access follow-on care if required. | |
| ● Preferably the episode of care will be communicated electronically. | |

**Figure 7.12: Shaping a healthier future urgent care centre standards, staff competencies**

<table>
<thead>
<tr>
<th>No.</th>
<th>Standard</th>
<th>Adapted from source</th>
</tr>
</thead>
</table>
| 14 | All registered healthcare practitioners working in urgent care services to have a minimum level of competence in caring for adults, and children and young people | ● Healthcare for London (2010) A service delivery model for urgent care centres
● The College of Emergency Medicine (2009) Unscheduled Care Facilities: minimum |
### No. | Standard                                                                                                                                                                                                 | Adapted from source                                                                                                                                 |
<table>
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</thead>
<tbody>
<tr>
<td>15</td>
<td>(where the service accepts children), including: Basic life support; Recognition of serious illness and injury; Pain assessment; Identification of vulnerable patients At anytime the service is open at least one registered healthcare practitioner is to be trained and competent in intermediate life support and paediatric intermediate life support, where the service accepts children.</td>
<td>requirements for units which see the less seriously ill or injured RCPCH (2012) Standards for children and young people in emergency care settings</td>
</tr>
<tr>
<td>15</td>
<td>All registered healthcare practitioners working in urgent care services to have direct access referral to specialist on-call services when necessary, and the right to refer those patients who they see within their scope of practice.</td>
<td>Healthcare for London (2010) A service delivery model for urgent care centres The College of Emergency Medicine (2009) Unscheduled care facilities: minimum requirements for units which see the less seriously ill or injured</td>
</tr>
</tbody>
</table>

**Supporting information:**
- [DN: Should examples of referrals to specialist services being included - include mental health, maternity services, elderly and dementia care, allied health professionals, social and voluntary services, general dental services, pharmacy services, and community nursing.]
- Patients requiring referrals for routine outpatient appointments are to be discharged back to their GP.

### Figure 7.13: *Shaping a healthier future* urgent care centre standards, supporting services

<table>
<thead>
<tr>
<th>No.</th>
<th>Standard</th>
<th>Adapted from source</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Urgent care services to have arrangements in place for staff to access support and advice from experienced doctors (ST4 and above or equivalent) in both adult and paediatric emergency medicine or other specialties without necessarily requiring patients to be transferred to an emergency department or other service.</td>
<td>Healthcare for London (2010) A service delivery model for urgent care centres</td>
</tr>
</tbody>
</table>

**Supporting information:**
- Where possible advice from adult and paediatric emergency medicine is to be given from the partner emergency department.
- Arrangements are to be in place to access specialist advice from other speciality teams required.
- Access to support and advice could refer to telephone and or remote access to digital images and x-rays.
- Where specialist input has been sought, clinical responsibility for the patient remains with the urgent care service clinician.
- Equivalent to ST4 is a career grade doctor (staff doctor, speciality doctor, associate specialist or other non-training grade doctor), with clinical competencies at least equivalent to a trainee at ST4 level.

| 17  | Single call access for mental health referrals to be available during hours the urgent care service is open, with a maximum response time of 30 minutes. | 2011 Adult emergency services standards Developed by the paediatric clinical expert panel RCPCH (2012) Standards for children and young people in emergency care settings |

**Supporting information:**
- Including access for children and adolescent mental health (CAMHS) (or adult mental health
services with paediatric competencies for children over 12 years old).
- Training should be provided to all clinical staff to ensure that they able to recognise patients that may require a mental health referral.
- The 30 minutes response time starts at the first attempt to contact the mental health liaison team.
- A response is classified as a phone call answered/referred accepted, a conversation regarding the patient and a plan for further assessment in place.

**Figure 7.14: Shaping a healthier future urgent care centre standards, patient experience:**

<table>
<thead>
<tr>
<th>No.</th>
<th>Standard</th>
<th>Adapted from source</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>Patient experience data to be captured, recorded and routinely analysed and acted on. Data is to be regularly reviewed by the board of the urgent care provider and findings are to be disseminated to all staff and patients.</td>
<td><strong>Healthcare for London (2010) A service delivery model for urgent care centres</strong>&lt;br&gt;<strong>Primary care foundation (2012) Urgent care centres: what works best?</strong>&lt;br&gt;<strong>2011 Adult and emergency services clinical quality standards</strong>&lt;br&gt;<strong>Developed by adult patient experience panel</strong>&lt;br&gt;<strong>NICE (2012) Patient experience standards</strong></td>
</tr>
</tbody>
</table>

**Supporting information:**
- Information is going up the hierarchical chain to the provider board and back down again to staff working in the urgent care service in terms of reasoned guidance so that staff feel both informed and involved.
- It should be possible to identify changes made as a result of the feedback collected.
- Patient experience tools should be updated regularly based on the data and findings captured.
- In cases where the patient is too ill to communicate (or too young), families’/carers’ experience data is to be captured, recorded, and routinely analysed and acted on.

| 19  | All patients to be supported to understand their diagnosis, relevant treatment options, ongoing care and support by an appropriate clinician. | **Healthcare for London (2010) A service delivery model for urgent care centres**<br>**2011 Adult and emergency services clinical quality standards**<br>**NICE (2012) Quality standard for patient experience in adult NHS services**<br>**Developed by adult patient experience panel** |

**Supporting information:**
- Support to include the provision of appropriate material, including patient information leaflets.
- The provision of patient information leaflets should be available on the most common urgent care presentations.
- Provision of any information leaflets should be available in an appropriate format and should be available in languages appropriate for the providers’ local population.
- All communication with patients and their families and carers should be compliant with local policy.
- Support to include phone interpreting services during opening hours.
- This standard does not supersede existing patient confidentiality policies and protocols.
- From arrival to discharge all patients must be treated with dignity, kindness and respect from all members of staff.

| 20  | Where appropriate, patients to be provided with health and wellbeing advice and sign-posting to local community services where they can self-refer (for example, smoking cessation services and sexual health, alcohol and drug services). | **Healthcare for London (2010) A service delivery model for urgent care centres**<br>**Developed by adult patient experience panel** |

**Supporting information:**
- Advice on health and well being and self-care to include the provision of appropriate material, including information leaflets.
- Verbal and written communication to be provided on local community services which patients can
7.3.2 Shaping a healthier future paediatrics standards

The Shaping a healthier future paediatric standards are detailed in Figures 7.16 – 7.20. For details about the development of the standards and how the Paediatric CIG considered feedback from stakeholders in their development please refer to Section 7c.

Figure 7.16: Shaping a healthier future paediatric standards

<table>
<thead>
<tr>
<th>#</th>
<th>Standard</th>
<th>Surgery, Medicine, Both</th>
<th>Adapted from source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a paediatrician on the middle grade or consultant rota within four hours of admission. All paediatric emergency admissions to be seen and assessed by the responsible consultant within 12 hours of admission or within 14 hours of the time of arrival at the hospital. Where children are admitted with surgical problems they should be jointly managed by teams with competencies in both surgical and paediatric care.</td>
<td>Both</td>
<td>● RCPCH (2011) Facing the future&lt;br&gt;● NCEPOD (2007) Emergency admissions: A journey in the right direction?&lt;br&gt;● RCP (2007) The right person in the right setting – first time&lt;br&gt;● RCS (2011) Emergency Surgery Standards for unscheduled care. (LHP standard 1)</td>
</tr>
<tr>
<td>#</td>
<td>Standard</td>
<td>Surgery, Medicine, Both</td>
<td>Adapted from source:</td>
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</tr>
<tr>
<td>2</td>
<td>All emergency departments which see children to have a named paediatric consultant with a designated responsibility for paediatric care in the emergency department. All emergency departments are to appoint a consultant with sub-specialty training in paediatric emergency medicine. Emergency departments to have in place clear protocols for the involvement of an on-site paediatric team. Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians. Every child or young person with an acute medical problem who is referred for a paediatric opinion is seen by, or has the case discussed with, a paediatrician on the consultant rota, a paediatrician on the middle grade rota or a registered children’s nurse who has completed a recognised programme to be an advanced practitioner.</td>
<td>Both</td>
<td>• Intercollegiate Committee (2012) Services for children in emergency departments</td>
</tr>
<tr>
<td>3</td>
<td>Paediatric inpatients should be seen twice daily by a paediatric consultant.</td>
<td>Both</td>
<td>• SaHF pre-consultation standard</td>
</tr>
<tr>
<td>4</td>
<td>A consultant paediatrician is to be present and readily available in the hospital during times of peak emergency attendance and activity. Consultant decision making and leadership to be available to cover extended day working (up until 10pm), seven days a week.</td>
<td>Medicine</td>
<td>• RCPCH (2011) Facing the future.</td>
</tr>
<tr>
<td>5</td>
<td>All short stay paediatric assessment facilities to have access to a paediatric consultant throughout all the hours they are open, with on-site consultant presence during times of peak attendance. Paediatric Assessment Units should have clearly defined responsibilities, with clear pathways, and should be appropriately staffed to deliver high quality care as locally as possible.</td>
<td>Both</td>
<td>• RCPCH (2011) Facing the future.</td>
</tr>
<tr>
<td>6</td>
<td>All hospital based settings seeing paediatric emergencies including emergency departments and short-stay paediatric units to have a policy to identify and manage an acutely unwell child. Trusts are to have local policies for recognition and escalation of the critical child and to be supported by a resuscitation team. All hospitals dealing with acutely unwell children to be able to provide stabilisation for acutely unwell children with short term level 2 HDU. (See standard 20)</td>
<td>Both</td>
<td>• DH (2006) The acutely or critically sick or injured child in the DGH</td>
</tr>
<tr>
<td>7</td>
<td>When functioning as the admitting consultant for emergency admissions, a consultant and their team are to be completely free from any other clinical duties or elective commitments.</td>
<td>Both</td>
<td>• NCEPOD (2007) Emergency admissions: A journey in the right direction?</td>
</tr>
<tr>
<td>#</td>
<td>Standard</td>
<td>Surgery, Medicine, Both</td>
<td>Adapted from source:</td>
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<tr>
<td>8</td>
<td>Hospital based settings seeing paediatric emergencies, emergency departments and short stay units to have a minimum of two paediatric trained nurses on duty at all times, (at least one of whom should be Band 6 or above) with appropriate skills and competencies for the emergency area.</td>
<td>Both</td>
<td>• Intercollegiate Committee (2012) Services for children in emergency departments</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• RCN (2010) Maximising nursing skills in caring for children in emergency departments</td>
</tr>
<tr>
<td>9</td>
<td>Paediatric inpatient ward areas are to have a minimum of two paediatric trained nurses on duty at all times and paediatric trained nurses should make up 90 per cent of the total establishment of qualified nursing numbers.</td>
<td>Both</td>
<td>• Intercollegiate Committee (2012) Services for children in emergency departments</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• RCN (2010) Maximising nursing skills in caring for children in emergency departments</td>
</tr>
</tbody>
</table>
| 10 | All hospitals admitting medical and surgical paediatric emergencies to have access to all key diagnostic services in a timely manner 24 hours a day, seven days a week to support clinical decision making:  
|    | • Critical – imaging and reporting within 1 hour  
|    | • Urgent – imaging and reporting within 12 hours | Both                    | • RCP (2007) The right person in the right setting – first time                     |
|    |                                                                          |                         | • RCS (2011) Emergency Surgery Standards for unscheduled care                       |
|    |                                                                          |                         | • NICE (2008) Metastatic                                                            |
### 7a. Clinical vision, standards and service models

<table>
<thead>
<tr>
<th>#</th>
<th>Standard</th>
<th>Surgery, Medicine, Both</th>
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</tr>
</thead>
</table>
| 11 | Hospitals providing paediatric emergency surgery services to be effectively co-ordinated within a formal network arrangement, with shared protocols and workforce planning. | Surgery | ● DH (2006) The acutely or critically sick or injured child in the DGH Healthcare Commission (2007). Improving services for children in hospital  
● RCS (2010) Ensuring the provision of general paediatrics surgery in the DGH  
● NCEPOD (2011) Are we there yet?  
(LHP standard 10) |
| 12 | All inpatient paediatric services units need to have paediatric consultant availability within 30 minutes. All general paediatric inpatient units adopt an attending consultant (or equivalent) system, most often in the form of the ‘consultant of the week’ system. | Both | ● SaHF pre-consultation standard  
● RCPCH (2011) Facing the future.  
(LHP standard 12) |
| 13 | At least one medical handover on the inpatient ward in every 24 hours is led by a paediatric consultant. | Both | ● RCPCH (2011) Facing the future.  
(LHP standard 12) |
| 14 | A unified clinical record to be in place, commenced at the point of entry, which is accessible by all healthcare professionals and all specialties throughout the emergency pathway. | Both | ● RCP (2007) The right person in the right setting – first time  
(LHP standard 13) |
| 15 | All admitted patients to have discharge planning and an estimated discharge date as part of their management plan as soon as possible and no later than 24 hours post-admission. GPs to be informed when patients are admitted and patients to be discharged to their registered practice. Where there are concerns relating to safeguarding, children are to only be discharged home after discussion and review by the responsible consultant with a clear plan written in the notes detailing follow up and involvement of other agencies. | Both | ● NCEPOD (2007) Emergency admissions: A journey in the right direction?  
● RCP (2007) The right person in the right setting – first time  
(LHP standard 14) |
| 16 | All hospitals admitting emergency surgery patients to have access to a fully staffed emergency theatre | Surgery | ● NCEPOD (1997) Who operates when?  
(LHP standard 15) |

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**Figure 7.17: Shaping a healthier future paediatric standards for admissions, patient review and theatre**

<table>
<thead>
<tr>
<th>#</th>
<th>Standard</th>
<th>Surgery, Medicine, Both</th>
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</table>
| 12 | All inpatient paediatric services units need to have paediatric consultant availability within 30 minutes. All general paediatric inpatient units adopt an attending consultant (or equivalent) system, most often in the form of the ‘consultant of the week’ system. | Both | ● SaHF pre-consultation standard  
● RCPCH (2011) Facing the future.  
(LHP standard 12) |
| 13 | At least one medical handover on the inpatient ward in every 24 hours is led by a paediatric consultant. | Both | ● RCPCH (2011) Facing the future.  
(LHP standard 12) |
| 14 | A unified clinical record to be in place, commenced at the point of entry, which is accessible by all healthcare professionals and all specialties throughout the emergency pathway. | Both | ● RCP (2007) The right person in the right setting – first time  
(LHP standard 13) |
| 15 | All admitted patients to have discharge planning and an estimated discharge date as part of their management plan as soon as possible and no later than 24 hours post-admission. GPs to be informed when patients are admitted and patients to be discharged to their registered practice. Where there are concerns relating to safeguarding, children are to only be discharged home after discussion and review by the responsible consultant with a clear plan written in the notes detailing follow up and involvement of other agencies. | Both | ● NCEPOD (2007) Emergency admissions: A journey in the right direction?  
● RCP (2007) The right person in the right setting – first time  
(LHP standard 14) |
| 16 | All hospitals admitting emergency surgery patients to have access to a fully staffed emergency theatre | Surgery | ● NCEPOD (1997) Who operates when?  
(LHP standard 15) |
<table>
<thead>
<tr>
<th>#</th>
<th>Standard</th>
<th>Surgery, Medicine, Both</th>
<th>Adapted from source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>All patients admitted as emergencies are discussed with the responsible consultant if surgery is being considered. For each surgical patient, a consultant takes an active decision in delegating responsibility for an emergency surgical procedure to appropriately trained junior or specialty surgeons. This decision is recorded in the notes and available for audit.</td>
<td>Surgery</td>
<td>• RCS (2011) Emergency Surgery Standards for unscheduled care. (LHP standard 16)</td>
</tr>
<tr>
<td>18</td>
<td>Clear policies to be in place to ensure appropriate and safe theatre scheduling and implementation of clear policies for starvation times.</td>
<td>Surgery</td>
<td>• RCoA (2006) Raising the standard: A compendium of audit recipes – Paediatric anaesthesia services. (LHP standard 17)</td>
</tr>
<tr>
<td>19</td>
<td>Anaesthetists who perform paediatric anaesthesia to have completed the relevant level of training, as specified by the Royal College of Anaesthetists, and have on-going exposure to cases of relevant age groups in order to maintain skills.</td>
<td>Both</td>
<td>• RCoA (2010) Guidance on the provision of paediatric anaesthetic services • NCEPOD (2011) Are we there yet? (LHP standard 18)</td>
</tr>
<tr>
<td>20</td>
<td>All emergency surgery to be done on planned emergency lists on the day that the surgery was originally planned (within NCEPOD classifications). The date, time and decision maker should be documented clearly in the patient’s notes and any delays to emergency surgery and the reasons why recorded. Any operations that are carried out at night are to meet NCEPOD classifications – immediate life, limb or organ-saving interventions.</td>
<td>Surgery</td>
<td>• NCEPOD (2004) The NCEPOD classification of Intervention. (LHP standard 19)</td>
</tr>
<tr>
<td>21</td>
<td>The responsible consultant must be directly involved and in attendance at the hospital for the initial management and referral of all children requiring critical care. The paediatric intensive care retrieval consultant is responsible for all decisions regarding transfer and admission to intensive care. The safety of all inter-hospital transfers of acutely unwell children not requiring intensive care is the joint responsibility of the referring and accepting consultants. Staff and equipment must be available for immediate stabilisation and time appropriate transfer by the local team when this is required.</td>
<td>Both</td>
<td>• NCEPOD (2005) An acute problem • DH (2006) The acutely or critically sick or injured child in the DGH • RCA (2010) Guidance on the provision of Paediatric Anaesthesia services. (LHP standard 20)</td>
</tr>
<tr>
<td>22</td>
<td>All general acute paediatric rotas are made up of at least ten WTEs, all of whom are EWTD compliant.</td>
<td></td>
<td>• RCPCH (2011) Facing the Future</td>
</tr>
</tbody>
</table>
Figure 7.18: *Shaping a healthier future* paediatric standards for key services

<table>
<thead>
<tr>
<th>#</th>
<th>Standard</th>
<th>Surgery, Medicine, Both</th>
<th>Adapted from source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>Single call access for children and adolescent mental health (CAMHS) (or adult mental health services with paediatric competencies for children over 12 years old) referrals to be available 24 hours a day, seven days a week with a maximum response time of 30 minutes. Psychiatric assessment to take place within 12 hours of call.</td>
<td>Both</td>
<td>• AoMRC (2008) Managing urgent mental health needs in the acute trust. (LHP standard 21)</td>
</tr>
</tbody>
</table>
| 24 | All children and young people, children’s social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least Level 3 safeguarding competencies) available to provide immediate advice and subsequent assessment, if necessary, for children and young people under 18 years of age where there are safeguarding concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported with a written report. | Both                     | • RCPCH (2011) Facing the Future  
• Intercollegiate Committee (2012) Services for children in emergency departments  
• London SIT visits 2008-10. (LHP standard 22) |

Figure 7.19: *Shaping a healthier future* paediatric standards for training

<table>
<thead>
<tr>
<th>#</th>
<th>Standard</th>
<th>Surgery, Medicine, Both</th>
<th>Adapted from source:</th>
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</thead>
<tbody>
<tr>
<td>25</td>
<td>Organisations have the responsibility to ensure that staff involved in the care of children and young people are appropriately trained in a supportive environment and undertake on-going training.</td>
<td>Both</td>
<td>• Intercollegiate Committee (2012) Services for children in emergency departments. (LHP standard 23)</td>
</tr>
</tbody>
</table>
| 26 | All nurses looking after children to be trained in acute assessment of the unwell child, pain management and communication, and have appropriate skills for resuscitation and safeguarding. Training to be updated on an annual basis. | Both                     | • Intercollegiate Committee (2012) Services for children in emergency departments  
• RCN (2010) Maximising nursing skills in caring for children in emergency departments  
Figure 7.20: *Shaping a healthier future* paediatric standards for patient experience

<table>
<thead>
<tr>
<th>#</th>
<th>Standard</th>
<th>Surgery, Medicine, Both</th>
<th>Adapted from source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>Consistent and clear information should be readily available to children and their families and carers regarding treatment and on-going care and support.</td>
<td>Both</td>
<td>(LHP standard 25)</td>
</tr>
<tr>
<td>28</td>
<td>Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item on the trust board agenda and findings are disseminated.</td>
<td>Both</td>
<td>(LHP standard 26)</td>
</tr>
</tbody>
</table>

In addition, the Clinical Board determined that paediatric inpatient facilities should be co-located with A&Es.

### 7.3.3 *Shaping a healthier future* maternity standards

The *Shaping a healthier future* maternity standards are detailed in Figures 7.21 – 7.24. For details about the development of the standards and how the Maternity CIG considered feedback from stakeholders in their development please refer to Section 7d.

Figure 7.21: *Shaping a healthier future* maternity standards

<table>
<thead>
<tr>
<th>#</th>
<th>Standard</th>
<th>Adapted from source</th>
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</thead>
</table>
| 1  | Obstetric units to be staffed to provide 168 hours (24/7) of obstetric consultant presence on the labour ward. The consultant will conduct a physical ward round as appropriate at least twice a day during Saturdays, Sundays and Bank Holidays, with a physical round every evening, reviewing midwifery-led cases following referral. | ● RCOG (2007) Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour  
● RCOG (2011) High Quality Women’s Health Care: A proposal for change  
● RCOG (2012) Tomorrow’s Specialist SaHF pre-consultation standard. |
| 2  | Midwifery staffing ratios to achieve a minimum of one midwife to 30 births, across all birth settings. | ● BirthRate Plus (2009). |
| 3  | Midwifery staffing levels should ensure that there is one consultant midwife for every 900 expected normal births. | ● RCOG (2007) Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour. |
| 4  | All women are to be provided with 1:1 care during established labour from a midwife, across all birth settings. All women’s care should be coordinated by a named midwife throughout pregnancy, birth and the postnatal period. Where specialist care is needed this should be facilitated by her named midwife. Clinical responsibility for women with complex care needs | ● Cochrane Review (2007) Continuous support for women during childbirth  
● NICE  
● SaHF pre-consultation standard. |
<table>
<thead>
<tr>
<th>#</th>
<th>Standard</th>
<th>Adapted from source</th>
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</thead>
<tbody>
<tr>
<td>5</td>
<td>There is to be one supervisor of midwives to every 15 WTE midwives.</td>
<td>● NMC (2010) Midwives rules and standards.</td>
</tr>
</tbody>
</table>
| 6  | A midwife labour ward co-ordinator, to be present on duty on the labour ward 24 hours a day, 7 days a week and be supernumerary to midwives providing 1:1 care.                                                                 | ● Kings Fund (2011) Improving safety in maternity services  
● NHS Institute for Innovation and Improvement  
● NHS London Maternal Death Review.                                                                                                                                 |
| 7  | All postpartum women are to be monitored using the national modified early obstetric warning score (MEOWS) chart. Consultant involvement is required for those women who reach trigger criteria. | ● Clinical expert panel consensus  
● CNST  
● British Association of Perinatal Medicine (2011) Neonatal support for stand-alone midwifery units  
● SaHF pre-consultation standard.                                                                                                                                 |
| 8  | Obstetric units to have 24 hour availability of a health professional fully trained in neonatal resuscitation and stabilisation who is able to provide immediate advice and attendance.  
All birth settings to have a midwife who is trained and competent in neo-natal life support (NLS) present on site 24 hours a day, 7 days a week. | ● NICE (2006) Clinical Guideline 37 – Postnatal care: Routine postnatal care of women and their babies  
● NICE (2007) Clinical Guideline 55 – Intrapartum care: Care of healthy women and their babies during childbirth  
| 9  | Immediate postnatal care to be provided in accordance with NICE guidance, including:  
- advice on next delivery during immediate post-natal care, before they leave hospital  
- post-delivery health promotion  
- care of the baby  
- consistent advice, active support and encouragement on how to feed their baby  
- skin to skin contact  
- Follow-up care is to be provided in writing and shared with the mother’s GP. |  

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<thead>
<tr>
<th>#</th>
<th>Standard</th>
<th>Adapted from source</th>
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</table>
|    | Obstetric units to have a consultant obstetric anaesthetist present on the labour ward for a minimum of 40 hours (10 sessions) a week.                                                                 | - NICE (2010) Clinical Guideline 98 – Neonatal jaundice  
(LHP standard 9)                                                                 |
| 10 | Units that have over 5,000 deliveries a year, or an epidural rate greater than 35%, or a caesarean section rate greater than 25%, to provide extra consultant anaesthetist cover during periods of heavy workload.          | - Obstetric Anaesthetists’ Association/Association of Anaesthetists of Great Britain and Ireland for Obstetric Anaesthesia Services (2005) Guidelines for Obstetric Anaesthesia Services (LHP standard 10) |
| 11 | Obstetric units to have access 24 hours a day, 7 days a week to a supervising consultant obstetric anaesthetist who undertakes regular obstetric sessions.                                                       | - Obstetric Anaesthetists’ Association/Association of Anaesthetists of Great Britain and Ireland for Obstetric Anaesthesia Services (2005) Guidelines for Obstetric Anaesthesia Services  
- Clinical expert panel consensus. (LHP standard 11) |
| 12 | Obstetric units should have a competency assessed duty anaesthetist immediately available 24 hours a day, 7 days a week to provide labour analgesia and support complex deliveries. The duty anaesthetist should not be primarily responsible for elective work or cardiac arrests. | - RCoA (2009) Guidance on the provision of obstetric anaesthesia services.  
(LHP standard 12)                                                                 |
| 13 | There should be a named consultant obstetrician and anaesthetist with sole responsibility for elective caesarean section lists.                                                                          | - RCoA (2009) Guidance on the provision of obstetric anaesthesia services  
(LHP standard 13)                                                                 |
<p>| 14 | All labour wards to have onsite access to a monitored and nursed facility (appropriate non-invasive nursing monitoring) staffed with appropriately trained staff.                                               | - NHS London (2011) Adult emergency services:                                                                                                           |</p>
<table>
<thead>
<tr>
<th>#</th>
<th>Standard</th>
<th>Adapted from source</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Obstetric units to have access to interventional radiology services 24 hours a day, 7 days a week and onsite access to a blood bank.</td>
<td>• NHS London (2011) Adult emergency services: Commissioning standards. (LHP standard 14)</td>
</tr>
<tr>
<td>16</td>
<td>Obstetric units to have access to emergency general surgical support 24 hours a day, 7 days a week. Referrals to this service are to be made from a consultant to a consultant. There must be access to emergency theatre when required.</td>
<td>• Clinical expert panel consensus • Shaping a Healthier Future Consultation. (LHP standard 15)</td>
</tr>
<tr>
<td>17</td>
<td>Consultant delivered obstetric services should include a collocated midwife-led unit to provide best care and choice for women and babies. Women should be able to choose the option of an out of hospital pathway (home birth and standalone midwife-led unit) if appropriate</td>
<td>• SaHF pre-consultation standard.</td>
</tr>
</tbody>
</table>

**Figure 7.23: Shaping a healthier future maternity standards for training**

<table>
<thead>
<tr>
<th>#</th>
<th>Standard</th>
<th>Adapted from source</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>Maternity services to be provided in a supportive training environment which promotes multi-disciplinary team working, simulation training and addresses crisis resource management.</td>
<td>• Kings Fund • CNST. (LHP standard 17)</td>
</tr>
</tbody>
</table>

**Figure 7.24: Shaping a healthier future maternity standards for women’s experience**

<table>
<thead>
<tr>
<th>#</th>
<th>Standard</th>
<th>Adapted from source</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>Both quantitative and qualitative data on women’s experience during labour, birth and immediate post-natal care to be captured (including but not limited to standards 2 – 10), recorded and regularly analysed and continually acted on. Feedback to be collected from the range of women using the service, including non-English speakers. Review of data and action plans is to be a permanent item on the Trust board agenda. Findings to be disseminated to all levels of staff, service users and multidisciplinary groups including MSLCs (maternity services liaison committee).</td>
<td>• Adult emergency services standards (2011) (LHP standard 18)</td>
</tr>
<tr>
<td>20</td>
<td>During labour, birth and immediate post-natal care, all women who do not speak English or women with minimal English should receive appropriate interpreting services.</td>
<td>• Centre for Maternal and Child Enquiries (CMACE) (2011) The eight report on confidential enquiries into maternal deaths in the United Kingdom (LHP standard 19)</td>
</tr>
<tr>
<td>21</td>
<td>During labour, birth and immediate post-natal care all women and their families/birthing partner to be treated as individuals with dignity, kindness, respect.</td>
<td>• NICE (2012) Patient experience standards (LHP standard 20)</td>
</tr>
<tr>
<td>#</td>
<td>Standard</td>
<td>Adapted from source</td>
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<tr>
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<td>-------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 22 | During labour, birth and immediate post-natal care all women and their families/birthing partners to be spoken with in a way that they can understand by staff who have demonstrated competency in relevant communication skills. | NICE (2012) Patient experience standards  
CQC (2010) National maternity survey  
(LHP standard 21)                                                                          |
| 23 | During labour, birth and immediate post-natal care all women (with assistance from birthing partners where appropriate) to be given the opportunity to be actively involved in decisions about their care. | CQC (2010) National maternity survey  
(LHP standard 21)                                                                          |
| 24 | During labour, birth and immediate post-natal care all women and their families/birthing partner are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team. | NICE (2012) Patient experience standards  
(LHP standard 22)                                                                          |
| 25 | During labour, birth and immediate post-natal care all women and their families/birthing partner are to be supported by healthcare professionals to understand relevant birthing options, including benefits, risks and potential consequences to help women make an informed decision about their care. All healthcare professionals are to support women’s decisions to be carried out. | NICE (2012) Patient experience standards  
(LHP standard 23)                                                                          |
| 26 | During labour, birth and immediate post-natal care all women (with assistance from their birthing partners where appropriate) are to be made aware that they can ask for a second opinion before making a decision about their care. | NICE (2012) Patient experience standards  
(LHP standard 24)                                                                          |
| 27 | Women to receive care during labour and birth that support them to safely have the best birth possible.                                                                                                        | Midwifery 2020 Measuring Quality Work stream  
(LHP standard 25)                                                                          |
| 28 | During immediate post-natal care women to receive consistent advice, active support and encouragement on how to feed their baby.                                                                                | CQC (2010) National maternity survey  
(LHP standard 26)                                                                          |

Given the co-dependencies with paediatric services and neo-natal units, clinicians recommended that maternity units should be co-located with A&Es and paediatric units.

### 7.3.4 How we considered feedback to refine the standards

During consultation we received feedback about the standards for care in NW London. Full details of all the feedback can be found in Sections 7b, 7c and 7d of this chapter and is summarised in Chapter 9. The standards detailed above incorporate all this feedback. In summary this is how we responded to the feedback:

- Updated standards for maternity, paediatrics, and emergency and urgent care were discussed and agreed at the Clinical Board on 6 December. Key changes included:
  - No changes were made to the out of hospital standards
  - **Maternity**: 24/7 consultant cover for all units, not just those with over 6,000 births
  - **Paediatrics**: standards are consistent with LHP standards
  - **Urgent and emergency care**: the proposed standard UCC specification has been further developed to provide details which describe the conditions that UCCs should treat, those that are excluded, the service models and transfer protocols, staff competencies, quality standards and governance arrangements
• The final standards are more demanding in workforce terms, making the case for reconfiguration even more compelling
• The Finance and Business Planning workstream lead has reviewed these standards against the modelling assumptions and concluded this does not have an impact on our modelling.

7.4 Service models to deliver the vision and clinical standards

The vision and standards have been developed to address an urgent Case for Change across community and hospital care. Delivery of the vision and standards will support the reduction in health inequalities, reduce unnecessarily high mortality and ensure patients are treated safely. Though services are sufficient at the moment, they will not be in the future and it will be patients, and the clinicians who treat them, who will be the first to feel the consequences. It is important that the changes needed to implement the vision and standards are carried out in a systematic, organised way.

A fundamental part of achieving this vision is to establish a seamless sequence of delivery models that cater for all conditions and all degrees of severity. Clinicians in NW London have proposed eight settings of care, from the patient’s home to specialist hospitals. These settings span primary, secondary and tertiary care with a local hospital for each borough providing the bridge between primary and acute care. A summary of the delivery models is shown in Figure 7.25 with more detail on the current and future services that will be delivered in each of the eight settings shown in Figure 7.26.
## Figure 7.25: Summary of eight proposed settings of care in NW London

| Home | • GP, community and social care services delivered in patients’ homes  
  • Patient navigation using 111  
  • Patient triage and response within 4 hours |
| GP practice | • GP consultations and long term condition management  
  • Health promotion and delivery of preventative services |
| Care network | • Delivery of multi-disciplinary care  
  • Access to diagnostic and therapy services |
| Health centre | • Access to GP, therapy, rehabilitation and diagnostic services  
  • Access to specialist GP services |
| Local hospital | • Urgent Care Centres  
  • Outpatients and diagnostics  
  • Additional services on some local hospital sites, including specialist clinics, outpatient rehabilitation and specialist clinics |
| Major hospital | • A&E, Urgent Care Centres and trauma care  
  • Emergency surgery and intensive care  
  • Obstetrics & midwifery unit and inpatient paediatrics |
| Elective hospital | • Elective surgery and medicine  
  • Outpatients and diagnostics  
  • High dependency care |
| Specialist hospital | • Sites delivering highly specialised care such as cardiothoracics and cancer |
Figure 7.26: Proposed services to be provided at the eight settings of care in NW London

<table>
<thead>
<tr>
<th>Setting</th>
<th>Existing Services on All Sites</th>
<th>New Services on All Sites</th>
<th>Enhancements on Some Sites</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>Health information and signposting</td>
<td>GP consultations – triage &amp; response within 4 hours</td>
<td>Multi-disciplinary group case conferences involving all providers</td>
<td>Cardiothoracic&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>GP practice</td>
<td>Preventative services</td>
<td>Specialist GP services</td>
<td>Specialist clinics involving acute and primary care clinicians</td>
<td>Cancer</td>
</tr>
<tr>
<td>Care network</td>
<td>GP consultations (extended access)</td>
<td>Therapy services</td>
<td>Diagnostics e.g, imaging, path with enhanced access</td>
<td>Spinal surgery</td>
</tr>
<tr>
<td>Health centre</td>
<td>Simple diagnostics (e.g. blood tests)</td>
<td>Enhanced access diagnostics</td>
<td>UCC (24/7 with extended range – 60-80%)</td>
<td>(1) Could include heart attack unit</td>
</tr>
<tr>
<td>Local hospital</td>
<td>Simple treatments (e.g. blood tests)</td>
<td>Improved access to diagnostics (e.g. ECG)</td>
<td>Outpatient rehab. services</td>
<td></td>
</tr>
</tbody>
</table>
The names of these eight settings of care and the services associated with them have been determined by clinicians and commissioners in NW London. However, we recognise there is a confusing array of different titles in use across London and nationally. The Department of Health is currently undertaking a piece of work on emergency and urgent care to support a more consistent approach across the country. Once the work is published, we will make sure that our proposals are aligned with the Department’s recommendations.

7.5 Out of hospital care

As set out in the overall vision, patients will be able to receive care in a variety of settings. When possible, care will be at home, or close to home but as care becomes more specialised, patients will have to travel to the specialist centres that have the most appropriate skills and equipment to support their care. Improving access will mean opening at convenient times, offering a wider range of services and being located in the right places. Convenience is crucial for patients and services need to be available when people want to use them.

7.5.1 Home

Some services can be provided in people’s homes, for example through nursing care or telephone support. Services like tele-care enable people living with long term conditions to live more independently at home for longer.

7.5.2 GP practice

The GP practice will be at the centre of out of hospital care, with overall accountability for the patient’s health. GP practices can provide lots of services other than GP appointments, such as immunisation screening, blood tests and therapy services. Of course, individual GPs will not have to co-ordinate the patient’s care across providers personally but they will be expected to make sure that this is happening. All NW London CCGs are investing in tools and new roles to support primary care to coordinate care better.

7.5.3 Care networks

Improving quality will mean ensuring that care is being delivered to the right clinical standards, in excellent facilities and with good patient service. Practices will work in networks to support each other, provide extended opening hours and a wider range of services. This will make it more cost effective to provide the skilled workforce and specialist equipment needed. This includes some diagnostic tests (such as ECG) and therapies, and services for some long term conditions. Grouping practices together also means urgent cases can be seen within four hours. All of this means patients will have an improved experience of primary care.

Change will be introduced across a range of areas, including front of house, planning and scheduling, back office, referrals, prescriptions and the consultation itself, to support the best use of the different skills, resources and tools within GP practices. This will allow GP practices to invest more time to improve patient and carer experience and outcomes.
Each CCG is taking steps to help practices work more closely together. Working collectively in a structured way has benefits for all practices involved, whether to share learning, maximise skills, increase capacity or coordinate care. These networks will service populations of between 50,000 – 70,000 to ensure delivery of local care for communities. Community and social services will align their services, where appropriate, to these networks to co-ordinate care. For example, in each health network, there may be a member of the district nursing team leading district nursing, who will work with the GP chair of a multi-disciplinary team to ensure effective working. Services operating at a network level could include:

- Rapid response teams
- Specialist primary care
- Community outpatients
- District nursing
- Social services re-ablement
- End of life care
- Multidisciplinary groups that are part of the Integrated Care Pilot.

7.5.4 Health centres

Certain intermediate services benefit from co-location in a single building within a health network, as patients can receive a range of complementary services that would otherwise need to be provided at a centralised site. These hubs or health centres have sufficient scale to offer a range of services to our GP networks, including extended primary care, management of patients with long-term conditions, diagnostics, therapies and outpatient services (including consultant-led clinics). Locating services within a network health centre enables us to offer services closer to patients’ homes while also ensuring we have sufficient scale to ensure clinical viability.

7.6 Acute service delivery models

As set out in the Case for Change, none of the current existing nine acute hospital sites in NW London is able to deliver the desired level of service quality that will be sustainable in the future. Local clinicians agreed that they needed to look objectively at the types of hospitals they want to have in NW London going forward. Local clinicians decided that agreeing the models for these types of hospital had to be done before beginning any discussions on the configuration and location of any specific services.

Local clinicians began this process by identifying the clinical dependencies between services. Figure 7.27 sets out the core dependencies that they defined for a major A&E centre.
The clinical board determined that delivering safe and effective A&E services on a 24/7 basis requires rapid access to emergency surgery and expertise for complex medical cases on a 24/7 basis as well as level 3 critical case (intensive care). The Clinical Board identified additional services that required access to level 3 critical care and/or emergency surgery. These included:

- Complex elective surgery
- Obstetric units
- Acute cardiac and hyper acute stroke care
- Major trauma units.

Clinicians used the combination of clinical standards and clinical interdependencies to set out proposals for four acute service delivery models, they are:

1. Local hospital
2. Major hospital
3. Elective hospital
4. Specialist hospital

A fifth service delivery model was considered, one with urgent care and some acute medicine, however this was judged to not be sustainable in the long term in NW London due to the lower quality of care it would offer and the low travel times between sites. However, it was recognised that some of the hospitals in NW London are currently be configured in this way and that they could continue to safely operate in the short to medium term as a stepping stone to becoming one of the other service delivery models.

7.6.1 Local hospitals

The local hospital is a site from which most care currently delivered in traditional district general (DGH) hospitals will be delivered in the future. We estimate over 75% of the care that would be delivered in a DGH in 2014/15 can be delivered from a local hospital. It will be a place that provides specialist staff (many of whom will also work
in major hospitals) and equipment to support the networks of GP practices where much care in the future will be delivered, and a place for access to urgent care when required. Specialists will be full members of the wider out-of-hospital team, making their contribution to planned and personalised health and care. Indeed, GP services, community services, and social care may also be co-located in local hospitals, bringing the full range of services together around the needs of patients, close to home. Further details about local hospitals can be found in Chapter 16.

7.6.2 Urgent care centres

When individuals have urgent needs, it is important that they can access the advice or care that they need as rapidly as possible. In the new system of out of hospital care, people will be able to access services through a number of routes. These include community pharmacy, extended GP opening hours, such as weekends and evenings (within an individual practice or the practice network), greater availability of telephone advice from the practice or through 111, and GP out-of-hours services.

Today, many people with a wide range of urgent illnesses and injuries are seen by A&E departments when they could be cared for more appropriately and closer to home by a primary care urgent care service. For that reason, all local hospitals will have an urgent care centre (UCC) that will be open 24/7 – and fully integrated with the wider integrated and coordinated out-of-hospital system to ensure appropriate follow up. UCs specialise in the treatment of patients with emergency conditions that do not need hospital admission. They have strong links with other related services, including GP practices and pharmacies in the community. They are also networked with local A&E departments, whether on the same hospital site or elsewhere, so that any patients who do attend an UCC with a more severe complaint can quickly receive the most appropriate specialist care. Further details about UCCs can be found in Section 7b.

7.6.3 Major hospitals

Major hospitals will provide a full range of acute clinical services. They will have sufficient scale to support a range of clinically interdependent services and to provide high quality services for patients with urgent and/or complex needs. At their core they will be equipped and staffed to support a 24/7 A&E with 24/7 urgent surgery and medicine and a level 3 ICU. Major hospitals will also provide a psychiatric liaison service as well as maternity services with appropriate consultant cover alongside interventional radiology services. They may also host complex surgery, a hyper-acute stroke unit (HASU), inpatient paediatrics, a heart attack centre (HAC) and a major trauma centre.

In NW London each major hospital would also provide local hospital services, particularly access to an urgent care centre.

7.6.4 Elective hospitals

Elective hospitals will provide patients with non-complex elective medicine and elective surgery services, including operations such as hip replacements and cataract operations. Elective services are planned, non-emergency services. The advantage of dedicated elective centres is that they allow clinicians to focus on the delivery of elective services without complexity of also seeking to provide unscheduled services, which can reduce efficiency. Elective hospitals can be located within, or independently of, major hospitals as they do not rely on any of the specialist services of a major hospital. Local clinicians
recommended that we should make use of any high quality buildings that have spare space to house elective hospitals. This would particularly include the buildings at West Middlesex Hospital and Central Middlesex which have been purpose-built to deliver high-quality elective care.

7.6.5 Specialist hospitals

Specialist hospitals will provide specialist clinical services which are either not dependent on co-location with other specialties for high quality/safe care (e.g. ophthalmology), or which can be operated at scale to sustain dedicated co-located services (e.g. stand-alone cancer hospital).

7.6.6 How we considered feedback to refine the service models

During consultation we received feedback about the service models. Details of the feedback can be found in Sections 7b, 7c, and 7d, Chapter 9, 9.6 and Appendix F and is summarised in Chapter 9, Section. Whilst the feedback received helped us develop the models of care, particularly local hospitals and UCCs, there was no viable alternative to the eight models proposed. The requests we received for more detailed descriptions for UCC and local hospitals were addressed during consultation when we provided factsheets.

Given the clinical support for the proposals and the absence of viable alternative suggestions, the service models and principles are largely unchanged. However, the following work has been undertaken:

- The Maternity CIG considered the issue of standalone birthing and midwife led units but do not consider there would be sufficient demand for a standalone or birthing centre for the population of NW London gives six collocated units with obstetrics. Therefore the proposal at this stage is to recommend that NW London will not have standalone birthing units
- We will ensure that there is a Midwifery led homebirth community service for all women in NW London
- The Paediatric CIG has agreed that amongst the six NNUs there will be two Level 3 units and the location of these units is defined in Chapter 9. The final disposition of the other four units will be decided during implementation.

National policy and planning guidance, such as the offers described in ‘everyone counts’ (which include NHS services seven days a week, improved outcomes, higher standards and safer care), require the NHS in NW London to reconsider how services are changed to achieve the improved patient care. Making the service models and the configurations described in Shaping a healthier future a reality will be a key enabler to delivery of the national standards and the benefits described in ‘everyone counts’.

7.7 Patient journeys will be improved once our vision is successfully delivered

The vision has been developed by local clinicians, working with patients and the public. They are aware of the issues and challenges that patients face when interacting with their local health system. Once the vision has been made a reality, clinicians believe that there will be
tangible differences for patients’ journeys in NW London. This section provides seven patient journeys, Figure 7.28:

- Out of hospital care
- Emergency care
- Emergency surgery
- Maternity care
- Planned care – elective hip replacement
- Paediatrics
### Illustrative patient journeys in out of hospital care

<table>
<thead>
<tr>
<th>Theme</th>
<th>Example Patient</th>
<th>From...</th>
<th>To...</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong> Easy access to high quality, responsive care</td>
<td>Melanie is 36. A working mother with a young daughter (Maya) who has a fever</td>
<td>Melanie rings her GP but cannot get through, and takes Maya to A&amp;E. The traffic is heavy and after a stressful journey they finally arrive. Maya is quickly triaged and not deemed high risk. After three hours they finally see a doctor who diagnoses that Maya is teething.</td>
<td>Melanie rings 111 and is given advice and an appointment for the evening at a local practice with extended hours or primary care centre by GP’s out of hours service.</td>
</tr>
<tr>
<td><strong>B</strong> Simplified planned care pathways</td>
<td>Maria is 48. She has made an urgent appointment with her GP after bleeding vaginally for the last two days.</td>
<td>Maria meets with her GP who is unsure of the best treatment options and refers her to a consultant in her outpatient clinic. Maria has an appointment scheduled for a follow-up appointment which takes several weeks to arrange.</td>
<td>Two hours later the GP checks in on the results and phones a consultant for specialist opinion and together agree on appropriate procedure.</td>
</tr>
<tr>
<td><strong>C</strong> Rapid response to urgent needs</td>
<td>Archie is 80, a family member has taken him to the doctor as he is in some pain and having difficulty passing urine.</td>
<td>The GP had diagnosed Archie as having a urinary tract infection. He is given a course of oral antibiotics and sent home. The next day his son visits and finds Archie in a confused state, unsure what to do, he takes him to A&amp;E. The strange surroundings make him more confused and he is admitted. Three weeks later, Archie is still in hospital and his mental state has deteriorated.</td>
<td>The GP has left a contact number for the rapid response service, following his appointment. His son visits and finds Archie in a confused state and rings the rapid response hotline. A GP, social worker and physiotherapist from the rapid response team arrive and assess Archie at home authorising a 3 day package of care to stabilise him at home.</td>
</tr>
<tr>
<td><strong>D</strong> Integrated care for LTC and elderly</td>
<td>Sameera is 45. She sees her GP complaining of shortness of breath and chest tightness.</td>
<td>Sameera continues to struggle at home with her condition and after a series of complications is admitted to A&amp;E.</td>
<td>Sameera is identified as a patient in need of an integrated care plan by her GP, and he raises it at a case conference with a specialist at chest doctor. They identify that Sameera needs education on how to use her inhaler properly, rather than a stronger dose.</td>
</tr>
<tr>
<td><strong>E</strong> Appropriate time in hospital</td>
<td>David is 80. He has recently fallen, fractured his hip and been admitted to hospital.</td>
<td>Following treatment, David’s hip is mending well so the duty doctor reviews his case and deems him fit to leave following physiotherapy review. The review happens on a Friday and the physiotherapists are not available until Monday, leaving David in hospital over the weekend. Social care takes 3 weeks to organise a package of care for discharge.</td>
<td>When David was admitted to hospital his history is available to staff. His health and social care coordinator is notified and discharge planning begins immediately. Next steps are captured in a clear care plan and all places are in place for discharge when the time comes.</td>
</tr>
</tbody>
</table>
Illustrative patient journey in emergency care

- Ruth is 23 years old and generally considers herself healthy. She has had 36 hours of stomach aches and a temperature and on Saturday morning she wakes up with worsening symptoms. At 8am she phones her GP and gets a morning appointment.
- The GP examines her, is concerned about her high temperature and abdominal pain and refers her to A&E for further investigations.
- Within 1 hour of arrival, an A&E doctor sees and examines Ruth and is concerned she may have appendicitis.
- She is transferred to ASU.
- She is reviewed by a consultant, who also suspects appendicitis.
- She is given pain relief, rehydrated with IV fluid and is kept nil-by-mouth. All information is recorded on a document which travels with her. Her GP is informed that she has been admitted.
- Differential diagnostic tests are performed to confirm Ruth’s suspected appendicitis. Ultrasound does not give a clear result so a CT scan is performed and reported within 2 hours.
- Based on the severity of symptoms and diagnostic findings, the consultant recommends Ruth for emergency surgery.
- Ruth consents to a laparoscopic appendicectomy (LA). Following a discussion with consultant anaesthetist she is classified as ASA1 and “low risk”. A fully staffed emergency theatre and consultant on site within 30 minutes is available, and her surgery is performed 6 hours after admission.
- Postoperatively Ruth is transferred back to the surgical ward, where she is assigned with an estimated discharge date and discharge plan.
- She is seen by a consultant on twice daily ward rounds. After 2 days, she feels much better and the consultant gives her permission to go home.
- Before she leaves the hospital an appointment with her GP is booked for three days time.
- She is given an emergency helpline number to contact in case of complications.
- Her GP is sent her full patient record and discharge information on the day she leaves the hospital.

Mr Sarang Patel arrives at A&E in an ambulance at 2am. He is unconscious, in shock and he has been resuscitated during the journey. A&E has been alerted in advance of his arrival.

- He is 67 years old, smokes and has high blood pressure.

- He is seen by the A&E team on arrival who examine him, instigate treatment with an IV line and conduct tests.
- Sarang gains consciousness briefly and talks about his abdominal pain.
- The A&E consultant suspects a possible abdominal aortic aneurysm (AAA) and he is immediately transferred to a vascular unit for emergency surgery.

- While the operating theatre is being prepared, ultrasound is used to confirm the diagnosis.

- During transfer, the operating theatre was prepared. Within 30 minutes of arriving at A&E, Sarang is in theatre. An open repair operation is performed. Sarang loses a large amount of blood, but the operation is successful.

- Sarang is admitted to ICU (level 3)
- The surgeon briefs the ICU consultant. The ICU has full ventilatory support and monitoring and is staffed by a medical team with specialist training.
- Sarang stays on ICU for 5 days.

- Sarang is transferred to the surgical ward, where he is given an estimated discharge date and discharge plan. He is seen by a consultant on twice daily ward rounds. After 14 days, he feels much better and the consultant gives him a permission to go home. He is provided with information about follow-up and next steps.

Illustrative patient journey maternity care – Sarah’s difficult labour

- Sarah is 31 years old and pregnant with her second child. She uses her GP’s website to book an appointment with the midwife directly.
- The midwife estimates Sarah is 8 weeks pregnant and takes her medical history. She explains that she and the local midwifery team will provide care throughout Sarah’s pregnancy. Sarah agrees for her GP to give her midwife access to her medical records. Sarah had obstetric cholestasis during her last pregnancy, so the midwife also refers her to an obstetrician.
- At 12 weeks, Sarah has her first ultrasound scan and at 20 weeks she has her second scan. The midwife encourages Sarah’s partner to come along to Sarah’s appointments.
- Sarah has an appointment with the obstetrician and they discuss what to do if the obstetric cholestasis recurs.
- In her antenatal appointments routine checks are performed and written in her pregnancy notes. Her midwife talks to her about a birth plan, options for pain relief and birth settings (risks and benefits), and gives her a leaflet to take home. Sarah prefers a midwife led unit and is offered a visit to the unit.
- At 28 weeks, Sarah gets stomach pains and vomits over the weekend. She rings her midwife who advises her to go to A&E. She is seen by A&E staff as well as the obstetrician on-call, who contacts her midwife. She is given fluids and sent home later that day for follow up in community. She recovers quickly.
- At 39 weeks, Sarah goes into labour. She rings the midwife-led unit and the midwife suggests she comes into the unit.
- Sarah is greeted and assessed by a midwife, who introduces her to the team and explains she will be responsible for her care throughout her labour.
- Her contractions are regular but her midwife is concerned about the baby’s heartbeat. She informs Sarah and speaks to the consultant midwife, who advises her to contact the neighbouring consultant-led obstetric unit.
- The senior obstetrician in the unit advises transfer to the unit. The midwife ensures Sarah and her partner understand what’s going on. Sarah is transferred immediately.
- On arrival she is cared for by a senior midwife and an obstetrician. She and her baby are constantly monitored.
- Sarah requests an epidural. The anaesthetist arrives in 20 minutes and after discussion the epidural is performed.
- The baby’s heartbeat shows persistent changes, and the consultant obstetrician asks for a fetal blood sample to be taken. The obstetrician discusses the results with Sarah and her partner, and advises an emergency C-section; they agree. Indications for the C-section are clearly documented in Sarah’s notes.
- While Sarah is prepared for theatre a senior paediatric colleague trained in neonatal resuscitation is informed; she attends the procedure.
- Sarah delivers a healthy baby boy weighing 3.5kg.
Postoperatively Sarah and her baby boy are transferred to the postnatal ward for monitoring.

Whilst recovering from anaesthesia, Sarah is observed on a 1-to-1 basis. All seems well so she is then monitored every half an hour for the next couple of hours and then hourly by her midwife.

Two days after the birth, Sarah feels a bit down and quite tearful. She wants to go home, but she is finding breastfeeding difficult; her midwife encourages her to continue and spends some time discussing the benefits and that initial difficulty is a common problem. They also talk through the labour and the need for an emergency C-section with Sarah and her partner. They agree that so long as she feels happier and confident with her breast feeding, she can soon be discharged.

On the 2nd day, the baby has a documented baby check.

Before she is discharged, Sarah and her partner are given their baby’s personal child health record, and the Birth to Five information book. They are also given contraceptive advice (which will be reiterated by her midwife and GP).

Sarah’s usual midwife visits her at home several times to check she and the baby are well. The midwife encourages Sarah to continue to breastfeed.

On day 7, the midwife (with Sarah’s permission) performs a bloodspot screening test.

As care shifts from the midwife to the health visitor Sarah is offered a joint home visit involving them both. From this point onwards the health visitor will support Sarah and her partner.

Footnote: *Patient story adapted from Maternity services, DoH (2005), * Routine checks in accordance with NICE guidelines include: check size of abdomen, measure blood pressure, and urine analysis.

Illustrative patient journey in maternity care – Claire’s emergency complication

**Booking and antenatal care**
- Claire is 28 years old and this is her first pregnancy. Claire books an appointment with her GP who estimates that she is 7 weeks pregnant and advises her to book an appointment with the midwifery team.
- The midwife advises that she (and the midwifery team) will provide care and advice throughout Claire’s pregnancy. After taking Claire’s medical history, she explains what to expect in the next few months and recommends that Claire and her partner attend antenatal classes. The midwife explains screening tests offered and gives Claire a leaflet with more information.
- Claire agrees to screening tests and has scans at 12 and 20 weeks.

**Antenatal care (26-39 weeks)**
- Claire attends her antenatal appointments. Routine checks** are performed and written in her pregnancy notes. The midwife continues to provide advice to promote about a healthy lifestyle and encourages involvement of Claire’s partner.
- Claire’s midwife talks to her about a birth plan and options for pain relief in labour. Claire has no significant past medical, obstetric or social history, so her pregnancy is assessed as ‘low-risk’. Her midwife also discusses (and gives her a leaflet) about birth settings including the option of a home birth. Claire wants to give birth in a midwife-led unit and is offered to visit the unit prior to delivery.
- Claire and her partner attend antenatal and parenting classes.

**Presentation and admission to maternity ward**
- Two days after her due date, Claire goes into labour. She rings the midwife-led unit. The midwife advises her to come in, and that they will be ready for Claire when she arrives.
- The midwife on-duty also reminds her to bring her pregnancy notes and an overnight bag.
- Claire is greeted and assessed by a midwife who introduces her to the rest of the team who will be involved in her care.
- Claire’s midwife explains she will be responsible for her care throughout her labour.

**Delivery**
- Claire delivers a healthy baby but afterwards she continues to bleed. The midwife calls for help and tries to stem the bleeding, but Claire loses over a litre of blood.
- The consultant midwife arranges immediate transfer to the consultant-led unit next door. She informs the obstetric ward so they are prepared for resuscitation, monitoring and investigation into underlying causes.
- The bleeding continues and Claire is going into shock. Protocols are followed involving the senior midwife, consultant obstetrician, consultant anaesthetist and consultant haematologist. Porters deliver blood from the transfusion lab. As her vital signs deteriorate, Claire is given a general anaesthetic and taken to theatre.
- The obstetric unit has access to an interventional radiology service. This enables the bleed to be controlled through selective closure of blood vessels.

**Postnatal care and admission to postnatal ward**
- Claire is transferred to ICU on the labour ward where she is monitored continuously. Monitoring takes the form of an early warning system.
- Support and information is provided for Claire’s partner to help him understand what happens and to help him take care of their newborn baby.
Claire makes good progress over the next week and continues to be monitored by midwife for signs of complications. The obstetrician talks through what happened with Claire and her partner and they have a chance to ask questions.

- Claire’s partner is very supportive and has been solely responsible for care of their new baby boy.
- On the 2nd day, a baby check is carried out and documented.

A discharge plan is made. The midwife talks to Claire and her partner about screening tests and support services. Claire is given contraceptive advice.

- Claire and her baby are discharged home with ongoing support from the midwife and a contact telephone number. Claire’s usual midwife continues to pay home visits which continue according to her needs.
- On day 7, the community midwife asks Claire for permission to perform a bloodspot screening test and tells Claire that she will get the results before her 6-8 week postnatal check.
- To ensure continuity of care, the midwife and the health visitor offer Claire a joint home visit. From this point onwards the health visitor will provide support and advice for Claire and her partner.
Reginald is 69 and lives alone. He’s been enjoying an active retirement, but over the last couple of years he has found walking increasingly painful. It’s got so bad that he finds leaving the house difficult—and with so little exercise, he’s also struggling with his weight.

He goes to see his GP and describes his pain and difficulty walking. His GP organises investigations including an x-ray and asks Reginald to come back in two weeks time.

At the next appointment, the GP explains to Reginald that he has degenerative changes in his left hip. The GP talks about the treatment options and together they work out a management plan, including changes to Reginald’s diet. The GP refers Reginald to a physiotherapist, tells him about the other healthcare professionals who will be involved in his care and gives him information to read at home.

Reginald’s pain worsens over the next few months. He visits his GP again, who suggests the option of a hip replacement.

Reginald agrees to consider a hip replacement.

The GP goes through an assessment of reginald’s severity, drawing on the physiotherapist input. There is a standard form which the GP, Reginald and physio complete and this gives a “score” which indicates whether or not Reginald can expect to benefit from surgery.

The GP also gives Reginald a booklet about having a hip replacement for him to read.

Reginald meets the criteria for hip replacement surgery and is keen to have it done, so the GP places him on the waiting list.

Reginald attends an outpatient pre-op assessment appointment to assess his fitness for surgery 2 weeks before his scheduled procedure and also has an opportunity to ask the nurse questions about the procedures.

The date of his operation arrives. Reginald goes to the hospital in the morning. An anaesthetist and the surgeon who will be carrying out the operation come to see him. They explain what will happen and the surgeon marks the limb which is to be operated on. Reginald is assessed for risks of complications.

There are no complications in the operation, and Reginald is transferred to the wards for recovery.

In the ward he is continuously monitored, and his care includes pain relief and antibiotics. His physiotherapy and mobilisation start straight away.

An X-ray of Reginald’s hips is taken 2 days after his operation to assess its success.

Reginald rehabilitation is going well; by the time he is discharged 3 days after the operation he can manage stairs and has a home exercise programme.

A multidisciplinary care plan is arranged, and a discharge summary is sent to his GP for followup in the community. He’s also given contact details of someone to call if he’s worried.

Laura is 6 years old and has asthma. On Sunday, Laura starts wheezing badly and has some difficulty breathing. She has a temperature.

Laura’s mother calls 111. She speaks to a nurse who asks questions to understand Laura’s condition, and advises her to go to the Urgent Care Centre to see a GP.

Within 10 minutes of arriving at the UCC she sees a GP who starts her treatment immediately. Within an hour Laura has stopped wheezing.

Within 4 hours her symptoms suddenly deteriorate. Her mother calls 111 again; as her breathing problems are severe now the nurse advises her parents to take her to the nearest A&E.

On arrival, the triage fast-tracks her to be seen immediately in paediatric A&E.

Treatment is effective and Laura soon gets better. In an hour she is transferred to the children’s ward by a paediatric nurse.

During the night, Laura’s condition worsens and the duty paediatrician calls the duty consultant on-call for the acute retrieval service for advice.

Laura gets further treatment but transfer to the specialist unit is unnecessary. Laura steadily improves, she stays in hospital for the next 2 days and is treated according to the agreed plan.

Laura’s parents are offered a bed beside Laura in her room in the children’s ward.

Before discharge, a revised asthma action plan is agreed between Laura, her parents and the consultant. Inhaler technique and information of what to do if it Laura becomes breathless again are taught to both Laura and her parents.

A follow-up appointment is booked at the outpatient clinic, a discharge letter is written to the GP and the GP receives an update to Laura’s patient record about her admission to hospital.

Laura’s parents are given a phone number to call, if Laura’s condition deteriorates again.

In her follow-up appointment with her GP, the GP discusses with Laura’s mother how best she and Laura can manage her asthma. She also has an appointment with the asthma specialist nurse.

### Illustrative patient journey – long term condition (diabetes)

- **Joan Smith** is 70 and lives alone. Over the past few months she has been feeling increasingly tired; she books an appointment with her GP.
- Her GP does a blood test which shows her blood glucose levels is raised. A urinalysis and formal glucose tolerance test are performed (OGTT) which confirm the diagnosis. He arranges a follow-up appointment.
- At the next appointment, Joan’s GP explains the diagnosis and the importance of self-monitoring, diet and exercise. He does further tests including BMI, blood pressure, cholesterol and a foot check. He tells Joan about all the health care professionals who will be involved in her care and gives her a booklet about managing her diabetes. She starts regular medication.

- At her next appointment, Joan and her GP agree on an integrated care plan over the next 12 months. Her GP explains the importance of documenting her blood sugar levels to reduce chances of complications, attending regular follow ups and how her treatment will be monitored.
- A target HbA1c is recorded and agreed with Joan.
- She has retinal screens and feet checks annually and her care is reviewed every 3 months.
- The GP and patient agree for Joan to be a patient in the ICP service but since Joan is a low risk, she remains on a standard low-risk ICP. The care plan has a series of interventions agreed by the local MDT and this is shared securely with all providers, including Joan and the A&E.
- On her 6 month appointment, Joan fails to attend. Her absence is followed up by her care-coordinator.
- 12 months later Joan’s care plan and glycaemic control are reviewed.

- One evening Joan feels dizzy and has a fall. She is found by her daughter the following morning still lying on the floor. She remembers little about the fall and has not had any food or drink since last night. Her daughter calls 999 and an ambulance takes Joan to the nearest hospital. The UT system flags that Joan is a member of the ICP and the receptionist provides her care plan to the clinical staff.
- The diabetes care Joan receives is seamless from the care she receives from her GP.
- Within an hour of arrival, Joan is reviewed and a hip fracture is suspected. She is given pain relief and referred for early radiological assessment. She is given IV fluid to fluid and electrolyte abnormalities. Her care is overseen by the specialist diabetes team. She is reviewed by the medical team and followed up by the diabetic specialist nurse, who checks her current and past glycaemic control.

- Imaging is performed within an hour and radiological assessment confirms a hip fracture. Within 4 hours, Joan is transferred onto an acute orthopaedic ward.
- Within 12 hours, a multi-disciplinary assessment is completed. The consultant surgeon recommends a surgical fixation (hemi-arthroplasty). Joan consents to the procedure.
- A discharge plan and an estimated discharge date are formalised.
- Within 36 hours of admission, Joan is in theatre for surgical fixation. Afterwards, her blood glucose levels are regularly monitored.
- Shortly after Joan’s multidisciplinary rehabilitation plan is started with the help of the physiotherapist, she starts to mobilise.

- Joan continues to make good progress in hospital and is reviewed on a daily basis by both the orthopaedic and diabetic team. Before her discharge, Joan is mobilising well, managing stairs and has a home exercise programme.
- A multidisciplinary care plan is agreed by the multi-disciplinary team set up to look after patients in the community. Joan’s GP and community nursing team attend this and it means that the care package agreed is only slightly more intensive than she was receiving before.
- Follow up includes monitoring her diabetes in accordance with her ICP as well as a routine elderly check-up. Since Joan had her fall at home a community nurse and social worker visit Joan to check on her social circumstances, and perform a needs assessment.

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7b. Work of the Emergency and Urgent Care Clinical Implementation Group

This section sets out the revised proposals for the future development of emergency and urgent care in NW London, as part of the wider reconfiguration proposals for the *Shaping a healthier future programme*:

- Provides an overview of the original consultation proposal and the consultation responses to it
- Describes the work undertaken by the Emergency and Urgent Care Clinical Implementation and Planning Group (E&UC CIG) to review the original proposal in the light of consultation responses and further discussion by clinicians working in NWL
- Sets out recommendations that will be used to inform decision-making by the Shaping a Healthier Future Clinical and Programme Boards in relation to the post-reconfiguration structure of emergency and urgent care services in NW London.

7.8 Summary of the CIG’s recommendations

Pre-consultation we set out a number of recommendations for emergency and urgent care:

1. We propose five EDs located at Major Acute hospital sites in NW London
2. We propose nine UCCs in NW London
3. All UCCs will operate on a 24/7 basis
4. London Health Programme’s London Quality Standards covering Emergency Surgery and Acute Medicine and UCCs should be adopted across NWL for Major Acute Hospitals.

The E&UC CIG supports these recommendations and has made the following additional recommendations:

1. London Health Programmes quality standards covering Emergency Departments should be adopted in addition to those LHP standards already stipulated in the PCBC
2. All UCCs in NWL will operate to a consistent set of standards, irrespective of whether they are co-located with an ED
3. A UCC is a primary care service and will be expected to operate with a distinctive primary care ethos. This will be reflected in staffing, case-mix, integration with local primary care services and the implementation of positive re-direction back into the care of the patient’s registered GP
4. Each UCC should partner with a specific ED. The partnership should include oversight of joint governance arrangements (e.g. a Joint Clinical Governance Group)
5. Robust transfer protocols will be implemented to ensure that, where necessary, UCC patients can be transferred to ED in a manner that is both timely and clinically safe
6. Detailed modelling work is required to understand anticipated ED and UCC activity volumes, including the likely volume and acuity of UCC to ED patient transfer, and its impact on the LAS and other ambulance transport to ensure that patient safety and experience of care are maintained.
7.8.1 **Scope of the CIG’s work**

The proposals referred to in this section are for improving emergency and urgent care across NWL cover urgent care services (UCCs co-located with EDs, and those that are not) and emergency departments (ED).

Emergency and urgent care services have important links with other services. The E&UC CIG is committed to developing recommendations for the pathway in its entirety as part of planning for implementation. The scope of this section of the chapter therefore includes recommendations for improving integration with other services, including:

- Transfer from UCC to ED (including ‘blue light’ transfers)
- Positive re-direction to general practice from UCC
- Onward referral to specialist services from UCC
- Onward referral to community, social care and mental health services from UCC
- UCC integration with GP Out of Hours services.

7.8.2 **The Emergency and urgent care CIG**

The E&UC CIG was established to take forward the *Shaping a healthier future* proposals relating to emergency and urgent care by:

- Developing recommendations in response to pre-consultation review, consultation feedback and input from clinicians, providers and commissioners
- Ensuring that the implications for emergency and urgent care communicated and fully understood at a local level, and that clinical colleagues are kept informed
- Ensuring that plans for implementing changes to emergency and urgent care receive appropriate input from clinicians and patients.

The E&UC CIG is chaired jointly by Dr Susan LaBrooy (Medical Director, Hillingdon Hospital Trust) and Dr Tim Spicer (Clinical Commissioning Group Chair, NHS Hammersmith and Fulham). Its membership includes:

- GPs
- UCC and ED clinicians
- Commissioners and providers drawn from across NWL
- NW London Patient and Public Advisory Group (PPAG)
- College of Emergency Medicine
- London Ambulance Service (LAS)
- Local Mental Health Trusts
- London Deanery.

7.9 **Approach to stakeholder engagement**

The CIG itself represents a broad range of emergency and urgent care stakeholders from across NWL. In addition, the CIG has sought to engage with a wider body of stakeholder opinion via two routes:

- Site visits to all EDs and UCCs in NW London
- Focus groups with the public from across NW London to understand views and needs of urgent care.
7.9.1 **Site visits**

Site visits provided the CIG chairs with an opportunity to speak with frontline clinicians and managers, hear their ideas and concerns, and build an understanding of how ED and UCC services operate in practice. This exercise provided a useful alternative perspective that complemented and contextualised published research.

Key observations included:

- Organisational barriers between ED and UCC providers inhibit genuinely integrated working, preventing potential issues being pro-actively identified and resolved
- Where both parties have worked to establish formal and informal working relationships patient pathways have worked much better. This is dependent on a stable UCC clinician base
- Importance of joint governance for partnered EDs and UCCs, including a cross-site escalation policy
- Importance of using an experienced clinician (doctor or nurse) to conduct initial assessment – both in terms of clinical quality and the management of waiting times;
- Importance of UCCs being able to refer direct to certain specialties. For example, the need for some orthopaedic UCC patients to be referred to specialty via ED is a potential cause of friction
- Value of being able to rotate staff between UCCs and EDs, both for training purposes and to manage surges in activity (NHS indemnity is a significant barrier to achieving this)
- Importance of maintaining a pool of suitably trained Emergency Nurse Practitioners (ENPs). All contributors indicated that there is a shortage of ENPs and that this staff type is crucial to the smooth running of emergency and urgent care services
- Opinion of both ED and UCC managers and clinicians that UCCs should aim to treat approximately 60% of combined emergency and urgent care activity.

7.9.2 **E&UC CIG service user focus groups**

The E&UC CIG established a number of informal focus groups with the public. This included targeting discussions with groups that tend to make disproportionately high use of urgent care services (for example, parents of young children, older people, members of minority ethnic groups) as well as carer groups.

Focus groups were held across NW London, involving in excess of 250 patients in total. The key messages heard during this exercise are referenced in Figure 7.29.

**Figure 7.29 Key messages from focus groups**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Details</th>
</tr>
</thead>
</table>
| Convenience | • Waiting: it takes too long to get a GP appointment (both for a routine and urgent cases) or people had an urgent need when their GP was closed. This was especially voiced by people from ethnic minority groups. People also wanted appointments to run to time, especially those with younger children. There was some good feedback on a Rapid Response service – getting help quickly when it’s needed.  
• Location: views were mixed – some people wanted to stay local, others preferred to travel further to receive a better service, this was particularly the case for parents who preferred the more child-friendly services within a hospital paediatric team.  
• Administration: re-booking and moving of appointments was frustrating and... |
<table>
<thead>
<tr>
<th>Theme</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical outcomes</strong></td>
<td>• Participants valued quick diagnosis and onward treatment.</td>
</tr>
<tr>
<td></td>
<td>• Often, the most glowing reports of their experience of NHS came out of their stories about how they (or a loved one) had been seriously unwell, and the NHS had ‘got them back on their feet’ quickly, acting with expertise and compassion.</td>
</tr>
<tr>
<td></td>
<td>• Most people thought they had used an ED or UCC appropriately – i.e. they were ill and needed urgent care. However, some people did not have a clear understanding of what their GP could or should provide.</td>
</tr>
<tr>
<td><strong>Staff attitudes</strong></td>
<td>• Customer service was seen as really important, and rude staff were a common complaint (‘they can’t wait to get rid of me…’, ‘I just want to be treated like a human being…’).</td>
</tr>
<tr>
<td></td>
<td>• A tenacious attitude was often commented on when reflecting on current strengths, where staff take control and ‘gets things done’.</td>
</tr>
<tr>
<td></td>
<td>• One group felt particularly let down with the complaints process, they didn’t feel listened to or that their complaints were effectively resolved.</td>
</tr>
<tr>
<td><strong>Patient information and continuity of care</strong></td>
<td>• For people with an ongoing condition, they wanted to see the same clinician so they didn’t have to ‘start from scratch’. Some clinicians were preferred for a range or reasons – they’re ‘nicer’, ‘more knowledgeable’, ‘they get things done’.</td>
</tr>
<tr>
<td></td>
<td>• They also wanted more written information on their condition or for the person they cared for – this would help them to manage more things on their own.</td>
</tr>
<tr>
<td><strong>Integration and coordination across services</strong></td>
<td>• This tended to be a source of frustration for people, e.g. with discharge summaries not adequately being shared with GPs or those caring for people.</td>
</tr>
<tr>
<td></td>
<td>• Linked to this, some people wanted to have someone actively follow them up with a phone call to check everything was ok.</td>
</tr>
<tr>
<td></td>
<td>• For some, the lack of coordination with social care was a real issue, with lots of people turning up at different times and no coordination, even making the point about the resources wasted and negative impact on health. Quite a few people wanted one person to be responsible, and to know who to contact,</td>
</tr>
</tbody>
</table>

### 7.9.3 Shaping a healthier future stakeholder event

Following the consultation, on 28 November 2012 the *Shaping a healthier future* programme and Ipsos Mori presented back the findings from the consultation. This was proceeded by a number of smaller sessions, which included two sessions on urgent care. Both clinical and public stakeholders were given a short overview of the engagement and work to date, the key themes emerging from this engagement and the resulting standards. The remainder of the session focused on questions from the participants, including:

- Protocol for transfer from UCCs to EDs
- How to ensure consistency of standards (both between different providers and at non co-located sites)
- The case for change
- How patients will find out which services they should use.

### 7.10 Evidence base

The E&UC CIG has developed recommendations based on the best available evidence. This includes a broad range of best practice guidelines and research publications, including:

7b. Work of the Emergency and Urgent Care CIG

- ‘Guidance for commissioning integrated urgent and emergency care. A ‘whole system’ approach’ – Dr Agnelo Fernandes; RCGP Centre for Commissioning; August 2010
- ‘Building the evidence base in pre-hospital urgent and emergency care. A review of the research evidence and priorities for future research’ – Janette Turner; University of Sheffield, 2011
- ‘Standards for children and young people in Emergency Care settings’ – Royal College of Paediatrics and Child Health; 2012
- ‘Emergency Medicine consultants – workforce recommendations’ - College of Emergency Medicine; April 2011
- Seven Day Consultant Present Care The Academy of Royal Colleges (Sam you will have to look up the proper reference)
- London Health Programmes Emergency Department commissioning standards (awaiting publication)
- London Health Programmes urgent care centre commissioning standards (awaiting publication)

The E&UC has also been able to draw on a considerable body of evidence from UCCs and EDs already operational in NWL. Taken together, NWL clinicians, commissioners and providers possess extensive experience of designing, commissioning and delivering emergency and urgent care services. The E&UC CIG has sought to harness this by building a detailed understanding of what works well in practice and what could be improved.

7.11 Consultation

In addition to the independent evidence gathering activities set out above, the E&UC CIG drew on feedback from the formal Shaping a Healthier Future consultation to develop E&UC recommendations.

The Shaping a Healthier Future consultation was held between July and October 2012. A total of 17,022 responses were received. During the consultation period, the “Shaping a healthier future” team attended or arranged over 200 events which included two road-shows in each of the eight North West London boroughs as well as an additional roadshow in the neighbouring boroughs of Camden, Richmond and Wandsworth; public meetings and debates; GP events and other events for staff.

This section summarises those consultation responses pertaining to emergency and urgent care. For a full discussion of the Shaping a healthier future consultation, please refer to “Shaping a healthier future consultation for NHS North West London – Final Report” published by Ipsos Mori on 28th November 2012.

7.11.1 Key messages from consultation

National Clinical Advisory Team feedback

In May 2012, the National Clinical Advisory Team (NCAT) was invited to review the Shaping a Healthier Future pre-consultation business case. Their observations and recommendations in relation to emergency and urgent care proposals can be summarised as follows:

- The NCAT team supports moving from 9 emergency departments to 5
Further stakeholder engagement is needed to ensure that clinicians from existing EDs are involved fully in the development of the proposals.

More detailed work on service specification is required to ensure:
- The likely case-mix of UCCs and EDs is well understood;
- A consistent approach to governance across UCCs and EDs is developed.

Better modelling is required in order to:
- Understand the scale of higher dependency (ambulance borne) patients that will be redistributed around NWL after reconfiguration and ways in which ‘exit block’ from the ED into the hospital bed base can be minimised;
- Build a better understanding of likely admission rates and length of stay at each of the proposed EDs.

A workforce strategy is required to:
- Develop a staffing model for UCCs and EDs (we used the LHP requirements)
- Ensure capacity and capability exists to operate UCCs 24/7
- Ensure senior decision-makers are available during peak periods
- Build a sustainable, multi-disciplinary workforce
- Develop an integrated approach to training for all UCC and ED clinical staff
- Understand the cost implications of expanding the ED senior workforce to provide the level of cover set out in the proposals.

The feasibility and potential benefits of further integration with GP Out of Hours services should be explored in more detail.

In July 2012, the Emergency and Urgent Care Clinical Implementation and planning Group (E&UC CIG) was established in part to respond to NCAT feedback. The CIG was also tasked to respond to feedback from the main consultation exercise, when this became available in early November 2012.

**Qualitative feedback**

Figure 7.30 summarises the key qualitative themes that emerged during consultation. Please consult ‘Shaping a healthier future’ consultation for NHS North West London – Final Report for a more detailed analysis of responses to consultation.

**Figure 7.30 Qualitative themes that emerged during consultation**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Notes</th>
<th>Source</th>
</tr>
</thead>
</table>
| Consistent UCC service model | ● It is important to develop a definitive list of conditions that can be treated by UCCs. The public need to understand how and where to access care. | ● Westminster City Council, Adult Services and Health Policy and Scrutiny Committee.  
  ● London Borough of Hounslow Health and Adult Care Scrutiny Panel.  
  ● Kensington and Chelsea LINk  
  ● NCAT |
| UCC clinical safety          | ● Challenged the non co-located model for UCCs.                       | ● Onkar Sahota, London Assembly Member for Ealing and Hillingdon  
  ● Ealing Hospital A&E team  
  ● Brent LINk |
UCC to ED transfers

- More detail is needed on how patients will be transferred from non co-located UCCs to EDs. Without a better understanding of how this will work, many respondents have concerns about the clinical safety of non co-located UCCs.
- The likely volume and acuity of UCC to ED patient transfer should be analysed in more detail.

Activity

- Post reconfiguration UCC and ED activity is not well understood and should be analysed in more detail. This is necessary to support capacity planning across the system.

Workforce

- UCC minimum competences required to underpin a stable, multi-disciplinary workforce
- ED and UCC minimum levels of cover
- Quantitative analysis of ED workforce requirements

Communication

- Concern that lack of public awareness will lead to confusion about where to access care. This could result in reduced speed of access if patients present at the ‘wrong’ service.

NCAT
- College of Emergency Medicine
- North West London Joint Health Overview and Scrutiny Committee
- Westminster City Council, Adult Services and Health Policy and Scrutiny Committee
- Ealing Council
- Ealing Hospital
- Brent LINk

NCAT
- College of Emergency Medicine
- Hillingdon LINk
- Royal Borough of Kensington and Chelsea Health, Environmental Health and Adult Social Care Scrutiny Committee
- Ealing Council

NCAT
- College of Emergency Medicine
- North West London Joint Health Overview and Scrutiny Committee

NCAT
- North West London Joint Health Overview and Scrutiny Committee
- Central London Community Healthcare Trust
- Westminster and City of London Liberal Democrats
- Westminster LINk
- Harrow Council Health and Social Care Scrutiny Sub-Committee

7.12 London Health Programmes clinical standards

The London Health Programmes’ Quality and Safety Programme have developed clinical standards for UCCs and EDs. These comprise a set of minimum requirements that will be applied consistently across London. The CIG has worked closely with LHP to ensure that NW London CIG recommendations are aligned with the E&UC standards defined for London as a whole.

7.13 Summary of E&UC CIG responses to NCAT recommendations

Figure 7.31 summarises the E&UC CIG response to the recommendations made by NCAT. Each CIG response is dealt with in more detail elsewhere in this document. The relevant section is stipulated in the table.
<table>
<thead>
<tr>
<th>NCAT recommendation</th>
<th>CIG response</th>
<th>See section</th>
</tr>
</thead>
</table>
| What is the case mix going to be for each of the UCCs and what is it for the EDs? | • Clinical scope of UCCs defined using clinical exclusion criteria.  
• Criteria used to inform activity model, allowing calculation of likely volumes. | • Section 7.14.2 - UCC clinical scope |
| How will patients who are seen by a private AQP in an UCC who are then transferred to an ED be costed and what is the scale of this work (this model has recently started in the West Middlesex Hospital and there may be valuable data to apply in any modelling).? What cost efficiencies will be realised in this type of model versus an integrated EM service? | • We are paying a rate below A&E tariffs for UCC attendances. The lower tariff is justified due to the narrower scope of diagnostics and a different case mix at UCCs. As UCCs see the majority of urgent care work this provides a cost efficiency. Furthermore UCCs are incentivised to reduce re-attendances. | |
| What is the staffing model for each of the UCCs and EDs based upon the above. It is not enough to say “we want ED Cons on 24/7 basis in the big centres”. Indeed it is unlikely that ED Cons on a 24/7 basis will be achievable at any of the centres in the foreseeable future. | • Minimum ED staffing requirements defined by LHP and endorsed by the E&UC CIG  
• ED consultant requirements calculated using LHP ‘level of cover’ assumptions (i.e. 16hrs per day, 7 days a week)  
• Minimum competences and levels of cover for UCCs agreed by CIG.  
• Standards around GP cover and ‘primary care ethos’ defined.  
• CIG recommendation that it is more appropriate for specific UCC staffing models to be agreed locally between UCC commissioners and providers | • Section 7.3.1 - LHP Emergency Department clinical standards  
Chapter 14 – UCC workforce standards |
| What is the likely cost model of expanding the EM senior workforce to provide that level of cover and what are the likely timescales to coincide with the proposed reconfiguration? | • ED consultant requirements calculated using LHP ‘level of cover’ assumptions (i.e. 16hrs per day, 7 days a week)  
• Further work is required to identify the cost implications of the revised levels of cover. This work will be taken forward by the F&BP work stream in January and February 2013. | • Section 7.3.1 - LHP Emergency Department clinical standards |
| What is the depth of the senior decision makers (ie. number of senior decision makers on at any one time during peak periods) in the EDs to cater for the high intensity workload and how will they ensure it is a sustainable multidisciplinary workforce that they have created within a wider EM system in the NWL health economy? | • Minimum ED staffing requirements defined by LHP and endorsed by the E&UC CIG  
• ED consultant requirements calculated using LHP ‘level of cover’ assumptions (i.e. 16hrs per day, 7 days a week) | • Section 7.3.1 - LHP Emergency Department clinical standards |
<table>
<thead>
<tr>
<th>NCAT recommendation</th>
<th>CIG response</th>
<th>See section</th>
</tr>
</thead>
</table>
| What is the detail around an integrated training strategy for EM doctors, nurses,  | • Consistent joint governance arrangements linking UCCs and EDs developed.  
• CIG recommendation that arrangements are put in place to rotate staff through ED, UCC and primary care for training purposes.  
• CIG recommendation that joint training programme is established which allows for the rotation of staff through UCCs and EDs. Development of this training course should be led by NW London Lead Providers of Training, LETBs and Deaneries. | Section 7.14.8 – UCC governance  
• Chapter 14 – UCC minimum staff competences                                                                                             |
| ENPs, ANPs, PAs etc. Linking all major EDs and UCCs together with a consistent clear  |                                                                                                                                                                                                                                                                          |                                                                                                |
| governance system will be vital to selling it to the staff – the most valuable  |                                                                                                                                                                                                                                                                          |                                                                                                |
| commodity!                                                                          |                                                                                                                                                                                                                                                                          |                                                                                                |
| How exactly will the Out Of Hours GP service work and where will they be based?     | • Recommendation that GP OOH services are integrated with UCCs.  
• In the opinion of the CIG, any decision on the integration of GP Out of Hours services with UCC services should be taken by local commissioners, based on a consideration of local needs and contractual arrangements.  
• Further work at a local level is required in this area. | Chapter 8b – UCC integration with primary care                                                                                               |
| What is the predicted workload that it will off load from the UCC and EDs based     |                                                                                                                                                                                                                                                                          |                                                                                                |
| upon the success of the last 3 years?                                              |                                                                                                                                                                                                                                                                          |                                                                                                |
| Better modelling data is recommended in order to understand the scale of higher     | • Detailed activity modelling conducted to understand distribution of ambulance-borne patients, post reconfiguration  
• Detailed activity modelling conducted to understand likely volume of UCC to ED transfers (ambulance-borne and otherwise)  
• UCC to ED transfer protocol drafted                                                                                                                                                         |                                                                                                |
| dependency (ambulance borne) patients that will be redistributed around NWL after  |                                                                                                                                                                                                                                                                          |                                                                                                |
| reconfiguration.                                                                    |                                                                                                                                                                                                                                                                          |                                                                                                |
| What is the economic model for running each of the UCCs (payment per patient by a   | • Current NWL approaches to UCC contract management collated and shared with CCGs (this analysis contains confidential financial information and is not included in this report)  
• In the opinion of the CIG, UCC payment structures should be determined by local commissioners.                                                                                     |                                                                                                |
| private AQP model or as part of an EM commissioned integrated service)?             |                                                                                                                                                                                                                                                                          |                                                                                                |
| The clinical teams within existing emergency departments do not feel they are       | • Consultants form all NWL EDs represented on CIG and actively involved in developing recommendations  
• CIG chair site visits to all NWL EDs and UCCs to engage with staff                                                                                                                                               | Section 4 – the Emergency and Urgent Care Clinical Implementation and Planning Group                 |
<p>| involved enough in the process and developing the “story” of the emerging models    |                                                                                                                                                                                                                                                                          |                                                                                                |
| being proposed for unscheduled care.                                               |                                                                                                                                                                                                                                                                          |                                                                                                |</p>
<table>
<thead>
<tr>
<th>NCAT recommendation</th>
<th>CIG response</th>
<th>See section</th>
</tr>
</thead>
</table>
| Nurses are key to this reconfiguration, and they need to be more involved. All the key leadership positions within the clinical redesign program are held by doctors! | • Nurses from all NWL EDs and UCC providers represented on CIG and actively involved in developing recommendations  
• CIG chair site visits to all NWL EDs and UCCs to engage with staff | • Section 7.8.2 – the Emergency and Urgent Care Clinical Implementation and Planning Group |
| NCAT recommends some more modelling work around the likely admission rates and length of stay at each of the proposed EDs, this is to give the clinical teams confidence in the proposals | • CIG advised that this modelling has already been completed as part of the financial analysis.  
• Modelling work to be re-visited by F&BP work-stream. Outputs will be incorporated into the DMBC in January. |                                                                                   |
| The story of what services will be available at each of the sites is something that needs to be developed. The public are not interested in the number of doctors and the quality of doctors; they want to know what can be treated in each of the sites and what cannot be treated. | • Local Hospital factsheet published  
• Out of Hospital factsheet published  
• Ongoing engagement with public via SaHF comms work-stream  
• Further communication materials to be developed and publicised by SaHF comms work-stream pending confirmation of which services will be available at each hospital site. |                                                                                   |
| Some detail around the development of the workforce to support the middle tier of clinical decision-making would be helpful. | • Minimum ED staffing levels defined by LHP and endorsed by the E&UC CIG. | • Section 7.3.1 - LHP Emergency Department clinical standards |

### 7.14 UCC operating model (co-located with ED)

In the opinion of the CIG, a single, consistent operating model, with appropriate localisation, should be implemented at all NW London UCCs. However, the *Shaping a healthier future* proposals are likely to lead to the creation of two forms of UCC: UCCs co-located with an ED and UCCs that are not co-located with an ED. The two operating models will necessarily differ in some respects. In this section, the recommended operating model for co-located UCCs is set out.

#### 7.14.1 Intended service outcomes

The urgent care centre will work on the principle that all patients should receive a consistent and rigorous assessment of the urgency of their need and an appropriate and prompt response.

The aims and intended service outcomes are:

- The service model is based upon the need to provide improved access to urgent, unplanned care, while ensuring that the patient’s ongoing healthcare needs are met in the most appropriate setting within the community or primary care. This may involve streaming patients back into services (e.g. GP practices, community services) via a process of positive re-direction.
- The UCC will operate over twenty four hours, seven days a week, and will share a single reception with the ED. The UCC will act as a single point of access to on-site emergency and urgent care services for walk-in patients.
The UCC will integrate with current service provision but will develop the distinctive culture and approach of a primary care service, with experienced and appropriately skilled primary care clinicians leading the service, working alongside other healthcare professionals undertaking assessments and seeing and treating patients.

The UCC will not constitute a further access point for routine NHS care in the health economy; neither will it allow duplication of existing services. Patients attending who do not have urgent care needs will be supported by staff in the centre to access advice and care from their local community pharmacist, or to make an appointment with their own GP within the target timescales.

Service providers of the UCC and the ED will be required to work together to ensure integrated and seamless care pathways.

The UCC should ensure patients receive a consistent and rigorous assessment of the urgency of their needs and an appropriate and prompt response.

The UCC Information and Communication Technology (ICT) processes should be inter-operable with both GP and Trust systems in order to facilitate effective information sharing.

The main elements of the service will include:

- Streaming, registration and initial assessment
- Diagnosis and treatment
- Referral and discharge.

### 7.14.2 Clinical scope

All UCCs should have the ability to manage the full range of emergency and urgent care presentations appropriate to its function. The E&UC CIG recommends a consistent clinical scope for UCCs across NW London as follows:

- The scope of the UCC will include both Minor Illnesses and Minor Injuries;
- Interventions considered in-scope include:
  - The management of uncomplicated fractures
  - Non-complex regional anaesthesia for wound closure and local anaesthesia
  - Incision and drainage of abscesses not requiring general anaesthesia; and
  - Minor ENT/ophthalmic procedures (e.g. packing noses; removing foreign bodies from eyes, ears and noses)
- The interpretation of X-rays and other diagnostics/investigations will be in scope
- There will be no age limit for UCC patients.

Figure 7.32 summarises the urgent care centre clinical inclusion and exclusion criteria for adult and paediatric patients. This is for illustrative purposes; more detailed exclusion criteria have been developed.

**Figure 7.32: Urgent care centre clinical inclusion and exclusion criteria**

<table>
<thead>
<tr>
<th>Conditions suitable for UCC</th>
<th>Clinical exclusions (adults)</th>
<th>Clinical exclusions (children)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The scope of the UCC will include both minor illnesses and minor injuries:</td>
<td>Markedly abnormal baseline signs</td>
<td>In addition to the adult exclusion criteria:</td>
</tr>
<tr>
<td>o cuts and grazes</td>
<td>Chest Pain (likely cardiac)</td>
<td></td>
</tr>
<tr>
<td>o minor scalds and burns</td>
<td>Complex fractures (e.g. open fractures, long bone fracture of legs, spinal injury)</td>
<td></td>
</tr>
<tr>
<td>o strains and sprains</td>
<td>Patients receiving oncological therapy</td>
<td>Acutely ill children (defined using PEWS)</td>
</tr>
<tr>
<td>o bites and stings</td>
<td></td>
<td>Paediatric head injury</td>
</tr>
<tr>
<td>o minor head injuries</td>
<td></td>
<td>Procedure requiring sedation</td>
</tr>
</tbody>
</table>

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152
### Conditions suitable for UCC
- ear and throat infections
- minor skin infections / rashes
- minor eye conditions / infections
- stomach pains
- suspected fractures

### Clinical exclusions (adults)
- Sickle cell crisis
- Acute Shortness Of Breath (inc. severe shortness of breath compared to normal, cyanosis, increased peripheral oedema)
- Signs of severe or life threatening asthma
- Airway compromise
- Acute exacerbation of heart failure
- Burns (> 5%; facial/eye; inhalation, chemical/electrical)•New CVA
- Significant DVT
- Temporarily unable to walk
- Haematemesis/ Haemoptysis
- Overdose / Intoxicated and not able to mobilise
- Acute psychosis / neurosis
- Significant head injuries

### Clinical exclusions (children)
- Repeat attendances: 3 attendances in 3 months
- Fever with non-blanching rash
- Fitting
- History of decreased or varying consciousness
- Combination of headache, vomiting and fever
- History of lethargy or floppiness

Figures 7.33 and 7.34 set out detailed clinical exclusion criteria for both adult and paediatric patients. NB. Many of the clinical exclusion criteria listed in the table below will only be identified after clinical assessment. As a result, it will not always be possible to apply these criteria at the point of streaming. Some patients may therefore be identified as unsuitable for UCC care during assessment or treatment.

**Figure 7.33: UCC clinical exclusion criteria (adults)**

<table>
<thead>
<tr>
<th>Exclusion criterion</th>
<th>Additional information</th>
</tr>
</thead>
</table>
| Markedly abnormal baseline signs         | - tachycardia > 110 beats per minute
                                           | - bradycardia < 40 beats per minute
                                           | - hypotension < 100 mm Hg systolic (unless known to be normal for that individual)
                                           | - respiratory rate <10 or >=25 breaths per minute (adults)
                                           | - oxygen saturation <92%
                                           | - hypoglycaemia                          |
| Chest Pain                               | - Nature of the pain is consistent with ischaemia
                                           | - Chest pain associated with tachycardia > 110 beats per minute
                                           | - Chest pain associated with tachypnoea > 25 respirations per minute
                                           | - Central chest pain or left sided pain with radiation to the neck or arm
                                           | - Chest pain associated with nausea, shortness of breath or sweating
                                           | - A previous history of heart disease if relevant
<pre><code>                                       | - History of Cocaine use within the previous 48 hours |
</code></pre>
<table>
<thead>
<tr>
<th>Exclusion criterion</th>
<th>Additional information</th>
</tr>
</thead>
</table>
| Complex fractures                                      | For example (but not limited to):                                                                                                    ● Long bone fracture of legs  
● Open fractures  
● Spinal injury |
| Patients receiving oncological therapy                 | ● Patients receiving oncological therapy should be transferred to a hospital with an Acute Oncology Service. All Major Acute Hospitals have Acute Oncology services.                                                                 |
| Sickle cell crisis                                      |                                                                                                                                                                                                                       |
| Shortness of Breath                                    | ● "Severe" shortness of breath compared to normal  
● Cyanosis  
● Increased peripheral oedema  
● Impaired consciousness or acute confusion  
● Rapid rate of onset  
● Associated with tachycardia > 110 beats per minute  
● Inability to speak in sentences  
● Shortness of breath associated with chest pain  
● Shortness of breath associated with pallor and cold sweats  
● Respiratory rate greater than 25 per minute  
● Oxygen saturation < 95% in a previously healthy individual [E:e]  
● History of severe asthma or recent emergency admission or a single ITU admission.  
● Shortness of breath associated with chest trauma. |
| Adults with signs of severe or life threatening asthma  | ● cannot complete sentences  
● pulse ≥ 110 beats per minute  
● respiration ≥ 25 breaths a minute  
● peak flow ≤ 50% predicted or best  
● silent chest  
● cyanosis  
● bradycardia (heart rate < 40 bpm)  
● exhaustion |
| Airway compromise                                       | ● stridor  
● quinsy  
● oedema of tongue  
● unable to swallow  
● saliva/ drooling |
| Acute exacerbation of Heart Failure                     |                                                                                                                                                                                                                       |
| Burns                                                   | ● >5%  
● Facial/ eye involvement  
● Inhalation injury  
● Chemical/ electrical involvement |
| New CVA                                                 |                                                                                                                                                                                                                       |
| Significant DVT                                         | ● Patients with suspected DVT associated with chest pain/SOB or HR > 110 |
| Haematemesis / Haemoptysis                             |                                                                                                                                                                                                                       |
| Overdose / Intoxicated and not able to mobilise         | ● Are experiencing acute alcohol withdrawal or delirium tremens  
● Are a danger to themselves or others  
● Acute mental health presentation compromised by alcohol/drugs  
● Unaccompanied by other responsible adult and need a period of observation  
● Have taken any drug overdose |
| Significant head injuries                              | ● Clinical concerns about a Cervical Spine injury:  
  ○ Neck pain or midline boney tenderness  
  ○ Focal neurological deficit |
<table>
<thead>
<tr>
<th>Exclusion criterion</th>
<th>Additional information</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Head injury associated with GCS &lt; 13 at presentation</td>
<td></td>
</tr>
<tr>
<td>● GCS &lt; 15 when assessed 2 hours after the injury</td>
<td></td>
</tr>
<tr>
<td>● History of significant Loss of Consciousness</td>
<td></td>
</tr>
<tr>
<td>● More than one episode of vomiting</td>
<td></td>
</tr>
<tr>
<td>● Persistent headache</td>
<td></td>
</tr>
<tr>
<td>● Suspected open or depressed skull fracture</td>
<td></td>
</tr>
<tr>
<td>● Sign of basal skull fracture</td>
<td></td>
</tr>
<tr>
<td>○ haemotympanum, ‘panda’ eyes, cerebrospinal fluid otorrhoea, Battle’s sign</td>
<td></td>
</tr>
<tr>
<td>● Post traumatic seizure</td>
<td></td>
</tr>
<tr>
<td>● Focal neurological deficit</td>
<td></td>
</tr>
<tr>
<td>● Significant amnesia</td>
<td></td>
</tr>
<tr>
<td>● Dangerous Mechanism of injury</td>
<td></td>
</tr>
<tr>
<td>● pedestrian/cyclist stuck by a car, ejection from vehicle, fall from over 1 meter or 5 stairs</td>
<td></td>
</tr>
<tr>
<td>Mental health</td>
<td></td>
</tr>
<tr>
<td>● Overdose</td>
<td></td>
</tr>
<tr>
<td>● Other significant self harm (adults). NB. Mental Health Trust advice is that this criterion should be open-ended and subject to clinical judgment. For example, a ‘simple laceration’ would be in scope for the UCC.</td>
<td></td>
</tr>
<tr>
<td>● Any self harm (children)</td>
<td></td>
</tr>
<tr>
<td>● Severe withdrawal, delirium tremens and withdrawal seizures (as these are very likely to require medical admission)</td>
<td></td>
</tr>
<tr>
<td>● Acute psychosis with disturbed behaviour.</td>
<td></td>
</tr>
<tr>
<td>● Acute confused state/ delirium</td>
<td></td>
</tr>
<tr>
<td>● Require a secure environment (ie the main Emergency Dept) for assessment including suicide risk using current screening tool</td>
<td></td>
</tr>
</tbody>
</table>

In addition to the exclusion criteria set out above, the following exclusion criteria will apply to paediatric patients:

**Figure 7.34 UCC clinical exclusion criteria (children)**

<table>
<thead>
<tr>
<th>Exclusion criterion</th>
<th>Additional information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acutely ill children</td>
<td>● All children identified as ‘acutely ill’ using Paediatric Early Warning System (PEWS)</td>
</tr>
<tr>
<td>Children with signs of severe or life threatening asthma</td>
<td>● too breathless to talk or feed</td>
</tr>
<tr>
<td></td>
<td>● respiration ≥ 40 breaths a minute in children over 5 years or &gt; 50 breaths per min &lt;5 years</td>
</tr>
<tr>
<td></td>
<td>● pulse ≥ 120 beats per minute in children over 5 years or &gt; 140 beats per minute &lt; 5 years</td>
</tr>
<tr>
<td></td>
<td>● use of accessory muscles of breathing</td>
</tr>
<tr>
<td></td>
<td>● peak flow ≤ 50% predicted or best in older children</td>
</tr>
<tr>
<td>Paediatric head injury</td>
<td>● Witnessed loss of consciousness</td>
</tr>
<tr>
<td></td>
<td>● Amnesia (antegrade or retrograde) lasting &gt; 5 minutes</td>
</tr>
<tr>
<td></td>
<td>● Abnormal drowsiness</td>
</tr>
<tr>
<td></td>
<td>● 2 or more discrete episodes of vomiting</td>
</tr>
<tr>
<td></td>
<td>● Clinical suspicion of non-accidental injury</td>
</tr>
<tr>
<td></td>
<td>● Post-traumatic seizure</td>
</tr>
<tr>
<td></td>
<td>● Use AVPU to assess level of alertness.</td>
</tr>
<tr>
<td></td>
<td>● Suspicion of skull injury or tense fontanelle</td>
</tr>
<tr>
<td></td>
<td>● Any sign of basal skull fracture</td>
</tr>
<tr>
<td></td>
<td>○ haemotympanum, ‘panda’ eyes, cerebrospinal fluid</td>
</tr>
<tr>
<td>Exclusion criterion</td>
<td>Additional information</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Leakage from ears or nose, Battle’s sign</td>
<td></td>
</tr>
<tr>
<td>Focal neurological deficit</td>
<td></td>
</tr>
<tr>
<td>Age &lt; 1 year: presence of bruise, swelling or laceration &gt; 3 cm on the head or any-sized bruise if pre-mobile</td>
<td></td>
</tr>
<tr>
<td>Dangerous mechanism of injury</td>
<td></td>
</tr>
<tr>
<td>o high-speed road traffic accident either as pedestrian, cyclist or vehicle occupant, fall from &gt; 3 m, more than 5 stairs, high-speed injury</td>
<td></td>
</tr>
<tr>
<td>Procedure requiring sedation</td>
<td></td>
</tr>
<tr>
<td>Multiple pathologies deemed to be complex</td>
<td></td>
</tr>
<tr>
<td>Repeat attendances</td>
<td>Paediatric patients attending the UCC in excess of three times in three months should be referred to the paediatric team at a Major Acute Hospital. This criterion is also standard in NW London EDs and is intended to reduce repeat admissions.</td>
</tr>
<tr>
<td>Fever with non-blanching rash</td>
<td></td>
</tr>
<tr>
<td>Fitting</td>
<td></td>
</tr>
<tr>
<td>History of decreased or varying consciousness</td>
<td>See paediatric head injury guidance above</td>
</tr>
<tr>
<td>Headache, fever and vomiting</td>
<td>For clarity, this exclusion only applies if all three symptoms occur in combination.</td>
</tr>
<tr>
<td>Any infant with a history of lethargy or floppiness</td>
<td></td>
</tr>
</tbody>
</table>
### 7.14.3 Streaming, registration and initial assessment

#### Figure 7.35 UCC Streaming, registration and initial assessment process

As part of the streaming, registration and initial assessment process, the following activities will take place:

- Patient streaming to the most appropriate service based on clinical assessment of need, including redirection to community services if appropriate
- Patient registration on the appropriate IT system
- Initial assessment of patient by an experienced primary care clinician or experienced nurse
- Analgesia and ordering of X-ray, if appropriate.

The E&UC CIG recommends the following key features:

#### Figure 7.36 Recommended key features

<table>
<thead>
<tr>
<th>Streaming, registration and initial assessment key features</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Single, integrated reception for self-presenting patients – UCC will be patient's single point of access to ED services.</td>
</tr>
<tr>
<td>- Patients will be clinically streamed to appropriate areas by a GP or experienced nurse.</td>
</tr>
<tr>
<td>- Patients self-presenting at UCC with major emergencies will be identified immediately by the streamer and, when appropriate, accompanied to the ED by a doctor or nurse.</td>
</tr>
<tr>
<td>- Patients arriving by ambulance will access services via the ambulance entrance. The default pathway for ambulance patients is direct to the ED, bypassing the UCC. However, patients with minor complaints may be streamed to the UCC by the London Ambulance Service, or by the ED nurse receiving the patient from the LAS.</td>
</tr>
<tr>
<td>- Patient details will be captured once on the appropriate IT system at reception – IT processes</td>
</tr>
</tbody>
</table>

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7b. Work of the Emergency and Urgent Care CIG
Streaming, registration and initial assessment key features

- must be inter-operable with both Trust and GP systems to ensure that:
  - Patient details will not have to be taken again in the event of streaming/transfer to ED.
  - Child/vulnerable adult ‘Red Flags’ can be picked up by UCC staff.
- UCC patient streaming should be complete within 20 minutes (adults) or 15 minutes (paeds).
- A suitably competent clinician will carry out the assessment of patients attending the centre. Clinicians with suitable competencies will include GPs, emergency nurses and other suitably qualified clinicians to meet case-mix demands.
- Single assessment process for all UCC/ED walk-in patients – patients requiring transfer to ED should not need to be assessed again on arrival.
- Some aspects of treatment and diagnostic investigation could and should be provided at the streaming and assessment stage (e.g. analgesia, ordering of X-ray). Clinicians providing initial assessment should possess the skill set necessary to provide this treatment.
- In accordance with Healthcare for London guidance, the UCC is expected to make all ‘see and treat’ decisions within 60 minutes; that is to say, the UCC is expected to identify and pass all appropriate patients through to ED within 60 minutes from the time of registration, so the 4-hour target remains achievable for the ED.
- Patients attending who do not have urgent care needs will be supported by the staff in the centre to access advice and care from their local community pharmacist, or to make an appointment with their own GP practice. Where appropriate, this will be achieved using the ‘111’ service.
- Patients attending the UCC who are not registered with a GP will be treated by the UCC according to the same criteria as a registered patient. In addition, they will be supported by the staff in the centre to register with a local practice of their choice.
- Patients may be referred to community based services, including general dental services, pharmacy services, community nursing, and social and voluntary services. UCC reception staff will have up-to-date details of all community and primary care based services and will be able to provide patients with contact numbers/service details and opening times in order that they are redirected to core primary care service provision.
- Contingency plans should be put in place to deal with unexpected surges in demand in order to ensure that waiting times are kept under control. These plans should minimise the volume of clinically inappropriate transfers to ED.

7.14.4 Diagnostic scope

The UCC will have access to diagnostics and investigations run by the hospital Trust from the hospital site. Only urgent diagnostic action will be initiated. It is therefore not anticipated that the level of diagnostics provided will exceed that provided in a standard GP surgery, other than the additional diagnostics that may be required for minor injuries (e.g. X-ray). Requests for diagnostic testing will be audited on a regular basis.

UCC patients may require access to diagnostics where this would contribute to a decision regarding the patient’s immediate treatment or referral. It is therefore recommended that, with the exception of tests requested as part of an onward referral to a specialist clinic, all test results should be available within one hour.

The E&UC CIG recommends that the following investigations and diagnostics are available to UCC clinicians:

**Figure 7.37 Recommended diagnostics available at a UCC**

<table>
<thead>
<tr>
<th>Diagnostic area</th>
<th>Diagnostic tests available to UCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electrocardiogram (ECG)</td>
<td>Full blood count (FBC)</td>
</tr>
<tr>
<td>Haematology</td>
<td>D-Dimer</td>
</tr>
</tbody>
</table>

1 College of Emergency Medicine Triage Position Statement, April 2011.
In addition, the UCC should have the ability to book other diagnostic tests as part of specific onward referral pathways. For example, DVT ultrasound.

**Performance Standards**

The UCC is expected to make all 'see and treat' decisions within 60 minutes; that is to say, the UCC is expected to identify and pass all appropriate patients through to the ED within 60 minutes from the time of registration, so the 4-hour target remains achievable for the ED. In some cases, a diagnostic or investigation will be required before this decision can be made. Therefore, in order for the UCC to comply with the 60-minute pass-through standard, the outcome of all diagnostics and investigations will be returned to the UCC within an agreed time period.

**Interpretation and Reporting**

The UCC is expected to interpret all diagnostics and investigations it requests, except for those which it requests as part of an onward referral to a specialist clinic. This applies to Radiology as well as Pathology.

For Radiology, the UCC is required to develop a process through which X-rays can be subject to a medical interpretation, as part of the episode of care. It will be for the UCC Provider to demonstrate that the process defined is safe and effective. Measures must include having an abnormal results review process in place.
Diagnosis and treatment

Figure 7.38 Diagnosis and treatment

This section describes the functions highlighted below in red.

Figure 7.39 E&UC CIG recommended key features

<table>
<thead>
<tr>
<th>Minor Illness/ Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients identified by the clinical streamer as requiring a primary care consultation will be registered on the UCC clinical IT system by the reception staff and be seen by an appropriate clinician.</td>
</tr>
<tr>
<td>All self-referred patients will be seen in order of arrival unless the streamer or consulting clinician feels they should be seen more urgently.</td>
</tr>
<tr>
<td>Options for the provision of bookable appointments via the ‘111’ service (and potentially, GP Out of Hours services) should be explored.</td>
</tr>
</tbody>
</table>

Specialist input

- UCC clinicians should be able to access input from a range of specialists, including ED consultants, orthopaedic specialists, paediatric specialists and radiologists. Principle that access to specialist opinion should be no different to that available at a GP surgery.
- Where the UCC and its partner ED are not operated by the same provider, thought should be given to a contractual mechanism that allows the UCC provider to purchase specialist advice from the hospital Trust.
- Where specialist input has been sought, clinical responsibility for the patient remains with the UCC clinician unless and until the patient is formally transferred to an alternate service.

Paediatric care delivery

- Children under 16 years will wait in the designated paediatrics waiting room.
The Provider must deliver appropriate and responsive care to all children. This must be in accordance with the standards set out in the Children Act 2004, National Service Framework for Children and any local protocol within North West London Health economy.

Children under the age of 2 years suitable for the UCC will be seen by a suitably qualified clinician.

All UCC staff must:
- Have relevant professional registration, indemnity and have undergone enhanced Criminal Record Bureau checks.
- All staff caring for children shall have appropriate paediatric experience, including core paediatric competencies.
- Know who to contact for advice on child protection matters at all times.

- For children and young people, the episode of care should be communicated to their health visitor or school nurse no later than 8am on the second working day following the child or young person’s episode of care.

### Mental Health care delivery

- Mental Health presentations account for at least 20% of primary care attendances\(^2\). UCCs should have 24/7 direct access to Psychiatric Liaison Team.
- On the assumption that liaison psychiatry teams are funded beyond 2013, local psychiatric liaison teams will be responsible for ensuring consistent levels of cover for both co-located and non co-located UCCs. With regard to non co-located UCCs, this responsibility may devolve to the Mental Health Crisis Team if one is available on-site.
- All UCCs will have access to a Mental Health assessment room that is compliant with the relevant Royal College of Psychiatrists safety standards\(^3\).

### Transfer to/from UCC

- Following clinical streaming to the UCC any patient found, on detailed examination, to require more complex care will be referred directly to the ED.
- A ‘Patient Transfer’ protocol for establishing an appropriate time to transfer patients between services should be agreed between the Provider and hospital Trust prior to service commencement. Please see Figure 7.40 for a generic UCC to ED transfer protocol. This protocol should adapted to reflect local needs and processes.
- This protocol will support both services in delivering the 4 hour Standard. To this end, the protocol should comply with Healthcare for London guidance that all transfers should take place within 60 minutes of presentation. The four hour clinical standard will commence from the patients arrival to the UCC and NOT from the time of their transfer.
- As part of this process the patient’s details will be transferred from the UCC clinical system to the ED IT system by staff without the need for the patient to re-register.

### 7.14.5 Commissioning arrangements for liaison psychiatry

NW London psychiatric liaison teams are commissioned to support both EDs and UCCs. It is anticipated that this will continue post reconfiguration.

On the assumption that liaison psychiatry teams are funded beyond 2013, local psychiatric liaison teams will be responsible for ensuring consistent levels of cover for both co-located and non co-located UCCs. With regard to non co-located UCCs, this responsibility may devolve to the Mental Health Crisis Team if one is available on-site. Psychiatric liaison teams offer 24/7 support to UCCs in the following ways:

\(^2\) ‘Guidance for commissioning integrated urgent and emergency care. A ‘whole system’ approach’ – Dr Agnelo Fernandes; RCGP Centre for Commissioning; August 2010

\(^3\) ‘Psychiatric services to accident and emergency departments; Council Report CR118, Feb 2004’
To provide specialist input (NB. As with other specialist input, the psychiatric liaison team will be responsible for the advice they provide, but responsibility for the overall care of the patient will remain with the UCC).

To provide advice on onward referral of psychiatric patients and support UCCs to manage this process.

To provide UCC clinicians with training designed to improve their ability to identify and treat psychiatric patients.

In support of the principle of integrated clinical governance, the proposed Joint Clinical Governance Groups will require Mental Health representation in order to be quorate (in line with current ED practice).

The UCC clinician will determine whether the patient’s condition requires specialist input from the psychiatric liaison team, transfer to ED, or referral back to their GP. In the majority of cases the patient can be seen and treated by a UCC clinician.

The escalation path is UCC clinician, then psychiatric liaison team / on-call psychiatrist. This escalation route relates purely to the nature of the mental health issue. A patient whose clinical condition deteriorates significantly would be transferred to the ED (as for any other type of patient).

7.14.6 Referral and discharge

Figure 7.40: Referral and discharge
## Referral and discharge key features

### Referral

- UCC ability to refer to Outpatient services directly should be defined by local commissioners and should follow locally agreed protocols (for example, the use of GP referral management services).

- In collaboration with local commissioners, the UCC Provider will be expected to agree direct referral pathways to additional specialist services and clinics including specialist gynaecology services, GUM and ACDU. Where an admission is required this will be made directly to the specialty concerned. Patients will then be transferred directly to suitable admitting/assessment units. Patients will not be referred back to the ED for diagnostics or admission.

- The ability to direct book should not be used as a means to allow patients to bypass their GPs. To prevent unequal access to services, UCC direct booking protocols should be defined at CCG level in line with local approaches.

- Patients may be referred to community based services, including general dental services, pharmacy services, community nursing, and social and voluntary services.

- The UCC will be fully integrated with the Directory of Services (e.g. via 111), both for patients ‘referred in’ to the UCC, and when referring patients into community services and General Practice.

### Discharge

- The Provider will issue discharge summaries to GP practices within 24 hours, providing relevant clinical and treatment information, medication and any necessary follow-up care.

These recommendations are dependent on local CCG Strategies and may vary locally.

### 7.14.7 Demand management

**Positive direction into primary care**

Patient experience and – to a degree – clinical outcomes are contingent on the public’s ability to navigate the system effectively. In practice, this means that information on available services should be made available to the public across a variety of media. Proposed channels include:

- The ‘111’ telephone advice service - set up to ensure that patients are directed to a setting appropriate to their condition. All UCC providers should ensure that the 111 service is aware of the clinical scope of UCC services and where relevant, the hours of that availability of specific diagnostic tests (e.g. X-ray)

- Web-based information – information on services hosted on NHS websites

- Shaping a Healthier Future communication strategy – publication of ‘Local Hospital’ and ‘Out of Hospital’ factsheets. NB. A more detailed communication strategy will be developed once a final decision on reconfiguration has been taken by the JCPCT in February 2013, as the final shape of E&UC services has yet to be agreed.

Directing patients to the right service first time will reduce the extent to which UCCs will need to re-direct or transfer patients.
**Positive re-direction back into primary care**

It is important that a UCC is planned and delivered as a service that is fully integrated with every other part of the local health community; and that it operates as part of the overall urgent care strategy for the local health economy\(^4\).

In a recent survey conducted by the Office of Public Management (OPM) on behalf of NHS NW London\(^5\), 25% of respondents said that they had used a UCC to get a consultation that they could have had at their GP practice.

The use of UCCs as an alternative to General Practice results in service duplication and undermines the sustainability of the system. It is therefore recommended that patients attending who do not have urgent care needs should be supported by UCC staff to access advice and care from their local community pharmacist, or to make an appointment with their own GP practice within the target timescales.

It is recommended that commissioners work with UCC providers to agree a realistic target for positive re-direction based on a local assessment of UCC case-mix and patterns of use.

**7.14.8 Governance**

**Integrated clinical governance**

An integrated service model is fundamental to a UCC’s ability to deliver safe, high quality care. In practice, this means close integration with EDs and other health services via formal governance mechanisms and strong informal working relationships.

The key features of a genuinely integrated service model are:

- Clear lines of responsibility and accountability, both within and between provider organisations;
- Clearly defined handovers of care between providers;
- An approach to review and continuous improvement that transcends organisational boundaries;
- Clear policies aimed at managing risk and procedures to identify and remedy poor professional performance.

In order to address these issues, providers will be expected to develop an operating model that supports the following principles:

**Partnership with specific ED**

The UCC should partner with a specific ED. The partnership should include oversight of joint governance arrangements (e.g. a Joint Clinical Governance Group).

Though it is recognised that providers delivering urgent care will have discrete transactional systems such as those involving clinical leadership and financial reimbursement, integration should be managed in a way that ensures the patient experiences a seamless journey through all urgent care services, irrespective of provider. The vision is that the UCC provider

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\(^4\) ‘Guidance for commissioning integrated urgent and emergency care. A ‘whole system’ approach’ – Dr Agnelo Fernandes; RCGP Centre for Commissioning; August 2010

\(^5\) ‘Priorities for General Practice – report to NHS NW London Delivery Support Unit’ Office of Public Management; December 2012
will be able to establish a service where the patient is not aware of moving across transactional or organisational boundaries.

There must be a tangible commitment to working in this way. Therefore, the UCC provider will be expected to put forward clear plans on how integrated clinical governance will work across two separate provider organisations. In order to be workable in practice, close co-operation with Major Hospital colleagues to develop and implement the plans will be essential.

**Joint Clinical Governance Group**

A Joint Clinical Governance Group should be established to foster joint working and drive continuous improvement. Membership will include clinicians from the UCC provider, the hospital Trust and the appropriate CCG.

In support of the principle of integrated clinical governance, the proposed Joint Clinical Governance Group will require Mental Health representation in order to be quorate (in line with current ED practice).

Terms of reference for the group will include:

1. Creation and regular review of the Joint Clinical Policy, including:
   a. Assessment guidelines for Clinical Streamers
   b. Staff competency framework
2. Service audit, including:
   a. On a case by case basis, the appropriateness of the initial clinical navigation where a patient’s treatment is begun in the UCC and subsequently transferred to ED
   b. On a case by case basis, the appropriateness of the initial clinical navigation where a patient’s treatment is begun in ED and subsequently transferred to the UCC
   c. At overview level, patient case mixes will be reviewed regularly to assure clinical governance and standards and retain confidence in both services
   d. On a regular basis, audit against staff competency framework
   e. Patient experience data, SUIs, complaints and professional feedback
   f. Review of re-directions back to primary care
   g. Review of diagnostic tests/investigations
   h. Review of prescribing
3. Review and learning from all outcome data, incidents and complaints to improve quality of care.

**Patient transfers**

Where patients are transferred from the UCC to another provider organisation (information about likely transfer options are in Section 7.15.4), it is essential that there is clarity with regard to governance arrangements. Both organisations have a responsibility to ensure that there are appropriate systems in place to ensure patient safety. Individual clinicians also have a personal professional responsibility to ensure safe, high quality care. During any transfer, it will be necessary to:

- Be clear about who retains overall responsibility for the patient
- Provide for a comprehensive transfer of information relating to the patient’s condition and investigations already conducted. Minimum standards for information provided on transfer should be agreed between providers.
A proportion of transfers to ED will involve high acuity patients who have presented with conditions that are out of scope for the UCC. It is therefore important that UCC staff possess the training, equipment and facilities required to stabilise patients in the event that their condition deteriorates before transfer can take place (e.g. resuscitation training and equipment).

**Specialist input**

Where a patient is not moved, but expertise is given by another organisation (e.g. expert wound management by an ED consultant or a radiology report) it is important that there is clarity as to who retains overall responsibility for the patient. The GMC guidance ‘Good Medical Practice’ on working with colleagues is relevant here.

The provider is responsible for working with Trust colleagues to put in place arrangements for remote specialist input. This may require a contractual arrangement in the event that specialist advice is provided by a separate organisation.

**Working across organisational interfaces**

It is recommended that all policies, processes and procedures relating to organisational interfaces are developed jointly between the UCC provider and the relevant hospital Trust prior to implementation. These interfaces should be kept under review and regularly discussed at Joint Clinical Governance Group meetings.

However, on their own, formal governance structures are not sufficient to deliver a genuinely integrated service model. Evidence suggests that strong informal working relationships between ED and UCC managers and clinicians are a necessary pre-condition for effective joint working. This is especially true where UCC and ED services are operated by different provider organisations.

Feedback from providers indicates that most barriers to inter-organisational working are not structural, and could be resolved more effectively via the fostering of strong, day-to-day relationships between provider organisations. In many instances, potential issues can be pro-actively identified and addressed without the need to resort to formal escalation.

**Patient Involvement**

The UCC provider will make arrangements to carry out regular patient experience surveys in relation to the service and will co-operate with such surveys, including surveys of the ED that may be carried out by the Commissioner or hospital Trust. In discharging its obligations under this clause the provider shall have regard to any Department of Health guidance relating to patient experience.

The UCC provider will be expected to demonstrate evidence of having used patients' experience of using the service to make improvements to service delivery. CCGs and UCC providers should consider collaborating to develop a standard Patient Experience questionnaire to allow service comparability across NW London.

**Accountability**

The UCC provider will be accountable to the appropriate local Clinical Commissioning Group as commissioners of the service.

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\(^6\) Primary Care and Emergency Department Primary Care Foundation 2010
The UCC provider will be responsible for performance, clinical and financial management of the service.

**Incident Reporting**

All incidents (both clinical and non-clinical) must be reported. The service will ensure that there are appropriate reporting mechanisms for all incidents and that these reports feed into the relevant monitoring and reporting systems already set up by the Commissioner and DOH. There will also be effective procedures for the management of all Serious Untoward Incidents. These will align with existing ED protocols and NHS London requirements for reporting and investigating SUI's.

**Complaints**

The Lead Clinician of the UCC should deal with all complaints in line with the provider’s complaints policy. The complaints should be given to the most relevant lead to respond to depending on the issue (nursing, medical or admin staff). All complaints should be logged, and escalated to the Joint Clinical Governance group where appropriate.

The volume and content of complaints should be regularly analysed and used to inform internal continuous improvement processes.

**Safeguarding of Children**

The UCC must provide at least the same level of service as currently provided by an ED to ensure appropriate safeguarding of children and must adhere strictly to current national safeguarding policy.

UCC IT system must be able to identify safeguarding ‘Red Flags’ present on Trust and GP systems.

**Protection of Vulnerable Adults**

The UCC must provide at least the same level of service as currently provided by an ED to ensure appropriate protection of vulnerable adults and must adhere strictly to current national policy on the protection of vulnerable adults.

UCC IT system must be able to identify safeguarding ‘Red Flags’ present on Trust and GP systems.

**7.15 UCC operating model (non co-located)**

Implementation of the Shaping a Healthier Future proposals would result in some UCCs operating from ‘Local’, ‘Specialist’ and ‘Elective’ hospital sites. The fact that these UCCs will not be physically co-located with EDs has a number of implications for the shape of the services they will be able to offer, not least with regard to patient transfer, access to specialist opinion and calculations of clinical risk.

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7 Working Together to Safeguard Children (2010), Department of Children, Schools and Families.
8 Clinical Governance and Adult Safeguarding (2010), DH; No Secrets (2000), DH.
The E&UC CIG has considered the implications of commissioning non co-located UCCs carefully, and has developed a set of recommendations articulating how non co-located UCCs should differ from those that share a site with an ED.

Figure 7.42 summarises the key differences between co-located and non co-located UCCs.

### Figure 7.42: Key differences between co-located and non co-located UCCs

<table>
<thead>
<tr>
<th>Key differences</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| **Access to diagnostics and investigations** | - If X-ray is not available on-site 24/7, patient care should be transferred to an alternative site (usually the partner ED) within 90 minutes.  

  - All UCCs should have 24/7 access to X-ray. For some non co-located UCCs, X-ray may not be available on-site during periods of low activity.  

  - Non co-located UCCs must be able to process diagnostic tests on-site.  

  - 24/7 ‘hot’ phlebotomy labs are unlikely to be available at Local Hospital sites. |
| **UCC to ED transfer**               | - Serious ‘999’ emergency cases should be transferred to an appropriate ED by the London Ambulance Service.  

  - The UCC will be expected to provide safe transport for non-emergency patients requiring transfer to ED.  

  - Some non-emergency patients requiring transfer to ED may not be able to make their way to an alternative service safely (e.g. some elderly patients, patients with a broken jaw)  

  - UCC will be expected to confer with the patient in order to come to a decision on whether safe transport is required  

  - The receiving ED should be informed that the patient will be attending  

  - The patient should be provided with a case-number to ensure that they do not have to repeat registration and assessment on arrival at the ED.  

  - Patients needing further treatment at an ED but who require neither ‘999’ or ‘safe’ transport should be provided with advice and information on where to access follow-on care, and discharged from the UCC.  

  - The vast majority of patients requiring follow-on care at an ED will have low acuity complaints  

  - The receiving ED should be informed that the patient will be attending  

  - The patient should be provided with a case-number to ensure that they do not have to repeat registration and assessment on arrival at the ED. |

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9 This is the current London Quality Standards – Emergency and Maternity care, however this may be modified due to demand and cost. Suitable facilities must be available at another site with transfer protocols in place.
The following sections set out E&UC CIG recommendations for non co-located UCCs in detail. All of the recommendations for co-located UCCs set out in section 8 apply equally to non co-located UCCs, unless explicitly stipulated below.

7.15.1 Clinical scope

In the opinion of the E&UC CIG, expanding the scope of non co-located UCCs to cater for a broader case-mix than their co-located UCC counterparts has a number of drawbacks:

- Risk of duplicating existing ED services
- Increased clinical risk in the absence of on-site ED support
- Confusion for service users attempting to navigate the system
- Requirement to build capacity and capability that would be rarely used, increasing costs.

However, the absence of on-site ED support will mean non co-located UCCs will require some capabilities that may not be needed at co-located UCCs, even if the case-mix remains the same. For example, staff will need additional training in order to deal with emergencies and unusual cases.

As with co-located UCCs, non co-located UCCs will have 24/7 access to a Psychiatric Liaison Team. 24/7 access to psychiatric liaison will be provided by the Psychiatric Liaison Team present at an appropriate partner ED. When deciding which Psychiatric Liaison Team will provide cover, consideration should be given to the team’s base location and the Mental Health Trust provider involved.

7.15.2 Initial assessment

As patients requiring ED services will require transport off site, early identification of seriously ill patients is crucial. The E&UC CIG believes that clinicians at non co-located
UCCs will need to maintain high standards of initial assessment and manage waiting times especially pro-actively.

**Recommendations**

1. Initial assessment should be conducted by a suitably competent clinician to ensure that serious cases are identified and transferred to ED early.

### 7.15.3 Access to diagnostics and investigations

In the opinion of the E&UC, non co-located UCCs should provide the same range of diagnostic tests as their co-located counterparts. With the partial exception of X-ray, target times for diagnostic tests and standards covering the ability of UCC staff to interpret results will continue to apply.

The E&UC recommends that non co-located UCCs should have 24/7 access to X-ray equipment and the radiographers needed to operate it. The UCC is required to develop a process through which X-rays can be subject to a medical interpretation, as part of the episode of care.

Where X-ray is not available on-site (for example, during periods of low activity), patients should be transferred to an alternate site within 90 minutes if necessary.

Whereas co-located UCCs will be able to make use of pathology facilities available on ‘Major Acute’ hospital sites, 24/7 ‘hot’ phlebotomy labs are unlikely to be available at ‘Local’ hospitals. Non co-located UCCs must therefore be able to run, process and interpret diagnostic tests ‘in house’.

**Recommendations**

1. Co-located and non co-located UCCs should provide the same range of diagnostics and investigations to the same set of standards.
2. UCCs should have 24/7 access to X-ray. Where this is not available on-site, patient care should be transferred to an alternate site within 90 minutes if necessary.
3. UCCs must make provision for running, processing and interpreting diagnostic tests without support from the type of pathology facilities usually available at ‘Major Acute’ hospital sites.

### 7.15.4 Patient transfer to ED/ specialist acute units (e.g. cardiac)

**Non-emergency transfers**

A proportion of non co-located UCC patients will need to continue their care pathway at an ED (or other specialist acute unit). The vast majority of this cohort will be stable patients\(^\text{10}\), for example:

- Patients who require testing or care that is out of scope for the UCC (e.g. urgent CT scans, arterial blood gas)
- Instances where the UCC clinician is unable to decide on an appropriate diagnosis or treatment.

In the opinion of the E&UC CIG, the majority of these patients will not require ‘blue light’ ambulance transfer. In many instances, these patients will possess their own means of transport. The E&UC CIG therefore recommends that stable, non-emergency patients

\(^{10}\) ‘Building the evidence base in pre-hospital urgent and emergency care. A review of the research evidence and priorities for future research’ – Janette Turner; University of Sheffield, 2011
should be provided with appropriate advice and information on where to access follow-on ED care, and discharged from the UCC. The receiving ED should be informed that the patient will be attending and the patient should be provided with a case-number to ensure that they do not have to repeat registration and assessment on arrival at the ED.

The E&UC CIG recognises that some stable, non-emergency patients will be unable to make their way to an alternative service safely (for example, some paediatric patients). In this instance, the UCC will be expected to confer with the patient in order to come to a decision on whether safe transport is required. Where safe transfer is needed, the UCC provider will be responsible for arranging the transport of the patient.

In line with Department of Health guidance\(^\text{11}\) a non co-located UCC patient requiring transfer to an ED will be regarded as eligible for safe transport if they comply with any of the following minimum criteria:

- Where the medical condition of the patient is such that they require the skills or support of Patient Transport Service (PTS) staff on/after the journey and/or where it would be detrimental to the patient's condition or recovery if they were to travel by other means
- Where the patient's medical condition impacts on their mobility to such an extent that they would be unable to access healthcare and/or it would be detrimental to the patient’s condition or recovery to travel by other means
- Recognised as a parent or guardian where children are being conveyed
- PTS will also be provided to a patient’s escort or carer where their particular skills and/or support are needed e.g. this might be appropriate for those accompanying a person with a physical or mental incapacity, vulnerable adults or to act as a translator.

Please note that the *Shaping a healthier future* Travel Advisory Group is currently reviewing the whole issue of patient transfer, with the aim of increasing patient convenience. The outcome of this work may result in a revision of these recommendations.

**Emergency (‘999’) transfers**

A small number of patients will require urgent, ‘blue light’ transfer to an ED or specialist acute unit (e.g. suspected cardiac). Where this occurs, the E&UC CIG recommends that transport is provided by the London Ambulance Service (LAS). To ensure patient safety, the E&UC CIG recommends that any Service Level Agreement with the LAS should include the following requirements:

- LAS response time should be the same as when responding to a ‘999’ emergency in an out of hospital setting (i.e. a maximum of 8 minutes). The necessity for this response standard will be kept under review
- LAS ambulances should be appropriately crewed, such that UCC staff will not be required to accompany the patient during transfer
- Responsibility for deciding where a patient should be transported to should lie with the LAS. This decision should be made according to their knowledge of the diagnosis and in line with their internal protocols\(^\text{12}\)
- In line with CEM guidance, the LAS should not consider the UCC to be a ‘place of safety’ for prioritisation purposes\(^\text{13}\).

\(^{11}\) ‘Eligibility criteria for Patient Transport Services (PTS)’; Department of Health; September 2007

\(^{12}\) ‘Building the evidence base in pre-hospital urgent and emergency care. A review of the research evidence and priorities for future research’ – Janette Turner; University of Sheffield, 2011

\(^{13}\) ‘Unscheduled Care Facilities - Minimum requirements for units which see the less seriously ill or injured’ – College of Emergency Medicine, July 2009
Recommendations: non-emergency transfers

1. Stable, non-emergency patients should be provided with appropriate advice and information on where to access follow-on ED care, and discharged from the UCC.
2. The receiving ED should be informed that the patient will be attending and the patient should be provided with a case-number to ensure that they do not have to repeat registration and assessment on arrival at the ED.
3. Some stable, non-emergency patients will be unable to make their way to an alternative service safely (for example, some paediatric patients). In this instance, the UCC will be expected to make a clinical decision on whether these patients require safe transfer.
4. Where safe transfer is needed, the UCC provider will be responsible for arranging the transport of the patient.

Recommendations: emergency (‘999’) transfers

5. Only serious, ‘999’ emergency cases are transported by the London Ambulance Service (LAS). For example, suspected cardiac.
6. In line with College of Emergency Medicine guidance, the LAS should not consider the UCC to be a ‘place of safety’ for prioritisation purposes.
7. LAS response time should be the same as when responding to a ‘999’ emergency in an out of hospital setting (i.e. a maximum of 8 minutes for the majority of cases). The necessity for this response standard will be kept under review.
8. LAS ambulances should be appropriately crewed, such that UCC staff will not be required to accompany the patient during transfer.
9. Responsibility for deciding where an ‘999’ emergency patient should be transported to should lie with the LAS. This decision should be made according to their knowledge of the diagnosis and in line with their internal protocols.
Figure 7.43: Generic UCC to ED transfer protocols

**Process map 1: Assessing UCC patient suitability for ED transfer**

- Patient presents at UCC
- Patient assessed by Streamer
- Meets UCC criteria?
- Initial assessment by GP/ENP
- Meets UCC criteria?
- Patient treated in UCC
- Needs ED transfer during treatment?
- Discharge / referral (end)
- ED transfer protocol (co-located)
- ED transfer protocol (non co-located)
- Refer to other service (end)

- Requires transfer to ED?
- Yes
- No

• Streamed within **20 minutes** (adults)
• Streamed within **15 minutes** (paeds)

- Decision taken within **60 minutes** of time of registration

- Eg. GP, community services, pharmacy
Process map 2: UCC to ED transfer protocol (co-located)

• 4 hour target applies from time of UCC registration to completion of treatment in ED

Patient identified for ED transfer

Call ED resus team → Commence resus → Continue resus until team arrives → Follow resus team instructions → END

Cardio-pulmonary arrest?

Yes → Commence resus → Continue resus until team arrives → Follow resus team instructions → END

No → Tel. ED triage nurse and alert to transfer → Limited/holding treatment as indicated → Escort to ED waiting room → Wait with patient if clinically appropriate → Communicate all relevant info to ED → Patient in care of ED (end)
Process map 3: UCC to ED transfer protocol (non co-located)

- **4 hour target** applies from time of UCC registration to completion of treatment in ED

- Map 1
  - Patient identified for ED transfer
  - Clinical assessment of urgency (LAS matrix)
  - Requires LAS transfer?
    - Yes: Dial 999 and request ambulance
      - Provide holding treatment as indicated
      - Hand patient over to LAS and brief crew
      - LAS transfer to ED
      - Patient in care of ED (end)
      - LAS responsible for deciding destination
    - No: Discussion with patient regarding mode of transfer to ED
      - ‘Safe transport’
        - Select appropriate transfer mode
        - Patient provided with appropriate advice and information regarding where to access follow-on ED care
        - ‘Safe transport’
          - Arrange transport as per local protocol
            - Alert ED of incoming transfer
              - Wait with patient if clinically appropriate
                - Transport to ED
                  - Patient in care of ED (end)
        - Self transfer
          - Patient discharged from UCC – 4 hour target does not apply. Local UCC commissioners to agree target transfer times with providers
        - See 7.15.4 for eligibility criteria
  - 4 hour target applies from time of UCC registration to completion of treatment in ED
  - 4 hour target applies from time of UCC registration to completion of treatment in ED

- No: Discussion with patient regarding mode of transfer to ED
  - ‘Safe transport’
    - Select appropriate transfer mode
      - Patient provided with appropriate advice and information regarding where to access follow-on ED care
      - ‘Safe transport’
        - Arrange transport as per local protocol
          - Alert ED of incoming transfer
            - Wait with patient if clinically appropriate
              - Transport to ED
                - Patient in care of ED (end)
      - Self transfer
        - Patient discharged from UCC – 4 hour target does not apply. Local UCC commissioners to agree target transfer times with providers
        - See 7.15.4 for eligibility criteria
  - Max. 8 minute response time in most cases

Patient advised to attend ED and provided with guidance
Discharge from UCC
Patient discharged (end)
### 7.15.5 Governance

In the opinion of the E&UC CIG, the same standards of governance should be applied to all UCCs in NWL, irrespective of whether they are co-located with an ED. This will result in the need for non co-located UCCs to partner with an appropriate ED for the purpose of overseeing joint governance arrangements (e.g. a Joint Clinical Governance Group). When selecting an ED partner, existing relationships and patient flows should be considered. Partnership arrangements should be agreed with local commissioners.

Feedback from clinicians and managers across UCCs and EDs highlighted the importance of strong informal relationships as the foundation for effective joint working. Because they do not share a site with an ED, developing and maintaining these relationships will be more challenging for non co-located UCCs. With this in mind, the E&UC CIG emphasises the importance of achieving absolute clarity around organisational interfaces.

#### Recommendations

| 1. | Consistent approach to governance across co-located and non co-located UCCs. |
| 2. | Required to establish a formal partnership arrangement with a named ED. This partnership should include oversight of joint governance arrangements (e.g. a Joint Clinical Governance Group), patient transfer protocols, staff rotation and training. |
| 3. | Clarity around organisational interfaces, handovers and expected response times. |
| 4. | Clear emergency care pathways for sourcing specialist advice when needed. |
| 5. | Develop a robust governance framework for remote working, covering where clinical responsibility for the patient lies in circumstances where remote specialist input is provided. |
| 6. | Establish strong formal and informal relationships between UCC and ED clinicians and managers. This could be achieved by removing barriers to effective communication. For example, developing contractual arrangements to ensure that ED clinicians do not feel that they are being asked to provide ‘free’ advice across organisational boundaries. Requirement to provide specialist input would need to be specified in ‘job plans’. |

### 7.16 UCC integration with primary care

The UCC is required to develop the distinctive culture and approach of a primary care service. With this in mind, a key element of the UCC operating model is effective integration with local primary care services in general, and General Practice in particular. The minimum standards set out above articulate how integration could be achieved. For clarity, this section summarises the steps UCC providers must take to integrate with primary care under two headings:

- Minimum standards for integration with primary care
- Recommendations for local determination.

#### 7.16.1 Minimum standards for integration with primary care

- The UCC ICT processes should be inter-operable with both GP and Trust systems in order to facilitate effective information sharing
- The UCC will develop the distinctive culture and approach of a primary care service working with hospital and secondary care clinicians, with experienced and appropriately skilled primary care clinicians leading the service
- The UCC will ensure full integration with 111 service, both for patients ‘referred in’ to the UCC, and when referring patients into community services and General Practice. This will include access to the 111 Directory of Service
- Patients attending who do not have urgent care needs will be supported by the staff in the centre to access advice and care from their local community pharmacist, or to
make an appointment with their own GP practice. Where appropriate, this will be achieved using the ‘111’ service

- Patients attending the UCC who are not registered with a GP will be treated by the UCC according to the same criteria as a registered patient. In addition, they will be supported by the staff in the centre to register with a local practice of their choice
- Patients may be referred to community based services, including general dental services, pharmacy services, community nursing, and social and voluntary services. UCC reception staff will have up-to-date details of all community and primary care based services and will be able to provide patients with contact numbers/service details and opening times in order that they are redirected to core primary care service provision
- The Provider will issue discharge summaries to GP practices within 24 hours, providing relevant clinical and treatment information, medication and any necessary follow-up care.

7.16.2 Recommendations for local determination

- Consider entering arrangements with local GP Networks to ‘ringfence’ small numbers of appointment slots for patients positively re-directed from the UCC (specifically those presenting with non-urgent indications who feel they are unable to secure an appointment with their own GP).
- Explore options around integrating UCC with local GP Out of Hours service.
- General Practice representation on Joint Clinical Governance Group – CCGs are already represented as commissioners, however, there may be value in additional GP representation as clinicians.
- Consider incorporating rotations through local primary care services into the ongoing training of UCC GPs and ENPs.
- Hold regular audits of UCC patient attendance to identify patterns (for example frequent attenders). Communicate results to relevant GP practices and Networks in support of their continuous improvement processes.

7.17 UCC workforce standards

Drawing on recommendations made by Healthcare for London14, College of Emergency Medicine15 and London Health Programmes, the E&UC CIG has proposed a set of minimum competences for urgent care centre staff and minimum levels of cover. Chapter 14 details the workforce implications and discusses the training and recruitment approach for UCCs.

7.18 Equalities

In addition to the work conducted by the CIG. Additional analysis of the proposals has been undertaken by the programme to understand the impact on the groups defined as protected by legislation. The resulting impact assessment identified four key sub-groups that could potentially be adversely affected by the proposed changes to emergency and urgent care services:

- Children

14 'A service model for urgent care centres – commissioning advice for PCTs’ – Healthcare for London; January 2010
- Pregnant women
- Black and Minority Ethnic Groups (BME)
- Disabled people.

### 7.18.1 Access impacts

Figure 7.44 summarises the key stakeholder concerns and the plans currently in place to address these. Please see the full report for additional detail\(^\text{16}\).

**Figure 7.44: Key stakeholder concerns and current plans to address these points**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Summary of concern raised</th>
<th>Plans currently addressing points raised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Travel and access</td>
<td>Impact of potential increases in distances travelled</td>
<td>- Ensure a geographic spread of sites.</td>
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<tr>
<td></td>
<td></td>
<td>- Produce local hospital and travel analysis fact sheet.</td>
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<td></td>
<td></td>
<td>- Develop a patient transfer process between UCC and Accident &amp; Emergency (A&amp;E).</td>
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<td></td>
<td></td>
<td>- Work with local authorities to explore patient transfer process.</td>
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<td></td>
<td></td>
<td>- Continue work with Transport for London (TfL) on bus routes and stops.</td>
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<td></td>
<td></td>
<td>- Capacity and workforce planning with ambulance services.</td>
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<td></td>
<td></td>
<td>- Further model transport and travel times to address issues.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Assessment concludes that there does not appear to be any fundamental or systematic differences in the travel impact on any protected characteristic, as defined in the Equality Act 2010, relative to the general population.</td>
</tr>
<tr>
<td>Cost</td>
<td>Increased costs incurred</td>
<td>- Commission additional analysis on economically deprived communities.</td>
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<td></td>
<td></td>
<td>- Explore the eligibility criteria for travel concessions and whether this can be standardised across the cluster.</td>
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<tr>
<td>Service quality</td>
<td>Increased demand, reduced choice and demands on staff</td>
<td>- ‘Double run’ some services before implementation.</td>
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<td></td>
<td>UCC or out of hospital (OOH) providers capability</td>
<td>- Support Clinical Commissioning Groups (CCGs) through the work in developing their relationship with social care.</td>
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<td></td>
<td></td>
<td>- Work with local authorities to integrate care models, care needs, and community budgets</td>
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<td>- Ensure UCCs have partner A&amp;Es to aid patient transition.</td>
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<tr>
<td>Language &amp; cultural issues</td>
<td>Language and cultural barriers to services</td>
<td>- Implement a standard UCC specification.</td>
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<td></td>
<td>- Develop Key Performance Indicators (KPIs) for implementation and a framework that tests the safety of changes.</td>
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<td></td>
<td></td>
<td>- Develop a framework based on existing CCG governance that certifies safety at the point of service change.</td>
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</tbody>
</table>

It is recommended that Emergency and Urgent Care implementation group continues to work with providers and commissioners of services to ensure that access to and quality of services is rigorously maintained during the implementation period.

\(^{16}\) Focused sub-group analysis: supporting the equality duty across NHS North West London; December 2012
7.19 ED workforce

A programme-wide work-stream has been established to analyse the implications of reconfiguration for workforce. Workforce is described in Chapter 14 and Appendix P.

It is clear that detailed workforce analysis is required as part of the implementation programme and this will be informed by results from the programme-wide work stream.
7c. Work of the Paediatric Clinical Implementation Group

This section of the chapter has been developed following public consultation, by the members and Chair of the Paediatric Clinical Implementation Group (CIG). It is intended to address the clinical model and standards covering hospital and paediatric emergency services in NW London.

Some of the work regarding the disposition of Neonatal Units has been undertaken jointly with the Maternity Clinical implementation Group (CIG).

7.20 The recommendations of the Paediatric CIG

1. There should be six maternity units. These would be co-located with the proposed Major Acute Hospitals, with an additional Maternity Unit at Queen Charlotte's and Chelsea Hospital (QCCH)
2. There would be five paediatric units (all incorporating emergency care, inpatients and short stay /ambulatory facilities and co-located neonatal unit), all co-located with the proposed Major Hospitals
3. There would be an additional "stand alone" NeoNatal Unit (NNU) supporting Queen Charlotte's Maternity Unit
4. Amongst the six NNUs there would be two Neonatal Intensive Care Units (NICU) (Level 3 units) C&W and QCCH. The final disposition of the other four units will be decided during implementation, recognising that current and future workforce issues may be a constraint
5. Existing specialist paediatric services (e.g. paediatric surgery, burns/plastics, infectious diseases and intensive care), including inpatient care would not specifically be affected by the reconfiguration
6. Reconfiguration would help towards improving implementation of the paediatric medical consultant and paediatric nursing standards in the LHP standards (extended consultant working and minimum nursing requirements in the paediatric area of the Emergency Department (ED))
7. Reconfiguration would help towards improving the paediatric competencies of surgical and anaesthetic staff (see case for change for Paediatric Emergency Services from LHP)
8. There will be work with existing providers, commissioners and networks e.g. to ensure there is adequate safe and high quality provision of the management of High Dependency children outside of the PICU setting, children with acute mental health problems needing assessments, and those children requiring a detailed safeguarding examination and assessment
9. A NW London Paediatric Network will be established, with its own governance structure and resourcing, to oversee the implementation of the reconfiguration
10. The NW London Paediatric Network will work with providers and commissioners of services during implementation to ensure that access to and quality of services is rigorously maintained during the implementation period
11. During implementation, particular emphasis will need to be given to patient groups who are most affected by the changes in terms of access, Where this involves access to a Major Acute Hospital, as well as ensuring these patients are adequately signposted to the nearest Acute Hospital, close work will be needed with the Out of Hospital strategy to ensure better access to local urgent care facilities
12. For training and education issues we will take a joint approach, across sites and disciplines to discussions with the new Local Education and Training Board (LETB).
The purpose of this section is to set out the background to and recommendations of the Paediatric Clinical Implementation Group (CIG). The paper provides details of the standards reviewed, responses to consultation and other matters that have been considered. The CIG was specifically formed to consider service models, clinical standards and issues arising during consultation. The recommendations will be submitted to the Clinical Board for their consideration and subsequently will form part of the Decision Making Business Case (DMBC). These recommendations are made after careful consideration of clinical standards, organisational and individual responses to consultation and the particular requirements of the population of NW London.

7.21 Scope of the CIG’s work

The CIG’s work has been limited to the consideration of hospital based and emergency paediatric and neonatal services.

Please note that for the purpose of this report there are three types of service provision discussed:

- Paediatric emergency care
- Short stay paediatric facilities (sometimes called Observation Units)
- Paediatric inpatient units.

Paediatric Assessment Units (PAU) can be co-located with any of these three types of units. It is also important to note that specialist paediatrics exists in NW London and was excluded from the CIG/ToR, but these services are currently the subject of a London Children’s Specialist Services Review and that any recommendations from this review may need to be considered during implementation.

The two hospitals providing these specialist services are: St Mary’s - which has a Paediatric Intensive Care Unit as well as infectious diseases and haematology, and Chelsea and Westminster, which has specialist surgery, High dependency Unit (HDU) as well as Burns and Plastics. All these services have an inpatient facility.

The Shaping a healthier future programme will not affect these specialist units.

7.22 Pre-consultation paediatric clinical standards for hospital care

To drive the improvements in clinical quality for all emergency care (Medicine, Surgery, A&E, Maternity and Paediatrics) and reduce the variation that has been documented in the Case for Change, local clinicians have developed a set of clinical standards, based on latest evidence from Royal Colleges, reviews by the NHS in London, NICE guidelines etc.

The clinical board reviewed a wide body of evidence in determining what clinical standards should apply in NW London. The core documents were:

- London Health Programme Review - Adult Emergency Services: Acute medicine and emergency general surgery (2011)
- London Health Programme Review - Paediatric Emergency Services
- NCEPOD (2007) Emergency admissions: A journey in the right direction?
- RCP (2007) The right person in the right setting - first time
- RCS (2011) Emergency Surgery Standards for unscheduled care
- AoMRC (2008) Managing urgent mental health needs in the acute trust
- NCEPOD (1997) Who operates when?
- ASGBI (2010)
- The Royal College of Anaesthetists: Guidelines for the Provision of Anaesthetic Services (Chapter 9, section 1.2)
- Safer Childbirth - Minimum Standards for the Organisation and Delivery of Care in Labour (2007), RCOG
- Facing the Future: Standards for Paediatric Services, Royal College of Paediatrics and Child Health, April 2011.

The clinical standards for Paediatric services in NW London (to ensure seven day per week access to high quality paediatric emergency care across the whole of NW London) were agreed pre-consultation. Implementing these standards will require closer integration of paediatric emergency, urgent, short stay and ambulatory care as well as major changes in working patterns for the medical and nursing workforce. The case for change for paediatrics is therefore largely driven by the medical and nursing workforce. Across NW London there are some paediatric units which already run with 20% Registrar / middle grade vacancies, and in some units, periods of time where there is a lack of Paediatric trained nurses working in the Paediatric area of the Emergency Department (ref LHP survey in their Case for change). For high quality care, we need to staff units properly. This could be done by concentrating emergency paediatric care into a smaller number of units.

Similar staffing issues exist with neonatal care. To ensure that recent improvements in neonatal care are maintained, we must ensure that we have the appropriate workforce in place. The medical vacancies for Paediatrics apply equally to neonatology and we also do not have enough nurses to care for sick babies: NW London has the highest vacancy rate in London – 22% in 2011 compared to a London average of 14%.

The DH Toolkit for High Quality Neonatal Services, NICE Standards for Neonatal Care and the British Association of Perinatal Medicine (BAPM) standards are that 70% of the registered nursing workforce should be Qualified in Specialty (QIS). In NW London this figure is 62%. NW London has the highest use of bank and agency staff in London - 30% in 2011 compared to a London average of 22%.

7.23 Key messages from consultation

A public Consultation on three options was undertaken during the summer and autumn of 2012. Respondents were asked to indicate the extent to which they supported or opposed the recommendation that all major hospitals should have inpatient paediatric units.

Of the 4,572 respondents answering this question, just over half support the proposal (54%), and most of these ‘strongly support’ it (33% of all respondents answering the question, compared with 21% who ‘tend to support’ it). Three in ten respondents oppose the recommendation (28%), giving a net support score of +27 percentage points.
Levels of support vary across key demographic groups, with those aged 16-24 more likely to support the recommendation (65%) than overall (54%). This is also the case for respondents aged 25-34 (65%) and 35-44 (59%). Support is higher among white ethnic groups than BME (62% compared with 43%). Respondents with a disability are more likely to oppose the proposal than those without a disability (40% compared to 23%). More of those respondents currently or formerly working for the NHS or the independent health sector support the proposal (68% and 69% respectively) than those who have never worked in the health sector (50%).

Opposition to this proposal is significantly higher among residents of Ealing (45%). Levels of support are highest in Richmond (91%), Kensington & Chelsea (85%), Hounslow (82%) and Hammersmith & Fulham (71%).

Respondents more likely to attend Chelsea & Westminster and West Middlesex Hospitals for urgent care are most likely to support the proposal (87% of respondents for both compared to 54% overall). Meanwhile, opposition is significantly greater among those who would attend Ealing Hospital for urgent care (55% compared with 28%).

7.23.1 Paediatric and maternity units in major hospitals

Very few stakeholders commented on the specific proposal that all major hospitals should have inpatient paediatric units. Those that did, including the Royal College of Paediatrics & Child Health, supported it.

The proposal for all major hospitals to have consultant-led maternity units, together with a maternity unit at Queen Charlotte’s and Chelsea Hospital if Hammersmith Hospital is not a major hospital, was also supported by most of the relatively small numbers of stakeholders commenting on it.
The Royal College of Midwives supported the proposals but criticised the absence of any freestanding midwife-led units in the proposals or discussions on how to facilitate home births:

*The loss of consultant obstetric services at Ealing could have a negative impact on tackling health inequalities in the borough; this could be mitigated – at least for women at low medical risk - if the obstetric service were replaced by a FMU…. we are extremely disappointed that Shaping a Healthier Future does not include any proposals for the establishment of freestanding midwife-led units (FMUs).*

This proposal also attracted some concerns and criticisms. Ealing Hospital Medical Staff Committee questioned where the ‘extra births’ were going to go to and how maternity services are going to cope. Ealing Council raised “the clear risk of loss of valued and high quality maternity services should SaHF proposals be taken forward.”

Hillingdon LINk argued that the targets to increase the number of home births are highly ambitious and questioned whether “large maternity units” meet the needs of expectant mothers.

**7.23.2 Specific feedback considered by the CIG**

During Consultation a number of specific organisational responses were received. These were individually considered by the CIG. Details of these and other responses are below. For most of these specific issues, adoption of the London Health Programme standards for Paediatric Emergency Services will ameliorate the concerns expressed.
<table>
<thead>
<tr>
<th>Sub-Theme</th>
<th>Organisation raised</th>
<th>Support</th>
<th>Concerns/Comments</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case for Change</td>
<td>Royal College of Paediatrics and Child Health</td>
<td>Strongly support the Case for Change set out in the consultation document. We agree that in NWL, as in a number of other areas of the country, services are spread too thinly to ensure safe, sustainable, high quality care. Our own modelling, in common with that of the project team, demonstrates that only by reducing the number of inpatient units will we be able to improve outcomes for the sickest patients</td>
<td></td>
<td>The London Health Programmes (LHP) standards which include the RCPCH standards, have been adopted by the Paediatric CIG. There is an opportunity within the reconfiguration to re-deploy staff as a result of the change from 6 to 5 paediatric units.</td>
</tr>
<tr>
<td>Case for Change</td>
<td>K&amp;C HOSC</td>
<td>Broadly support the principle to centralise specialist care where this will lead to improved clinical outcomes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staffing and competencies (Maternity/ Paediatrics)</td>
<td>Ealing HOSC</td>
<td>Panel would like to place on record its concern at PCBC stating that staffing at maternity and paediatric units would still be challenging after reconfiguration, and query what future maternity services might look like if appropriate staffing levels are not met.</td>
<td></td>
<td>Proposals made as a result of reconfiguration will ensure staffing issues are addressed as well as LHP standards.</td>
</tr>
<tr>
<td>Standards</td>
<td>Royal College of Paediatrics and Child Health</td>
<td>Full agreement with the standards set for both in hospital and out of hospital care. The hospital-based standards are in line with the recommendations previously laid out by RCPCH in our standard-setting document Facing the Future. We strongly support the principle of care provision using integrated care pathways within the</td>
<td></td>
<td>The London Health Programmes (LHP) standards which include the RCPCH standards, have been adopted by the Paediatric CIG. We will establish networks e.g. for management of HDU children outside of the PICU setting.</td>
</tr>
<tr>
<td>Sub-Theme</td>
<td>Organisation raised</td>
<td>Support</td>
<td>Concerns/Comments</td>
<td>Actions</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>clinical network model, and that outcome measures must drive service improvement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standards</td>
<td>K&amp;C HOSC</td>
<td>Broadly support the principle to centralise specialist care where this will lead to improved clinical outcomes.</td>
<td>Would like more detail on future plans for paediatrics services, in particular in relation to the role of education.</td>
<td>The LHP standards being adopted help to address this issue. Other work considering best deployment and training needs of workforce is being undertaken. See LHP Standards Nos. 23 and 24.</td>
</tr>
<tr>
<td>Other partnerships</td>
<td>Richmond LINk</td>
<td>Need to consider BSBV (preferred option for Kingston Hospital to retain A&amp;E and maternity services) and SaHF together to ensure Richmond not negatively impacted e.g. distance between the two preferred sites for planned care could adversely affect no. of residents in Richmond.</td>
<td>BSBV is currently being reviewed. This is only an issue if Option C is adopted, in which case additional travel modelling will be undertaken.</td>
<td></td>
</tr>
</tbody>
</table>

### 7.23.3 National Clinical Advisory Team feedback

**Figure 7.47: New information the Paediatric CIG has considered (from NCAT)**

<table>
<thead>
<tr>
<th>NCAT recommendation</th>
<th>Original Programme response</th>
<th>Further Progress</th>
</tr>
</thead>
</table>
| Medium to long term proposals for maternity and neonatal services. | We have:  
- Established the Paediatric and Maternity Clinical Implementation Group to explore in more detail. |  
- Agreed acceptance of DH Toolkit (2009) and BAPM (2010) guidance as the principles for staffing neonatal services.  
- Benchmarked paediatric emergency activity which affects staffing available to "cross cover" general paediatrics and neonatology.  
- Are benchmarking neonatal activity (absolute numbers and breakdown by gestation) to inform medical staffing. |

References:
<table>
<thead>
<tr>
<th>NCAT recommendation</th>
<th>Original Programme response</th>
<th>Further Progress</th>
</tr>
</thead>
</table>
| Development of an overall strategic direction for maternity and paediatric services with a supporting workforce strategy to support the proposals. | We have:  
- Established the Paediatric and Maternity Clinical Implementation Group to explore in more detail  
- Having agreed workload intensity we will use the DH Toolkit and BAPM guidance to construct appropriate medical (middle grade and consultant) and nursing cover at all the five co-located paediatric/neonatal sites and QCCH neonatal services  
- We have accepted the LHP paediatric emergency care standards and the medical / nursing staffing implications of this  
- A comprehensive workforce strategy is to be put in place by the NWL Paediatrics and Perinatal (neonatal) Networks during implementation. |
| Workforce modelling to ensure support staffing of five paediatric units and six neonatal units and recruitment and retention of community staff and robust service plans for community services. | We have:  
- Established the Paediatric Clinical Implementation Group to explore in more detail  
- Further developed workforce models with the Paediatric Network and Maternity CIG. |  
- There is an opportunity within the reconfiguration to re-deploy staff as a result of the change from six to five paediatric units, as well as closure of the Hammersmith paediatric ambulatory unit.  
- A comprehensive workforce strategy is to be put in place by the NWL Paediatrics and Perinatal (neonatal) Networks during implementation. |
| Further engagement with public and patients regarding the maternity and paediatric reconfiguration proposals. | We have:  
- Undertaken further communication and engagement activities, including the large stakeholder event held on 15 May 2012.  
- Produced newsletters and dissemination of CCG strategies.  
- Participated in Council and Patient and Public Advisory Group meetings and Health and Wellbeing Boards. |  
- During the consultation we conducted a NWL focus group for mothers of children less than two years to ensure we understood relevant issues.  
- Now also engaging with pregnant women and new mothers as part of the post-consultation Equalities Impact Assessment work which is ongoing.  
- An engagement event for the public and other key stakeholders was held to discuss the consultation findings. The issue arising were subsequently included in the CIG’s consideration. |
7.24 Establishing the Paediatric clinical implementation group

The Paediatric Clinical Implementation Group (CIG) was set up in response to recommendations from the National Clinical Advisory Team; it succeeded other clinical groups that had been considering clinical standards and models early on in the programme. The CIG was specifically tasked with reviewing existing and newly emerging clinical standards, engaging with clinical stakeholders and responding to issues and responses from consultation. Additionally, patient group representatives were invited to be members of the Group.

The CIG met and spoke regularly, considered evidence, responses to consultation and has agreed this report.

The CIG has representatives from all hospitals in NW London as well as representatives of the patients.

As well as promoting best practice/evidence based high quality care standards, the purpose of the CIG was to:

- To ensure the reconfiguration programme develops robust implementation plans for the delivery of paediatric services.
- To ensure that implications for paediatric services are communicated and fully understood at local level and that clinical colleagues are kept informed.

It's responsibilities were:

- To ensure the robustness of proposals and modelling underpinning the paediatric services aspects of the programme.
- To ensure alignment between the plans for implementing changes to paediatric services and the agreed clinical standards.
- To lead the implementation of relevant recommendations made by the National Clinical Advisory Team (NCAT) and the Office of Government Commerce (OGC) review reports.
- To provide information to the Programme Board, and its groups, to support the implementation of changes to the configuration of services in NHS NW London.

7.25 Paediatric clinical standards agreed post-consultation

Through the expertise and experience of its members, the CIG considered existing guidelines, standards from professional bodies, Royal colleges and the London Health Programmes. The CIG also responded to a review and subsequent discussions with the Department of Health National Clinical Advisory Team (NCAT)

The CIG has adopted the new London Health Programme standards for Paediatric Emergency Services, which have in turn drawn on a wide range of other guidance and data from London hospitals.

Additionally the CIG have considered and adopted the Department of Health’s Toolkit for High-Quality Neonatal Service (2009), the British Association of Perinatal Medicine (BAPM) Service Standards for Hospitals Providing Neonatal Care (2010), NICE Quality standard for specialist neonatal care (2010) and the standards detailed in the document “Facing the Future: Standards for Paediatric Services (December 2011)”, and “Facing the Future: Review of Paediatric Services (April 2010) from the RCPCH (Royal College of Paediatrics and Child Health)”.
7.25.1 London Health Programmes clinical standards

The London Health Programme identifies the health needs of Londoners and redesign NHS services to improve the way healthcare is delivered in the capital. They work with London’s commissioners to transform frontline services and drive up standards in care quality. In consultation with patients, clinicians and GPs, we have developed new ways of delivering care that is expected to save thousands of lives, improve the health of our population and deliver efficient healthcare services. The Chair of the CIG and other CIG members have been closely involved in the design of new standards for Paediatric Emergency Standards.

These standards (published early 2013) form a core part of the recommendations of the Group. Whilst they ostensibly deal with emergency service standards they also touch upon the standards for Paediatric inpatients.

To implement all these standards will require working with existing providers, commissioners and networks. It is recommended that a Paediatric Network, similar to the NW London Maternity Network, is set up to take this forward through implementation. This co-working will need to be extended to ensure there is adequate safe and high quality provision of the management of High Dependency children outside of the PICU setting, children with acute mental health problems who require inpatient care, and ensuring that there are arrangements for all children requiring a detailed safeguarding examination and assessment.

7.25.2 Neonatal standards

The CIG has adopted the same definitions for type of care and neonatal unit used in the British Association of Perinatal Medicines (BAPM) 2010 and 2011 standards, these and the NHS Commissioning Board National Service Specification for Neonatal Critical Care Services will help inform the decision on the disposition of the Neonatal units in NW London.

Key references for further detail are:


The Toolkit for High Quality Neonatal Services describes networks as being comprised of three types of unit:

Special Care Units (SCU): These provide special care for their own local population. They also provide, by agreement with their neonatal network, some high dependency services.

Local Neonatal Units (LNU): These provide special care and high dependency care and a restricted volume of intensive care (as agreed locally) and would expect to transfer babies who require complex or longer-term intensive care to a Neonatal Intensive Care Unit.

Neonatal Intensive Care Unit (NICU): These are larger intensive care units that provide the whole range of medical (and sometimes surgical) neonatal care for their local population and additional care for babies and their families referred from the neonatal network in which they are based, and also from other networks when necessary to deal with peaks of demand or requests for specialist care not available elsewhere. Many will be sited within perinatal
centres that are able to offer similarly complex obstetric care. These units will also require close working arrangements with all of the relevant paediatric sub-specialties.

Access to a specialised transport service is also essential. The transport service should facilitate not only the transfer of babies needing urgent specialist support but also enable the timely return of babies to their “home” unit as soon as clinically possible.

7.26 Workforce

One of the key issues when considering the organisation of paediatric services is the availability of an appropriately skilled, experienced and trained workforce. Workforce is considered in Chapter 14 and Appendix P.

7.27 Equalities

In addition to the work by the CIG. Additional analysis of the proposals has been undertaken by the programme to understand the impact on the groups defined as protected by legislation.

The following groups were identified as requiring further engagement:

- Children under 16 year of age
- Children under 1 year of age.
- Children with long-term illnesses.

These groups were identified for increased engagement for the following reasons:

- High use of services. Demographic profiling shows increased rates of growth in these groups, and that boroughs have high use of services by children with long term illnesses.
- Dependency on hospital services under review. The group of children under one year old interfaces with other focus groups, such as BME mothers, who are considered to be reliant on A&E for the primary care needs of their children.

7.27.1 Access impacts

The ability to access A&E or inpatient services on a timely and convenient basis was a consistent theme throughout the stakeholder engagement. The inpatient service of focus for the children’s groups was inpatient paediatrics, and the question of access was mostly raised by those in proximity of the potential sites of reconfiguration.

Similar to all other groups with protected characteristics, the potential increase in travel time was raised by the children’s groups. The issue of accessibility and complexity of the journey was also raised and carers of children noted that the challenge of longer, or more complex routes undertaken by public transport, can be exacerbated when travelling with children.

7.28 Service provision capacity and capabilities

Regarding the future quality of services and outcomes, most stakeholders sought assurance that future investments would focus on addressing capacity and some capabilities, as well as identifying concerns relating to:
- Future capacity in centralised services. Stakeholders suggested that increased patient traffic at major hospital sites could limit disability parking or allowed parking times, increase waiting times, or stretch a service to a lower quality of provision.
- Over UCC’s paediatric capability. There was a local concern that the level of paediatric expertise at the UCCs could be reduced if inpatient paediatric services are moved from a (proposed) local hospital.

Whilst the proposals describe future investment, training and integration, those caring for children sought assurance that provider networks would remain strong with easy access

(For further information please see the Deloitte Equalities Report, Appendix G).

It is recommended that NW London Paediatric Network works with providers and commissioners of services during implementation to ensure that access to and quality of services is rigorously maintained during the implementation period.

7.29 Mental Health

It is recognised that there are range of issues with older children presenting with mental health issues. To ensure that this is dealt with the CIG has agreed the Implementation of LHP standard 21:

- Single call access for children and adolescent mental health (CAMHS) (or adult mental health services with paediatric competencies for children over 12 years old) referrals to be available 24 hours a day, seven days a week with a maximum response time of 30 minutes. Psychiatric assessment to take place within 12 hours of call.

For children with acute mental health disturbance (e.g. acute severe behavioural disturbance or psychosis) requiring inpatient care, currently these children are looked after on a general paediatric inpatient ward by staff that don’t have the resources (skills and nursing ratios) to look after these children. Further work will need to be done with mental health providers within NW London to set up clear protocols and pathways to ensure these children are looked after safely and transferred to an appropriate therapeutic facility as soon as possible. The proposed NW London Paediatric Network will take this work forward as part of implementation.

7.30 Implementation Issues to be addressed

The implementation of all of the recommendations must be made in a safe and step wise way, ensuring that services are properly maintained and improved:

1. A NW London Paediatric Network will be established, similar to the NW London Maternity Network, to oversee the implementation of the reconfiguration. Governance arrangements and resourcing for this network will need to be decided early on during implementation
2. Amongst the six NNUs there would be two Neonatal Intensive Care Units (NICU) (Level 3 units) C&W and QCCH. The final disposition of the other four units will be decided during implementation, recognising that current and future workforce issues may be a constraint. To support the designation of units, the Paediatric and Neonatal Networks will work with both Commissioners and Providers, understanding staffing
constraints but also to make sure the right referral and transfer protocols are in place to ensure that there are appropriate admissions to the units.

3. The NW London Paediatric Network will work closely with the NW London Perinatal Network to ensure appropriate delivery of neonatal services (which are specialist commissioned services).

4. Reconfiguration would help towards improving implementation of the paediatric medical consultant and paediatric nursing standards in the LHP standards (extended consultant working and minimum nursing requirements in the paediatric area of the Emergency Department (ED)). Reconfiguration would help towards improving the paediatric competencies of surgical and anaesthetic staff (see case for change for Paediatric Emergency Services from LHP). To enable this, the Paediatric Network will work closely with providers to enable optimal deployment of clinical staff across paediatric units.

5. The Case for Change has highlighted the shortage of middle grade medical staff and paediatric nurses. Furthermore implementation of the LHP standards for enhanced 7 days per week consultant paediatric medical cover will require additional staff. The reconfiguration will also allow the redistribution of paediatric middle grade and paediatric nursing staff, which means that the paediatric services envisaged can be provided in all five Major Acute Hospitals. We recognise that although the proposed reconfiguration substantially reduces the risks associated with staff shortages, that this may become a problem in the years ahead, depending upon national training numbers and distribution. The NWL Paediatric network will continue to monitor this and may need to alert all stakeholders and work with them to provide an alternative suitable model of care on one or more of the sites, for example a short stay paediatric unit.

6. The NW London Paediatric Network would work with existing providers, commissioners and networks e.g. to ensure there is adequate safe and high quality provision of the management of High Dependency children outside of the PICU setting, children with acute mental health problems and those children requiring a detailed safeguarding examination and assessment.

7. The NW London Paediatric Network would work with providers and commissioners of services during implementation to ensure that access to and quality of services is rigorously maintained during the implementation period.

8. During implementation, particular emphasis will need to be given to patient groups who are most affected by the changes in terms of access. Where this involves access to a Major Acute Hospital, as well as ensuring these patients are adequately signposted to the nearest Acute Hospital, close work will be needed with the Out of Hospital strategy to ensure better access to local urgent care facilities.

9. For training and education issues the NW London Paediatric Network (and the NW London Perinatal Network) would take a joint approach with other London networks, to discussion, with the new Local Education and Training Board (LETB) regarding the provision of appropriate and sufficient training courses and continuing professional development to ensure availability of properly trained and skilled staff.

7.31 The recommendations of the Paediatric CIG

The Paediatric CIG has made the following recommendations:

1. There should be six maternity units. These would be co-located with the proposed Major Acute Hospitals, with an additional Maternity Unit at Queen Charlotte’s Hospital.
2. There would be five paediatric units (all incorporating emergency care, inpatients and short stay/ambulatory facilities and co-located neonatal unit), all co-located with the proposed Major Hospitals.
3. There would be an additional "stand alone" NeoNatal Unit (NNU) supporting Queen Charlotte’s Maternity Unit
4. Amongst the six NNUs there would be two Neonatal Intensive Care Units (NICU) (Level 3 units) C&W and QCCH. The final disposition of the other four units will be decided during implementation, recognising that current and future workforce issues may be a constraint
5. Existing specialist paediatric services (e.g. paediatric surgery, burns/plastics, infectious diseases and intensive care), including inpatient care would not specifically be affected by the reconfiguration
6. Reconfiguration would help towards improving implementation of the paediatric medical consultant and paediatric nursing standards in the LHP standards (extended consultant working and minimum nursing requirements in the paediatric area of the Emergency Department (ED))
7. Reconfiguration would help towards improving the paediatric competencies of surgical and anaesthetic staff (see case for change for Paediatric Emergency Services from LHP)
8. We would work with existing providers, commissioners and networks e.g. to ensure there is adequate safe and high quality provision of the management of High Dependency children outside of the PICU setting, children with acute mental health problems needing assessments, and those children requiring a detailed safeguarding examination and assessment
9. We will establish a NW London Paediatric Network, with its own governance structure and resourcing, to oversee the implementation of the reconfiguration
10. The NW London Paediatric Network will work with providers and commissioners of services during implementation to ensure that access to and quality of services is rigorously maintained during the implementation period
11. For training and education issues we will take a joint approach, across sites and disciplines to discussions with the new Local Education and Training Board (LETB).

(Note: The definition of Level 1 to 3 units is as determined by the BAPM 2011 document).
7d. Work of the Maternity Clinical Implementation Group

The purpose of this section is to set out the work and recommendations of the Maternity Clinical Implementation Group.

This section has been developed following public consultation, by the members and Joint Chairs of the Maternity Clinical Implementation Group (CIG) as part of the supporting evidence for the Decision Making Business Case. Some of the work around the disposition of Neonatal Units has been undertaken jointly with the Paediatric Clinical implementation Group.

The Maternity Clinical Implementation Group has been considering the feedback from consultation, the national Clinical Action Team and the responses from consultation and other engagements with stakeholders. Work has also been undertaken to consider what the implications are for both activity and staffing levels.

Additionally the purpose of the CIG was to:

- To ensure the NW London Reconfiguration Programme develops robust implementation plans for the delivery of safe and secure maternity services.
- To ensure effective joint working and communication between acute services and maternity services in NW London.
- To ensure that the plans for implementing changes to maternity services receive appropriate input from clinicians and patients.

7.32 Summary of the Maternity CIG’s recommendations

As a result of this work it has proposed the following recommendations in connection with maternity services.

1. The CIG propose six maternity units
2. The neonatal support required is as outlined in the Paediatric CIG Section of the chapter. The Paediatric and Maternity CIGs have worked together to ensure the correct provision taking into account maternity, neonatology and paediatric factors. There would be five paediatric units (all incorporating ED, inpatients and short stay/ambulatory facilities and co-located neonatal unit), all co-located with the proposed Major Hospitals. There would be an additional "stand alone" neonatal unit (NNU) supporting Queen Charlotte's Maternity Unit
3. The CIG recommends that NWL should adopt and aim to achieve the London Health Programme Maternity Service Clinical Quality Standards during implementation of the programme (i.e. within three years)
4. The proposal is for a sector wide collaboration to increase staff and develop a homebirth service in NWL in line with the national evidence. The national evidence demonstrates that Homebirth is safe and recommended practice. Other regions of London demonstrate much more success in homebirth midwifery led births. NWL will ensure it is a true option for women. The Maternity CIG has considered the issue of standalone birthing and midwife led units. They agree that these can be important elements of maternity provision. However, for Shaping a Healthier Future, since they are proposing six maternity units with alongside midwife led units, they do not at this stage consider, there would be sufficient demand for a standalone or birthing centre for the population of North West London. The maternity CIG has considered the recommendations from the birth place study and the CIG will ensure that all women
in NWL will have a choice of delivering at Home, in a alongside midwifery led unit or on an obstetric led labour ward

5. As SaHF is implemented, the requirements of pregnant women and mothers will remain at the heart of our approach and should the need for a standalone midwifery unit arise we will ensure it is properly considered

6. The Maternity CIG have considered and endorsed the proposed London commissioning standards for work force planning with respect to 168 hours consultant presence in all the units and a midwifery ratio of 1 to 30 in all birth settings

7. The maternity CIG have considered the Antenatal and post natal packages of care provision. They agree that low risk women will be offered midwifery led antenatal care in a local community setting. Women with high risk medical needs will be offered obstetric led antenatal care in a hospital setting. Postnatal care will be provided to all women in NWL in a community setting. Women at risk or women with social or complex health needs will be provided care in the antenatal and post natal period which will be midwifery led but in partnership with multi-agencies such as perinatal mental health, social services and health visitors

8. The Equalities review has shown that there are a number of issues pertaining to maternity, specific to protected groups (particularly within the BME community and the Children demographic). The CIG recommends that these issues are taken in to account during implementation and that the NWL Maternity Network works with the relevant community groups to ensure that appropriate services are provided throughout and after reconfiguration.

7.33 Pre-consultation maternity clinical standards for hospital care

To drive the improvements in clinical quality and reduce the variation that has been documented in the Case for Change, local clinicians have developed a set of clinical standards, based on latest evidence from Royal Colleges, reviews by the NHS in London, NICE guidelines etc.

The clinical board reviewed a wide body of evidence in determining what clinical standards should apply in NW London. The core documents were:

- London Health Programme Review - Adult Emergency Services: Acute medicine and emergency general surgery (2011)
- NCEPOD (2007) Emergency admissions: A journey in the right direction?
- RCP (2007) The right person in the right setting – first time
- RCS (2011) Emergency Surgery Standards for unscheduled care
- AoMRC (2008) Managing urgent mental health needs in the acute trust
- NCEPOD (1997) Who operates when?
- ASGBI (2010)
- The Royal College of Anaesthetists: Guidelines for the Provision of Anaesthetic Services (chapter 9, section 1.2)
- Safer Childbirth - Minimum Standards for the Organisation and Delivery of Care in Labour (2007), RCOG
- Facing the Future: Standards for Paediatric Services, Royal College of Paediatrics and Child Health, April 2011
The Future Workforce in Obstetrics and Gynaecology England and Wales. (2009) 
RCOG.

The clinical standards have been defined for the same three clinical areas (Emergency Surgery and A&E, Maternity and Paediatrics) to support the visions. Delivery of the clinical standards creates the need for changes that drive the hospital reconfiguration proposals, ultimately leading to improved clinical outcomes for patients as well as improved experiences for both patients and staff.

7.34 Consultation

A public Consultation on three options was undertaken during the summer and autumn of 2012.

These paragraphs consider the proposal in the consultation document that all major hospitals will have a consultant-led maternity unit.

Respondents were asked how far they support or oppose the recommendation that all major hospitals in North West London should have consultant-led maternity units, with an extra consultant-led maternity unit at Queen Charlotte’s and Chelsea Hospital if Hammersmith Hospital is not a major hospital.

Figure 7.48 shows that this question was answered by 4,564 respondents, and a large majority support the proposal (75%). However, this view is not strongly held, and respondents are more likely to ‘tend to support’ than ‘strongly support’ this proposal (47% and 28% respectively). One in twenty of the respondents answering this question oppose the proposal (5%), giving a net support score of +70 percentage points.

Figure 7.48: Consultation responses to the recommendation for all major hospitals to have a consultant-led maternity unit

<table>
<thead>
<tr>
<th>Support</th>
<th>75%</th>
<th>3,421</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oppose</td>
<td>5%</td>
<td>224</td>
</tr>
</tbody>
</table>
Support for the proposal is higher among women (77%) than men (72%), and higher among those from BME groups (82%) compared with those from white backgrounds (73%). Those aged 25-34 are more likely to support the proposal than overall (81% vs 75%). There is no significant difference in support between respondents with a disability and those without a disability.

There is no significant difference in overall support between current/past workers of the NHS or independent health sector and those who have never worked in the health sector.

Across the eight North West London boroughs, support is significantly higher among those living in Kensington and Chelsea than overall (85%). Higher levels of support are also seen among those living in Richmond (87%) and Wandsworth (92%).

Support for the proposal is also significantly higher than overall among those most likely to receive urgent care at Chelsea and Westminster Hospital (83%) and West Middlesex Hospital (81%).

### 7.35 Paediatric and maternity units in major hospitals

Very few stakeholders commented on the specific proposal that all major hospitals should have inpatient paediatric units. Those that did, including the Royal College of Paediatrics and Child Health, supported it.

The proposal for all major hospitals to have consultant-led maternity units, together with a unit at Queen Charlotte’s and Chelsea Hospital if Hammersmith Hospital is not a major hospital, was also supported by most of the relatively small numbers of stakeholders commenting on it.

The Royal College of Midwives supported the proposals but criticised the absence of any freestanding midwife-led units in the proposals or discussions on how to facilitate home births:

> "The loss of consultant obstetric services at Ealing could have a negative impact on tackling health inequalities in the borough; this could be mitigated – at least for women at low medical risk - if the obstetric service were replaced by a FMU…. we are extremely disappointed that Shaping a healthier future does not include any proposals for the establishment of freestanding midwife-led units (FMUs)."

This proposal also attracted some concerns and criticisms. Ealing Hospital Medical Staff Committee questioned where the ‘extra births’ were going to go to and how maternity services are going to cope. Ealing Council raised “the clear risk of loss of valued and high quality maternity services should SaHF proposals be taken forward.”

Hillingdon LINk argued that the targets to increase the number of home births are highly ambitious and questioned whether “large maternity units” meet the needs of expectant mothers.

### 7.36 Specific Feedback

During Consultation a number of specific organisational responses were received. These were individually considered by the CIG. Details of these and other responses are below.
For a number of the concerns expressed (and detailed in the tables below), adoption of the London Health Programmes Standards provide a resolution to those concern. However there were also significant concerns expressed by the Royal College of Midwives about the provision of standalone and midwife led birthing units. The Maternity CIG has considered these issues. They agree that these can be important elements of maternity provision. However, for Shaping a Healthier Future, since we are proposing six maternity units with alongside midwife led units, we do not at this stage consider, there would be sufficient demand for a standalone or birthing centre for the population of North West London. We will ensure that there is a Midwifery led homebirth community facility for all women in NWL. However as SaHF is implemented, the requirements of pregnant women and mothers will remain at the heart of our approach and should the need for such a unit arise we will ensure it is properly considered.

The maternity CIG have considered the Antenatal and post natal packages of care provision. They agree that low risk women will be offered midwifery led antenatal and postnatal care in a local community setting. Women with high risk medical needs will be offered obstetric led Antenatal care in a hospital setting. Postnatal care will be provided to all women in NWL in a community setting. Women with social needs and vulnerable women will be provided care in the antenatal and post natal period which will be midwifery led but in partnership with multi-agencies such as perinatal mental health, social services and health visitors.
### Figure 7.49: Specific feedback the Maternity CIG has considered

<table>
<thead>
<tr>
<th>Sub-Theme</th>
<th>Organisation raised</th>
<th>Support</th>
<th>Concerns/Comments</th>
<th>Actions</th>
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</thead>
<tbody>
<tr>
<td>Hospital care/ Standards</td>
<td>Hounslow HOSC</td>
<td>Support standards for emergency, maternity and paediatric services</td>
<td>Strong concerns about capacity and resources available to deliver them</td>
<td>London Health Programme standards adopted. Workforce strategy in development.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Support centralisation</td>
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<tr>
<td>Hospital care/ Standards</td>
<td>Royal College of Midwives</td>
<td>Hospital care in NW London should be based on the principles of localising routine services, centralising specialist care and integrating primary and secondary care. Recognise that there needs to be some concentration of obstetric-led care for women and infants that requires emergency or specialist care. Agree to centralise maternity services from seven to six.</td>
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<tr>
<td>Hospital care/ Standards</td>
<td>Royal College of Midwives</td>
<td>Lack of detailed proposals in relation to improving the coverage and quality of community midwifery services in NWL</td>
<td></td>
<td>This will be configured in the NWL midwifery home birth and community model. A comprehensive homebirth service is proposed.</td>
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<td>Sub-Theme</td>
<td>Organisation raised</td>
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<tr>
<td>Staffing (Maternity/ Paediatrics)</td>
<td>Ealing HOSC</td>
<td>Royal College of Midwives</td>
<td>Panel would like to place on record its concern at PCBC stating that staffing at maternity and paediatric units would still be challenging after reconfiguration, and query what future maternity services might look like if appropriate staffing levels are not met. Too much emphasis on medical staffing and not enough on improving services and making them more accessible to local women and their families. Concerned that proposals will constrain the choices available to local women and families, particularly those living in the borough of Ealing.</td>
<td>London Health Programme standards adopted. Workforce strategy in development. The Maternity CIG has considered the issue of standalone birthing and midwife led units. They agree that these can be important elements of maternity provision. However, for Shaping a healthier future, since we are proposing six maternity units with alongside midwife led units, we do not at this stage consider, there would be sufficient demand for a standalone or birthing centre for the population of North West London. We will ensure that there is a Midwifery led homebirth community facility for all women in NW London. However as SaHF is implemented, the requirements of pregnant women and mothers will remain at the heart of our approach and should the need for such a unit arise we will ensure it is properly considered.</td>
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<tr>
<td>Units (No. and standalone) (Maternity)</td>
<td>Hillingdon LINk</td>
<td></td>
<td>Concerned that stand-alone maternity units operating in the absence of sufficient consultant-led support and associated resources is an extremely risky approach</td>
<td>The CIG has concluded at this stage that there is not sufficient demand for a stand-alone unit as there will be six maternity units each with an alongside midwife led unit in NWL.</td>
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<tr>
<td>Sub-Theme</td>
<td>Organisation raised</td>
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<tr>
<td>Units (No. and standalone) (Maternity/ Paediatrics)</td>
<td>Royal College of Midwives</td>
<td>The RCM will only support the closure of the obstetric unit at Ealing Hospital if it is replaced by a midwife-led unit. In this respect, we are extremely disappointed that SaHF does not include any proposals for the establishment of Freestanding Midwife-led Units (FMUs). Although FMUs are not attached to obstetric units, there is no reason why they cannot be co-located alongside other services. Accordingly, if the FMU was located at Ealing this would avoid the costs entailed with constructing a new build birth centre elsewhere in NW London. Close proximity of hospitals in NW London to each other means that access can be sustained without the need for stand-alone units. We do not understand the logic of this argument. If anything the close proximity of units supports the establishment of an FMU because distances and travel times for women who need to transfer to an obstetric unit will be relatively short.</td>
<td>The priority is that all units have an alongside birth centre in NWL. The Maternity CIG has considered the issue of standalone birthing and midwife led units. They agree that these can be important elements of maternity provision. However, for SaHF, since we are proposing six maternity units with alongside midwife led units, we do not at this stage consider there would be sufficient demand for a standalone or birthing centre for the population of North West London. We will ensure that there is a Midwifery led homebirth community facility for all women in NWL. However as SaHF is implemented, the requirements of pregnant women and mothers will remain at the heart of our approach and should the need for such a unit arise we will ensure it is properly considered.</td>
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<tr>
<td>Units (No. and standalone) (Maternity/ Paediatrics)</td>
<td>Royal College of Midwives</td>
<td>Agree with the stated intention of maintaining units delivering up to 6,000 births a year and would oppose any proposals to reduce the number of obstetric units to five or fewer. Evidence suggests that in general, larger units (above 5,000 births a year) find it more difficult to reduce unnecessary interventions</td>
<td>We also note that maternity clinicians interviewed by the NCAT team that reviewed maternity services in NWL, commented that “a sector-wide standalone MLU might work if placed in the most accessible site”.</td>
<td>London Health Programmes Maternity Clinical Quality Service Standards have been wholly adopted to ensure NHS NWL is aligned to the most current thinking on maternity policy. There are six obstetric units proposed, which have more than enough capacity for the expected number of births in NW London at the end of the implementation period.</td>
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<tr>
<td>Sub-Theme</td>
<td>Organisation raised</td>
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<td>than smaller units.</td>
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<td>Options</td>
<td>Camden Council</td>
<td>Welcome and support the proposal for the retention of St Mary’s as a major acute hospital, providing choice, particularly in maternity care.</td>
<td></td>
<td>Will continue to build on our existing good working relationships with the Imperial group of hospitals to maintain smooth discharges from hospital into our community services.</td>
</tr>
<tr>
<td>Options</td>
<td>GSTT</td>
<td>Concerns for Option B - Would mean significant activity shift to St Thomas and site does not have capacity to absorb extra activity - Have done modelling which shows 25% shift and estimate more maternity and paediatric activity.</td>
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<td>Were option B to be recommended as a result of consultation, further analyses would be undertaken.</td>
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<tr>
<td>Options</td>
<td>ChelWest</td>
<td>Support for Option A - Will ensure sustainable healthcare system for the future (Also support for emphasis on OHH care) Option A is the right choice - CW is a modern, purpose-built hospital which provides a first class physical environment for patients (see response for full details of why CW is well-placed to be major hospital).</td>
<td>Concern if Option A not selected - i.e. Downgraded to UCC - Hospital would lose its maternity unit which delivers 6k babies/year and other children’s services incl. paediatric and neonatal surgery. Patients would lose other services e.g. NICU, Burns and ICU.</td>
<td>If other options recommended as a result of consultation, further analyses would be undertaken.</td>
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<tr>
<td>Quality of current care</td>
<td>Hillingdon LINk</td>
<td>SaHF proposal to reduce maternity unit bed occupancy rates by delivering more births at home is highly ambitious - Low rates (&lt;1%) of home-births across NW London. Will require a cultural/behavioural shift in expectant mothers and National evidence demonstrates that Homebirth is safe and recommended practice. Other regions of London demonstrate much more success in homebirth midwifery led births. NW London</td>
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<td>Sub-Theme</td>
<td>Organisation raised</td>
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<tr>
<td>Space and investment</td>
<td>Royal College of Midwives</td>
<td>Support</td>
<td>significantly greater investment in Community Midwives and their recruitment and retention than is currently modelled in the SaHF proposals.</td>
<td>will ensure it is a true option for women - this will be promoted in the NW London midwifery home birth and community model.</td>
</tr>
<tr>
<td>Space/ Location</td>
<td>Royal College of Midwives</td>
<td>Support retention of Queen Charlotte. Oppose transfer of maternity to CXH from Chel West.</td>
<td>NHS NWL will need to commit additional funding to upgrade and improve the physical environment of existing maternity units. This is because some units, particularly Chelsea and Westminster, will need additional physical space in order to cope.</td>
<td>There is a discrete finance work stream that as part of the Business Case will ensure that suitable provision is made for any required capital investment.</td>
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<td>We would have expected the consultation process to have developed concrete proposals for significantly increasing the home birth rate.</td>
<td>The proposal is for an increase in and the development of a homebirth service in NW London in line with the national evidence.</td>
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<td>There are reasonable clinical grounds for discontinuing obstetric services at Ealing Hospital. The current level of activity (2970 births in 2010/11) is below that of the other consultant-led units in NWL and is probably insufficient to sustain an obstetric service that is not co-located with other major hospital services, such as A&amp;E. Furthermore, because of the central location of Ealing within North West</td>
<td>NHS NW London will need to commit additional funding to upgrade and improve the physical environment of existing maternity units. This is because some units, particularly Chel West, will need additional physical space in order to cope with any increase in demand for services while other units are in urgent need of modernisation.</td>
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<td>There is a discrete finance work stream that as part of the Business Case will ensure that suitable provision is made for any required capital investment.</td>
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<td>Sub-Theme</td>
<td>Organisation raised</td>
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<td>London, it is likely that the additional activity resulting from the closure of the obstetric unit can be managed across several units rather than being directed to only one site</td>
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7.36.1 National Clinical Advisory Team feedback

The National Clinical Advisory Team is a collection of independent clinicians working on behalf of the Department of health. Their advice is sought when there are proposed significant reconfiguration of services are proposed.

NCAT supported in principle the proposals outlined in *Shaping a healthier future*. Two separate reports, for emergency and urgent care services, and for maternity and paediatric services, were received. Both reports acknowledge that the case for change focuses on delivering better care more effectively, and that wider changes in the NHS will have an impact on the timing of the proposals.

The NCAT maternity and paediatrics report acknowledges the rationale for the proposed change from nine acute units to five and the change from seven obstetric-led maternity units to six maternity units and from six paediatric units to five paediatric units. It highlighted the importance of the following:

- Medium to long term proposals for maternity and neonatal services
- Development of an overall strategic direction for maternity and paediatric services with a supporting workforce strategy to support the proposals
- Workforce modelling to ensure support staffing of five paediatric units and six neonatal units
- The need to ensure that community services are in place before closing acute services
- Developing primary care to support the reconfigured maternity and paediatrics services
- Further engagement with public and patients regarding the maternity and paediatric reconfiguration proposals.

The Out of Hospital Programme is addressing the issue of community and primary care services and there has been engagement during and post consultation. A more detailed response to the other areas highlighted is below.

**Figure 7.50: Feedback from the National Clinical Advisory Team considered by the Maternity CIG**

<table>
<thead>
<tr>
<th>NCAT recommendation</th>
<th>Original Programme response</th>
<th>Actions</th>
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</table>
| Medium to long term proposals for maternity and neonatal services. | We have:  
- Established the Maternity and Paediatric Clinical Implementation Groups to explore in more detail. | Two Clinical Implementation Groups were formed: Paediatrics (including Neonatology) and Maternity. These two groups have worked closely together to ensure there is coherent model of care and standards. |
| Development of an overall strategic direction for maternity and paediatric services with a supporting workforce strategy to support the proposals. | We have:  
- Established the Maternity and Paediatric Clinical Implementation Groups to explore in more detail  
- Had wider dissemination and discussion of the maternity and paediatric strategies, at Clinical Board and discussion at Programme Board | The Maternity CIG has met five times with other work happening throughout the consultation and post consultation period  
- Papers were regularly submitted for discussion at Clinical Board, with the CIG Chairs attending. Programme Board is also updated on progress as a matter of course  
- A comprehensive workforce strategy is to be put in place by the NW London |
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<th>NCAT recommendation</th>
<th>Original Programme response</th>
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<tbody>
<tr>
<td>Maternity CIG</td>
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</tbody>
</table>

Workforce modelling to ensure support staffing of five paediatric units and six neonatal units and recruitment and retention of community staff and robust service plans for community services.

- We have:
  - Established the Maternity and Paediatric Clinical Implementation Groups to explore in more detail.
  - Further developed workforce models with the Maternity Network and Maternity CIG.
- The Maternity CIG has met five times with other work happening throughout the consultation and post consultation period.
- Analysis has taken place and the gap in staffing identified. A comprehensive workforce strategy is to be put in place by the NW London Maternity Network during implementation.

Clarity as to how the reconfiguration proposals will affect antenatal and postnatal care.

- We have:
  - Established the Maternity Clinical Implementation Group to explore in more detail.
- The CIG has met five times with other work happening throughout the consultation and post consultation period.
- Assessment of impact (of proposed change) on current unit capacity from facilities, estate and workforce standpoint.
- Recommendation of alongside MLU with all Obstetric units which will cater for low risk women in antenatal periods and for birth.
- Recommendation to move single maternity information system and national maternity records to enable women to transfer easily within sector and help staff work across units in the sector.
- Specific issues have been identified on ante and post natal care and are part of the implementation proposals of the CIG.

The need to ensure that community services are in place before closing acute services and developing primary care to support the reconfigured Maternity services.

- We have:
  - Produced signed-off of out of hospital strategies for each of the eight boroughs.
- The proposal is for sector wide collaboration to increase staff and develop a homebirth service in NW London in line with national evidence. The national evidence demonstrates that Homebirth is safe and recommended practice.
7.37 Establishing the Maternity clinical implementation group

The Clinical Implementation Group (CIG) was specifically formed to consider service models, clinical standards and issues arising during consultation. During and post consolation the group has met a number of times to discuss responses, models of care, clinical staffing and other issues.

The CIG has representatives from all the affected hospitals as well as representatives from and patients groups. A full list of the membership and the Terms of Reference can be found at Appendix A.

The purpose of the CIG is to:

- To ensure the NW London Reconfiguration Programme develops robust implementation plans for the delivery of safe and secure maternity services.
- To ensure effective joint working and communication between acute services and maternity services in NW London.
- To ensure that the plans for implementing changes to maternity services receive appropriate input from clinicians and patients.

Responsibilities:

- To ensure proposals and modelling underpinning the maternity services are clinically robust
- To ensure alignment between the plans for implementing changes to maternity services and the agreed London commissioning standards
- To lead the implementation of relevant recommendations made by the National Clinical Advisory Team (NCAT) and the Office of Government Commerce (OGC) review reports
- To provide information to the Programme Board, and its groups, to support the implementation of changes to the configuration of services in NW London.
7.38 Post consultation clinical standards

Through the expertise and experience of its members the CIG considered existing guidelines, standards from professional bodies, Royal colleges and other professionally recognised bodies. The CIG also responded to a review and subsequent discussions with the Department of Health National Clinical Advisory Team (NCAT).

The CIG has adopted the new London Health Programme standards for Maternity Services, which have in turn drawn on a wide range of other guidance and data from London hospitals. The standards are detailed in 7a.

7.39 London Health Programmes Clinical standards

The London Health Programme identifies the health needs of Londoners and redesign NHS services to improve the way healthcare is delivered in the capital.

They work with London’s commissioners to transform frontline services and drive up standards in care quality. In consultation with patients, clinicians and GPs, we have developed new ways of delivering care that is expected to save thousands of lives, improve the health of our population and deliver efficient healthcare services.

Members of the CIG have been involved in development of the design of new standards for maternity

These standards (to be published early 2013) form a core part of the recommendations of the Group.

7.40 Workforce

A programme-wide work-stream has been established to analyse the implications of reconfiguration for the maternity, paediatrics and neonatal workforce. Workforce is described in Chapter 14 and Appendix P.

It is clear that detailed workforce analysis is required as part of the implementation programme and this will be informed by results from the programme-wide work stream.

7.41 Education and training

The maternity CIG is committed to ensuring the continuation of high quality training of student midwives and trainee doctors in obstetrics and gynaecology across all hospitals providing maternity services in North West London. Following the reduction of maternity units from seven to six, postgraduate doctors in training in obstetrics and gynaecology from the reconfigured unit will be reallocated to other hospitals across North West London, ensuring they continue to receive high quality training. This process will be managed by the Lead Provider for training in North West London in collaboration with the London Deanery and the Local Education and Training Board.

The maternity CIG recognises the need for 168 hour consultant obstetrician labour ward presence in order to improve the quality of patient care, and supervision of junior doctor training in maternity units across North West London. We are also aware that postgraduate junior doctor training posts in obstetrics and gynaecology in London are being reduced and
redistributed nationwide. We envisage that as Trusts shift to more consultant led delivery of care this will lead to an improvement in supervised high quality training of junior doctors with less reliance on them for service delivery.

7.42 Equalities

In addition to the work by the CIG, additional analysis of the proposals has been undertaken by the programme to understand the impact on the groups defined as protected by legislation. The main findings of this for maternity services are:

- The current maternity services provision has generally been highly regarded by service users. Users currently have a great deal of choice over their maternity services, and choice is highly regarded, but the impact of any reduced choice with the proposals would be minimal if quality continued to remain high.
- From the BME, and children and carers communities, interviews indicated that these communities required assurance on the future reconfiguration, with the following expectations or areas to address: An expectation of available and qualified staff at delivery. The main request from mothers, in any option, was assurance for the availability of high quality staff. The location of the service whether borough or hospital versus home, was a lesser issue across the stakeholder engagement. Though reports have cited that the number of women delivering at home is dropping across both the UK (now 2.39%) and London (1.9%), consultees did not suggest that any option would drive their preference for home or hospital based delivery in the future.
- Additionally concerns were expressed about language and cultural understanding by clinical and other staff of families and services users’ needs.
- Many new mothers were positive about the strategy to continue to develop community services. Though a number of consultees suggested that their confidence in out of hospital GP care was low, others suggested that confidence in Health Visitor care was high. OOH care after birth was excellent and suggested this could be implemented as a best practice model for other maternity services.

The CIG will ensure that these requirements are taken in to account during implementation and that the NWL Maternity Network will work with the relevant community groups to ensure that appropriate services are provided.

7.43 Mental Health

There is evidence indicating that untreated mental health in pregnancy and post-partum is associated with increase adverse obstetric and infant emotional development adverse outcome.

Perinatal Mental Health Services offer specialist care to women suffering from or at risk of developing a mental illness during pregnancy and up to 12 months post-delivery. Currently limited perinatal provisions are based on a liaison model operating at the interface between maternity and psychiatry services.

Integrating specialist psychiatric care in Maternity should be part of the drive to improvement in clinical quality to reduce the variation documented in the Case for Change. This process necessitates a coordinated approach to advocate for increasing perinatal mental health provisions in NWL both in hospital and community.
7.44 Implementation Issues to be addressed

The implementation of all of the recommendations must be made in a safe and step wise way, ensuring that services are properly maintained and improved:

1. Six maternity units are proposed. To enable this each unit should have a planned capacity of at least delivering a minimum of 5000 deliveries. All six Obstetric units will have alongside midwifery led units. These obstetric units may vary in the complexity of care offered and specialist services provided. There may be facilities or estate adaptation required to achieve this agreed model in some units. These are being addressed by the Business and Financial Planning work stream. For implementation, the Maternity Network will ensure that it is consulted on any changes and, where necessary will seek to approve the scheduling and implementation of such changes

2. The neonatal support required is as outlined in the Paediatric CIG Report. The Paediatric and Maternity CIGs have worked together to ensure the correct provision taking into account maternity, neonatology and paediatric factors. There would be five paediatric units (all incorporating ED, inpatients and short stay /ambulatory facilities and co-located neonatal unit), all co-located with the proposed Major Hospitals. There would be an additional "stand alone" neonatal unit (NNU) supporting Queen Charlotte's Maternity Unit

The Maternity Network will work closely with paediatric colleagues to implement this model. To do this there will need to be consideration of the workforce requirements needed to support complex maternity cases as well as the number of deliveries and the activity of the wider acute paediatrics service

3. The CIG recommends that NWL should adopt and aim to achieve the London Health Programme Maternity Service Clinical Quality Standards during implementation of the programme (i.e. within three years). For these standards to be implemented fully the Maternity Network will work closely with commissioners and providers during implementation to ensure that the standards are implemented in a way that mothers and their families continue to have comprehensive and appropriate access to services across north west London

4. The proposal is for a sector wide collaboration to increase staff and develop a homebirth service in NWL in line with the national evidence. The national evidence demonstrates that Homebirth is safe and recommended practice. Other regions of London demonstrate much more success in homebirth midwifery led births. The NWL maternity Network will ensure it is a true option for women (see issue 5 below)

5. The Maternity CIG has considered the issue of standalone birthing and midwife led units. They agree that these can be important elements of maternity provision. However, for Shaping a Healthier Future, since they are proposing six maternity units with alongside midwife led units, they do not at this stage consider, there would be sufficient demand for a standalone or birthing centre for the population of North West London. The Maternity CIG will ensure that there is a Midwifery led homebirth community facility for all women in NWL. However as SaHF is implemented, the requirements of pregnant women and mothers will remain at the heart of their approach and should the need for such a unit arise they will ensure it is properly considered. To implement this approach the NWL Maternity Network will work with the commissioners and providers, as well as the communities themselves to enable a comprehensive homebirth service is across North West London
6. The Maternity CIG have considered and endorsed the proposed London commissioning standards for work force planning with respect to 168 hours consultant presence in all the units and a midwifery ratio of 1 to 30 in all birth settings. The maternity CIG have also considered the Antenatal and post natal packages of care provision. They agree that low risk women will be offered midwifery led antenatal and postnatal care in a local community setting. Women with high risk medical needs will be offered obstetric led Antenatal care in a hospital setting. Postnatal care will be provided to all women in NWL in a community setting. Women with social needs and vulnerable women will be provided care in the antenatal and post natal period which will be midwifery led but in partnership with multi-agencies such as perinatal mental health, social services and health visitors.

7. The Equalities work has shown that there are a number of issues pertaining to maternity specific to protected groups (particularly within the BME community and the Children demographic) arising. The CIG recommends that these issues are taken into account during implementation and that the NWL Maternity Network works with the relevant community groups to ensure that appropriate services are provided throughout and after reconfiguration. To do this the Maternity Network will further engage with Maternity Services Liaison Committees, equalities leads and other groups to ensure that service provision takes into consideration the needs of these protected groups.
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Chapter 8
Development of out of hospital plans in NW London
Out of hospital improvements

This chapter gives an overview of the work being undertaken by NW London to improve out of hospital care. 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. Within five years, we will be spending £190 million on out of hospital each year, building on improvements already being made to out of hospital care across NW London.

8a. Development of out of hospital plans in NW London

As Chapter 7 described (see Section 7.1.3), we have a clear vision for out of hospital care in NW London that will ensure patients are cared for in a high quality, consistent, integrated way in the most appropriate location. This includes ensuring patients have the support they need to take better care of themselves, an understanding of different settings of care, access to primary care in urgent situations, timely access to specialist care, and up-to-date hospital facilities. Chapter 7 also described the pledge by clinical leaders and the clinical standards for out of hospital care.

To deliver this, we developed an overarching strategy to say that health services need to be localised where possible, centralised where necessary and that in all settings, care should be integrated across health, social care and local authority providers wherever that improves seamless patient care.

Delivering this strategy entails a variety of changes to how we provide care, including improvements to out of hospital care. To this end, in 2012, all eight CCGs across NW London developed an out of hospital strategy (see Section 8.22 and Appendix L). While each CCG had a different strategy, all eight focused on services that will ensure:

1. Easy access to high quality, responsive care
2. Simplified planned care pathways
3. Rapid response to urgent needs
4. Integrated care for elderly patients and patients with a long-term condition
5. Appropriate time in hospital.

These strategies are a key enabler of the recommendation, and successful delivery of the plans for each CCG would support the recommended changes to hospital services we have outlined.

To provide confidence in the delivery of these out of hospital services and ensure patients receive high clinical quality care, we have defined consistent quality standards (see Section 7.2). These standards set expectations across four domains:

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

All providers will be held to these standards as out of hospital services are implemented.
CCGs are now beginning to deliver their out of hospital strategies to achieve the vision of care described in Section 8.23 and Chapter 16. This chapter describes the ways that the CCGs are achieving this and provides further detail about the different settings of care. This reflects the progress we are beginning to make, which provides confidence that the recommendation is feasible and supported by the CCGs’ out of hospital plans.

8.1. Principles of delivering out of hospital care

Local clinicians have recommended that out of hospital care will be delivered by:

- Setting and maintaining standards
- Primary care being at the heart of change
- GP practices working together
- All providers working together.

These are shown in Figure 8.1.

Figure 8.1: Four principles of out of hospital care

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. Increasingly throughout NW London, practices will be working collaboratively together to serve a local population, maximising use of their skills and capacity to improve access and quality. These networks of GP practices will work with other providers to deliver joined up services to the local community, improving care planning and local services. Above this, there will be borough-wide services that encompass all health and social care working together. This would include new ways of working in multidisciplinary teams across community, health and social care. Importantly, all providers within this system will be held to high clinical standards of care, monitored and enforced by local GP practice networks and CCGs.

As a result of this, the settings of care will change.
8.2. Settings of out of hospital care

The delivery of out of hospital care will occur in many of the settings of care described in Chapter 7 (and described in Figure 8.2): a patient’s home, GP practice, care network, health centre and local hospital will all be important settings for out of hospital care. The ways these settings will be used in the future are described in Chapter 7, Section 7.5.

Figure 8.2: Summary of settings of care in NW London

- **Home**
  - GP, community and social care services delivered in patients’ homes
  - Patient navigation using 111
  - Patient triage and response within 4 hours

- **GP practice**
  - GP consultations and long term condition management
  - Health promotion and delivery of preventative services

- **Care network**
  - Delivery of multi-disciplinary care
  - Access to diagnostic and therapy services

- **Health centre**
  - Access to GP, therapy, rehabilitation and diagnostic services
  - Access to specialist GP services

- **Local hospital**
  - Urgent Care Centres
  - Outpatients and diagnostics
  - Additional services on some local hospital sites, including specialist clinics, outpatient rehabilitation and specialist clinics

8.3. Understanding the views of NW London residents

To understand the views of the public in response to our vision for out of hospital care, we have conducted a range of consultation and engagement exercises, including:

- Asking all residents about out of hospital care through the *Shaping a healthier future* consultation
- Engaging with carers across NW London to understand how out of hospital services will affect them
- Surveying the public to understand priorities for primary care.

The views collected through these three exercises then contributed to the development of plans for delivering out of hospital care in NW London. Out of hospital plans for the area have been significantly updated post-consultation: these changes are described throughout the rest of this chapter.
8.4. Consultation responses

The *Shaping a healthier future* consultation highlighted a number of key areas of focus for residents of NW London regarding out of hospital services. The plans for delivery of out of hospital services, and the service models for different settings of care, were refined in response to this feedback.

In the overall responses to consultation, a number of stakeholder organisations supported the principle that out of hospital services are vital to the delivery of *Shaping a healthier future* and offer improvements for patients. However, concerns were raised that the plans for out of hospital delivery are less well developed than the reconfiguration proposed by *Shaping a healthier future* and that the sequencing of service changes will be vital, as out of hospital services need to have sufficient capacity and capability to deliver as planned.

In response, we have further developed our plans for delivering care out of hospital. CCGs are delivering a significant proportion of their plans for out of hospital care in the next financial year (see Section 8.23.3 and Appendix J), and our plan for implementation of *Shaping a healthier future* makes clear the services that need to be delivering before changes to acute provision can be made (see Chapter 17). Delivery of new services in the out of hospital setting will require redesign and procurement of services working to the new operating model including the workforce associated with the activity.

Specific comments were made during the consultation about the importance of access to primary care and the integration of health and social care. In response to this, primary care is organising into networks to enhance its capacity. Many of the settings of community services will offer extended primary care services and integrate with social care services.

Specific consultation responses were also received about some of the key elements of our plans for out of hospital services, including standards for care outside of hospital, delivering services locally, urgent care centres, elective hospitals, local hospitals, and Central Middlesex Hospital. Responses to these issues are summarised below.

8.4.1. Quantitative feedback

Described below are the main quantitative findings for the consultation process; further details about each area can be found in Appendix F.

- The **quality standards for care** outside of hospital received widespread support across NW London (67% support vs. 12% opposed)
- Support for the **delivery of services locally** was more mixed:
  - Delivering hospital services locally received more support (43%) than opposition (25%)
  - However, improving the range of services delivered outside of hospital had slightly less support (44%) than opposition (48%), with open-ended comments suggesting some scepticism about the capacity and skill-mix of out of hospital care
- Plans for **urgent care centres** received more support (41%) than opposition (24%); more detailed discussion of responses to feedback on urgent care centres can be found in the report of the clinical implementation group (see Chapter 7b)
- Developing hospital sites into **elective hospitals** received support from over two-thirds of respondents (68% support vs. 21% opposed). Open-ended responses suggested it would be a good use of existing space and resources to utilise hospital sites in this way
- Developing **Central Middlesex Hospital** into a local hospital received more support (30%) than opposition (19%). Most open-ended responses suggested it was a
practical solution for the site, which is not the best placed in NW London to provide major acute services.

8.4.2. **Qualitative feedback**

In addition to the survey responses summarised above, a range of stakeholders and respondents provided additional, qualitative, feedback that helps describe the range of views towards *Shaping a healthier future* across NW London. A selection of this feedback is highlighted in this section; full details on the consultation responses can be found in Appendix F.

The principle of **delivering out of hospital services** received support from a range of stakeholders, both as an improvement in care and as a means to delivering *Shaping a healthier future*. For example:

**Central London Community Healthcare Trust**

“Our Trust strongly supports the proposals relating to Out of Hospital Care that are contained within the consultation document….If, as is proposed, resources will be redirected and realigned, we agree that a sufficient scale in the organisation of primary and community health provision will be achieved to secure good health outcomes for patients in the setting of their choice in or closer to home within the available resource limits. This will reduce the current level of demand for hospital bed days.”

**Harrow Council Health and Social Care Scrutiny Sub-Committee**

“The out of hospital strategy will be the foundation to ensuring changes in acute services succeed.”

The main area for development highlighted by individuals and organisations responding to the consultation was the need for **confidence in the capacity of services to deliver out of hospital strategies**; this confidence will provide confidence in *Shaping a healthier future*. In particular, implementation planning was highlighted as a key area of concern. For example:

**Kensington & Chelsea LINk**

“We welcome the move to improved out of hospital services and see these as the essential building block, which must be in place and effective before any reduction of current hospital services.”

**Harrow LINk**

“We support the vision outlined in the consultation but advise caution in implementation of hospital service reconfiguration until robust out of hospital services are in place.”

**Hammersmith and Fulham LINk**

“Whilst the H&F LINk very much welcomes this initiative, the timeframes for implementation seem very challenging and there is an absence of detail in the strategy. Indicators of success and safeguards to protect patient safety during the transition are required.”

**London Borough of Hounslow Health and Adult Care Scrutiny Panel**

“The described vision for out of hospital care must be in place before the reconfiguration of hospital services begins. In addition, to ensure that the vision is delivered in practice, the NHS Commissioning Board must put in place robust contract levers so that GPs deliver the quality standards and vision for primary care set out in the consultation document.”
London Borough of Ealing and London Borough of Hammersmith & Fulham (separate responses)
“The proposed improvements to out of hospital care are appropriate but there are concerns about the realism and deliverability of both the proposed scale and pace of the improvements.”
“The proposed clinical standards and visions are appropriate”.
“The proposed improvement of out of hospital care is appropriate, given the current shortcomings in primary care and the significant extent to which the proposed reconfiguration is dependent upon these improvements. Detailed plans should now be developed and urgently implemented before any reduction is hospital services is decided upon, let alone begun.”

Royal Borough of Kensington and Chelsea Health, Environmental Health and Adult Social Care Scrutiny Committee
“We recommend NHS NWL provides far more detail on the implementation of the out of hospital service. CCGs need to set out detailed implementation plans for their out of hospital strategies.”

North West London Joint Health Overview and Scrutiny Committee
“There are concerns over the readiness and capacity of out of hospital services, the realism of timescales for change and the likelihood of cost transfer from the NHS to others.”

Two particular elements of this transition were workforce and estates, where stakeholders expressed sentiments that our plans needed further development to offer confidence in out of hospital services. For example:

Westminster City Council, Adult Services and Health Policy and Scrutiny Committee
“There is a clear issue in relation to workforce strategy which needs further detailed consideration, since out-of-hospital services need to be built up before surplus staff are released from the acute sector for re-deployment.”

Richmond Clinical Commissioning Group
“[We need] clear plans to deliver the necessary workforce and estate configurations to facilitate the out of hospital care expectations that underpin many of the delivery assumptions behind the options.”

Kensington & Chelsea LINk
“Moving services and human resources to an out of hospital setting will involve retraining large numbers of staff to work in a different environment requiring a different skillset, greater independence and responsibility. We have not seen any studies on the feasibility of this, and seek assurances that existing staff are willing to make this transition.”

Linked to this, the importance of investing in out of hospital services was widely recognised. For example:

Brent Health Partnerships Overview and Scrutiny Committee
“We have significant concerns that the out of hospital care strategy won’t receive the required investment needed to ensure that it is successfully delivered as money will continue to flow into acute services as demand can’t be properly controlled.”

Hammersmith and Fulham LINk
“Successful implementation of the ‘out of hospital’ strategy will also require ‘pump priming’ funding.”
Brent Health Partnerships Overview and Scrutiny Committee
“We would want to see at the earliest opportunity how commissioners intend to ensure the necessary investments in community services are to be made and the transition risks managed, whilst ensuring service continuity in the transition period.”

Karen Buck, MP for Westminster
“We need far greater clarity than we have had to date about the capital provision and, possibly more crucially, the long-term revenue funding to support these services in Westminster.”

Royal Borough of Kensington and Chelsea Health, Environmental Health and Adult Social Care Scrutiny Committee
“We agree that North West Londoners could benefit from a move to more integrated care. The early results from the integrated care pilot are promising. However, it has not yet been fully evaluated.”
“It is unusual to roll-out a service before the pilot has been fully assessed…”
“We question the assumption that the roll-out of the INWL integrated care pilot across the whole of NWL will give the level of benefits predicted.”

To deliver our plans for out of hospital services, stakeholders highlighted a number of services that will need specific improvements. This included primary care and integration between health and social care. For example:

Westminster City Council, Adult Services and Health Policy and Scrutiny Committee
“A number of Westminster residents and the Council agree that there is a need to improve access for residents at GPs and other local services so patients can be seen more quickly and at a time that is convenient to them.”

Harrow Council Health and Social Care Scrutiny Sub-Committee
“Social care is central to the success of the out of hospital strategy and therefore it must be ensured that social care colleagues are engaged throughout the process.”

Hillingdon LINk
“The Sahf proposals heavily rely on the delivery of the ambitious OOH [Out of Hospital] strategies of each of the 8 CCGs in the NHS NWL region. The delivery of OOH strategies in turn is heavily dependent upon the need to integrate health and social care services across all 8 of the London Boroughs in NWL. This is particularly important in the London context as patients usually do not recognise borough boundaries and access both health and social care services across boundaries.”

Specific plans for Central Middlesex Hospital were commented on through the consultation process. Plans for developing the site into a local hospital and elective centre received support from a number of stakeholders. A number of stakeholders also expressed opposition to any closure of the site, which current plans avoid. For example:

London Borough of Hounslow Health and Adult Care Scrutiny Panel
“Central Middlesex is not currently providing the services that would be delivered at a major hospital site and it therefore makes sense for it to continue to operate as a local hospital.”

North West London Hospitals NHS Trust
“We have considered the future role for CMH [Central Middlesex Hospital] and while a number of staff and local people would like to retain all traditional DGH [District General Health] services they recognise that the commissioning of the Brent Urgent Care Centre
(that is able to treat the vast majority of patients who use it and will remain open 24/7) has enabled the Trust to improve a number of hospital delivered services."

The Community Voice
“The provision of elective services at Central Middlesex Hospital is of direct relevance to a section of our membership and the proposals are recognised as a pragmatic compromise. Providing elective services at the hospitals without A&E departments is seen as protection of those services.”

Brent Health Partnerships Overview and Scrutiny Committee
“On balance [the Committee] does not object to the Shaping a healthier future proposal that it becomes a local hospital and elective centre…would oppose any measures to close the hospital…the real work explaining the changes should begin now.”

In developing our plans, a number of stakeholders raised concerns that we had not sufficiently considered the impact of services changes on carers. Carers UK Hounslow observed that carers are only mentioned twice in the consultation document. Ealing Council and Hillingdon LINk both argued that the proposals could negatively impact carers.

8.4.3. Developments since consultation

Figure 8.3 summarises the key themes across all the feedback we received from the consultation process, together with reference to where further details about the development of our plans can be found.

Figure 8.3: Qualitative feedback relevant to out of hospital plans

<table>
<thead>
<tr>
<th>Consultation theme</th>
<th>Qualitative feedback</th>
<th>Source(s)</th>
<th>Developments since consultation</th>
</tr>
</thead>
</table>
| Impact of changes on carers              | ● The impact of out of hospital changes on carers needs to be understood.             | ● Carers UK Hounslow  
● LB Ealing  
● Hillingdon LINk.  
● We have commissioned further work to fully understand how out of hospital services affect carers; the findings are summarised in Chapter 8, Section 8.5.2 and Appendix H. |
| Primary care development                 | ● Access to GPs and other local services needs to be improved so patients can be seen quickly. | ● Roadshow responses  
● Focus groups  
● Westminster City Council Adult Services and Health Policy and Scrutiny Committee.  
● Primary care development is a crucial strand of our out of hospital work, and we have conducted further work to develop a programme (see Chapter 8, Section 8.5.1)  
● Primary care estates will be improved through the delivery of out of hospital care, with investment in improving the quality and access of practice buildings (see Chapter 16)  
● Access to primary care is one strand of all out of hospital strategies (including 111 and extended hours), and significant work has been delivered in 2012/13 and is planned for 2013/14 to improve this (see Appendix L). |

1 Sources are not aligned to feedback.
<table>
<thead>
<tr>
<th>Consultation theme</th>
<th>Qualitative feedback</th>
<th>Source(s):</th>
<th>Developments since consultation</th>
</tr>
</thead>
</table>
| Standards for care outside of hospital | ● Standards are appropriate. | ● Open consultation responses  
● LB Hammersmith & Fulham, LB Ealing. | ● Standards will continue to be implemented across out of hospital services (see Chapter 7, Section 7.2). |
| Workforce | ● Plans for developing the workforce for delivering out of hospital services is critical  
● Such plans need to include consideration of phasing as services move from hospital to out of hospital settings  
● Staff will need to be engaged in any transition. | ● Roadshow responses  
● Westminster City Council Adult Services and Health Policy and Scrutiny Committee  
● Kensington & Chelsea LINk  
● Harrow Council Health and Social Care Scrutiny sub-Committee. | ● We have developed, with the LETB, more detail about how we will then develop the workforce we need for out of hospital services (see Chapter 16). |
| Estates | ● Clear plans for the development of the estate needed to deliver out of hospital services are needed. | Richmond CCG. | ● Our estates plans are now much more detailed, including plans for use of existing sites and the additional buildings required (see Chapter 8, Section 8c and Chapter 16). |
| Urgent care centres | ● Urgent care centres offer quicker access than existing services  
● Staff need to have the skills and experience to deal with issues presenting at urgent care centres  
● The public need to be clear about where to go for treatment  
● The quality of care needs to be as good as that in A&E  
● Standards for urgent care centres need to be consistent across NW London  
● Patient transfers need to be quick and smooth. | ● Open consultation responses  
● Westminster City Council Adult Services and Health Policy and Scrutiny Committee, LB Hounslow Health and Adult Care Scrutiny Panel, Ealing Council  
● Brent LINK, Hillingdon LINk  
● NW London Joint Health Overview and Scrutiny Committee  
● Central London Community Healthcare Trust  
● The College of Emergency Medicine. | ● Clinicians across NW London have developed an updated specification for urgent care centres, including a range of KPIs to ensure performance expectations are met. This specification will be implemented in 2012/13 and 2013/14. This is discussed further in Chapter 8d. |
<table>
<thead>
<tr>
<th>Consultation theme</th>
<th>Qualitative feedback</th>
<th>Source(s)</th>
<th>Developments since consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity of services to deliver out of hospital care</td>
<td>● Out of hospital strategies are vital to the delivery of <em>Shaping a healthier future</em>&lt;br&gt;● Services need to be demonstrably able to provide out of hospital care before reducing acute provision.&lt;br&gt;● More detail about out of hospital plans are needed, especially access to GPs, the skills available in community care, and the capacity of community care to deliver an extended range of services.&lt;br&gt;● The timescales for delivery are vital, and confidence is needed that the changes are deliverable within them.</td>
<td>● Open consultation responses&lt;br&gt;● Roadshow responses&lt;br&gt;● Focus groups&lt;br&gt;● Central London Community Healthcare Trust&lt;br&gt;● Harrow Council Health and Social Care Scrutiny sub-Committee, Labour Group at Kensington &amp; Chelsea Council, LB Hounslow Health and Adult Care Scrutiny Panel, LB Hammersmith &amp; Fulham, LB Ealing&lt;br&gt;● Kensington &amp; Chelsea LINk, Harrow LINk, Richmond Upon Thames LINk, Hammersmith &amp; Fulham LINk&lt;br&gt;● User Panel, NHS Central London CCG&lt;br&gt;● The Community Voice&lt;br&gt;● NW London Joint Overview and Scrutiny Committee.</td>
<td>● Out of hospital services are already in place and plans are in place within each CCG for 2013/14 (see Chapter 16). As a result, a significant proportion of our out of hospital services will be in place in 2013/14&lt;br&gt;● Out of hospital delivery is supported across NW London by a range of transformation programmes, including primary care development and integrated care (see Chapter 8b)&lt;br&gt;● Plans have been developed to couple the development of out of hospital services with changes to acute services. These plans include ways to monitor delivery of out of hospital strategies, timescales for changing acute provision to 2017/18, and the mechanism for aligning decision-making with out of hospital delivery (see Chapter 18 for implementation plans).</td>
</tr>
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</table>
### Integration

- Delivery of out of hospital services relies on effective integration with local authorities, especially social care
- Consistency of care across an integrated pathway will improve care for patients
- Continuity across settings and providers (especially physical and mental health) will be important as care changes
- The existing integrated care pilot should be evaluated.

### Investment

- Out of hospital services require sufficient investment to ensure they succeed.

### Source(s): 1

- Focus groups
- Harrow Council Health and Social Care Scrutiny Committee, RB Kensington & Chelsea Health Environmental Health and Adult Social Care Scrutiny Committee, Camden Council Housing and Adult Social Care
- Hillingdon LInK
- NW London Joint Health Overview and Scrutiny Committee
- West London Mental Health NHS Trust.

### Developments since consultation

- Effective integrated care is one strand of all out of hospital strategies (including integrated care pilots covering all eight CCGs in NW London). Delivery began in 2012/13 and further developments are planned for 2013/14, including whole systems integrated care (see Chapter 8, Section 8.23.2)
- Mental health services will be located on many hub/health centre and local hospital sites, improving continuity and consistency of care (see Chapter 8, Section 8.12)
- Independent evaluation of the Inner NW London Integrated Care Pilot suggests early successes (see Chapter 8, Section 8.21.2).

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### Investment

- Out of hospital services require sufficient investment to ensure they succeed.

### Source(s): 1

- Brent Health Partnerships Overview and Scrutiny Committee
- Hammersmith & Fulham LInK.

- Significant investment in out of hospital services is planned across the life of Shaping a healthier future (see Chapter 16)
- This investment includes revenue investment in services and capital investment in new settings of care.

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### 8.5. Developments since consultation

Since consultation, our plans for the delivery of out of hospital services have developed further, to both respond to the points raised by the public and to provide more detailed information about how out of hospital services will be delivered.

This includes:

- Understanding further the views of NW London patients and carers regarding primary care development and the impact of out of hospital services on carers
- Developing our plans for workforce and out of hospital estate (including local hospitals, networks and hubs/health centres) further
- Beginning the implementation of out of hospital standards in accordance with our out of hospital strategies and in concordance with the recommendation
- Refining our plans for urgent care centres to ensure they meet the needs of patients
- Providing further confidence in the delivery of out of hospital services, including our investment in out of hospital, performance to date and plans for 2013/14.

Each of these developments is detailed further below.
8.5.1. Primary care development

We recognise that the development of primary care is crucial to the success of the eight CCGs’ out of hospital strategies and a vital means to ensuring patients have access to the right care when they need it.

To further understand patients’ priorities for primary care, we have conducted a major research programme – including a survey of over 1,000 patients – to understand priorities for primary care.

From this, we have developed a programme of activity that will support primary care across the right CCGs to work together and support each other, thus realising the ambition of delivering better care closer to home.

Details of this programme can be found in Chapter 8b.

8.5.2. Understanding the impact of out of hospital services on carers

As the consultation reported, several stakeholders raised the need to understand the impact of Shaping a healthier future proposals on carers. We commissioned an independent assessment of the impact of these changes on carers. The process highlighted common features of carers in NW London which reflect the role of carers in delivery of out of hospital services:

- Home is the main locus of health care
- Carers often have a deep understanding of the person they are caring for
- Carers provide practical support to people.

To ensure out of hospital services do this, we conducted a three-step assessment of out of hospital initiatives across NW London and developed resources for CCGs to conduct detailed assessments as services are designed:

- Stage 1 – Where might new health services impact on carers?
- Stage 2 – How should the NHS measure and judge the impact?
- Stage 3 – What changes might be made to make sure the impact is as positive as possible?

The assessment identified ways that out of hospital services could impact carers – both in improvements to the services they receive and risks to how this is implemented. The assessment identified recommendations that apply to any and all reconfigurations and redesigns. These themes echo findings from other pieces of work around Shaping a healthier future and out of hospital initiatives, including the consultation and equalities reviews (see Appendices F and G). They add weight to the importance of particular aspects of service design.

The project also made some system-level recommendations. We developed a toolkit - the Impact on Carers Assessment - that supports CCGs to take account of carers in the design and redesign of services. This toolkit will be rolled out in 2013. We will also develop ‘expert carers’ in partnership with local carer organisations across the CCGs and consider appropriate carers outcome measures to be monitored.

Detail of our work to understand how the out of hospital initiatives affect carers, the assessment process, our findings and next steps can be found in Section 13.6.

The full carers report is included at Appendix H.
8.5.3. Workforce

Following feedback from consultation, workforce plans were developed further. Building on the work completed before the consultation process, we have developed a detailed view of the type and scale of workforce changes required to deliver reactive and proactive care in the community, as described in the out of hospital strategies. There was a specific focus on rapid response and case management services as these areas are the most essential in enabling the shift of care and where the greatest workforce changes are required.

Developing this understanding involved defining a representative care model, defining skills, competencies and new and enhanced roles for reactive care and case management. This enabled us to determine staffing volume requirements against a representative service model, and develop a workforce modelling tool for these two services, enabling CCGs to adapt care package and staffing assumptions.

Delivering the out of hospital vision will require a significant workforce shift for the entire community workforce – to empower patients and their carers, support collaboration across professions and organisations (including health and social care), and better manage risk in the community.

Reactive and proactive services form a continuum and patients will move in and out of them depending on their needs at any time. Proactive care – including better case management – relies on empowering patients and carers, providing a single point of contact, and dedicated health and social care coordination. Conversely, efficiency and effective reactive care requires multi-skilled multi-professional teams at the right scale.

We estimate that the delivery of the CCGs’ out of hospital strategies will require approximately 800 additional staff across NW London. To deliver the reactive and proactive care elements of these strategies, we estimate that approximately 250-275 additional whole time equivalents (WTEs) will be required within the community setting across NW London to provide home-based proactive and reactive care. This figure is made up of new and enhanced roles providing dedicated reactive and proactive care.

A number of these roles will work across both services reflecting the continuum of out of hospital care whilst others are dedicated to providing either reactive care (e.g. rapid response) or proactive care (e.g. case management).

These new roles will help to ensure the delivery of high quality and effective out of hospital care at the scale required across NW London but also critically will provide our staff within NW London with opportunities to work at the forefront in delivering new models of care as well as career development.

These roles will hold a number of the key skills and competencies that are essential to deliver effective out of hospital care, including ability to empower patients, individuals and their carers; providing integrated and seamless care across health and social care; working in multi-professional teams and the clinical skills required to deliver care to more acutely ill patients in the community.

The new and enhanced roles are included in Figure 8.4.
It is assumed that the teams will in addition have access to condition-specific specialist opinion, and to regular care already provided by in the community, e.g., primary care, pharmacist support as needed.

1: It is assumed that the teams will in addition have access to condition-specific specialist opinion, and to regular care already provided by in the community, e.g., primary care, pharmacist support as needed.
Delivering this workforce shift will require a comprehensive vision and strategy comprising of key workforce-related initiatives, and other non-workforce enablers. In the short-term, targeted training will be needed, depending on their current role and existing skill base. And the primary care workforce will need to collaborate more across practices and with NHS workforces in other settings, as well as social care.

The full findings of this work, having been developed with CCGs, are also being disseminated to the Community Steering Group and wider stakeholders in order to inform local service design and commissioning. Joint discussions with the NWL LETB are also continuing to ensure that the findings help to inform education commissioning across NW London.

The details of the workforce implications of out of hospital can be found in Chapter 16.

8.5.4. Delivering the estate we need for out of hospital services

Alongside the local hospitals, hubs/health centres and GP practices will offer a vital location for the delivery of out of hospital services.

The consultation highlighted ways in which we might provide more detail on each site in order to offer more information about how the hospitals will operate.

To provide further details on each site – including the potential service mix and use of estate – we conducted a detailed programme of reviewing each site and developing, with a range of stakeholders, service models for each hospital. This considered both the estate and service ramifications of changes to the sites.

As a result of this work, we can provide more information about the services that could move to each site, the changes to the estate needed to create the right amount of space, and the capital implications of changes.

These details can be found in Chapter 8c.

8.5.5. Urgent care centres

As all the hospitals in NW London will include an urgent care centre, to enable them to respond to urgent needs, it is vital that we are clear about what an urgent care centre includes and ensure consistency across NW London.

To this end, one of our clinical implementation groups has further developed the requirements for urgent care centres. This has led to the development of a new, consistent specification for urgent care centres, which will be implemented across all major and local hospital sites.

Details of the updated urgent care centre specification can be found in Chapter 8d.

8.5.6. Standards of out of hospital care

As we implement our out of hospital standards (described in Chapter 7), it will be important for CCGs to be able to measure:

- The extent to which the standards have been successfully implemented. This includes measures such as the percentage of eligible patients who have received a care plan
The extent to which the anticipated benefits of implementing the standards have been achieved. This would include measures such as the percentage of patients with care plans reporting an improved sense of independence.

To understand more about the different measures we could use to achieve this, we reviewed a wide range of existing national and international frameworks to identify potential existing measures that we could use to track the implementation of out of hospital standards. These measures fell into two categories. First, **over-arching outcome measures** to measure the benefits of implementing the standards in aggregate. Second, **process measures** within each domain of the standards, to assess the extent to which each standard is being implemented.

On the whole, the measures attempt to look at both health and social care measures and include efficiency, outcome and user experience measures, where available.

These potential measures are summarised in Figure 8.5.

**Figure 8.5: Potential measures of out of hospital standards**

<table>
<thead>
<tr>
<th>Measure type</th>
<th>Domain</th>
<th>Potential measures</th>
</tr>
</thead>
</table>
| Outcome / benefits measures | All                           | ● Rate of non-elective admissions  
                                   ● Re-admissions within 28 days  
                                   ● Unplanned hospitalisations for individuals with an ambulatory care sensitive chronic condition (over 18 years) per 100,000 population  
                                   ● Unplanned hospitalisations for asthma, diabetes or epilepsy in under 19s per 100,000 population  
                                   ● Individuals with long-term conditions feel independent and in control of their condition  
                                   ● The proportion of people who use services who have control over their daily life  
                                   ● Social care related quality of life  
                                   ● Carer reported quality of life  
                                   ● Survey question: Overall, how would you describe your experience of your GP surgery? |
| Process / implementation measures | Individual empowerment and self care | ● Proportion of people who use services and carers who find it easy to find information about support  
                                   ● Friends and Family test  
                                   ● Survey question: My GP was good or very good in involving me in decisions about my care  
                                   ● Survey question (for patients with long term conditions): In the last 6 months have you had enough help from local services and organisations to help you manage your long term conditions. |
Based on this, we have developed measures for our standards and their associated benefits across *Shaping a healthier future*. These emerging measures are included in Chapter 17. In the coming months, they will be refined further to ensure we can monitor progress against our out of hospital standards.

As new out of hospital services are developed, they will be aligned with these quality standards. Examples of how this is happening with new out of hospital services are included in Figure 8.6; further detail on the initiatives can be found in Chapter 8e.

**Figure 8.6: Examples of out of hospital initiatives delivering quality standards**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Examples of delivery across NW London²</th>
</tr>
</thead>
</table>
| **Individual empowerment and self care** | • New community services in CCGs across NW London include patient education and self-management  
• Integrated care pilots help involve patients in their own care and support self-management. |
| **Access, convenience and responsiveness** | • In line with NHS London quality standards, adults will wait no more than 20 minutes and children no more than 15 minutes to be assessed at an urgent care centre  
• 111 provides telephone access to non-urgent appointments  
• Rapid response reacts to urgent care needs within two hours  
• CCGs are using local enhanced services to extend access to primary care. |

² These are highlights from across the eight CCGs in NW London, and there is local variation in how services are commissioned.
8a. Development of out of hospital plans in NW London

### Domain: Care planning and multi-disciplinary care

- **Integrated care** across NW London embeds care planning and coordination, and providers are being required to work in new ways to enable this.
- Systems incorporating case management (e.g., Wellwatch, Hospital at Home) are being embedded across NW London.
- Improved **end of life care** will embed care planning, clear pathways and an end of life care register.
- **Multi-disciplinary groups**, aligned to networks of care, are in development across all CCGs in NW London.
- **Pooled budgets** between health and social care enable multi-disciplinary working.

### Domain: Information and communication

- **Common and integrated IT systems** (e.g., SystmOne, EMIS Web) are being developed in CCGs across NW London.
- **Virtual wards** enable information sharing for admitted patients.
- ‘**Co-ordinate My Care**’ enables the sharing of care records for patients in the last year of life.
- **Re-ablement, rehabilitation and rapid response teams** share information to ensure effective discharge planning.

#### 8.5.7. Delivering out of hospital services

Central to the successful delivery of *Shaping a healthier future* is the successful delivery of the eight CCGs’ out of hospital strategies. Therefore, we are focusing on delivering new services in line with these strategies.

In 2012/13, the CCGs began to deliver their out of hospital strategies, supported by NW London-wide developments such as integrated care pilots and 111. Since consultation, CCGs have progressed in their planning for 2013/14, and we can now provide detailed intentions for next year that indicate there is further progress planned in 2013/14 that will ensure we have the services we need to make *Shaping a healthier future* a success. Appendix J contains the Commissioning Intentions. Please note, these Commissioning Intentions are currently being updated and the latest proposals can be found on CCG websites.

This will require investment, and we have developed our modelling since the consultation to provide estimates of the revenue and capital needed for new services from 2013/14 to 2017/18.

Details of the progress made in 2012/13, the plans for 2013/14 and the planned investment in out of hospital services can be found in Chapter 8e and Chapter 16. The implementation of out of hospital care by each CCG is described in Chapter 16. In addition, an implementation plan for *Shaping a healthier future* – including out of hospital services – can be found in Chapter 17.
8b. Primary care development

8.6. Supporting primary care across NW London

The development of primary care is recognised as a central strand of delivering care out of hospital and critical to ensuring that patients have both easy access to care and integrated care when they need it.

GP practices will continue to offer core primary care services, and as GP networks and other integrated ways of working develop, these local networks will be able to offer additional expertise and capacity for more appointments. In addition, depending on local needs, some existing community sites will provide other services locally, serving as a support “hub” to local integrated teams. The services offered at these hubs will vary depending on local needs and infrastructure, ranging from bases for multidisciplinary teams working together to “one-stop” local centres for GP appointments, diagnostics and outpatient appointments. Finally, all patients will have access to urgent care 24 hours a day, seven days a week at their local hospital through urgent care centres. In the future, residents in NW London will experience a coordinated and integrated health and social care service using evidence-based pathways, case management and personalised care planning.

This will require close management of demand at peak times. Out of hospital care will enhance its seven-day a week service, with telephone advice and triage, in conjunction with Urgent Care Centres, available 24 hours a day, seven days a week. To improve access at peak times, a wider range of access routes into services will be developed, e.g. face-to-face, by telephone, by email and by video consultation. Some practices already offer email consultations, or contact people by text and this will be expanded for those patients who want this rather than more traditional consultations.

Demand on general practice is already high, and in order to achieve our vision for out of hospital care practices we will need to work both collaboratively and innovatively. There are a number of areas in which practices have already started to work in new ways and to inform further developments NHS NW London has completed a significant research programme, involving the surveying of over 1,000 patients registered with GPs in the area, to understand their priorities for the service.

A programme of activity has been agreed between all CCG chairs in NW London which will enable them to work together to support over 400 practices in the area to realise the ambition of delivering better care closer to home. This programme will run throughout the implementation out of hospital strategies to ensure that primary care is prepared for the activity shift resulting from these strategies.

8.7. Patient priorities

NHS NW London, on behalf of the CCG chairs, has conducted research into the priorities of patients in the area by surveying over 1,000 patients. The methodology was to initially use research literature to develop a long list of over 200 aspects of General Practice important to patients. This list was reduced to 59 items and discussed at two patient workshops with a total of 100 participants. Participants from the workshops ultimately voted on their most important items and from this a list of ten priorities was established which was shared more widely through a street survey of 1,040 patients. This process is summarised in Figure 8.7.
Figure 8.7: The process of establishing patient priorities for primary care

The process we have gone through to understand patient priorities is as follows:

Stage 1: Literature review (October)
- A thorough review of the literature was conducted to identify aspects of General Practice important to patients, from this a list of over 200 aspects was compiled
- This was consolidated to a list of 59 distinct things which were grouped into categories. (Relationships with professionals, access, healthcare setting, information and communication, co-ordinating with the wider healthcare system)

Stage 2: Workshops (10th and 12th November)
- Two workshops were held with a combined attendance of 93 people, reflective of the population of North West London in terms of demography
- Some PFAG and PPE representatives were also invited and chose to attend
- The outcome of these workshops was a ranked list of the 59 priorities along with a record of the discussions from the day and a video recording patient experiences

Stage 3: Street survey (Late November)
- A representative sample of North West London’s population (1,040 people) was surveyed
- The survey included a question to rank the top 10 priorities identified in the workshop and additional questions about access and use of UCCs
- The survey provided a robust data set for analysis

Stage 4: Final list of patient and public priorities (December)
- The results of the workshop and survey were analysed and a final priority list established
- The patient priority list was compared with the GPPS data to evaluate how we are doing on the factors which patients find most important

Note:
The following additional patient engagement has been carried out:
- Discussions with CCG patient representative groups
- Workshops with patients with learning difficulties and non-English speakers
- Patients from a variety of BME groups

From the survey, we have been able to understand the ranked top ten items of importance. These are outlined in Figure 8.8.

Figure 8.8: Top 10 priorities from primary care survey

<table>
<thead>
<tr>
<th>Survey</th>
<th>Mean rank</th>
<th>1st priority (%)</th>
<th>In top 3 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can quickly get an emergency appointment when I need one.</td>
<td>3.8</td>
<td>26</td>
<td>56</td>
</tr>
<tr>
<td>I have enough time in my appointment to cover everything I want to discuss.</td>
<td>4.5</td>
<td>19</td>
<td>44</td>
</tr>
<tr>
<td>I can rely on getting a consistently good service at my GP surgery.</td>
<td>4.7</td>
<td>12</td>
<td>44</td>
</tr>
<tr>
<td>I am confident that my GP can correctly diagnose my condition and inform me about the best treatments.</td>
<td>4.9</td>
<td>11</td>
<td>34</td>
</tr>
<tr>
<td>There are a good range of diagnostic tests and services available at my GP surgery.</td>
<td>5.6</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>I have a continuing, trusted, personal relationship with a named health professional...</td>
<td>5.9</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>If my GP doesn’t have the specialist knowledge necessary to help me I have easy access to other health professionals who do.</td>
<td>6.0</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>I am treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty.</td>
<td>6.2</td>
<td>7</td>
<td>21</td>
</tr>
<tr>
<td>I can easily get through to someone on the phone if I need to make an appointment or ask for information or advice.</td>
<td>6.3</td>
<td>6</td>
<td>21</td>
</tr>
<tr>
<td>There are no big gaps between seeing the doctor, going for tests and getting the results.</td>
<td>7.0</td>
<td>4</td>
<td>14</td>
</tr>
</tbody>
</table>

* The average rank from all respondents – this measure has been used to order priorities
** % of patients who ranked this item as their top priority (shows the distribution of answers)
*** % of patients who ranked this item as one of their top 3 priorities (again shows the distribution of answers)

In addition the survey showed that, in terms of access, being able to get an urgent or same day appointment and being able to get through easily on the phone were the highest priorities. Around 25% of patients had used urgent care (A&E or urgent care centre) for a
consultation they could have received from their GP, with 70% of these identifying the reason as having an urgent medical need. This demonstrates the importance for patients of having confidence that they will get a same day appointment at their General Practice if they need one.

Figure 8.9: Results of the access questions on primary care survey

<table>
<thead>
<tr>
<th>Survey ranking of six aspects of access</th>
<th>Mean score</th>
<th>1st priority (%)</th>
<th>In top 3 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can easily get through to someone on the phone if I need to make an appointment or ask for information or advice.</td>
<td>2.5</td>
<td>38</td>
<td>74</td>
</tr>
<tr>
<td>When I arrive for my appointment I’m seen punctually and not kept waiting for too long.</td>
<td>2.9</td>
<td>21</td>
<td>67</td>
</tr>
<tr>
<td>There are a variety of appointment types available (e.g. face-to-face in the surgery, home visit, quick phone conversation) so I can choose what’s best for me.</td>
<td>3.5</td>
<td>11</td>
<td>53</td>
</tr>
<tr>
<td>I have access to a walk-in service so I don’t always need to make an appointment.</td>
<td>3.6</td>
<td>13</td>
<td>47</td>
</tr>
<tr>
<td>I have access to a range of health professionals and can choose to see someone I feel comfortable with.</td>
<td>4.2</td>
<td>11</td>
<td>33</td>
</tr>
<tr>
<td>The receptionists are friendly and helpful. They try to understand my individual circumstances and find a solution that suits me.</td>
<td>4.2</td>
<td>8</td>
<td>30</td>
</tr>
</tbody>
</table>

A notable and significant finding from the research was that patient priorities vary little by demographic group but vary consistently by condition. Where patients experience a minor acute problem they prioritise seeing any professional urgently, whereas in situation of high worry or long-term illness patients value seeing a healthcare professional with whom they have a prior relationship as it gives them more confidence.

These priorities can be grouped into three overall domains, which are emerging as the priorities for primary care development: quality, access and integration of services. These are outlined in Figure 8.10. The results of this study will be used to further develop the programme of primary care development with the chairs of the CCGs across NW London.
8.8. GP Outcomes Framework

NHS NW London has pioneered the use of the GP Outcomes Framework within its CCGs. Training in the tool has been provided for all CCG boards and wider CCG membership where requested, and this is a key enabler to effective peer review and self-review of practices.

In addition, significant analytical work has been done to understand the quality outcomes of practices in a way that will help CCGs in their support of continuous improvement. This has also been correlated with the financial position of practices in order to give a complete picture of the value-for-money landscape.

This has enabled practices to focus on areas of improvement, such as flu vaccination, and on feedback to the Outcomes Framework to improve the accuracy of measures.

8.9. Networks of care

All practices in NW London are aligned to a network of 5–15 practices. These practices are encouraged to support each other through peer-review and to share good practice. In addition networks are starting to consider how they might work together in new ways, for example by sharing specialist clinics or staff.

In some CCGs, multi-disciplinary groups operate in addition to networks. These groups provide a forum for discussion of patient pathways not only amongst GPs but with a wider group of healthcare professionals. This enables a more integrated experience of care for patients and also facilitates the development of consistent procedures between practices based on the joint experience of professionals.
8.10. Next steps

We are developing a programme of primary care development to support the 400 practices across NW London to deliver consistently high quality care in more efficient ways over the next three years. This programme will aim to provide the infrastructure that will support new ways of working along with support for the piloting of new ideas.

It is expected that this programme will be focused on developing primary care by encouraging innovation and entrepreneurship, and will recognise the need for infrastructure improvements (including workforce, estates, information, training, IT and organisational development). It is expected that this programme will focus on:

- Recognising the good current provision of care in general practice but also variation in performance and gaps in quality
- Prioritising patient experience and needs and recognising the need for it be more consistent
- Ensuring General Practice owns the agenda
- Commissioning additional services from practices that deliver against agreed quality standards.

This change will be led by the CCGs, and we will work with the CCG chairs, NHS Commissioning Board, patients and other key partners to develop the programme further and agree actions for 2013/14.

Alongside this, reducing variation in primary care is a key priority for Imperial College Health Partners, which has applied to become an Academic Health Science Network. Whether or not the Network is authorised as an AHSN, CCGs will look to harness the knowledge and skills of local partners to support improvements in primary care, for example through the clinical input of specialists, the development of more sophisticated measures of variation and a greater use of technology.
8c. Out of hospital estates

8.11. Delivering the estate we need for out of hospital

Based on the vision outlined by the CCGs and the views of the public, service models for the delivery of out of hospital care have been developed. These are described as part of the vision for *Shaping a healthier future* in Chapter 7, and are crucial to the delivery of the CCGs’ out of hospital strategies.

This infrastructure for delivering out of hospital services uses three of the elements of the model described in Chapter 7: local hospitals, hubs/health centres and networks of care.

- **Local hospitals** will offer a range of out of hospital services to their locality, including outpatient appointments, associated diagnostics and urgent care
- **Hubs/health centres** will provide a setting for a further range of services across all CCGs, including outpatient appointments, diagnostics, social care and therapies
- **Networks of care**, formed of GP practices, will offer opportunities for joint working between GPs and enhance the capacity of primary care to deliver out of hospital services.

To understand the requirements for each of these settings, we have engaged CCGs and providers further and reviewed the service models and estates requirements of local hospitals, hubs/health centres, networks, and primary care. This has enabled us to develop service models for different settings of care based on the recommendation and provide estimates of the financial implications of changes to delivery models and estates.

For our hubs/health centres and networks of care, this development has involved going further than our original, pre-consultation plans suggested. Following feedback from stakeholders, and the results of consultation, we have considered a range of options for the delivery of out of hospital services, ranging from the minimum required to deliver *Shaping a healthier future* to alternatives including a wider range of services at certain sites; we will be exploring these options further if the recommendation is agreed.

The options considered for each setting of care are summarised in this section (see below and Figure 8.11). Details of each the networks of care, hub/health centre and local hospital are included in the relevant CCG sections in Chapter 16.
We have identified the changes in our healthcare estate needed to deliver these services, which has enabled us to understand the capital implications. Our planned investment in the delivery of out of hospital care is included in Chapter 16.

8.11.1 Local hospitals

The benefits of local hospitals are more than just a matter of geographic proximity: local hospitals will be part of the local community. In practice, this means local patients, patient groups, the voluntary sector, the local council including the Health and Wellbeing Board, and local clinicians will be involved in developing and running the hospital. The services it offers will be based on the needs of the local population, determined through the Joint Strategic Needs Assessment process. As a practical consequence, beyond a core set of services, in the future there will be greater diversity of what is provided, dependent on the needs of local populations.

The local hospital will also act as the home for the local clinical community – a place for education and training, for continuing professional development, for clinicians and other professionals to come together to review and improve patient care. It will act as a repository for local knowledge and for the exchange of best practice, and as centres for research. As such, the local hospital will act as an engine for improvement across the wider health system.

The local hospital must be a seamless part of the landscape of care delivery, interconnected to the networks of GP practices and other out-of-hospital services and networked with local A&Es. This means that hospital-based professionals must be members of the wider out-of-hospital team, involved in the planning and coordination of care, and connected to the information systems that enable them to deliver. The 111 telephone advice service will be fully aware of the capabilities of each local hospital, and able to direct patients to attend if appropriate.
Delivering routine care close to home

The local hospital is designed to provide care close to patients' homes as part of a seamlessly integrated system including GPs, community services and major hospitals. The local hospital will provide the base from which much routine care is offered to patients in the future.

- **Earlier intervention and better coordinated care** - we recognise that people, particularly the elderly, frequently have several different conditions; they do not fit neatly into one specialty or another, and their needs are wider than their medical diagnosis – in short, people want, need, and deserve a holistic approach. This implies a multi-disciplinary approach that spans across primary, community, mental health, and specialist care and between health, social care, and other public services. The local hospital will act as a resource for specialist care for people with long-term conditions. Furthermore, the local hospital will act as a community resource. It will be a place to bring patients and carers together in self-care and support groups, expert patient programmes, structured education, and so on. Some GP practices and community services may be based in the local hospital, and it may also host the coordinators of health and social care.

- **Specialist opinion** - there will be times when specialist opinion is required to provide high quality care for patients. This specialist opinion will be accessible through multiple channels: through email or phone consultation between GPs or other professionals and specialists; through discussions at multi-disciplinary case conferences; or through traditional referrals from GPs to specialists for assessment, recommendations for treatment options, and the updating of care plans.

- **Specialist care** - in some cases, patients may require on-going specialist outpatient care. Many of these outpatient consultations will be provided in local hospitals, including pre-operative assessments and post-operative reviews. Some patients, for example, with Parkinson’s Disease or children requiring insulin for diabetes, will require a lifetime of specialist care, which will be provided close to home at the local hospital. In addition, some local hospitals will have the facilities to provide community-based treatments such as medical oncology, renal dialysis, day-case surgery, and other interventions.

- **Complex diagnostics** - Both generalist and specialist physicians will sometimes need investigations to enable them to make a diagnosis or to follow up on the efficacy of a course of treatment. Complex diagnostics such as x-ray, ultrasound, Endoscopy or MRI may be provided in local hospitals, supporting patients and professionals with the information they need to make the best possible decision about what care is required.

- **Services located together** - The local hospital will act as a venue for co-locating services to be organised around disease groups. This might include day assessment and planning facilities for elderly patients, with co-ordinated transport to and from home, an integrated facility for musculoskeletal and pain management services, or a urology and gynaecological one-stop-shop. Bringing together the breadth of clinical practice and diagnostics, it will enable patients and their carers to agree a diagnosis and a revised care plan.

- **Enhanced nursing, therapy and rehabilitation services** - Local hospitals will have the facilities to offer enhanced nursing, therapy, rehabilitation and community services such as physiotherapy, well-baby clinics, chiropody and wound clinics. In
some cases, these will be offered on an outpatient basis, while for others, the local hospital will provide inpatient care to stabilise patients and prevent further deterioration in their condition. The local hospital may also offer ‘step down’ facilities for patients who have previously been admitted to specialist centres, enabling their recovery and rehabilitation closer to their families and community.

The types of treatments patients will visit a local hospital for are summarised in Figure 8.12.

**Figure 8.12: Why patients will visit local hospitals**

**Examples of the local hospital model**

There are examples of the local hospital model in the NHS. Figure 8.13 gives a summary of the current services offered at Queen Mary’s Hospital, Roehampton. Figure 8.14 gives a summary of the current services provided at St Charles, Ladbroke Grove.
Figure 8.13 Summary of current services provided at Queen Mary’s Hospital, Roehampton

Description
- Large community hospital, new building opened February 2006
- Provides a wide range of community and other services including inpatient beds, outpatient clinics, a minor injuries unit and a sexual health clinic, as well as the world famous amputee rehabilitation centre.

Services
- Emergency nurse practitioner staffed walk in centre/minor injuries unit
- Outpatient clinics
- Inpatient psychiatry and elderly care
- Specialist community services
- On site radiology, pathology, outpatient diagnostics
- Therapy services
- Pharmacy
- Minor procedures
- Wheelchair and rehab services
- Mental health community services
- Day hospital for the elderly
- Sexual health clinic
- Prosthetic limb fitting services
- Specialist rehab services.

Infrastructure
- Housed in a state of the art, four-storey building containing a full range of modern diagnostic equipment
- Total development cost of £55 million.

Source: Wandsworth Teaching PCT website

Figure 8.14 Summary of current services provided at St Charles, Ladbroke Grove

Description
- The main aim of the centre is to offer people the support and or treatment to keep them healthy and prevent them from going to hospital.

Services
- Urgent Care Centre
- Minor injuries unit
- Walk-in Centre
- GP services
- X-Ray and Ultrasound
- Palliative medicine
- Pharmacy
- Family planning services
- Phlebotomy services
- Community podiatry services
- Community dentistry
- Weight management
- Smoking cessation.

Infrastructure
- Further development continues to restore the historic building enabling new services to move on site, including charities and third sector organisations.

Source: NHS Choices and Kensington & Chelsea PCT website
**Process for development of local hospital service models**

For each hospital, we have estimated the financial and estates implications of providing these services at each local hospital site. This process is summarised in Figure 8.15.

**Figure 8.15: Process of development of local hospital service models**

<table>
<thead>
<tr>
<th>Description of step</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site context and Shaping a Healthier Future (SaHF) implications</td>
<td>Review existing activity information from Trust</td>
</tr>
<tr>
<td>Description of clinical services and activity</td>
<td>Sense check against site visits</td>
</tr>
<tr>
<td>Space requirement for service mix</td>
<td>Test information with Trust</td>
</tr>
<tr>
<td>Current site configuration</td>
<td>Review consultation document</td>
</tr>
<tr>
<td>Required capital expenditure</td>
<td>Describe constraints on site use</td>
</tr>
<tr>
<td>Site economics (include revenue and costs)</td>
<td>Identify main services on site</td>
</tr>
<tr>
<td>Align with CCG strategy</td>
<td>Quantify activity at the site after the reconfiguration</td>
</tr>
</tbody>
</table>

This process has supported the further work undertaken to address how the local hospitals under the recommendation will be clinically and financially sustainable and be developed including changes to estates and capital expenditure requirements. More information on this can be found in Chapter 16.

**8.11.2. Hubs / health centres**

In their out of hospital strategies pre-consultation, the CCGs articulated their vision for delivering out of hospital services and looked in detail at the activity to be re-provided in response to activity avoided in acute. Since then, we have engaged with the CCGs to describe the distribution of services across different hubs/health centres, specify the space requirements, and estimate the volumes associated with the estates being planned. In parallel, a survey of potential sites was conducted to assess high level capacity and condition at these estates. The process of developing models for hubs/health centres is outlined in Figure 8.16.
**Figure 8.16: Approach to developing hub/health centre service models**

<table>
<thead>
<tr>
<th>Description of step</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Work with CCGs to confirm OOH vision, including specifying the distribution of services across different types of sites: hubs, nodes in a provider networks, or GP practices</td>
</tr>
<tr>
<td>▪ For key OOH service lines, determine differential space requirements either by estimating volumes where possible or estimating room requirements directly; build on previous OOH work and update with latest CCG QIPP/intentions where required</td>
</tr>
<tr>
<td>▪ Apportion differential requirement to individual hubs and then to provider networks and GP practices overall based on the distribution specified</td>
</tr>
<tr>
<td>▪ Assess whether space is in the right place and confirm quality of space available overall and for hubs /priority sites (existing condition and spare capacity provided by DJD)</td>
</tr>
<tr>
<td>▪ Assess capital requirements to make the estates fit to deliver OOH plans, based on condition and high-level estimates from the DJD estate review of cost to bring the building to an acceptable condition; estimate capital released as needed; develop performance standards to be linked to capital discussions</td>
</tr>
<tr>
<td>▪ Check high level affordability of the estates plan for each of the CCGs</td>
</tr>
</tbody>
</table>

Differential requirements refer either to the incremental requirements estimated in the OOH strategy work or to additional changes contemplated by CCGs (e.g., moving GP practices to a common site)
The result is an emerging picture of the hubs/health centres for NW London, including where estates need to be converted, extended, or built, and the types of services that patients will experience on site, including core primary care, enhanced out of hospital services, mental health services, and outpatient appointment. An indicative map of sites across NW London is provided as Figure 8.17.
Figure 8.17: Potential hubs/health centres across NW London

Locations shown are approximate
Across NW London, these sites will deliver a range of intermediate services, including extended primary care, management of long-term conditions, diagnostics, therapies and outpatient services (including consultant-led clinics).

Delivering these hubs/health centres is expected to require investment of £6 million for the minimum needed for *Shaping a healthier future* and £60–112 million for the range of enhanced services to offer a fuller clinical service at each site. These are indicative estimates: in the coming months, more detailed work will be carried out to deliver outline business cases for the investment in these sites, including detailed work on affordability.

Initial assessments of revenue affordability for individual proposed hubs suggest 58% of them would be affordable under current assumptions and affordability is most challenging for new-build hubs. Further work is required in this area and investments for each individual site will require an outline business case including detailed analysis of revenue affordability in the next phase of this process.

This configuration of hubs is based on the configuration of services outlined in the recommendation. A different option would result in a different range of hubs, reflecting changes in local hospitals. However, overall investment would remain the same.

Chapter 16 details – for each CCG – the services modelled for these locations, the associated volume, and the estimated investment needed.

### 8.11.3. GP premises

Pre-consultation, the CCGs articulated their vision for delivering out of hospital services and looked in detail at the activity to be re-provided in response to activity avoided in acute. Since then we have engaged with the CCGs to describe the distribution of services across the boroughs and the condition of different estates.

In parallel, a survey of GP premises was conducted in seven of the CCGs. The estates review, which eventually reached nearly half of practices in the participating CCGs, looked at the condition of GP estates as well as the cost for any upgrades needed to meet condition standards and ensure the sites comply with access legislation. This process is outlined in Figure 8.18.

NHS Brent CCG conducted an independent review, which has been aligned with the findings of the NW London-wide work.
The aim of this work was to understand how primary care estates in NW London can be used to deliver out of hospital services and how investment in the estate can be best prioritised to improve quality and capacity. The findings of this survey are summarised in Figure 8.19.

The investment identified by this review is of two types. Many practices can be upgraded to meet condition and accessibility standards with relatively low capital investment in existing buildings. However, a number of practices have significant constraints, which mean they...
need redeveloping or rebuilding to meet estates standards. Both these costs have been considered within the overall capital estimates for out of hospital services.

Indicative investment estimates are included as Figure 8.20, based on an extrapolation of those practices that participated in the survey. The survey indicates that approximately £5 million may be needed to upgrade existing premises across NW London and £69 million may be needed to redevelop or rebuild those premises that have structural constraints preventing upgrades. This is total investment in primary care estate of up to £74 million.

**Figure 8.20: Estimate of GP premises investment**

<table>
<thead>
<tr>
<th>Key assumptions</th>
<th>Estimated cost – for premises surveyed and in database¹</th>
<th>Estimated cost – extrapolated to all CCGs²</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Upgraded / Make compliant:</strong></td>
<td>Upgrade/make compliant</td>
<td>Rebuild/reprovision</td>
</tr>
<tr>
<td>• Cost to upgrade based on survey and estimates of work needed by estates specialists (for surveyed premises)</td>
<td>17</td>
<td>13</td>
</tr>
<tr>
<td>• Projection scaled based on list size</td>
<td>Non-DX</td>
<td>DX</td>
</tr>
<tr>
<td><strong>Rebuild / Reprovision:</strong></td>
<td>Upgrade/make compliant</td>
<td>Rebuild/reprovision</td>
</tr>
<tr>
<td>• GP premises assumed to occupy reduced footprint due to improved utilisation and opening hours³</td>
<td>5</td>
<td>40</td>
</tr>
<tr>
<td>• Cost to build per sq.m is half that of hubs (£2.6k)</td>
<td>Non-DX</td>
<td>DX</td>
</tr>
<tr>
<td>• Some premises modelled to co-locate to hubs (smaller premises and Dx rated³,⁴)</td>
<td>13</td>
<td>29</td>
</tr>
<tr>
<td>• Average cost of land/sqm of built space varies by CCG depending on typical plot sizes for 100 sq.m of built space (plot sizes do not necessarily scale to building space)</td>
<td>6</td>
<td>74</td>
</tr>
</tbody>
</table>

1 Excludes Brent
2 For all 7 CCGs participating in survey, extrapolated based on participating practices; Brent CCG estimated based on Ealing figures
3 Some of the smaller practices (i.e., less than 3k patients) will co-locate in the process of reprovision
4 Where there the hub modelling involves co-location of GP practices, these are assumed to be DX practices where possible and cost is not double-counted across the hub and the GP practice estimates
5 approx. 30m2 per 1000 patients on the list size

Based on extrapolations from our survey, assumptions about utilisation, and average rental rates across NW London, we have also considered the impact of this investment on GP rent reimbursements, as any investment may have an impact on rent reimbursement from the NHS Commissioning Board (NCB).

The decision to invest in GP practices needs to be linked to investment principles agreed by the CCGs and partners, including commitments to minimum performance standards that improve quality for primary care patients. If the recommendations are agreed, such criteria will be agreed before investments are made.

Following on from this work we will work with the NCB to understand further the impact on rent reimbursement, develop and agree criteria for investing in our premises, and develop a case for capital investment based upon this. This work aligns closely with our plans for primary care development, outlined in Chapter 8b, and will be supported by this developmental work.

**8.12. Delivering the estates for our out of hospital strategies**

As a result of this developmental work, we are confident that we can provide the estate we need to deliver the out of hospital strategies across NW London. Across our local hospitals,
hubs/health centres and primary care estate, we will re-configure existing estates and develop new buildings that have enough space.

In addition, separate work across NW London has been ongoing to explore the ways in which local hospital sites (Central Middlesex Hospital, Charing Cross Hospital and Ealing Hospital) can be developed further. The conclusions of this work suggest ways that we can enhance these local hospitals to the equivalent of a health and social care specialist hospital and offer an enhanced range of services. This work will be developed further if the recommendation is agreed.
8d. Urgent care centres

When individuals have urgent medical needs, it is important that they can access advice or care as rapidly as possible. In the new system of out of hospital care, people will be able to access services through a number of routes. These include community pharmacy, extended GP opening hours, greater availability of telephone advice from the practice or through 111, and GP out-of-hours services.

Today, many patients present at A&E with conditions that could be managed more appropriately in primary care. To ensure that these patients are treated in a setting appropriate to their clinical need, it is proposed that urgent care centres will be provided at all hospital sites on a 24/7 basis. Essential features of the UCCs would be:

- **Treatment** - where possible, UCCs will seek to resolve the patient’s health problem conclusively. This means that the patient will be able to return home with their problem addressed, for example, with a clear plan for self-management or for further appointments with their GP or another NHS provider. The UCC will be capable of treating patients with a wide range of illnesses and injuries. This will include the interpretation of X-rays and other diagnostics and investigations, the treatment of uncomplicated fractures, non-complex regional anaesthesia for wound closure, incision and drainage of abscesses not requiring general anaesthesia and minor ENT and ophthalmic procedures. Follow-up where it is clinically necessary, would take place in the UCC. Other types of follow-up care (for example, wound management) are undertaken by other out of hospital services under the care of the patient’s own GP.

- **Escalation** - clinicians within all UCCs will be competent to assess and stabilise patients requiring transfer to A&E departments. When the A&E department is not on the same site, agreed protocols will be in place to ensure rapid transfer to the appropriate specialist service. Examples might be patients with a complex fracture of upper and lower limbs and likely to require manipulation and patients needing procedures requiring sedation. Furthermore, clinicians in UCCs will develop strong working relationships with those in acute facilities; this will extend to the rotation of staff between acute and urgent care facilities to strengthen the bond between them.

- **Health and social care rapid support service** - all UCCs will be linked with community services to allow for an immediate assessment of needs, so that the appropriate package of services is in place for when the patient returns home. For example, patients who require meals on wheels to support independent living.

- **Admission to community beds** - all UCCs will be able to admit patients to community beds if their assessment indicates that this is appropriate. In some cases, these community beds will be on the local hospital site.

- **Signposting** - all UCCs will work collaboratively with colleagues in general practice to ensure that, when appropriate, patients are advised to seek care from their local GP in future instances. In addition, UCCs will support people to register with a local GP in cases where they are not already registered.

It is estimated that 60-80% of the patients currently seen within A&E could be seen at a UCC.

The Emergency and Urgent Care CIG has recommended a single, consistent operating model, with appropriate localisation, be implemented at all NW London UCCs. Further details on UCCs are found in Section 7b.
8.13. Developing a consistent specification for urgent care centres

Feedback from consultation emphasised the need for a consistent urgent care centre specification across NW London. In response, we established the Emergency and Urgent Care Clinical Implementation and Planning Group (E&UC CIG). The purpose of the CIG was to:

- Develop recommendations in response to pre-consultation review, consultation feedback and input from clinicians, providers and commissioners
- Ensure that the implications for emergency and urgent care were communicated and fully understood at a local level, and that clinical colleagues are kept informed
- Ensure that plans for implementing changes to emergency and urgent care received appropriate input from clinicians and patients.

Over a six month period, the E&UC CIG conducted a significant programme of stakeholder engagement and considered evidence from a broad range of sources.

UCCs are intended for patients with urgent primary care needs and who therefore do not require treatment at an A&E department. They have strong links with other related services, including GP practices, community services and community pharmacies. They are also networked with local A&E departments, whether on the same hospital site or elsewhere, so that any patients who do attend an urgent care centre with a more severe complaint can receive care appropriate to their condition quickly.

On completion of this programme of work the E&UC CIG made the following recommendations for urgent care centres:

1. **Nine urgent care centres in NW London.** They will be located at both major hospitals and local hospitals
2. **All UCCs will operate on a 24/7 basis**
3. **London Health Programmes quality standards covering emergency departments should be adopted** in addition to those London Quality Standards – emergency and maternity care already stipulated pre-consultation
4. **All urgent care centres in NW London will operate to a consistent set of standards**, irrespective of whether they are co-located with an emergency department
5. **An urgent care centre is a primary care service and will be expected to operate with a distinctive primary care ethos.** This will be reflected in staffing, case-mix, integration with local primary care services and the implementation of positive re-direction back into the care of the patient’s registered GP
6. **The urgent care centres should partner with a specific emergency department.** The partnership should include oversight of joint governance arrangements (e.g. a Joint Clinical Governance Group)
7. **Robust transfer protocols will be implemented** to ensure that, where necessary, urgent care centre patients can be transferred to emergency departments in a manner that is both timely and clinically safe
8. **Detailed modelling work has been conducted to understand anticipated emergency department and urgent care centres activity volumes,** including the likely volume and acuity of urgent care centre to emergency department patient transfer, and its impact on patient experience, the London Ambulance Service and other ambulance transport services.

Figure 8.22 outlines the key features of the urgent care centre specification developed by the E&UC CIG. This specification is explored in more detail in the following section.
### 8.14. Intended service outcomes

Urgent care centres will work on the principle that all patients should receive a consistent and rigorous assessment of the urgency of their need and an appropriate and prompt response.

The aims and intended service outcomes are:

- The service model is based upon the need to provide improved access to urgent, unplanned care, while ensuring that the patient’s on-going healthcare needs are met in the most appropriate setting within the community or primary care. This may involve streaming patients back into services (e.g. GP practices, community services) via a process of positive re-direction.

- The urgent care centre will operate over 24 hours, 7 days a week, and will share a single reception with the emergency department (if co-located). The urgent care centre will act as a single point of access to on-site emergency (if co-located) and urgent care services for walk-in patients.

- The urgent care centre will integrate with current service provision but will develop the distinctive culture and approach of a primary care service, with experienced and appropriately skilled primary care clinicians leading the service, working alongside other healthcare professionals undertaking assessments and seeing and treating patients.

- The urgent care centre will not constitute a further access point for routine NHS care in the health economy; neither will it allow duplication of existing services. Patients attending who do not have urgent care needs will be supported by staff in the centre to access advice and care from their local community pharmacist, or to make an appointment with their own GP within the target timescales.

- Service providers of the urgent care centre and the emergency department will be required to work together to ensure integrated and seamless care pathways.

---

#### Figure 8.22: NW London urgent care centre specification – key features

<table>
<thead>
<tr>
<th></th>
<th>Primary care led</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>- Staffed by at least one GP at all times</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Staffed by multi-disciplinary teams including GPs, nurses, emergency care practitioners</td>
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<table>
<thead>
<tr>
<th></th>
<th>24/7 service model</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>- Service available 24/7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- This includes 24/7 availability of dispensing and diagnostic services with X-ray either on site (or where not available on-site, e.g. during periods of low activity, patients should be transferred to an alternative site within 90 minutes if necessary)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Ability to treat minor injuries</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>3</td>
<td>- Able to treat minor injuries (including minor fractures) in addition to minor illness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- 24/7 access to (and ability to interpret) X rays and ‘rapid’ (60 minute) diagnostics</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th></th>
<th>Integration with General Practice</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>4</td>
<td>- Positive re-direction of patients to a service appropriate to their needs (e.g. GP, pharmacy)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Unregistered patients supported to register with a local GP</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Integration with ED</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>- Single point of walk-in access for on-site emergency and urgent care services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Seamless, clinically safe transfer of patients from UCC to ED; access to specialist advice from ED consultants and others (e.g. orthopaedics)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Integration with community services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>- Close integration with Rapid Response teams; Psychiatric Liaison Teams</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Well defined pathways for onward referral of patients into the care of community, social care and mental health services</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Facilities for paediatric patients</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>- Appropriate training and competences to provide suitable care for paediatric patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Dedicated paediatric waiting area</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Integration with GP out of hours services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>- Aspiration to co-locate with GP OOH services where feasible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Integrated with advice services/ switchboards – e.g. 111</td>
<td></td>
</tr>
</tbody>
</table>
The urgent care centre should ensure patients receive a consistent and rigorous assessment of the urgency of their needs and an appropriate and prompt response.

The urgent care centre information and communication technology processes should be inter-operable with both GP and Trust systems in order to facilitate effective information sharing.

The main elements of the service will include streaming, registration and initial assessment; diagnosis and treatment; and referral and discharge.

8.15. Clinical scope

Figure 8.23 summarises the urgent care centre clinical exclusion criteria for adult and paediatric patients (please see the Chapter 7b for a more detailed list of exclusion criteria).

Many of the clinical exclusion criteria listed in Figure 8.23 will only be identified after clinical assessment. As a result, it will not always be possible to apply these criteria at the point of streaming. Some patients may therefore be identified as unsuitable for the urgent care centre during assessment or treatment.

The E&UC CIG has developed a detailed transfer protocol to ensure that patients assessed to be out of scope for the urgent care centre can be transferred to a more intensive setting of care safely.

**Figure 8.23: UCC clinical exclusion criteria**

<table>
<thead>
<tr>
<th>Conditions suitable for UCC</th>
<th>Clinical exclusions (adults)</th>
<th>Clinical exclusions (children)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The scope of the UCC will include both Minor Illnesses and Minor Injuries:</td>
<td>Markedly abnormal baseline signs</td>
<td>In addition to the adult exclusion criteria:</td>
</tr>
<tr>
<td>o cuts and grazes</td>
<td>Chest Pain (likely cardiac)</td>
<td>Acutely ill children (defined using PEWS)</td>
</tr>
<tr>
<td>o minor scalds and burns</td>
<td>Complex fractures (e.g. open fractures, long bone fracture of legs, spinal injury)</td>
<td>Paediatric head injury</td>
</tr>
<tr>
<td>o strains and sprains</td>
<td>Patients receiving oncological therapy</td>
<td>Procedure requiring sedation</td>
</tr>
<tr>
<td>o bites and stings</td>
<td>Sickle cell crisis</td>
<td>Multiple pathologies deemed to be complex</td>
</tr>
<tr>
<td>o minor head injuries</td>
<td>Acute Shortness Of Breath (inc. severe shortness of breath compared to normal, cyanosis, increased peripheral oedema)</td>
<td>Repeat attendances: 3 attendances in 3 months</td>
</tr>
<tr>
<td>o ear and throat infections</td>
<td>Signs of severe or life threatening asthma</td>
<td>Fever with non-blanching rash</td>
</tr>
<tr>
<td>o minor skin infections / rashes</td>
<td>Airway compromise</td>
<td>Fitting</td>
</tr>
<tr>
<td>o minor eye conditions / infections</td>
<td>Acute exacerbation of heart failure</td>
<td>History of decreased or varying consciousness</td>
</tr>
<tr>
<td>o stomach pains</td>
<td>Burns (&gt; 5%; facial/eye; inhalation, chemical/electrical)•New CVA</td>
<td>Combination of headache, vomiting and fever</td>
</tr>
<tr>
<td>o suspected fractures</td>
<td>Significant DVT</td>
<td>History of lethargy or floppiness</td>
</tr>
<tr>
<td>The interpretation of X-rays and other diagnostics/ investigations will be in scope</td>
<td>Temporarily unable to walk</td>
<td></td>
</tr>
<tr>
<td>The treatment of Minor Fractures will be in scope.</td>
<td>Haematemesis/ Haemoptysis</td>
<td></td>
</tr>
<tr>
<td>Interventions considered in scope include:</td>
<td>Overdose / Intoxicated and not able to mobilise</td>
<td></td>
</tr>
<tr>
<td>o the manipulation of uncomplicated fractures</td>
<td>Acute psychosis / neurosis</td>
<td></td>
</tr>
<tr>
<td>o non-complex regional anaesthesia for wound closure</td>
<td>Significant head injuries</td>
<td></td>
</tr>
<tr>
<td>o incision and drainage of abscesses not requiring</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Conditions suitable for UCC

<table>
<thead>
<tr>
<th>Condition</th>
<th>Clinical exclusions (adults)</th>
<th>Clinical exclusions (children)</th>
</tr>
</thead>
<tbody>
<tr>
<td>general anaesthesia</td>
<td>o minor ENT/ophthalmic procedures</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• There will be no lower or upper age limit for UCC patients</td>
<td></td>
</tr>
</tbody>
</table>

### 8.16. Diagnostic scope

Only urgent diagnostic action will be initiated by urgent care centre clinicians. It is therefore not anticipated that the level of diagnostics provided will exceed that provided in a standard GP surgery, other than the additional diagnostics that may be required for minor injuries (e.g. X-ray).

Urgent care centre patients may require access to diagnostics where this would contribute to a decision regarding the patient’s immediate treatment or referral. It is therefore recommended that, with the exception of tests requested as part of an onward referral to a specialist clinic, all test results should be available within one hour.

The E&UC CIG recommends that the following investigations and diagnostics are available to UCC clinicians (Figure 8.24):

**Figure 8.24: Recommended urgent care centre diagnostics**

<table>
<thead>
<tr>
<th>Diagnostic area</th>
<th>Diagnostic tests available to UCC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Electrocardiogram (ECG)</strong></td>
<td>● ECG</td>
</tr>
<tr>
<td><strong>Haematology</strong></td>
<td>● Full blood count</td>
</tr>
<tr>
<td></td>
<td>● D-Dimer</td>
</tr>
<tr>
<td><strong>Biochemistry</strong></td>
<td>● Blood Glucose</td>
</tr>
<tr>
<td></td>
<td>● Pregnancy Test</td>
</tr>
<tr>
<td><strong>Microbiology</strong></td>
<td>● Urine</td>
</tr>
<tr>
<td></td>
<td>● Stool</td>
</tr>
<tr>
<td></td>
<td>● Throat, wound swabs etc.</td>
</tr>
<tr>
<td><strong>Radiology (X-ray)</strong></td>
<td>● Plain film for limbs and chest</td>
</tr>
<tr>
<td><strong>Ophthalmology</strong></td>
<td>● Slit lamp</td>
</tr>
</tbody>
</table>

In addition, the urgent care centre should have the ability to book other diagnostic tests as part of specific onward referral pathways (for example, DVT ultrasound).

### 8.17. Non co-located urgent care centres

Implementation of *Shaping a healthier future* would result in some urgent care centres operating from local, specialist and elective hospital sites. The fact that these urgent care centres will not be physically co-located with emergency departments has a number of implications for the shape of the services they will be able to offer, not least with regard to patient transfer, access to specialist opinion and calculations of clinical risk.

The E&UC CIG has considered the implications of commissioning non co-located urgent care centres carefully, and has developed a set of recommendations articulating how non co-located urgent care centres should differ from those that share a site with an emergency department.
Figure 8.25 summarises the key differences between co-located and non co-located urgent care centres.

### Figure 8.25: Key differences between co-located and non co-located urgent care centres

<table>
<thead>
<tr>
<th>Key differences</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access to diagnostics and investigations</strong></td>
<td></td>
</tr>
<tr>
<td>• If X-ray is not available on-site 24/7, patient care should be transferred to an alternative site (usually the partner ED) within 90 minutes.</td>
<td>• All UCCs should have 24/7 access to X-ray⁴. For some non co-located UCCs, X-ray may not be available on-site during periods of low activity.</td>
</tr>
<tr>
<td>• Non co-located UCCs must be able to process diagnostic tests on-site.</td>
<td>• 24/7 ‘hot’ phlebotomy labs are unlikely to be available at Local Hospital sites.</td>
</tr>
<tr>
<td>• Serious ‘999’ emergency cases should be transferred to an appropriate ED by the London Ambulance Service.</td>
<td>• A small minority of patients will present at the UCC with complaints that require immediate emergency transfer to ED</td>
</tr>
<tr>
<td><strong>UCC to ED transfer</strong></td>
<td></td>
</tr>
<tr>
<td>• The UCC will be expected to provide safe transport for non-emergency patients requiring transfer to ED.</td>
<td>• Some non-emergency patients requiring transfer to ED may not be able to make their way to an alternative service safely (e.g. some elderly patients, patients with a broken jaw)</td>
</tr>
<tr>
<td>• Patients needing further treatment at an ED but who require neither ‘999’ or ‘safe’ transport should be provided with advice and information on where to access follow-on care, and discharged from the UCC.</td>
<td>• UCC will be expected to confer with the patient in order to come to a decision on whether safe transport is required</td>
</tr>
<tr>
<td></td>
<td>• The receiving ED should be informed that the patient will be attending</td>
</tr>
<tr>
<td></td>
<td>• The patient should be provided with a case-number to ensure that they do not have to repeat registration and assessment on arrival at the ED.</td>
</tr>
</tbody>
</table>

⁴ This is the current London Quality Standards – Emergency and Maternity care, however this may be modified due to demand and cost. Suitable facilities must be available at another site with transfer protocols in place.
### 8.18. Urgent care centre workforce recommendations

Drawing on recommendations made by Healthcare for London\(^5\), College of Emergency Medicine\(^6\) and London Health Programmes, the E&UC CIG has proposed a set of minimum competences for urgent care centre staff and minimum levels of cover. Chapter 14 details the workforce implications and discusses the training and recruitment approach for UCCs.

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\(^5\) “A service model for urgent care centres – commissioning advice for PCTs” – Healthcare for London; January 2010

\(^6\) CEM (2011) Emergency Medicine The Way Ahead
8e. Delivering out of hospital care

8.19. Investment in out of hospital services

Across the care system, we will be investing in specific services to make these changes a reality. As the way in which services are delivered in NW London are changed over the next five years, investments in out of hospital services will result in more staff and better facilities to deliver it.

These investments have been developed based on modelling of the changes to investment associated with Shaping a healthier future over three years. As the programme will be delivered over five years, these have then been extended by two further years to provide estimates across the life of the programme.

This work suggests that in five years, we will be spending £190 million more a year on out of hospital services. In this time, we also expect to invest £81–229 million in our estate to ensure we have the buildings we need to provide services. This investment in primary and community care will result in greater capacity within out of hospital settings, thereby reducing the burden on hospital care. This level of investment in out of hospital will be required regardless of acute reconfiguration. Figure 8.26 summarises the initial plans for investment in out of hospital services. Detail on the implications of this investment for our workforce can be found in Chapter 16.

Figure 8.26: Planned investment in out of hospital services across NW London (2013/14–17/18)

The investment identified in the figures above is indicative, based on CCG strategic plans. Specific investments will need to be agreed through the normal planning and governance

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£43m is gross and excludes land sales. £190m is the additional recurrent revenue investment in out of hospital services. It will build up to this level over five years so that by 2017/18, we will be spending an additional £190 million annually on out of hospital services.
8e. Delivering out of hospital care

processes of the CCG and as such the production and agreement of robust business cases demonstrating both value for money and affordability to the CCG.

We therefore intend to undertake further work if the recommendation is agreed to design the new clinical models that would support the mix of services on the local hospital site, including:

- Engaging further with acute, mental health and community providers further on the benefits of moving services to local hospitals
- Examining productivity improvements that could be made by adopting different service models
- Confirming the mix, number and volume of services that best meet patients’ needs on the local hospital sites.

This further work would be used to develop outline business cases for each site verifying the mix of clinically appropriate and financially affordable services.

Chapter 16 provides a more detailed view of capital investment and affordability.

8.20. Progress across NW London

Across NW London, three key initiatives have supported all eight CCGs to begin to deliver out of hospital services in line with their strategies. These are the development of urgent care centres (see Chapter 8d), the deployment of 111 and integrated care. In addition, all the CCGs have, in their commissioning intentions for 2013/14, planned for a range of new services that will deliver major parts of their out of hospital strategies (see Appendix L).

These services enable the CCGs to deliver the vision articulated in their out of hospital strategies, and will be a key enabler of the recommendation for *Shaping a healthier future*. For further information on the implementation of the CCG strategies, please see Chapter 16.

8.20.1. 111

111 services are part of each CCG’s out of hospital strategy. **The aim of the 111 service is to provide people with an alternative to dialling 999** when they don’t believe that there condition is an emergency. The 111 service takes callers through NHS Pathways which determines where the patient should be seen and how quickly. Across NW London a comprehensive Directory of Service has been developed to support the 111 service; the Directory of Service tells the call handler which services are locally available to them.

Hillingdon, Hammersmith & Fulham, Central London and West London CCGs were all early pilot sites for the 111 service and went live in early 2012. Brent, Ealing, Harrow and Hounslow CCGs plan to go live in late February 2013.

The most recently available data is for December showing that in Hillingdon, 111 answered 5,568 calls. Of these calls:

- 96% calls were answered within 60 seconds exceeding the national standard of 80%
- There was a 15% ambulance dispatch rate.
- 17% of calls were referred to Clinical Advisor. In London the range of calls referred was between 16 and 32%.

The most recently available data for Hammersmith & Fulham, Central London and West London CCGs shows that 6,461 calls were answered in December. Of these calls:
- 95% were answered within 60 seconds exceeding the national standard of 80%.
- There was a 9% ambulance dispatch rate
- 16% of calls were referred to Clinical Advisor. In London the range of calls referred was between 16 and 32%.

**8.20.2. Integrated care**

The objective of integrated care – via our integrated care pilots (ICPs) – is to improve outcomes for thousands of patients with complex needs. This currently includes patients in the diabetic cohort, and patients over the age of 75 years. Over the coming months it will be expanded to include patients with chronic obstructive pulmonary disease (COPD) and coronary heart disease.

The ICP brings together providers across out of hospital care, social care, acute care and mental health to improve the co-ordination of care for patients, reducing unnecessary duplication with the intention of preventing unnecessary admissions to hospital.

The key components of integrated care are:

- **Risk stratification** – understanding the patients we care for and their level of risk of admission to hospital
- Having a **standardised care pathway** based upon the latest evidence-based knowledge
- Undertaking **care planning** for patients, setting goals jointly and formulating an action plan for their future care which allows them to better manage exacerbations of their condition where appropriate.
- Delivering on-going care in accordance with the **care pathway**
- Discussing patient cases at **case conference**, where a **multi-disciplinary group** discusses high-risk patients, formulating an action plan that aims to prevent unnecessary secondary care activity and admissions to hospital.

The ICP intends to achieve a change in the utilisation of health and social care, with a shift away from expensive unplanned care and a move towards more planned care and self-care in community and domiciliary settings. This is outlined in Figure 8.27.

**Figure 8.27 Change in utilisation of health and social care**

Figure 8.27 shows that, at the start of the process, the ICP works by identifying out of hospital or community services (for example intermediate care, STARRS or rapid response services) which patients can be referred to which prevent them going into hospital. The fact that the ICP gets health and social care professionals from different disciplines talking
around the table accelerates the understanding of what services are available and how to access them, and allows clinicians to ‘short-circuit’ unnecessary referrals and investigations.

Over the longer-term, the benefits of ICP will shift towards improved self-care and management through the care planning process. Care planning takes place during an extended GP consultation that involves the patient in setting goals to improve their health and, where appropriate, puts in place contingency plans that allow patients to care for themselves in the event of an exacerbation.

In NW London, there are currently two integrated care pilots running across all eight CCGs.

The Inner North West London (INWL) Integrated Care Pilot was formed in June 2011. It currently covers an adult population of 635,000 across the boroughs of Westminster, Kensington and Chelsea, Hammersmith and Fulham, Hounslow and Ealing / Acton locality.

The Outer North West London (ONWL) Integrated Care Pilot was formed in August 2012. It currently covers a population of 1 million patients across the boroughs of Brent, Ealing, Harrow and Hillingdon.

Both pilots follow an established 7 step process enhanced by an organisational form that brings all of the providers across all settings of health and social care, together with patient representatives in a provider partnership arrangement supported by legal documentation binding the partners together, a formal agreement between the partners and the commissioners and a hosting agreement with a provider organisation who acts as banker for the ICP Partnership.

One unique factor of the NW London Integrated Care Pilots is the scale and pace of the coverage that has been achieved. In the 18 months since the first pilot was established the population coverage is now close to 2 million people, with provider partners across NW London working in multi-disciplinary groups.

In the feedback from the Royal Borough of Kensington and Chelsea Health, Environmental Health and Adult Social Care Scrutiny Committee feedback they asked for further details of the achievements of the ICPs. This information is provided in the following sections.

**Inner North West London ICP: achievements in 2012/13**

The Inner North West London Integrated Care Pilot was an ambitious programme set up in June 2011 to engage a range of health and social care providers and GP Practices across Inner North West London in collaborative and proactive working for a defined and targeted group of higher risk patients. Much of year one concerned the mobilisation of the pilot in terms of developing clinical pathways, forming multi-disciplinary groups and implementing the IT tool. In year two, significant progress has been made in establishing and bedding down the pilot. There are now 13 MDG Groups operating and they have held 200 case conferences, discussing some 1,350 cases, with attendance between 75–80% across all partners. Case conferences now discuss an average of 10 patients in each meeting.

GPs have created 21,000 care plans for higher risk elderly and diabetic patients and there has been a significant increase in dementia diagnosis, which the independent evaluation was felt to relate to the increase in care planning. The care planning process has been positively evaluated through the patient survey which took place as part of the evaluation, citing that they had been involved in the undertaking of their care plan, and had improved access to NHS services as a result of the care plan. In June 2012, the existing pathways were refreshed, and in addition the Inner pilot worked with the Outer Pilot on two new pathways.
Whilst remaining true to the overall stepped approach, the INWL ICP has begun to introduce flexibility and localisation at borough levels, the most notable example being the operational model currently being introduced in Central London CCG through the Wellwatch case management service. This localisation to borough level has included strengthening local governance and oversight. Innovation funding requests now go to each CCG prior to approval.

Early performance monitoring suggests that integrated care may be having an impact on non-elective admissions, though robust analysis of the impact on hospital activity will need to wait until the pilot has been in place for longer.

In its second year, the ICP has focused on the education and learning agenda, which has been supported and developed in partnership with organisations such as the NHS London Deanery. This is recognised as a vitally important component of integrated care, seeking to leave a legacy which will influence behaviours and culture into the future.

**Inner North West London ICP: independent evaluation**

The Inner NW London ICP has been independently evaluated by research teams from Imperial and the Nuffield Trust to assess its effectiveness, focusing on the first year of the pilot. The executive summary of the evaluation report is attached in Appendix M.

"The North West London Integrated Care Pilot is an ambitious programme of transformational change, being implemented at a time of major reform of the NHS in England. The findings from the evaluation of its first year offer important lessons, not just for the pilot itself, but also for other integrated care programmes elsewhere in the NHS and overseas.

This evaluation reveals that the pilot has made substantial progress in designing and implementing a highly complex intervention, and in underpinning this progress with sophisticated governance arrangements, and new financial incentives.

The pilot has successfully brought together diverse health and social care providers, focused on planning and delivering better co-ordinated care for older people, and those living with diabetes. This improved collaboration between professionals has resulted in better communication across teams and organisations, more extensive use of care planning, and there are early signs of benefit for patients in respect of improved diagnosis and care planning for people with dementia, and increasing levels of testing for control of diabetes."

Though conducted at an early stage of the pilot, nonetheless it identified several areas of significant success in relation to improvements in the quality of clinical care and improvements in inter-professional relationships:

- **Earlier diagnosis of dementia**
- **Connecting clinicians** - the report recognises the practical value of case conferences in connecting clinicians across different organisations
- **Increased provider collaboration across care levels** - the report found that 68% of providers surveyed believe that the ICP has resulted in improved collaboration across settings of care, with equal representation among GPs and non-GPs on the IMB
- **Improved patient experience** - the report notes that “patients with a care plan demonstrated a great enthusiasm towards the new way of care planning”
• **Improved empowerment** - specifically, 80% of those with a care plan felt that they were appropriately involved in the care planning processes (compared to 13% of those without a care plan), and 71% said that they had an increased feeling that health professionals were talking to each other (compared to 45% without a care plan). Of those with a care plan, 86% said they had a clear understanding of how care plans worked.

The pilot also introduced appropriate integrated organisational structures and incentives to build upon:

• **Effective governance structures** - the pilot rapidly established workable governance and financial arrangements

• **Well-aligned financial incentives** - the report notes that "the financial arrangements within the ICP had been carefully designed to create aligned incentives" and that the "symbolism of the savings arrangements… have been critical in overcoming initial fears" [within acute trusts and primary care].

The report also highlighted areas which need to be improved:

• Streamlining and improving governance at an integrated management board level
• Improving the accountability and emphasis on quality outcomes at multi-disciplinary group level
• Placing more priority on patient involvement in the care planning process
• IT infrastructure and information should be exploited further
• Education has an important role in cultural change and should be a focus
• Innovation funding should be used effectively and fully utilised
• The ICP would benefit from further alignment, engagement and communication with partners.

The evaluation also looked at the impact that the ICP was having on overall reduction on care in acute settings. The evaluation reflected the analysis undertaken internally and mirrored national and international evidence in recognising most significantly that any sustainable impacts integrated care will achieve need to be measured over a three to five year period and need to encompass the range of initiatives contributing to improved integration of care.

These findings and other emergent priorities have been developed through engagement with the CCG Chairs, the IMB, and the wider Health and Social care community of commissioners and providers all of whom will ultimately govern the approach to developing the ICP further. Three umbrella priorities emerge and are integral to the development of the INWL ICP in 2013/14:

• Development and embedding a **locally led and accountable ICP governance structure** which facilitates a more business as usual approach to the pilot, and allows the ICP to support each CCG's Out of Hospital Strategy more proactively
• Building on the current **integrated platform** to further embed and develop the potential of the Multidisciplinary Groups
• Supporting the transition to the next phase of integration: the **whole systems** focus.

**Outer North West London: achievements in 2012/13**

For the Outer NW London ICP, the primary achievement of 2012/13 was the mobilisation of the pilot. The process of implementing the ICP commenced in April 2012, and the model of
integrated care envisaged in the business case is now an operational reality. In addition to mobilisation, a number of important early benefits have been realised.

From a standing start, the ICP now covers a population base of 1 million. Of this population, 113,000 fall within the current criteria for receiving integrated care. This scale of population coverage represents a significant achievement for the ICP.

This extensive population coverage was made possible by the rapid implementation of multi-disciplinary groups, which leverage the GP networks being formed across NW London. ICP members made the decision that it was most logical to build on these existing networks for their operating model, rather than creating something new and different. In addition to enabling a more rapid implementation than would otherwise have been possible, this approach also offers the potential for useful synergies between the ICP and other parts of a network’s activity to emerge.

The pilot is at a sufficiently early stage that it remains too soon to establish its impact on non-elective admissions in a statistically robust manner. However, the ICP has already delivered a range of important outcomes and benefits.

- Initial evidence suggests that the risk stratification approach has been successful, both in terms of identifying high-risk patients but also in changing clinical practice based on the information
- Patients welcome the opportunity to proactively plan their care, and 96% of patients surveyed think that having the care planning discussion has helped improve how they manage their health problem
- An audit of care plans showed evidence of improvements to care, including consistent screening for common problems, detection of previously unknown clinical or social problems and proactive discussion about how to manage health in the future
- The actions arising from care plans are themselves integrated, with 28% relating to social care, 15% to mental health and 57% to other providers. These integrated actions generate integrated responses
- Through the ICP, formal and informal networks have been developed that can improve patient care. Some 91% of attendees at case conference report that they have developed relationships that improve the way they are able to care for patients. Moreover, 65% of attendees say they have changed their clinical practice as a result of attending a case conference and 67% believe that the advice they gave or received as part of a case conference would help to reduce non elective admissions.
- Attendees at multi-disciplinary groups have been able to learn more about the local services available, and 71% of attendees at MDGs having learned about new services in their Boroughs through attendance at case conferences.

**Developing integrated care in 2013/14**

It is significant to note how far the formal evaluation of the INWL ICP mirrors the ongoing evaluation of the ONWL ICP in terms of early improvements for patients, carers and health and social care professionals, future opportunities to move further and faster towards population-based integration and the need to see the ICP approach as a component of a wider system response to integration. The business plan for both ICPs in 2013/14 will focus on five key themes which together address the requirements described previously, while crucially also helping move towards a truly whole systems approach to integrated care.

Figure 8.28 summarises the key priorities for integrated care from 13/14.
Whole systems integrated care

One of the key developments of the ICP in 2013/14 is the development of whole systems integrated care.

Since August 2012, we have been working to define what whole systems integrated care could mean, working closely with local authorities in and CCGs across Central London, Hammersmith and Fulham, Hounslow, and West London.

The timing of this work, and many of its aims, coincided with the Tri-boroughs Community Budget pilot. This national pilot looked at how local services can work together more effectively, including how reimbursement models and other ‘rules’ may be adapted or changed so they can co-ordinate their work more effectively and efficiently. These two programmes were fully aligned. Collectively, the CCGs of Central London, Hammersmith and Fulham, Hounslow, and West London, together with the Tri-borough and members of the wider health and social care system and representative from BEHH, set about an in-depth piece of work to define what whole systems integrated care could mean.

This work has brought together clinical commissioners, clinicians across all settings of care, social care professionals, patients and carers and has given us unique insight into the links between health and social care, enhancing our understanding of the potential for whole systems. In particular, we found that 20% of patients drive 75% of demand across the health and social care system, and were therefore priorities for any integrated approach.

We want to encourage a better way of caring for our highest risk patients. This means the whole system (i.e. health, social care and other providers) working together differently, so that integration and coordination becomes the norm for people who require care from more than one organisation or service. At the heart of our approach is a simple, fundamental
belief: that health and social care resources should be matched to the risk of the individual patient.

If we matched resources to needs, we could give providers more flexibility to adapt their service and organisational model so it became more effective. For example we are exploring how we can align incentives within the system and incentivise providers using a ‘capitated reimbursement model’ of funding per patient.

Delivering this requires a new commissioning model that pools health and social care budgets and commissions based on outcomes. Alongside this, we also want to explore the appetite amongst providers for taking a risk-share approach.

In 2013/14, we will explore how we can accelerate integration within NW London and develop whole systems integrated care across all eight CCGs in NW London. The NW London Collaboration of CCGs has agreed that there is value in working together as one large-scale integration programme, with localisation where appropriate, both in relation to commissioning outcomes and provider response.

In the coming months, these plans will be developed further to provide the basis for developing integrated care in 2013/14.

8.20.3. CCG commissioning intentions 2013/14

In addition to the NW London-wide initiatives outlined above, each CCG plans to commission a range of out of hospital services in 2013/14. These plans are detailed in each CCG’s commissioning intentions (see Appendix J).

Figures 8.29 and 8.30 summarise the commissioning intentions across NW London. Chapter 16 has details for each CCG.
Figure 8.29: Summary of CCG commissioning intentions 2013/14 (Inner NWL)

<table>
<thead>
<tr>
<th>C. London</th>
<th>W. London</th>
<th>H&amp;F</th>
<th>Hounslow</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy access to high quality, responsive care</td>
<td>Community anti-coagulation services</td>
<td>Multi-disciplinary enhanced primary care services</td>
<td>Primary care mental health services</td>
</tr>
<tr>
<td>Simplified planned care pathways</td>
<td>Commission community outpatient services across eight specialties.</td>
<td>Commission community outpatient services across five specialties.</td>
<td>Review 11 planned care pathways to improve community provision.</td>
</tr>
<tr>
<td>Rapid response to urgent needs</td>
<td>Implement Co-ordinate My Care and end of life hub</td>
<td>Expand rapid response to all patients</td>
<td>Joint reablement team with LB Hounslow</td>
</tr>
<tr>
<td>Integrated care for LTC and elderly</td>
<td>Improve utilisation of rapid response</td>
<td></td>
<td>Ambulatory emergency care service</td>
</tr>
<tr>
<td>Appropriate time in hospital</td>
<td>Re-tender hospital at home</td>
<td></td>
<td>New specification for psychiatric liaison services</td>
</tr>
<tr>
<td>• Extended walk-in services offered at GP practices</td>
<td>• Commission outpatient care in the community</td>
<td>• Commission psychiatric liaison services</td>
<td>• New role of care navigators</td>
</tr>
<tr>
<td>• Embed improved referral practices</td>
<td>• Implement Co-ordinate My Care and end of Life hub</td>
<td>• Implement Co-ordinate My Care</td>
<td>• Invest in psychiatric liaison.</td>
</tr>
<tr>
<td>• Multi-disciplinary enhanced primary care services</td>
<td>• Improved utilisation of rapid response</td>
<td>• Develop virtual wards, hybrid workers and MDTs</td>
<td></td>
</tr>
<tr>
<td>• Commission outpatient care in the community</td>
<td>• Re-tender hospital at home</td>
<td>• Embed multi-disciplinary care planning</td>
<td></td>
</tr>
<tr>
<td>• Broaden the scope and skill set of rapid response</td>
<td>• End of Life Programme, including Co-ordinate My Care</td>
<td>• Assess the potential for acute psychiatric liaison.</td>
<td></td>
</tr>
<tr>
<td>• Multi-disciplinary enhanced primary care services</td>
<td>• End of Life Programme, including Co-ordinate My Care</td>
<td>• Assess the potential for acute psychiatric liaison.</td>
<td></td>
</tr>
<tr>
<td>• Commission community outpatient services across eight specialties.</td>
<td>• End of Life Programme, including Co-ordinate My Care</td>
<td>• Implement Co-ordinate My Care</td>
<td></td>
</tr>
<tr>
<td>• Community anti-coagulation services</td>
<td>• End of Life Programme, including Co-ordinate My Care</td>
<td>• Jointly commission health and social care teams with LB Hounslow</td>
<td></td>
</tr>
<tr>
<td>• Multi-disciplinary enhanced primary care services</td>
<td>• End of Life Programme, including Co-ordinate My Care</td>
<td>• Jointly commission health and social care teams with LB Hounslow</td>
<td></td>
</tr>
<tr>
<td>• Commission community outpatient services across five specialties.</td>
<td>• End of Life Programme, including Co-ordinate My Care</td>
<td>• Jointly commission health and social care teams with LB Hounslow</td>
<td></td>
</tr>
<tr>
<td>• Review 11 planned care pathways to improve community provision.</td>
<td>• End of Life Programme, including Co-ordinate My Care</td>
<td>• Jointly commission health and social care teams with LB Hounslow</td>
<td></td>
</tr>
<tr>
<td>• End of Life Programme, including Co-ordinate My Care</td>
<td>• End of Life Programme, including Co-ordinate My Care</td>
<td>• Jointly commission health and social care teams with LB Hounslow</td>
<td></td>
</tr>
<tr>
<td>• Commission psychiatric liaison services</td>
<td>• End of Life Programme, including Co-ordinate My Care</td>
<td>• Jointly commission health and social care teams with LB Hounslow</td>
<td></td>
</tr>
<tr>
<td>• Implement Co-ordinate My Care and end of Life hub</td>
<td>• End of Life Programme, including Co-ordinate My Care</td>
<td>• Jointly commission health and social care teams with LB Hounslow</td>
<td></td>
</tr>
<tr>
<td>• Extend Putting Patients First LES</td>
<td>• End of Life Programme, including Co-ordinate My Care</td>
<td>• Jointly commission health and social care teams with LB Hounslow</td>
<td></td>
</tr>
<tr>
<td>• Care co-ordination and case management across health and social care</td>
<td>• End of Life Programme, including Co-ordinate My Care</td>
<td>• Jointly commission health and social care teams with LB Hounslow</td>
<td></td>
</tr>
<tr>
<td>• Mental health integrated care pilot</td>
<td>• End of Life Programme, including Co-ordinate My Care</td>
<td>• Jointly commission health and social care teams with LB Hounslow</td>
<td></td>
</tr>
<tr>
<td>• Develop joint intermediate care and reablement service</td>
<td>• End of Life Programme, including Co-ordinate My Care</td>
<td>• Jointly commission health and social care teams with LB Hounslow</td>
<td></td>
</tr>
</tbody>
</table>

8e. Delivering out of hospital care
### Figure 8.30: Summary of CCG commissioning intentions 2013/14 (Outer NWL)

<table>
<thead>
<tr>
<th>Brent</th>
<th>Ealing</th>
<th>Harrow</th>
<th>Hillingdon</th>
</tr>
</thead>
</table>
| **Easy access to high quality, responsive care** | • Invest in software, equipment, training and support for primary care  
• Improve IAPT service provision                                      | • Develop an enhanced primary care mental health team                                     | • Mental health shifting settings of care to primary care                                       |
| **Simplified planned care pathways**       | • Continue referral standardisation                                    | • Commission new pathways for five specialties to deliver care in community settings      | • Roll out new community pathways across 10 specialties                                       |
| **Rapid response to urgent needs**         | • Continued implementation and development of STARRS                  | • Continued implementation and development of STARRS                                      | • Widen the scope and skill set of rapid response services                                    |
| **Integrated care for LTC and elderly**    | • Implement end of life LES and care planning                          | • Commission integrated end of life pathway                                              | • Improve case management by community nurses                                                 |
|                                            | • Improve dementia services                                            | • Improve integration of dementia services                                               |                                                                                            |
|                                            | • Ensure equitable access to psychiatric liaison                       | • Develop existing psychiatric liaison services                                          | • Effective discharge planning to reduce LOS                                                 |
| **Appropriate time in hospital**           | • Enhance diabetic clinics with specialist nurses                      | • Effective discharge planning to reduce LOS                                             |                                                                                            |
|                                            | • Shift towards a community-based model of end of life care            | • Reduce pressure on A&E through rapid response, case management and UCCs                |                                                                                            |
|                                            | • Deliver a new dementia pathway                                       |                                                                                            |                                                                                            |
Chapter 9
Decision making analysis
9a. Decision making analysis stages 1 to 4

The four parts of this chapter describe the analysis undertaken to identify a recommended option for reconfiguration. Using the seven stage process for identifying options for consultation we explain the analysis undertaken at each stage of the process. We describe how we have considered the feedback received during consultation and undertaken new analysis based on this feedback (including re-appraisals of the latest evidence, activity and financial data) to enable the programme to review options at each stage in order to come to the final recommendation. The case for change, vision and clinical standards were reconfirmed. These were used in conjunction with agreed clinical dependencies to develop the service models. Options for the configuration of major hospitals were assessed using hurdle criteria to determine that five were needed and to produce a list of eight configuration options. These eight options were evaluated using criteria (covering quality of care, access to care, value for money, deliverability and research & education) developed before and after consultation. This evaluation enabled us to determine a preferred option. We confirmed that this remained the best option if our modelling assumptions changed through the sensitivity analysis.

9.1 What is decision making analysis

Chapter 5 describes the seven stage process for identifying a recommended option for reconfiguration. Decision making analysis is the analysis required at each stage of the seven stage process to enable the programme to undertake an evaluation before proceeding to the next stage of the process. This analysis includes exploring clinical evidence, defining service models, calculating financial implications and assessing travel times.

Pre-consultation we used the process and associated analysis to identify options for consultation. The clinical work was led by the Clinical Board (which includes clinical representatives for each provider Trust and for each CCG) with support from an Expert Clinical Panel (which provided external challenge to test and refine our proposals). The financial work was led by the Finance and Business Planning group (which has financial leads from all the CCGs, providers, a patient representative and NHS London). Patients, members of the public, local NHS Trusts, Local Authorities, the Travel Advisory Group, local HOSCs and the JHOSC also provided input. During consultation we received feedback about the decision making analysis.

9.2 The analysis for decision making

In Chapter 5 we explained why we have concluded that the seven stage process to identify options for consultation is appropriate to be re-used to make a recommendation to the Programme Board. In this chapter we describe how we used the process for a second time to identify a single recommended option for reconfiguring services in NW London. We went through the seven stage process, incorporating the feedback we received during consultation and additional analysis undertaken to support this process using the latest evidence, information and data.

Figure 9.1 summarises the seven stage process used in this chapter for identifying the recommended option followed in this chapter (see Chapter 5 for a full description).

The subsequent sections of this chapter describe the analysis for each stage of the process in detail.
Figure 9.1: Overview of the process for identifying a recommended reconfiguration option

Key principles:
- Continue expanding out of hospital services
- Located with, or independent of major hospitals
- All specialist services will remain as they are
- All 9 sites with an A&E to provide local hospital services and a UCC

Out of hospital: Case for change
- Provides platform for service change
- Defines improvements and clinical benefits
- Confirm 'do nothing' is not an option

Vision
1. Localising
2. Centralising
3. Integrating

Out of hospital: Standards
- Acute: Urgent and emergency care
- Maternity
- Paediatrics

Out of hospital: Service models
- Correct care setting to deliver high quality care
- Use existing sites
- Enough major hosp. to support population of 1.9 million
- Number of major hosp. must be viable in medium term
- Ensure good geographical spread
- Use sites currently delivering major hospital services
- Minimise access impacts for residents

Hurdle criteria
- Quality of care
- Access to care
- Value for money
- Deliverability
- Investment
- Next steps

Evaluation criteria
- Tests 22 underlying assumptions
- Sensitivity analysis

Recommended option
- Number of options: MILLIONS
- Number of options: ~3
- Number of options: ~3
- Number of options: 1
- Number of options: < 20

9a. Decision making analysis stages 1 to 4
9.3 Stage 1 – the Case for Change

This section describes the analysis for the first stage of the process to identify a recommended option – the Case for Change. Figure 9.2 highlights the relevant stage in the process.

Figure 9.2: Highlighting Stage 1 of the process described in this section

9.3.1 The purpose and outcome of Stage 1 – the Case for Change

The purpose of the first stage of the process is to document the Case for Change and confirm it supports the arguments for reconfiguring services. The outcomes are:

1. Ensure a robust platform exists for service change
2. Confirm required improvements and clinical benefits
3. Confirm ‘do nothing’ is not an option

9.3.2 The Case for Change

The *Shaping a healthier future* Case for Change was published by local clinicians in January 2012, see Appendix D. Chapter 4 summarises the Case for Change, describing the drivers for change and expressing the case that ‘do nothing’ is not a viable option.

Pre-consultation the Case for Change was approved by the Clinical Board and the Programme Board in January 2012.

9.3.3 Feedback received about the Case for Change during consultation

During consultation we sought feedback about the Case for Change. We wanted to understand if people agreed with the case and if people had any suggestions for how it could be improved.

We asked people the following question in our consultation response form:

**Q1. Do you agree or disagree that there are convincing reasons to change the way we deliver healthcare in NW London?**

4,951 people answered the question. Of these:
• 65% of respondents who answered the question agree, including 20% who strongly agree with the case for change
• 29% disagree, which includes 16% of respondents who strongly disagree
• The remaining 6% had no views either way or were not sure/didn’t know.

Figure 9.3 summarises the results.

**Figure 9.3: Summary of consultation feedback about the Case for Change**

Q1. Do you agree or disagree that there are convincing reasons to change the way we deliver healthcare in NW London?

<table>
<thead>
<tr>
<th></th>
<th>Number of People</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
<td>3,184</td>
</tr>
<tr>
<td>Disagree</td>
<td>1,455</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>975</td>
</tr>
<tr>
<td>Tend to agree</td>
<td>2,209</td>
</tr>
<tr>
<td>No views either way</td>
<td>236</td>
</tr>
<tr>
<td>Tend to disagree</td>
<td>645</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>810</td>
</tr>
<tr>
<td>Not sure/ don’t know</td>
<td>76</td>
</tr>
</tbody>
</table>

N.B. Numbers in graphs are rounded so may not always appear to reconcile

In addition to the feedback above, we received responses from organisations addressing the need for change:

**North West London Joint Health Overview and Scrutiny Committee**
“We support the drive to improve the quality, safety and sustainability of emergency care in NW London. The need to address current variations in services and poor outcomes for patients is urgent. The case has been clearly made.”

**Ealing Hospital NHS Trust**
“The Board agreed with SaHF premise that to leave healthcare in north west London as it is would be untenable.”

**Westminster City Council, Adult Services and Health Policy and Scrutiny Committee**
“The case for change is strong...no change presents a serious risk to patient safety. As such, we realise that a reconfiguration of this scale is necessary in order to meet these emerging challenges.”

**NHS West London Clinical Commissioning Group**
“We believe that the case for change that has been developed by clinicians from across North West London is based on the best available clinical evidence and when introduced will provide improved clinical outcomes for our patients.”

**Brent Health Partnerships Overview and Scrutiny Committee**
The Brent Health Partnerships Overview and Scrutiny Committee believes a strong clinical case for change has been made by NHS North West London and that health services need to be reconfigured to secure better outcomes for patients. This will mean that difficult decisions will need to be taken, but to “do nothing” is not an option and it is in everyone’s interests to ensure that services in London have a sustainable future.

Royal College of Paediatrics and Child Health
“We strongly support the case for change set out in the consultation document.”

Royal College of Surgeons
“Because of the importance of these standards [Commissioning Standards, published in 2012 by London Healthcare Programmes] for emergency surgical care, the College of Surgeons has been represented on the North West London reconfiguration Board to ensure that the principals of best practice in emergency surgical care will be strengthened and improved by the chosen or preferred options for change......At the present time, it is clear that the surgical standards cannot be met with any consistency across North West London.”

Ealing Council
“The Council recognises that NHS North-West London have attempted to make a strong case for the need for change, and that difficult decisions have to be made. It accepts that “do nothing” is not an option and it is in everyone’s interests to ensure that there is a sustainable and effective health economy in North West London.”

Feedback received also suggested alternatives to the case for change:

Labour Group at Kensington and Chelsea Council
“The present proposals are driven mainly by financial imperatives rather than a comprehensive review of what needs to happen to improve health in North West London.”

Independent reports conducted by Tim Rideout Limited on behalf of the London Borough of Ealing and Hammersmith & Fulham Council
“Trusts are successfully meeting the current quality and financial challenges without the need for radical reconfiguration.

Indeed, there are other options open to the NHS organisations in NW London. Locally, the potential merger of Ealing Hospitals NHS Trust and North West London Hospitals NHS Trust merger should be addressed first before reconfiguration. In addition there are other means of achieving financial sustainability not addressed within the business case, including:

- Renegotiation of Public Finance Initiative (PFI) contracts:
- Patient pathway reconfiguration
- Commissioner/provider agreement to modify Payment by Results (PbR)"

9.3.4 The implications of this feedback on the Case for Change

The feedback we received about the Case for Change did include suggestions for alternatives. We considered these alternatives to reconfiguration as follows:

- Response to feedback about renegotiation of Public Finance Initiative (PFI) contracts in the Rideout report: West Middlesex and NW London Hospitals have confirmed that they intend to review PFI contracts and achieve the lowest possible cost, but this work has no bearing on the SAHF appraisal of the options because it
doesn’t differentiate between options, as both West Middlesex and Central Middlesex PFI buildings are required under all options:
  o West Middlesex is a major hospital under Option A and B, with full use of its PFI. Under Option C, requiring its main PFI building for beds, theatre, UCC and outpatients operation
  o Central Middlesex remains an elective site under all options requiring its main PFI building for beds, theatre, UCC and outpatients operation

However we will explore the option of re-negotiating the PFI contract as part of the further work that is set out in Chapter 9d and the Brent out of hospital strategy in Chapter 16, section 16.1.

- **Response to feedback about renegotiation of Patient pathway reconfiguration in the Rideout report:** The out of hospital strategies already consider patient pathway reconfiguration to deliver as much care as close to home as possible.

- **Response to feedback about commissioner/provider agreement to PbR in the Rideout report:** The report suggests that there is an option for commissioners to negotiate local prices. This would add cost to the commissioners and could lead to commissioner deficits, therefore resolving financial pressures for providers, but replacing this with deficits to commissioners. In other words, commissioners subsidising hospitals. Given the additional investment required for out of hospital services it is financially unaffordable to pay more for services delivered in hospital.

  The Case for Change is primarily a clinical Case for Change which is why it is supported by the Medical Directors of every hospital in NW London and the Chairs of every Clinical Commissioning Group in NW London.

- The Rideout report implies the Case for Change is financially driven and suggests any savings yielded by the three proposed approaches should be reinvested in additional staff. The financial analysis shows that all savings yielded through the reconfiguration of services are needed to maintain financial balance and for the investment in out of hospital services. This includes the investment in new people with new skills to provide those services.

- The Rideout report also talks about the current “quality and financial challenges” but this programme also has to be concerned with a system fit for the future.

- The updated clinical standards are more demanding in workforce terms, making the case for reconfiguration even more compelling.

### 9.3.5 Outcome of the first stage about the Case for Change

We reached the following conclusions about the first stage of the process about the Case for Change:

- **Ensure a robust platform exists for service change:**
  Local clinicians have articulated a Case for Change. They describe what needs to change to deliver better care in NW London. Given the feedback the Case for Change is still valid.

- **Confirm required improvements and clinical benefits:**
  The Case for Change articulates the improvements that the changes could deliver and the clinical benefits this should result in. Given the feedback received the benefits are also still valid.
• **Confirming ‘do nothing’ is not an option:**
The Case for Change describes how the consequences of doing nothing are unacceptable. No viable alternative was proposed.

The evaluation against Stage 1 – the Case for Change, has been completed and we proceeded to Stage 2 – the vision. We confirmed this decision and the validity of the Case for Change with the Clinical Board and the Programme Board during the decision making phase.

9.4 **Stage 2 – the vision**

This section describes the analysis for the second stage of the process – the vision. Figure 9.4 highlights the relevant stage in the process.

**Figure 9.4: Highlighting Stage 2 of the process described in this section**

9.4.1 **The purpose and outcome of the vision**

The purpose of the second stage of the process is to document the vision for achieving the objectives stated in the Case for Change. The outcome is:

1. Confirm the vision created by local clinicians for *Shaping a healthier future* will deliver the required improvements and clinical benefits

9.4.2 **The vision for how to improve health of people in NW London**

Chapter 7, section 7.1 details the vision for health services in NW London, describing how patients will be treated in the future to ensure they receive the highest standards of care. In summary:

- **Localising**: Services will be provided locally where possible and centralised where necessary. Localising routine medical services means better access closer to home and improved patient experience
- **Centralising**: Centralising most specialist services means better clinical outcomes and safer services for patients
- **Integrated**: Where possible, care should be integrated between primary and secondary care, with involvement from social care, to give patients a co-ordinated service. This integration across organisational boundaries will provide a seamless experience of care in range of care settings.

The vision was agreed by the Clinical Board and the Programme Board pre-consultation.

**9.4.3 Feedback received about the vision during consultation**

During consultation we sought feedback about the vision. We wanted to understand if people agreed with the vision for localising and centralising care and if people had any suggestions for how it could be improved.

We asked people two questions in our consultation response form. The first question was:

**Q5. Do you agree or disagree that some services which are currently delivered in hospitals could be delivered more locally?**

4,595 people answered this question:

- 43% respondents answering this question agree that some services which are currently delivered in hospitals could be delivered more locally
- 25% disagree
- 31% express no view either way

We also asked people to consider the centralisation of services:

**Q6. How far do you support or oppose the idea of bringing more healthcare services together on fewer sites?**

4,628 people answered this question:

- 30% support the idea of bringing more healthcare services together on fewer sites
- 38% oppose
- 31% had no views either way

In addition to the feedback above, we received responses from organisations addressing the vision:

**Hammersmith & Fulham Council and its Health, Housing & Adult Social Care Scrutiny Committee (joint response)**

“The principles and objectives - to prevent ill health in the first place; to provide easy access to high quality GPs and their teams; and to support patients with long term conditions and to enable older people to live more independently - are appropriate.”

**Richmond Borough Council**

“The Council fully understands the case for change from both a service quality and financial perspectives, and fully supports the direction of travel which will enable people to receive health and care support in their own homes and in community settings, avoiding the need for hospital admission unless this is absolutely necessary.”

**Royal College of Paediatrics and Child Health**

“We strongly support the principle of care provision using integrated care pathways within the clinical network model, and that outcome measures must drive service improvement.”
Royal College of Midwives
“The RCM does accept, in general, that hospital care in North West London should be based on the principles of localising routine services, centralising specialist care and integrating primary and secondary care.”

Independent reports conducted by Tim Rideout Limited on behalf of the London Borough of Ealing and Hammersmith & Fulham Council
“The proposed clinical standards and visions are appropriate”

The College of Emergency Medicine
“The College supports the principle of consolidation of specialist expertise with a focus on a limited number of hospitals which provide the full range of specialist emergency care.”

London Borough of Hounslow Health and Adult Care Scrutiny Panel
“We support the idea of centralising specialist services and understand that from a clinical point of view this is necessary to deliver high quality care which results in better outcomes for patients.”

Hillingdon LINk
“Centralising the treatment of some specific types of conditions to a select number of hospitals (such as the London Hyper-acute Stroke Centres) makes clinical sense and yields measurable improvements in clinical outcomes. However, this in itself is not sufficient evidence that centralising all A&E activity onto fewer but bigger hospitals will also yield the same clinical outcomes or the quality of care experienced by patients. There is a counter argument (not addressed by SaHF) that once A&E departments get to a certain size, they essentially become “un-manageable” in a safe manner.”

Kensington & Chelsea LINk
“Where services are to be specialised there is a removal of choice for the patient, therefore it is important that these services are monitored to ensure that they are run in a sensitive manner, are accessible, and that all staff are trained in accordance with a robust equality delivery strategy.”

Focus groups
As part of the consultation process we invited members of the public to participate in two rounds of focus groups across the eight North West London boroughs and three neighbouring boroughs. The primary objective of these discussion groups was to obtain independent, qualitative feedback on people’s views. In broad terms the Case for Change and the vision and patient stories were understood and well received by the focus groups. For further information about the focus groups refer to Appendix F.

9.4.4 Implications of this feedback for the vision
The feedback received didn’t include any alternative to the vision. However it did include areas for further consideration. The programme responded as follows:

- **Response to feedback about bringing more healthcare services together on fewer sites:** Certain services, particularly complex emergency services, benefit from being centralised onto fewer sites (see Chapter 7 for further details). However, the majority of services will continue to be provided locally, through local hospitals or hub facilities within networks (see Chapter 8).
- **Response to feedback about choice:** We undertook further detailed analysis about patient choice during decision making. This work is described in Chapter 11. The
analysis in Chapter 11 indicates that for the majority of people patient choice will either be maintained or increased under these proposals as more services are offered in the community and the majority of acute services will remain unchanged. There will be slightly less choice of hospital locations for maternity and paediatrics, but the quality at all of these facilities will be greatly increased and patients will have greater access to senior staff.

- **Response to feedback about A&E size and manageability:** We were unable to find evidence to support the idea that A&Es become ‘unmanageable’ above a certain size. The A&Es in NW London will typically be smaller than other A&Es in London which are currently operating safely. For example, NHS London has informed us that Guys Hospital treats approximately 11,000 Type 1 patients a month, in comparison Chelsea & Westminster Hospital treats approximately 4,200 per month. Figure 9.5 contains a comparison of the projected Type 1 A&E activity for the five proposed major hospitals from consultation Option A against the current activity of two of the larger A&Es in London. The data indicates the projected Type 1 attendances at A&Es in NW London are not expected to exceed the current activity levels of other A&Es in London.

**Figure 9.5: Post reconfiguration Type 1 monthly activity for the reconfiguration option A major hospitals compared with two larger A&Es in London**

<table>
<thead>
<tr>
<th>Site</th>
<th>Hillingdon</th>
<th>Northwick Park</th>
<th>St Mary’s</th>
<th>Chelsea &amp; Westminster</th>
<th>West Middlesex</th>
<th>King’s College</th>
<th>Guys Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1 attendances</td>
<td>5,500*</td>
<td>5,700*</td>
<td>9,300*</td>
<td>5,600*</td>
<td>4,800*</td>
<td>9,500**</td>
<td>11,000**</td>
</tr>
</tbody>
</table>

* Anticipated post reconfiguration A&E Type 1 activity per month. Data produced by SaHF CiG and F&B modelling, based on activity assumptions, QIPP targets and demographic change.

** NHS London, Q&S Report Card data for London Clusters, data sources HES 2010/11

1= King’s College Hospital (Denmark Hill)

- **Response to feedback about multiple health needs and equalities:** Improvements in out of hospital care will result in coordinated individual care planning for patients with co-morbidities, led by GPs this planning will work across range of specialties and means patients will receive better integrated care. We have undertaken further equalities work as part of our post consultation work; this is described in Chapter 13.

Given the feedback received we have made no changes to the vision.

**9.4.5 Outcome of the second stage about the vision**

We reached the following conclusions about the required outcome of Stage 2 – the vision:

- **Confirm the vision created by local clinicians for Shaping a healthier future will deliver the required improvements and clinical benefits**
  
  Local clinicians explained their vision for how care should be shaped to deliver the improvements required by the Case for Change. No alternative has been suggested to this vision. Given the feedback received we believe the vision is still valid.

The evaluation against Stage 2 – the vision, has been completed and we proceeded to Stage 3 – the clinical standards. We confirmed this decision with the Clinical Board and the Programme Board during the decision making phase.

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1 NHS London, Q&S Report Card data for London Clusters, data sources HES 2010/11
9.5 Stage 3 – the clinical standards

This section describes the third stage of the process about the clinical standards. Figure 9.6 highlights the relevant step.

Figure 9.6: Highlighting Stage 3 of the process described in this section

9.5.1 The purpose and outcome of Stage 3 – the clinical standards

The purpose of the third stage is to document the clinical standards that will contribute to the delivery of the vision for healthcare in NW London. The outcomes are:

1. Establish the clinical standards are in place and are based upon the latest evidence and clinical thinking
2. Establish that if the standards are achieved they will contribute to the improvements outlined in the Case for Change

9.5.2 The clinical standards

Chapter 7a details the clinical standards for:

- Out of hospital
- Urgent and emergency care
- Maternity
- Paediatrics

To drive the improvements in clinical quality and reduce the variation that has been documented in the Case for Change, local clinicians developed a set of clinical standards, including latest evidence from Royal Colleges, reviews by the NHS in London and NICE guidelines.

The clinical standards were agreed by the Clinical Board and the Programme Board pre-consultation.

9.5.3 Feedback received about the clinical standards during consultation
During consultation we sought feedback about the clinical standards. We wanted to understand if people agreed with the proposed standards for care out of hospital and in hospitals and if people had any suggestions for how the standards could be improved.

We asked people to questions about the standards in our consultation form. The first question was:

**Q4a. How far do you support or oppose the standards that have been agreed for care outside of hospitals?**

4,598 people answered the question. Of these:

- 67% respondents answering this question support the standards that have been agreed for care outside hospital
- 12% oppose these standards of care
- 21% had no view either way or were not sure/ didn’t know.

We also asked people for their views on care in hospital. The second question we asked:

**Q4b. How far do you support or oppose the standards that have been agreed for care in hospital?**

4,540 people answered this question. Of these:

- 76% of respondents answering this question support the standards that have been agreed for care in hospital
- 6% oppose these standards of care
- 18% had no view either way or were not sure/ didn’t know.

In addition to this feedback we also received feedback from the following organisations:

**Royal College of Surgeons**

“Because of the importance of these standards [Commissioning Standards, published in 2012 by London Healthcare Programmes] for emergency surgical care, the College of Surgeons has been represented on the North West London reconfiguration Board to ensure that the principals of best practice in emergency surgical care will be strengthened and improved by the chosen or preferred options for change……At the present time, it is clear that the surgical standards cannot be met with any consistency across North West London.”

**Hillingdon LINk**

“Concerned that the proposed “agreed Quality Standards for Hospital Care” contained within the SaHF consultation document is far too vague and aspirational rather than offering confirmed commitments to improving care standards…We are concerned that the proposed “Quality Standards for care outside of Hospital” is far too vague, aspirational and lacking in substance. This does not give us or the public the confidence that the SaHF will be able to deliver on these commitments. This increases the risk that the SaHF will not be able to meet savings required to deliver the hospital reconfigurations proposed in the consultation.”

**9.5.4 The implications of this feedback on the clinical standards**

During the consultation period London Health Programmes defined standards for care across London, as indicated in the feedback above. These standards were agreed by the London Clinical Senate and the GP Commissioning Council for local implementation. Local
clinicians wanted to take this into account and the Clinical Implementation Groups (CIGs) have been considering this feedback and updating the programme’s standards accordingly:

- Updated standards\(^2\) for maternity, paediatrics, and urgent and emergency care were discussed and agreed at the Clinical Board on 6 December. Key changes include:
  - **Maternity**: 24/7 consultant cover for all units, not just those with over 6,000 births
  - **Urgent and emergency care**: the proposed standard UCC specification has been further developed to provide details which details the conditions that UCCs should treat, those that are excluded, the service models and transfer protocols, staff competencies, quality standards and governance arrangements.
  - **Paediatrics**: standards will be consistent with the London Standards
  - No changes were made to the out of hospital standards
- The final standards are more demanding in workforce terms, making the case reconfiguration even more compelling
- The Finance & Business Planning workstream lead has reviewed these standards against the modelling assumptions and concluded they do not have a material effect on the programmes modelling.
- In response to the feedback received from Hillingdon LINk we can confirm:
  - We have worked and will continue to work with patient groups and stakeholders to develop implementation plans. We are also happy to confirm that we will ensure we and successor bodies fulfil our legal requirements regarding engagement and consultation processes.
  - Each of our eight CCGs have developed local out-of-hospital strategies which have considered how they would like care to be delivered and how they plan to organise primary care in the future. This includes practices working together in networks – a key method of reducing variation in quality of, and access to, services. We have recently undertaken further work on understanding what is important to patients in NWL for general practice.

### 9.5.5 Outcome of the third stage about the clinical standards

We reached the following conclusions about the third stage of the process:

- **Establish the clinical standards are in place and are based upon the latest evidence and clinical thinking**
  Local clinicians agreed standards before consultation. They have been updated after consultation by local clinicians working in CIGs to reflect the latest guidance from London Health Programmes and clinical evidence. Local clinicians and the Clinical Board agreed the updated standards.

- **Establish that if the standards are achieved they will contribute to the improvements outlined in the Case for Change**
  These updated clinical standards are what we want to achieve in NWL and reconfiguration is still necessary. The changes to the standards do not impact on the need for change.

We confirmed this decision with the Clinical Board and the Programme Board during the decision making phase.

\(^2\) The London Emergency Medicine and Surgery Review updated the London-wide standards
9.6 Stage 4 – the service models to deliver change

This section describes the analysis for the fourth stage of the process – the service models to deliver change. Figure 9.7 highlights the relevant stage in the process.

Figure 9.7: Highlighting Stage 4 of the process described in this section

9.6.1 The purpose and outcome of the service models to deliver change

The purpose of the fourth stage of the process is to document the service models for the settings of care required to deliver the clinical standards. The outcomes are:

1. Confirm the service models reflect the latest clinical thinking and reflect relevant feedback received during consultation
2. Confirm the service models will contribute to deliver the clinical case required

9.6.2 Documenting the service models

Chapter 7a describes the eight service models identified by local clinicians:

- Home
- GP practice
- Care network
- Health centre
- Local hospital
- Major hospital
- Elective hospital
- Specialist hospital.

The service models were agreed by the Clinical Board and the Programme Board pre-consultation.
9.6.3 Feedback received about the service models during consultation

During consultation we sought feedback about the service models. We wanted to understand if people agreed with the different models and if people had any suggestions for how it could be improved.

We asked people the following question in our consultation response form:

Q8. We have described the proposals to deliver different forms of care in different settings. How far do you support or oppose these proposals?

4,563 people answered this question. Of these:

- 36% respondents answering this question support the proposals to deliver different forms of care in different settings
- 56% oppose
- 8% had no views either way or were not sure/didn't know

In addition to this feedback we also received feedback from the following organisations:

**London Borough of Hounslow Health and Adult Care Scrutiny Panel**
“We support the proposals to deliver different forms of care in different settings. We await further detail on what some of the proposed care settings will look like in practice. We would think it essential that there is consistency across the NW sector in relation to the services patients can access in each setting. Without a level of consistency, patients will find it harder to know which care setting is appropriate for their care needs.”

**London Borough of Hounslow Health and Adult Care Scrutiny Panel**
“We strongly support the proposal to use high quality hospital sites with capacity to deliver elective care. West Middlesex Hospital in Hounslow has been working for several years to increase the number of elective procedures carried out on site. We understand that this portfolio of work is intrinsic to the hospital regaining financial balance and securing its long term future. We believe that the proposals provide an opportunity to give impetus to this work.”

**Imperial College Healthcare NHS Trust**
“Based on previous work with NWL we recognise the value of separating elective from acute activities and can clearly see potential for expansion of the elective hospital model either on unique sites or organised as such on larger campuses. Such an approach has the potential to provide a more streamlined patient experience, better outcomes and substantial efficiencies not only in the delivery of quality care for patients requiring elective treatment but also in the delivery of acute and specialist care.”

**Royal College of Paediatrics and Child Health**
“We strongly support the principle of care provision using integrated care pathways within the clinical network model, and that outcome measures must drive service improvement.

The project team has described a strong vision for how primary care and community based services should be strengthened in order to support a model in which inpatient care is delivered by concentrated teams working on fewer major hospital sites… We agree that all major hospital should have an inpatient paediatric unit, as well as the possible neonatal service at Queen Charlotte’s and Chelsea Hospital, dependent on the other finally agreed locations.”
Royal College of Physicians
“The RCP believes that there will need to be a radical service redesign to ensure that patients receive safe and high quality care that they deserve at all times. For many communities this will require reorganisation and consolidation of hospital services to facilitate the optimum application of hospitals services for patients. This must be accompanied by supportive improvements in primary, community and social care, recognising the needs of public and patients across the spectrum of potential health intervention.”

The Royal College of Midwives
“The loss of consultant obstetric services at Ealing could have a negative impact on tackling health inequalities in the borough; this could be mitigated – at least for women at low medical risk - if the obstetric service were replaced by a FMU…. we are extremely disappointed that Shaping a healthier future does not include any proposals for the establishment of freestanding midwife-led units (FMUs).”

Focus groups
Broadly speaking the focus group attendees understood and accepted the models of care; for further information refer to Appendix F.

9.6.4 The implications of this feedback for the service models
The feedback received suggests no alternative to the eight models proposed by local clinicians. However, the following work has been undertaken:

- There was a request for more detailed descriptions for urgent care centres and local hospitals. We provided this information during consultation in factsheets and the urgent and emergency care CIG has been engaged in work to develop the UCC specification. This work is all reflected in the descriptions found in Chapter 7b.
- Ealing and Hammersmith & Fulham CCGs wish to respond in detail to the feedback about the range of services that would be available at Ealing and Charing Cross hospitals and have developed a separate set of proposals for the JCPCT to consider. These are set out in separate documents for the JCPCT to consider independent of this DMBC.
- The Maternity CIG considered the issue of standalone birthing and midwife led units but do not consider there would be sufficient demand for a standalone or birthing centre for the population of North West London. This was reinforced by the previous local experience of the Fetal Medicine Unit at Central Middlesex. Therefore the proposal at this stage is to continue recommend that NW London will not have standalone birthing units.
- We will ensure that there is a Midwifery led homebirth community service for all women in NWL.
- The Paediatric CIG has agreed that amongst the six Neonatal Units there will be two Level 3 (Neonatal Intensive Care) units. The final disposition of the other four units will be decided during implementation, recognising that current and future workforce issues may be a constraint.

Given the clinical support for the proposals and the absence of alternative suggestions, the service models and principles are largely unchanged.

9.6.5 Outcome of the fourth stage about the service models to deliver change
We reached the following conclusions about the service models to deliver change:
- **Confirm the service models reflect the latest clinical thinking and reflect relevant feedback received during consultation**
  The service models and principles proposed in consultation are still valid and have been reviewed by local clinicians and updated in accordance with the latest evidence and guidance from LHP.

- **Confirm the service models will contribute to deliver the clinical case required**
  Local clinicians and the CIGs have developed the standards to address the challenges described in the Case for Change. Their use will contribute to the delivery of clinical benefits.

We confirmed this recommendation and the validity of the Case for Change with the Clinical Board and the Programme Board during the decision making phase.
9b. Decision making analysis stage 5

This section describes the analysis to identify a recommended option for reconfiguration of stage five.

9.7 Stage 5 – the hurdle criteria

This section describes the analysis for the fifth stage of the process to identify a recommended option – the hurdle criteria. Figure 9.8 highlights the relevant stage in the process.

Figure 9.8: Highlighting Stage 5 of the process described in this section

9.7.1 The purpose and outcomes of the hurdle criteria

The purpose of this stage is to use seven hurdle criteria, developed by clinicians, to establish the right number of major hospitals in the options. The outcomes are:

1. Identify a medium list of options to undergo detailed evaluation
2. Ensure the medium list will deliver the clinical vision and meet clinical need

The seven hurdle criteria are described in Figure 9.9.
Figure 9.9: The seven hurdle criteria used in Stage 5 – the hurdle criteria

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 following sections describe the analysis and outcome of each of the seven hurdle criteria.

1. **The correct care setting model to deliver high quality care**

9.7.2 *Purpose of the first hurdle criterion to identify the correct setting of care*

The first of the seven hurdle criteria examines which care setting clinicians believe is required to deliver the high quality care outlined in the Case for Change.

9.7.3 *Analysis to identify the correct setting of care*

Clinicians want to ensure the provision of high quality care that meets the ‘acute clinical standards’, including those for emergency and urgent care (see Chapter 7b for the relevant standards). Clinicians recommended the major hospital service model based on the issues set out in the Case for Change and the ambition to achieve the standards. The Case for Change also highlighted the issues currently facing the current configuration of nine current acute hospitals, this includes:

- Lack of available manpower with sufficient skills/experience
- Staff being unable to build and maintain their skills/experience if patient volumes are spread too thinly across the sites (even if the staff were available)
- The costs of providing staff (even if they were available) on a 12-24/7 basis compared to the income streams for each of the nine sites.

Therefore clinicians also agreed the standards could not be met if all nine current NW London acute sites (Central Middlesex, Charing Cross, Chelsea & Westminster, Ealing, Hammersmith, Hillingdon, Northwick Park, St Mary’s and West Middlesex1) were to become major hospital sites because this outcome would exacerbate the three issues listed above.

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1 Royal Brompton, Harefield, Royal Marsden, St Mark’s and the Royal National Orthopaedic are out of scope of the programme because they only provide specialist services.
Prior to consultation clinicians recommended adopting the major hospital service model and to reduce the number of major hospital sites in NW London. This recommendation was approved by the Clinical Board and the Programme Board pre-consultation.

9.7.4 Feedback received about identifying the correct setting of care during consultation

During consultation we received feedback about the hurdle criteria. Part of this feedback is detailed in Chapter 5, Section 5.3.1. We described the feedback received during consultation about the process used to identify consultation options. We asked people to consider the way we decided which hospitals to recommend as major hospitals, as set out in sections 15 and 16 of our consultation document. 4,541 people answered this question. Of these 60% agreed, 28% disagreed and the remaining 12% of people either had ‘no views either way’ or responded ‘not sure/ don’t know. This feedback is also applicable to the hurdle criteria and the remainder of this chapter, because sections 15 and 16 of the consultation document also contain details of the hurdle criteria and the evaluation criteria used in Stage 6 (described in Section 9.8).

In addition to this feedback we received feedback from organisations addressing the first hurdle criterion:

**Hammersmith & Fulham Council and its Health, Housing & Adult Social Care Scrutiny Committee (joint response)**

“The methodology used to identify and choose between the various reconfiguration options is open to challenge as it contains a number of fundamental flaws.”

**Independent report conducted by Tim Rideout Limited on behalf of the London Borough of Ealing Council**

“Clinicians concluded that “their desired clinical standards could not be met if all nine current NW London acute sites … were to become major hospital sites”. This is attributed to manpower and skills/experience constraints, and staffing costs. The business case does not provide the evidence for this conclusion. Given its importance in underpinning the proposal to reduce services provided at four of the nine sites, this is a significant omission.”

**North West London Joint Health Overview and Scrutiny Committee**

We agree with the underlying principles and building blocks which “Shaping a Healthier Future” promotes as the basis for future emergency care provision; …We note the technical process followed to appraise the options and are broadly supportive of the conclusions reached in arriving at the eight options. We feel the criteria used can be seen as fair and have been applied objectively.

9.7.5 The implications of this feedback on our analysis to identify the correct setting of care

The feedback we received about the first hurdle criteria did not include suggestions for alternatives. We considered the feedback received as follows:

- **Response to feedback about available workforce as referenced in the Rideout report**: To achieve the standards for emergency surgery described in Chapter 7 requires 10 consultants per hospital. There are currently only 45 emergency
surgeons in NW London, but we would need at least 60\textsuperscript{2} surgeons to meet the clinical standards at six hospitals.

- **Response to feedback about skills and experience constraints referenced in the Rideout report:** Smaller hospitals have a smaller workforce and have difficulty in providing uniform consultant skills, particularly in the emergency out of hours setting. Surgical specialties are particular problems for emergency care. Acute abdominal pain is a common presentation in A&E and requires general surgical skills, preferably with laparoscopic skills to allow investigation and ‘keyhole’ treatment of conditions like appendicitis more effectively with fewer complications and shorter lengths of stay. Subspecialties of urology, vascular and breast surgery are no longer considered suitable for inclusion in the general surgical on-call rota.

The potential benefit from specialisation are greater for life-threatening conditions like stroke and heart attack, but is also true for less severe conditions. In 1996 the NHS Centre of Reviews and Dissemination published a systematic review showing that similar association between volumes and outcomes was also present for gastric surgery, intestinal surgery, cholecystectomy and lower limb amputation\textsuperscript{3}. Soljak reviewed a wider range of conditions that would benefit from such concentration of services\textsuperscript{4}. For example Orthopaedic surgery on a hip has better outcomes when performed by a surgeon with that specialist interest who operates frequently\textsuperscript{5}.

- **Response to feedback about staffing costs referenced in the Rideout report:** In the Case for Change (Appendix D) it describes how the financial problems in NW London are caused in part through the problem of serving typically smaller populations across nine acute hospitals and therefore having a cost per case that is much higher. This makes it relatively expensive to meet staffing guidelines which are often independent of the size of the hospital (for example, College of Emergency Medicine guidelines that 10 whole time equivalent consultants as a minimum in every emergency department independent of size).

### 9.7.6 Outcome of the first hurdle criterion to identify the correct setting of care

We have considered feedback received about clinicians’ recommendation that the major hospital service model is required to ensure the provision of high quality care. Given the feedback, the absence of any credible alternative that addresses the Case for Change, we reached the conclusion that the recommendation made pre-consultation is still robust and valid for decision making.

We confirmed this decision with the Clinical Board and the Programme Board during the post consultation phase. This outcome is unchanged from pre-consultation.

The focus for clinicians was then to determine how many major hospitals should be located in NW London to provide the highest quality healthcare.

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\textsuperscript{2} Chapter 16 assumes provision of 16 hour emergency cover would require at least 10 consultants. Further workforce analysis is conducted in Chapter 16.

\textsuperscript{3} NHS Centre for Reviews and Dissemination: Hospital Volume and Health Outcomes, cost and patient access. Effective Healthcare Bulletin (2) 8. 1996

\textsuperscript{4} M Soljak. ‘Volume of procedures and outcome of treatment’. BMJ 2002. 325. 787-8

\textsuperscript{5} JA Browne, R Pietrobon, SA Olson, J’ Hip fracture outcomes: does surgeon or hospital volume really matter?’ J Trauma. 2009 Mar;66(3):809-14
9.7.7 **Purpose of the second hurdle criterion to identify sites for major hospitals**

The second hurdle criterion examines which sites in NW London should be considered for locating major hospitals.

9.7.8 **Analysis to identify the sites for major hospitals**

In theory a hospital could be sited on any of the following three types of locations in NW London:

1. Current acute hospital sites
2. New ‘brownfield’ site (abandoned or under used industrial and commercial facilities available for re-use)
3. New ‘greenfield’ site (undeveloped land either used for agriculture, landscape design, or left to naturally evolve)

Clinicians considered these options as follows:

- New ‘brownfield’ or ‘greenfield’ locations are not suitable due to the timescale required to find and develop such a site. Choosing to build a brand new site for major hospitals would also have extremely high capital requirements and would not support a financially viable health system in NW London in the future.
- Planning permission would be required for any new site and the Clinical Board acknowledged the following comments about the general market for new sites in NW London:
  - The general market for redevelopment property in West London remains strong.
  - Truly ‘open market’ land sales are rare and often particularly costly, due to likely competition with residential developers.
  - The greatest likelihood of being able to identify a site suitable for the purpose under consideration is for land in an outdated ‘existing use’ (Govt/ Local Authority/ Statutory Undertaker/ major Utility) to become available.
  - Work investigating new sites for other programmes in NW London has established that many sites take years, if not decades to see physical development take place.

Prior to consultation clinicians recommended only current existing nine acute hospital sites should be considered for future location of major hospitals. This recommendation was approved by the Clinical Board and the Programme Board pre-consultation.

9.7.9 **Feedback received about identifying sites for major hospitals during consultation**

During consultation we received no feedback related to the second hurdle criterion.

9.7.10 **Outcome of the second hurdle criterion to identify sites for major hospitals**

Given the feedback received clinicians recommended that only current existing nine acute hospital sites should be considered for future location of major hospitals. This is due to the time required to find and develop a site and to manage the risk of access to capital.
We confirmed this decision with the Clinical Board and Programme Board during the post consultation phase. This outcome is unchanged from pre-consultation.

9.7.11 Purpose of third hurdle criterion to identify the number of major hospitals required for NW London

The third hurdle criterion examines the number of major hospitals required for the population of NW London.

9.7.12 Analysis to identify the number of major hospitals required for NW London

NW London population is forecast to increase by approximately 141,000 people (7%) growing from circa 2 million to circa 2.15 million over the period to 2018. Clinicians considered available evidence about the factors which contribute to high quality clinical care to define the correct number of major hospitals to serve this population:

- Evidence of the links between senior staff presence and quality of care, as referenced in the acute clinical standards in Chapter 7, Section 7.3.1.
- Patient volumes required to ensure staff build and maintain skills
- Technology required to support high quality care
- Interdependencies between different acute services and their required clinical support.

Using these four criteria clinicians identified that there should be between three to five major hospitals in NW London to support the projected population of over 2.15 million.

Rationale for proposing a maximum of five hospitals

The Case for Change noted that “National shortages of some clinical staff groups, such as paediatricians, midwives, radiologists and pathologists, due to the numbers of individuals currently entering training, are expected to continue in the future. Even if there were more suitably trained staff in place, they would quickly begin to lose their skills as they would not be seeing sufficient volumes of patients”.

Clinicians identified that having more than five major hospitals would be likely to lead to sub-optimal care because:

- Recent reports from professional bodies, such as the Royal Colleges and NCEPOD (National Confidential Enquiry into Patient Outcomes and Death) have highlighted deficiencies of care in adult and paediatric acute emergency services. Significant evidence demonstrates a variation in outcomes for patients depending on the time and day of the week that they attend an emergency department, or are admitted to hospital as an emergency. Additionally, London’s maternity services do not perform uniformly well with unacceptable inequalities in maternity outcomes in areas of mortality, morbidity and experience. This has been explicitly highlighted in several recent reports and reviews including the 2011 London maternal death review, Care Quality Commission (CQC) reports from individual Trusts and the London Local Supervisory Authority (LSA) annual report. Emergency admissions account for
roughly 31 per cent and births account for roughly six per cent of total hospital inpatient activity (including day cases)

- These variations in emergency services outcomes have been associated with a lack of immediate access to senior medical personnel in the assessment and management of acutely ill patients, access to imaging and consultant reporting, and input from multidisciplinary teams particularly outside of traditional normal working hours, which accounts for roughly three quarters of the week. Inequalities in maternal outcomes have been linked with variation in midwifery staffing levels, consultant presence and obstetric anaesthetic cover, particularly outside of normal working hours.

- There is a constraint on available consultants with sufficient skills. It is evident that senior clinicians are less often on site at weekends. A recent audit of London sites showed consultant surgeons are on site for an average of four hours at weekends\(^6\). Whilst they are always available to junior staff for advice and willing to be called in there is often a reluctance to bother a senior who will be responsible for the next reference. Audit of the acute providers in London in 2011\(^7\) showed very variable numbers of surgeons and even greater variability of access to laparoscopic skills, Figure 9.10.

**Figure 9.10: Total number of emergency surgeons in NW London**

Since this audit the access to laparoscopy at Ealing has improved substantially, but with small numbers of consultants available for rotas, routine availability out of hours (with the constraints of the European Working Time Directive) is limited.

The Kings Fund commented, "there is increasing recognition the services such as emergency surgery may be unsafe out of hours, and the provision of these services needs to be concentrated in fewer centres that are better able to provide senior medical cover"\(^8\) and the Royal College of Physicians recent report states, "it is increasingly clear that we must radically review the organisation of hospital care if the health service is to meet the needs of patients"\(^9\).

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\(^6\) Adult Emergency Services. Hospital Services Audit. London Health Programmes. 2011
\(^7\) London Health Programmes. NHS London. Adult Emergency Services Audit. Sept 2011
\(^8\) C Ham, A Dixon, B Brooke. Transforming the Delivery of Health and Social Care. King’s Fund 2012
Appropriate staffing is integral to an effective emergency department. Evidence suggests that consultant-delivered care brings benefits for patients receiving emergency care however significant variation exists in the numbers of hours that emergency medicine consultants are present in London’s emergency departments. Input from experienced, senior doctors twenty-four hours a day, seven days a week is required to ensure the delivery of high quality care and timely patient flow. However this practice is uncommon in London.\(^\text{10}\)

Currently, the nine acute sites require at least 45 surgeons on their rota to provide cover. However this level of cover isn’t delivering the standards defined in Chapter 7. To achieve the standards set out in Chapter 7 requires 10 WTEs per site (see Chapter 16), therefore the nine sites would need 90 surgeons. Figure 9.11 illustrates the current number of emergency surgeons against the number required to deliver the standards across different numbers of major hospitals, it shows that we currently have just over half the required number of emergency surgeons to achieve the standards.

Figure 9.11: Minimum required number of emergency surgeons for different numbers of major hospital sites

<table>
<thead>
<tr>
<th>Current WTEs in NW London</th>
<th>Number of major hospitals</th>
<th>Minimum required emergency surgeons for rota cover to achieve standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>X 9</td>
<td>X 9</td>
<td>c. 90 WTE*</td>
</tr>
<tr>
<td>X 8</td>
<td>X 8</td>
<td>c. 80 WTE*</td>
</tr>
<tr>
<td>X 7</td>
<td>X 7</td>
<td>c. 70 WTE*</td>
</tr>
<tr>
<td>X 6</td>
<td>X 6</td>
<td>c. 60 WTE*</td>
</tr>
<tr>
<td>X 5</td>
<td>X 5</td>
<td>c. 50 WTE*</td>
</tr>
<tr>
<td>X 4</td>
<td>X 4</td>
<td>c. 40 WTE*</td>
</tr>
<tr>
<td>X 3</td>
<td>X 3</td>
<td>c. 30 WTE*</td>
</tr>
</tbody>
</table>

Even if there were more specialist doctors and their teams available, spreading them across more than five sites would mean that they would each see fewer patients and therefore be unable to build and maintain the skills and expertise they need to ensure delivery of high quality care. The probability of seeing more complex or rarer cases also diminishes which has an impact on doctor’s experience. A full 24/7 emergency care site requires a sufficiently large population catchment to ensure that consultants and their specialist teams maintain their skills by conducting a sufficient number of operations. This particularly applies to emergency surgery, critical care and interventional radiology.

\(^\text{10}\) London Health Programmes (2012) Emergency departments: case for change
Royal Colleges have indicated that a population of 350,000 to 450,000 is required to have sufficient scale to run a high quality urgent surgery service where staff are seeing sufficient volumes to maintain skills\textsuperscript{11}. Alongside this evidence has shown that by establishing specialist centres and networks, patients will experience better clinical outcomes. An example of this in emergency surgery is around access to surgeons who are trained in laparoscopic surgery for emergency situations.

Clinicians agreed that having more than five major hospital sites would not enable the specialist expertise to be concentrated into enough centres and seeing sufficient volumes of patients to deliver the highest quality care.

**Rationale for proposing a minimum of three hospitals**

The Clinical Board recommended that potential options with only one or two major hospitals would be too difficult to deliver in the timescales required and would compromise access for patients.

Prior to consultation clinicians concluded that NW London required three to five major hospitals. This recommendation was approved by the Clinical Board and the Programme Board pre-consultation.

**9.7.13 Feedback received about identify the number of major hospitals required for NW London**

During consultation we received the following feedback related to the third hurdle criterion:

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**Independent reports conducted by Tim Rideout Limited on behalf of the London Borough of Ealing and Hammersmith & Fulham Council**

“The clinicians considered evidence about factors that were judged to contribute to high quality clinical care, including links between senior staff presence and quality, patient volumes to maintain skills, technology and the interdependencies between different acute and support services. The business case states that as a result of this consideration clinicians “identified that there should be between three to five major hospitals in NW London to support the projected population of 2 million”, with a view that more than five major hospitals would lead to sub-optimal care. The proposals centred on five as the proposed number, primarily in light of current capacity constraints. Although explained in summary terms, the detailed evidence base for this decision to propose five major hospitals is not provided with the business case and is therefore open to challenge.”

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**9.7.14 The implications of this feedback on our analysis to identify the number of major hospitals required for NW London**

The feedback we received about the third hurdle criterion did not include suggestions for alternatives. We considered the feedback received as follows:

- **Response to feedback from Rideout about current capacity constraints**: The statement; “The proposals centred on five as the proposed number, primarily in light of current capacity constraints” is incorrect. Our recommendation is based upon:
  - More than 5 hospitals would not provide the clinical quality required
  - Fewer than 5 would be difficult to deliver, require significant building work and patient journey time would increase

\textsuperscript{11} Academy of Royal Colleges, Acute Healthcare Services Report, 2007
The proposals are supported by Department of Health’s National Clinical Advisory Team (NCAT). NCAT scrutinised our proposals for in hospital care (emergency and urgent care, maternity and paediatrics) prior to consultation in May 2012. They made a number of observations and endorsed the clinical proposals.

9.7.15 Outcome of the third hurdle criterion to identify the number of major hospitals required for NW London

Given the feedback, the absence of any alternative suggestions, clinicians recommend that by changing to a configuration of three to five major hospitals in NW London, the right skills will be in place to meet the clinical standards and provide the highest quality of care.

We confirmed this decision with the Clinical Board and Programme Board during the post consultation phase. This outcome is unchanged from pre-consultation.

9.7.16 Purpose of the fourth hurdle criterion to identify the viable number of major hospitals

The fourth hurdle criterion examines how many major hospitals are viable in the medium term within the recommended range of three to five major hospitals.

9.7.17 Analysis to identify the viable number of major hospitals

Clinicians identified that only options that have five major hospitals are viable in the medium term.

Clinicians agree that whilst the clinical standards could be delivered, moving to three or four sites would cause major disruption to existing services which could affect the consistent delivery of high quality services. Moving to fewer than five major hospital sites would require transferring a large number of existing services simultaneously across the region increasing the likelihood of:

- A long implementation timeframe (approximately 7+ years) and period of change
- A large investment in capital to develop infrastructure on some sites during a period when access to capital investment is severely constrained.

Currently no sites currently have the capacity to deliver the volumes of activity in an option with less than five major hospitals, as shown in Figure 9.12.
The current site with the greatest bed capacity is Northwick Park and St Marks, with 739 beds. The smallest site is Central Middlesex with 235 beds.

If options with three or four major hospitals were considered, thereby requiring between 600 to 1000 beds at each site, all sites that were included within that option (even if comprised of the largest hospitals in NW London) would need significant levels of expansion to meet demand. This scale of change would be likely to have a long delivery timeframe, due to the investment (and subsequent building/development work) required.

By only considering options that have five major hospitals, there are several existing sites that are close to providing the capacity that is required. This has the effect of minimising the capital cost of the changes.

The Clinical Board recommended that five major hospital sites in NW London would provide the most sustainable model for delivering high quality care to the projected local population of 2 million.

Building on this work and the clinical quality standards, the programme’s maternity and paediatric clinical commissioning groups (CIGs), which are attended by clinicians with expertise in these specialities, considered the implications for paediatrics and maternity services, cross-referencing this work with the Case for Change set out Chapter 4 and other reviews, such as the London Health Programmes. The CIGs recommended that:

- To meet clinical standards and best utilise workforce, maternity units in NW London should plan capacity for approximately 6000 births per annum on average, although this is only a guide noting that larger units do exist in the UK, and that alongside midwifery units could deliver up to 25% of the total
- There should be five paediatric inpatient units
- Given co-dependencies with paediatric services and neo-natal units, there should be six maternity units, five to be part of the suggested five major hospital sites and a further unit at Queen Charlotte’s Hospital.

These are the current clinical recommendations for maternity and paediatrics. In the future, commissioners may establish that there are not enough consultant staff for sustainable, safe clinical rotas and may wish to revisit the number of maternity and paediatric units needed in

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12 There may also be specialist and elective hospital sites so therefore the change in total bed base across the sector cannot be calculated using only these numbers; current bed capacity includes adult general and acute beds, adult day care and critical care i.e. excludes paediatric, maternity and other beds
NW London to deliver high quality clinical care. Chapter 7 details the full standards agreed by the CIGs.

Prior to consultation (November 2011 to July 2012) clinicians recommend there should be five major hospitals in NW London. This recommendation was approved by the Clinical Board and the Programme Board pre-consultation.

**9.7.18 Feedback received about identify the viable number of major hospitals during consultation**

During consultation we sought feedback about proposals for five major hospitals in NW London. We wanted to understand if people agreed with the proposal and if people had any suggestions for how it could be improved. We asked people the following question in our response form:

**Question 17: How far do you support or oppose the recommendation that there should be five major hospitals in North West London?**

4,786 people answered this question. Of these respondents:

- 61% support
- 28% opposed
- 11% of people either had ‘no views either way’ or responded ‘not sure/ don’t know.

Figure 9.13 summarises the results.

**Figure 9.13 Results for feedback about five major hospitals in London**

<table>
<thead>
<tr>
<th>Question 17: How far do you support or oppose the recommendation that there should be five major hospitals in North West London?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support</td>
</tr>
<tr>
<td>Strongly support (948)</td>
</tr>
<tr>
<td>61%</td>
</tr>
<tr>
<td>2,912 people</td>
</tr>
</tbody>
</table>

During consultation we also received feedback from the following organisations:

**The College of Emergency Medicine**

“The College supports the principle of consolidation of specialist expertise with a focus on a limited number of hospitals which provide the full range of specialist emergency care.”
Independent reports conducted by Tim Rideout Limited on behalf of the London Borough of Ealing and Hammersmith & Fulham Council

“The core argument rests on the number of emergency surgeons available to support the rota at each site, and the relatively low population catchment per current rota. However this should be tested further. The extent to which this takes account of the differential needs of local people and the significant population increases anticipated over the coming years is not clear. The theory is also based on sound but general supporting evidence developed by the Royal Colleges. Again, this should have been tested further against the current reality of service need in NW London.”

9.7.19 The implications of this feedback on our analysis to identify the viable number of major hospitals

The feedback we received about the fourth hurdle criterion did not include suggestions for alternatives. We considered the feedback received as follows:

- **Response to feedback about differential needs in the Rideout report:** the guidelines from the Royal Colleges consider population size the key determinant of A&E distribution.

- **Response to feedback about population increases in the Rideout report:** We have explored the impact of possible population changes through our work on sensitivity analysis. The robustness of planning assumptions is examined using sensitivity analysis to ensure that the model is cognisant of all issues, including changes in the underlying activity data.

9.7.20 Outcome of the fourth hurdle criterion to identify the viable number of major hospitals

Given the feedback, the absence of any suggested alternative, clinicians identified that only options that have five major hospitals are viable in the medium term. We confirmed this decision with the Clinical Board and Programme Board during the post consultation phase. This outcome is unchanged from pre-consultation.

9.7.21 Purpose of the fifth hurdle criterion to identify the geographical spread of major hospitals

The fifth hurdle criterion examines the location of the five major hospitals across NW London.

9.7.22 Analysis to identify the geographical spread of major hospitals

There are 126 potential ways of configuring the nine current acute sites in NW London as five major hospital sites. Travel analysis was used during this part of the process to determine the location of five major hospitals. Travel time has been used in two ways to support the analysis of the potential reconfiguration options:
1. Support predicting where activity may flow if one hospital no longer offers a service, for example, if hospital X is not offering A&E services, how much extra capacity will surrounding hospitals need to be able to cope with the additional volumes?

2. Reflect the potential change in actual travel time that may be experienced by the public as a result of the proposed reconfiguration.

There are challenges in analysing travel time data. Journey times can be impacted by several factors such as the use of multiple forms of transport to get to hospital, traffic congestion varies during different times of the day and as a result of incidents or road works, and ambulance travel times vary significantly depending on the type of incident (they do not always travel under 'blue light' and LAS confirmed that just 10% of their journeys are conducted under true 'blue light' conditions) and time of day. As a result there is no comprehensive point to hospital database of actual visitor and staff journeys using different forms of transport.

Throughout the travel analysis conducted, a number of elements have been considered:

- **Transport types considered:**
  - Private Car (peak and off-peak) and Public Transport peak travel times.

- **Areas covered:**
  - Times between acute hospital sites
  - Times from small areas (lower super output areas) within NWL to acute hospital sites
  - From areas outside of NWL where >20% patients currently use NWL services.

- **Types of analyses:**
  - Impact on Travel times:
    - Individual hospital changes
    - For configuration options
  - Population weighted averages, 95th percentile and maximum travel times
  - Health deprivation as a function of changes in travel time
  - Estimated activity flows from major hospital if it were to no longer provide a service.

As patients rightly do not consider themselves constrained by commissioning boundaries, the travel analysis has included hospitals surrounding NW London where residents are currently being treated, e.g. Barnet, Guy's, Kingston, Royal Free, St George's, St Thomas', St Peter's, University College London Hospitals, Watford, Wexham Park and Wycombe. The analysis has also considered non-NW London residents, from the rest of London or the surrounding counties, who are treated within the region.

**The Shaping a healthier future travel model**

The travel data used to populate the models comes from the Health Service Travel Analysis Tool (HSTAT). This tool was provided by Transport for London (TfL) and its use by the programme was approved by NHS London (NHSL), TfL, and London Ambulance Service (LAS). HSTAT contains travel times by private car and public transport between a number of health service locations and all the Lower Super Output Areas (LSOAs) in London. LSOAs are geographical regions of consistent size. Their boundaries do not change which means they are useful for many types of statistical analysis (refer to the travel reports in Appendix K for further details). There are 1142 LSOAs in North West London. The model produces travel times from a point at the population centre of the LSOA to the hospitals.

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13 Residents from postcode regions where more than 1 in 5 residents are currently treated at NW London hospitals are included.
under different conditions, such as rush hour, and using different modes of transport; private car and public transport (which includes bus, rail and the Tube). Ambulance journey times are assumed to be 67% of private car peak hour travel times (peak hours, or the ‘rush hour’ are 7am to 10am). These assumptions were validated by the programme’s Clinical Board. For further details on travel analysis refer to Chapter 14.

Population weighted average travel times

To better understand the impact of different options on travel times, population weighted average travel times are used. Population weighted average travel times are used to consolidate the amount of data in the model from many thousands into a format that supports analysis and to avoid the results of the modelling from being ‘biased’, or distorted, by outliers in the data. For example, if one person travelled a hundred miles to a hospital and 100 people travelled one mile the average should reflect the fact that most people had the shorter journey and not be skewed in this case by the one long journey, known as an ‘outlier’. The diagram below describes how population weighted travel times are calculated. Figure 9.14 shows how the impacts of service changes on travel times are calculated.

**Figure 9.14: Calculating the impact of service changes on travel times**

**Travel time maps**

The outputs of the travel model were used to create ‘travel time maps’. This is a map that shows the potential increase in travel time for residents in North West London to the next nearest hospital if their current nearest hospital was not a major hospital. The colours on the map indicate the extra travel time that would be incurred. The ‘travel time map’ below, Figure 9.15 shows what would happen to blue light travel times if Northwick Park or Hillingdon were not major hospitals.
Figure 9.15: Example travel time maps

S-curves

The travel model was also used to produce ‘S-curves’. This is a graph that plots all the travel times to a specific hospital or hospitals for a particular region. The curve starts at the bottom of the graph (the x axis) with the shortest possible journey and then cumulatively adds on all the other possible journey times up to the very longest travel time at the top of the graph. This means the graph can be used to show the percentage of the population that can reach their destination within a specified time. See Figure 9.16 of an example S-curve.

Figure 9.16: Example travel time maps

Outcomes of the travel analysis

Figure 9.17 shows the travel maps for all the boroughs in NW London. The areas shaded in the darkest blue would experience an increase in travel time of between 6 to 34 minutes, if residents there had to go to their ‘next nearest’ hospital. The maps showing the current configuration minus either Northwick Park or Hillingdon have the greatest amount of area shaded, demonstrating that a larger area (and therefore significant population levels) would have to travel further if either of these hospitals were no longer major hospitals. This is in comparison with the maps for St Mary’s, Chelsea & Westminster and Charing Cross, where the area of impact is much smaller (refer to Appendix K for further details).
Figure 9.17: Impact on blue light travel times for each borough when A&E destination is changed (absolute change in blue light travel time against current configuration (mins))$^{14}$

1. Current configuration of major hospitals = Northwick Park, Hillingdon, Ealing, West Middlesex, St Mary’s, C&W and Charing Cross.
2. Hospitals outside of NWL included in analysis = Barnet, Guy’s, Kingston, Royal Free, St George’s, St Thomas’, St Peter’s, UCLH, Watford, Wrexham Park and Wycombe.
3. Travel times from population areas outside of London not included.

$^{14}$ TIL HSTAT travel time data. Blue light travel times estimated at 67% off-peak private car travel times.
The analysis shown in Figure 9.18, using the S-curves, further supports the likely impact on residents of each of the boroughs according to the different configurations. Should Northwick Park or Hillingdon no longer provide major hospital services, residents in Harrow and Hillingdon would be most affected, with peak car journeys likely to increase by a greater amount compared to other potential configurations.
Figure 9.18: Impact on private car travel times for each borough when A&E destination is changed (peak)\textsuperscript{15}

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|}
\hline
Borough & Current configuration & Without Hospital/Institution \\
\hline
Harrow PCT - Northwick Park Hospital: Cumulative population (%) vs. travel time (mins) & Current configuration & Without Northwick Park \\
& Average peak private car travel time (min) & Maximum peak private car travel time (min) \\
& 22 & 35 \\
\hline
Hounslow PCT - West Middlesex Hospital: Cumulative population (%) vs. travel time (mins) & Current configuration & Without WMUH \\
& Average peak private car travel time (min) & Maximum peak private car travel time (min) \\
& 22 & 36 \\
\hline
Brent PCT - Central Middlesex Hospital: Cumulative population (%) vs. travel time (mins) & Current configuration & Without CMH \\
& Average peak private car travel time (min) & Maximum peak private car travel time (min) \\
& 22 & 32 \\
\hline
Hillingdon PCT - Hillingdon Hospital: Cumulative population (%) vs. travel time (mins) & Current configuration & Without Hillingdon \\
& Average peak private car travel time (min) & Maximum peak private car travel time (min) \\
& 26 & 54 \\
\hline
\end{tabular}
\end{table}

\textsuperscript{15} TfL HSTAT travel times data. Notes from Figure 12.4:
1. Peak time = Morning peak = 7am – 10am
2. Current configuration of major hospitals = Northwick Park, Hillingdon, Ealing, West Middlesex, St. Mary's, C&W, Charing Cross, except for Brent PCT where current configuration is assumed to also have CMH in order to provide a comparison
3. Hospitals outside of NWL included in analysis = Barnet, Guy's, Kingston, Royal Free, St George's, St Thomas', St Peter's, UCLH, Watford, Wexham Park and Wycombe
4. Travel times from areas outside of London not yet included (will be updated with all LSOAs where >20% patients use NWL hospitals)
5. Population weighted average used for travel times
Figure 9.18: Impact on private car travel times for each borough when A&E destination is changed (peak)
Prior to consultation clinicians recommended that Northwick Park and Hillingdon should be major hospitals in all options because they are more geographically remote compared with the other sites and their inclusion minimises impact on access. This recommendation was approved by the Clinical Board and the Programme Board pre-consultation.

**9.7.23 Feedback received about identifying the geographical spread of major hospitals during consultation**

During consultation we sought feedback about proposals that Northwick Park and Hillingdon should be major hospitals in all options. We wanted to understand if people agreed with the proposal and if people had any suggestions for how it could be improved. We asked people two questions in our response form, the first question was:

**Question 28a. All the options above include the recommendation that Hillingdon Hospital should be a major hospital. How far do you support or oppose the recommendation that Hillingdon Hospital should be a major hospital?**

4,432 people answered this question. Of these respondents:

- **33%** support
- **9%** opposed
- **58%** of people either had ‘no views either way’ or responded ‘not sure/ don’t know.

Figure 9.19 summarises the results

**Figure 9.19 Hillingdon Hospital as a major hospital**

The second question was:

**Question 29a. All the options above include the recommendation that Northwick Park Hospital should be a major hospital. How far do you support or oppose the recommendation that Northwick Park Hospital should be a major hospital?**

4,424 people answered this question. Of these respondents:
- 33% support
- 10% opposed
- 57% of people either had ‘no views either way’ or responded ‘not sure/ don’t know.

Figure 9.20 summarises the results.

**Figure 9.20 Northwick Park Hospital as a major hospital**

<table>
<thead>
<tr>
<th>Strongly support (849)</th>
<th>Tend to support (609)</th>
<th>No views either way (1,933)</th>
<th>Tend to oppose (162)</th>
<th>Strongly oppose (282)</th>
<th>Not sure/ don’t know (589)</th>
</tr>
</thead>
<tbody>
<tr>
<td>19%</td>
<td>6%</td>
<td>44%</td>
<td>4%</td>
<td>13%</td>
<td>14%</td>
</tr>
</tbody>
</table>

During consultation we also received feedback from the following organisations:

**North West London Hospitals NHS Trust**

“We therefore believe that the hospital [Northwick Park] (with support from local CCGs) is generally well placed to support increased demand although new inpatient capacity is likely to be required until local out of hospital strategies are fully implemented.”

**The Hillingdon Hospitals NHW Foundation Trust**

“The implementation of the proposed changes will need to be carefully planned, with investment made to ensure that the capacity is in place at the proposed locations that will deliver the healthcare services outlined in the consultation document. Indeed, we have discussed the consultation proposals with our Foundation Trust Governors and members, who have highlighted the importance of ensuring the capacity is put in place to enable the Trust to respond to the proposed activity flowing from other hospitals.”

**Harrow Council Health and Social Care Scrutiny Sub-Committee**

“We remain concerned about the capacity and infrastructure at Northwick Park Hospital to take on the growth in demand in its services and the additional patient flow.”

**Hillingdon Council Health and Social Care Scrutiny Sub-Committee**

“Concern that the need to make short term efficiencies may lead to reduced services or capacity which might later then be needed to meet transferred demand from elsewhere.”

In addition, we received feedback about travel pertinent to hurdle criterion 5 is as follows:
Independent reports conducted by Tim Rideout Limited on behalf of the London Borough of Ealing and Hammersmith & Fulham Council

“there is insufficient robust rationale for automatically earmarking only two sites (Northwick Park and Hillingdon) as major hospital sites. The business case undertook a piece of analysis of blue light travel times analysing the impact of removing the A&E departments for all eight hospitals. The removal of Northwick Park and Hillingdon showed the greatest area that would be affected if these A&E destinations were removed. Ealing appears to be the third largest (and darkest blue – indicating further drive time) area affected if Ealing’s A&E is removed thus meaning that Ealing residents would have to travel further. No rationale was provided as to why only Northwick Park and Hillingdon were earmarked as major hospital sites, and not Ealing Hospital or West Middlesex. St. Mary’s, Chelsea & Westminster and Charing Cross were discounted due to the lesser impact of removing these A&E departments which, given the greater population concentration with a smaller area, is slightly more justified”

The remaining feedback on travel analysis is described in Chapter 14 and does not pertain to the evaluation of hurdle criterion 5.

9.7.24 The implications of this feedback on our analysis to indentify the geographical spread of major hospitals

The feedback we received about hurdle criterion 5 did not include suggestions for alternatives.

During consultation the travel modelling and the possible impact of increased journey times was raised by a number of people, and was identified in the Ipsos MORI analysis as a key theme from respondents. We undertook additional analysis to respond to this feedback. We considered the feedback received as follows:

- The travel map and s-curve analysis described above indicates that if Northwick Park or Hillingdon weren’t designated as major hospitals it could lead to the largest increase in travel times for the largest geographical area of people:
  - Blue light average times increase by 6 minutes (Northwick Park) and 4 minutes (Hillingdon), against a North West London average increase of 1 to 2 minutes
  - Average public transport times increase by 17 minutes (Northwick Park) and 6 minutes (Hillingdon) respectively against a North West London average of approximately 7 minutes
  - 14 minutes for average private peak car travel times if Northwick Park wasn’t a major hospital.

Watershed maps

We developed watershed maps (see Chapter 12, Section 12.2.2) to show in further detail the nearest major hospital as defined by the shortest journey time (private car, morning peak) for each LSOA in NW London. The purpose of this analysis is show the ‘catchment’ area, based on journey times to the nearest acute hospital site.

Figure 9.21 show the LSOAs shaded according to their ‘nearest’ hospital and the total catchment area for each acute hospital, based on journey times. The map shows that the catchment areas for Northwick Park and Hillingdon are the largest in NW London. Therefore if neither were designated a major hospitals it would affect the largest area of NW London.
Figure 9.21: Watershed map for blue light travel times* to nearest current acute hospital site

Nearest major hospital by blue light ambulance, (67% private car off peak)

Please note, LSOAs that appear to be closer to an acute hospital than the colour coding reflects occur because the HSTAT model will take the nearest part of the road network to the population weighted centroid. It will then calculate the route from here, along the road network.

The map also shows the current theoretical catchment areas around the remaining acute hospital sites are all smaller than the areas around Northwick Park and Hillingdon, and the catchment areas for West Middlesex, Central Middlesex and Ealing are comparable in size meaning that clinicians could not use this criterion to differentiate between the remaining proposed sites.

We also developed travel contour maps to explore actual travel times by LSOA. The purpose of this analysis is show which LSOAs have the longest travel times before and after reconfiguration. Figure 9.22 indicates the current blue light travel times.
The map shows that currently the longest blue light travel times are experienced by residents within LSOAs who currently use Northwick Park and Hillingdon.

9.7.25 *Outcome of the fifth hurdle criterion to identify the geographical spread of major hospitals*

Given the feedback, the absence of any alternative suggestions, clinicians reached the conclusion Northwick Park and Hillingdon Hospitals are proposed as major hospitals in all options to minimise impact on access.

We confirmed this decision with the Clinical Board and the Programme Board during the post consultation phase. This outcome is unchanged from that reached pre-consultation.

9.7.26 *Purpose of the sixth hurdle criterion to determine unsuitable sites*

The sixth hurdle criterion considered if any sites were unsuitable to be major hospitals.

9.7.27 *Analysis to determine unsuitable sites*

Over recent years, several services have ceased to be offered at Central Middlesex hospital because they were clinically unsustainable. This includes emergency surgery, inpatient paediatrics and obstetrics. The site itself is particularly small, with 35,000m² of clinical space and 235 beds. It also serves a small catchment population. Should Central Middlesex be
retained as a major hospital, because it is the smallest of the existing acute sites, it would require the largest proportional expansion of any of the current sites to accommodate the activity predicted for a typical major hospital.

Prior to consultation clinicians recommended that Central Middlesex should not be considered as a major hospital due to insufficient levels of clinical quality to meet the standards for major hospitals and due to the size of the site. This recommendation was approved by the Clinical Board and the Programme Board pre-consultation.

9.7.28 Feedback received about determining unsuitable sites during consultation

During consultation we sought feedback about proposing Central Middlesex is not a major hospital site. We wanted to understand if people agreed with the proposal and if people had any suggestions for how it could be improved. We asked people the following question in our response form:

Question 15: How far do you support or oppose our recommendation that we should use our high quality hospital buildings with spare space as elective hospitals?

4,596 people answered this question. Of these respondents:

- 68% in support
- 21% opposed to the recommendation
- 11% of people either had ‘no views either way’ or responded ‘not sure/ don’t know.

Figure 9.23 summarises the results.

Figure 9.23 Results for the recommendation for using high quality estate

During consultation we also received feedback from the following organisations:

London Borough of Hounslow Health and Adult Care Scrutiny Panel
“Central Middlesex is not currently providing the services that would be delivered at a major hospital site and it therefore makes sense for it to continue to operate as a local hospital.”
North West London Hospitals NHS Trust
“We have considered the future role for CMH [Central Middlesex Hospital] and while a number of staff and local people would like to retain all traditional DGH [District General Health] services they recognise that the commissioning of the Brent Urgent Care Centre (that is able to treat the vast majority of patients who use it and will remain open 24/7) has enabled the Trust to improve a number of hospital delivered services.”

The Community Voice
“The provision of elective services at Central Middlesex Hospital is of direct relevance to a section of our membership and the proposals are recognised as a pragmatic compromise. Providing elective services at the hospitals without A&E departments is seen as protection of those services.”

Brent LINk
“At the Brent LINk 24 September SAHF public debate, members of the public unanimously opposed the proposal to close Central Middlesex A&E …Central Middlesex Hospital has recently undergone a major rebuild…Brent LINk feels that this has resulted in a service being offered and then taken away.”

Sarah Teather, MP for Brent Central
“I am so bitterly disappointed that this consultation does not give Brent's residents the chance to save the A&E at Central Middlesex Hospital, especially as it seems like only yesterday that the hospital was rebuilt at a cost of £80 million….The decision to close the A&E has been taken anyway without any reference to the needs or views of local residents. This is an appalling decision.”

Harrow Council Health and Social Care Scrutiny Sub-Committee
“The closure of hospital A&Es raises questions about the future of hospitals in the longer term e.g. Central Middlesex Hospital and possibly Ealing Hospital. There is real concern that services will diminish incrementally at hospitals downgraded to local hospital status, as fewer and fewer services stay clinically viable.”

Brent Health Partnerships Overview and Scrutiny Committee
“On balance [the Committee] does not object to the Shaping a Healthier Future proposal that it [Central Middlesex] becomes a local hospital and elective centre…would oppose any measures to close the hospital..the real work explaining the changes should begin now.”

We also received a total of 18 petitions and campaign responses. Two of the petitions related to Central Middlesex and are summarised in the table below:

<table>
<thead>
<tr>
<th>Reference</th>
<th>Petition/campaign on behalf/in support of</th>
<th>Number of signatories</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>Petition opposing the downgrading of services and the closure of the A&amp;E Department at Central Middlesex Hospital from Harlesdon Methodist Church</td>
<td>43</td>
</tr>
<tr>
<td>Q</td>
<td>Petition calling for Ealing, Central Middlesex, Charing Cross and Hammersmith Hospitals to retain their status and keep all existing services, from Ealing Council</td>
<td>25,193</td>
</tr>
</tbody>
</table>

The petitions oppose changes to Central Middlesex. Ealing and Hammersmith and Fulham CCGs wish to respond in detail to the feedback about the range of services that would be available at Ealing and Charing Cross hospitals and have developed a set of proposals for the JCPCT to consider; these are set out in separate documents.
9.7.29 The implications of this feedback on our work to determine unsuitable sites

Given the feedback, the absence of any suggested alternative, we reached the conclusion that the recommendation made pre-consultation is still robust and valid post-consultation.

9.7.30 Outcome of the sixth hurdle criterion to determine unsuitable sites

We have considered feedback received. Given the feedback, we reached the conclusion that Central Middlesex should not be considered as a major hospital site.

We confirmed this decision with the Clinical Board and the Programme Board during the post consultation phase. This outcome is unchanged from pre-consultation.

9.7.31 Purpose of the seventh hurdle criterion to identify the best geographical spread of the remaining sites

The seventh step of the hurdle criteria considered the geographic distribution of the remaining sites to minimise potential impacts on local residents.

9.7.32 Analysis to identify the best geographical spread of the remaining sites

After recommending that Northwick Park and Hillingdon should become locations as a major hospital, and that Central Middlesex should not, there remained 20 possible configuration options utilising the other six sites.

Clinicians agreed that consideration should be given to the ‘geographic distribution’ of the remaining options for the location of the other three major hospital sites. There is not as much difference in travel times for people living near other hospitals in NW London. However, we wanted to make sure that the other three major hospitals were spread evenly across NW London. This is to make it easy for people to get to them.

We looked at where people are likely to go if their nearest hospital did not provide some services. Clinicians reviewed likely flows of activity, should a particular site no longer be ‘available’. For example, if patients normally travelled to Charing Cross, should Charing Cross not be a major hospital, the analysis considered the next hospital that they would go to.

Figure 9.24 sets out the patient flows that would occur if either of West Middlesex or Ealing were not proposed as a major hospital. The diagram shows that if West Middlesex became a major hospital and Ealing was not a major hospital, then:

- 52% of patients who currently use Ealing would go to West Middlesex instead
- Transversely, 41% of patients would head to Ealing if it was a major hospital, and West Middlesex was not, where they currently use West Middlesex.

By contrast, much lower percentages of patients (and ambulances) would switch to other hospitals. By considering an option of locating a major hospital at either Ealing or West Middlesex, the impact of any change on local residents will be minimised.
Figure 9.24: Potential activity flows for options based on Blue Light proxy travel time to next nearest hospital

The numbers highlighted in blue indicate those sites that would receive more than 20% of the activity of a hospital that was no longer offering major hospital services. For example, if Hillingdon was not designated a major hospital, then 71% of its activity would move to Ealing.

The numbers show the relationship between:

- **Ealing and West Middlesex:***
  - With between 41%-52% of activity transferring between the two sites (respectively), should one of them not be a major hospital.

- **Hammersmith and St Mary’s:***
  - Where between 59%-62% of activity would move between the two sites (respectively) should one of them not provide services

- **Charing Cross and Chelsea & Westminster:***
  - Where between 43%-57% of activity would move between the two sites (respectively) should one of them not provide services.

This analysis was also completed for private car travel times, as shown in Figure 9.25.

---

**Note:**
1. Blue Light travel times estimated as 67% Off-peak Private Car travel times.
2. Current configuration includes Central Middlesex and Hammersmith to understand flow to/from those sites
3. Hospitals outside of NWL included in analysis = Barnet, Guy’s, Kingston, Royal Free, St George’s, St Thomas’, St Peter’s, UCLH, Watford, Wexham Park and Wycombe
4. Travel times from population areas outside of London where >20% patients use NWL hospitals are included
The pattern for Figure 9.25 is very similar to Figure 9.24. The numbers show the relationship between:

- **Ealing** and **West Middlesex**:  
  - With between 57%-59% of activity transferring between the two sites (respectively), should one of them not be a major hospital.

- **Hammersmith** and **St Mary’s**:  
  - Where between 74%-77% of activity would move between the two sites (respectively) should one of them not provide services.

- **Chelsea & Westminster** and **Charing Cross**:  
  - Where between 55%-59% of activity would move between the two sites (respectively) should one of them not provide services the travel impact of this change on local populations is small.

This analysis based on public transport travel times can be found in Figure 9.26.
The data indicates:

- **Ealing and West Middlesex:**
  - With between 14%-53% of activity transferring between the two sites (respectively), should one of them not be a major hospital.

- **Hammersmith and St Mary’s**
  - Where between 33%-36% of activity would move between the two sites (respectively) should one of them not provide services

- **Charing Cross and Chelsea & Westminster**
  - Where between 41%-46% of activity would move between the two sites (respectively) should one of them not provide services.

Figure 9.27 shows the percentage changes in travel time for each borough where a major hospital is located at one of each of the key geographic choices, further supporting the relationship that exists between different pairs of hospitals.
The largest increase in travel times would be for residents in Ealing under configuration options where Ealing was not a major hospital. However they are likely to only see a

---

18 TIL HSTAT travel times data.
1. Peak time = Morning peak = 7am – 10am
2. Current configuration of Major hospital hospitals = Northwick Park, Hillingdon, Ealing, West Middlesex, St. Mary’s, C&W, Charing Cross
3. Hospitals outside of NWL included in analysis = Barnet, Guy’s, Kingston, Royal Free, St George’s, St Thomas’, St Peter’s, UCLH, Watford, Wexham Park and Wycombe
4. Negative numbers show the improvement in travel times for some residents due to Hammersmith being in a new Major hospital in some of the options
maximum increase of between 10%-13% to their average travel time depending on the other variations of configuration.

In contrast, if neither Ealing nor West Middlesex were designated as major hospital sites, residents in Ealing would be significantly affected. Under this scenario Ealing residents would be likely to experience between 23%-30% increase in travel time to reach the next nearest hospital as shown in Figure 9.28.

**Figure 9.28: Changes in travel time for each borough if there is no major hospital located at either Ealing or West Middlesex (private car peak time) (% change)**

![Figure 9.28: Changes in travel time for each borough if there is no major hospital located at either Ealing or West Middlesex (private car peak time) (% change)](image)

Figure 9.29 further highlights the impact of not locating a major hospital at one of the sites in the geographic pairings. If neither Charing Cross nor Chelsea & Westminster were designated as major hospital sites, residents in Hammersmith and Fulham would be significantly affected. In this scenario, residents would experience between 48%-57% increase in average travel times to the next nearest major hospital.

---

19 TfL HSTAT travel times data.
1. Peak time = Morning peak = 7am – 10am
2. Current configuration of Major hospital hospitals = Northwick Park, Hillingdon, Ealing, West Middlesex, St. Mary’s, C&W, Charing Cross
3. Hospitals outside of NWL included in analysis = Barnet, Guy’s, Kingston, Royal Free, St George’s, St Thomas’, St Peter’s, UCLH, Watford, Wexham Park and Wycombe
4. Negative numbers show the improvement in travel times for some residents due to Hammersmith being in a new Major hospital in some of the options
Figure 9.29: Changes in travel time for each borough if there is no major hospital located at either Chelsea & Westminster or Charing Cross (private car peak time) (% change)\textsuperscript{20}  

Private car peak\textsuperscript{1} time - % change in travel time by borough\textsuperscript{3}

<table>
<thead>
<tr>
<th>Borough</th>
<th>Status quo\textsuperscript{2} (Avg TT minutes)</th>
<th>HH, SM, WMUH</th>
<th>HH, SM, EH</th>
<th>HH, EH, WMUH</th>
<th>SM, EH, WMUH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brent</td>
<td>32</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ealing</td>
<td>30</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hammersmith and Fulham</td>
<td>23</td>
<td>48</td>
<td>48</td>
<td>48</td>
<td>48</td>
</tr>
<tr>
<td>Harrow</td>
<td>30</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>35</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hounslow</td>
<td>24</td>
<td>4</td>
<td>4</td>
<td>13</td>
<td>8</td>
</tr>
<tr>
<td>Kensington and Chelsea</td>
<td>22</td>
<td>-5</td>
<td>-5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Westminster\textsuperscript{4}</td>
<td>21</td>
<td>22</td>
<td>22</td>
<td>22</td>
<td>22</td>
</tr>
</tbody>
</table>

Weighted average travel time: 21, 22, 22, 22, 22

Maximum travel time: 60, 60, 60, 60, 60

The analysis is completed by looking at the impact on residents if neither Hammersmith nor St Mary’s are designated as a major hospital site, Figure 9.30.

\textsuperscript{20} TFL HSTAT travel times data.
\textsuperscript{1} Peak time = Morning peak = 7am – 10am
\textsuperscript{2} Current configuration of Major hospital hospitals = Northwick Park, Hillingdon, Ealing, West Middlesex, St. Mary’s, C&W, Charing Cross
\textsuperscript{3} Hospitals outside of NWL included in analysis = Barnet, Guy’s, Kingston, Royal Free, St George’s, St Thomas’, St Peter’s, UCLH, Watford, Wexham Park and Wycombe
\textsuperscript{4} Negative numbers show the improvement in travel times for some residents due to Hammersmith being in a new Major hospital in some of the options
For residents in Westminster, the analysis confirms that removing major hospital services from both Hammersmith and St Mary’s would see average travel times for residents increase by around 27%. In addition, residents from the neighbouring boroughs of Hammersmith & Fulham and Kensington & Chelsea would also be negatively impacted.

In reviewing this analysis, clinicians proposed that a geographic distribution of the remaining three locations for major hospitals to minimise the impact of changes on local residents, should be found. They agreed that the location of the remaining three major hospital sites would be between the following pairs:

- Either Charing Cross or Chelsea & Westminster
- Either Ealing or West Middlesex
- Either Hammersmith or St Mary’s.

Figure 9.31 illustrates the pairs of hospitals on a map.

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21 TIL HSTAT travel times data.
1. Peak time = Morning peak = 7am – 10am
2. Current configuration of Major hospital hospitals = Northwick Park, Hillingdon, Ealing, West Middlesex, St. Mary’s, C&W, Charing Cross
3. Hospitals outside of NWL included in analysis = Barnet, Guy’s, Kingston, Royal Free, St George’s, St Thomas’, St Peter’s, UCLH, Watford, Wexham Park and Wycombe.
4. Negative numbers show the improvement in travel times for some residents due to Hammersmith being in a new Major hospital in some of the options
Prior to consultation (November 2011 to July 2012) clinicians recommend the pairings. This recommendation was approved by the Clinical Board and the Programme Board pre-consultation.

9.7.33 Feedback received about identifying the best geographical spread of the remaining sites during consultation

During consultation we received the following feedback about the seventh hurdle criterion:

An independent report conducted by Tim Rideout Limited on behalf of the London Borough of Ealing and Hammersmith & Fulham Council

“Removing one hospital in a geographical pair does impact on car travel times, contrary to the statements in the business case. Once Northwick Park and Hillingdon have been earmarked as major hospital sites, the business case then couples the remaining hospitals into geographical pairs. Ealing and West Middlesex are paired together. The methodology of determining which remaining hospitals become major hospitals is based on the statement that removing services at one of each hospital in a pair has little impact on travel times. Travel time analysis indicated residents would see a 10-13% increase in average journey times if Ealing was not a major hospital, however, West Middlesex remained. No evidence was given on the impact of increased ambulance times on mortality ratios, and why a 10-13% increase in travel time was determined as low impact.

Given the proximity of Hillingdon to Wexham Park (out of area but with a Type 1 A&E, and closer to Hillingdon than Ealing is to West Middlesex), it could have made sense to designate the two major hospitals as Northwick Park and Ealing. The result would have been a different series of potential options…going forward into the options appraisal.”
9.7.34 The implications of this feedback on our analysis to identify the best geographical spread of the remaining sites

The feedback we received about the pairings did include suggestions for alternatives. We considered the feedback received as follows:

- **Response to feedback requesting evidence about increased travel times in the Rideout report:** There is a limited evidence base to consider the impact of travel time to outcomes. There is evidence showing no deterioration and improved outcomes in stroke, heart attack, aortic aneurysm and major trauma and these services have already benefitted from centralisation. Infant death risk has been shown not to be affected by hospital accessibility\(^{22}\) following a review of all infant deaths in Cumbria from 1950-1993, where travel times are much greater than experienced in North West London. A review by Nicholl\(^{23}\) suggests that the time to initial treatment is the key factor. There has also been much progression in training ambulance crews and the development of the paramedic role\(^{24}\). It is considered that ambulances are no longer just fast buses for the injured, but more akin to “Intensive Care Units on wheels”\(^{25}\). The areas of NW London furthest from hospital centres remain unchanged in the proposed consultation options.

- **Response to feedback suggesting alternative pairings in the Rideout report:**
  The suggested alternative is not supported by the data. The pairings analysis indicates the activity flowing between West Middlesex and Hillingdon is as follows:
  - **Blue light:** 8%-8% respectively
  - **Private car:** 4%-6% respectively
  - **Public transport:** 0%-0%

  The analysis indicates that if one of these hospitals was no longer providing a particular service then patients would not elect to use the other hospital on the basis of travel time.

  The pairings analysis indicates the activity flowing between Hillingdon and Wexham Park is as follows:
  - **Blue light:** 5% respectively
  - **Private car:** 22% respectively
  - **Public transport:** 57%

  The pairs analysis indicates that people travelling by ambulances and private car would not travel to Wexham Park on the basis of travel time.

9.7.35 Outcome of the seventh hurdle criterion to identify the best geographical spread of the remaining sites

We have considered feedback received about clinicians’ recommendation. Given the feedback, the absence of any viable alternative, clinicians concluded that a geographic distribution of the remaining three locations for major hospitals would minimise the impact of changes on local residents and the location of the remaining three major hospital sites would be between:

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\(^{23}\) J Nicholl (2007 op cit)

\(^{24}\) H Barratt, R Raine. Hospital Service reconfiguration: the battle for hearts and minds. BMJ (2012); 344:e953

\(^{25}\) Prof Martin Gore. conversation Clinical Board. Jan 2013
- Either **Charing Cross** or **Chelsea & Westminster**
- Either **Ealing** or **West Middlesex**
- Either **Hammersmith** or **St Mary’s**.

This is based on the analysis that:

- The impact of removing one hospital in each pair on peak car travel times had little impact on travel times
- The impact on peak car travel times on populations if both hospitals in a pair were removed showed a large impact on some residents
- Activity flows between Trusts based on blue-light and private car travel times showed the highest patient flows were between the pairs.

We confirmed this decision with the Clinical Board and the Programme Board during the post consultation phase. This outcome is unchanged from pre-consultation.

**9.7.36 Outcome of the hurdle criteria**

As a result of the process set out above, clinicians agreed that eight options were identified as a result of the fifth stage of the process to identify a recommendation. Each of these eight options located a major hospital at Northwick Park and Hillingdon Hospital and Central Middlesex was not proposed as a major hospital. Figure 9.32 illustrates the eight options.

**Figure 9.32: Summary of the outcome of Stage 5 (proposed eight options for the location of major hospitals in NW London) as recommended by the Clinical Board**

Central Middlesex is described as a local and elective hospital in the figure. Hospitals that aren’t recommended as major hospitals are therefore potential local hospital sites. Central Middlesex also has capacity that could be used for elective procedures. Therefore in the ongoing decision making analysis we explore the benefits of Central Middlesex being designated an elective centre.

We confirmed this decision with the Clinical Board and the Programme Board during the post consultation phase. This outcome is unchanged from that reached pre-consultation.
9. Decision making analysis stage 6

This section describes the analysis to identify a recommendation for reconfiguration for stage six. It is the third part of Chapter 9.

The fifth stage described in the previous section used the hurdle criteria to identify a list of eight options for further analysis. Prior to consultation the analysis for Stage 6 ranked Options 5, 6 and 7 as the highest with Option 5 had the highest relative ranking and therefore our preferred option. Sensitivity analysis for Stage 7 supported this ranking. Therefore during consultation we sought feedback about proposals for the location of major hospitals. We received a high volume of feedback about options and have used this feedback during our analysis. Our Clinical Board and Programme Board considered all this feedback during their decision making process.

9.8 Feedback received about the consultation options

This section summarises the feedback we received about the three consultation options. Prior to consultation we identified Option 5 as the preferred option for reconfiguration. Option 5 was relabelled Option A in our consultation document for simpler communication with stakeholders and we explained in the consultation document that it was our preferred option. In our consultation response form we asked people for their views about our preferred option. We wanted to understand if people agreed with the proposal and if people had any suggestions for how it could be improved. We asked people the following question in our response form:

*Question 24a. Please say how far you support or oppose each of the three proposed options for the location of major hospitals in North West London?*

**Option A**

For Option A, and excluding the campaign data\(^1\) from the responses, we received the following results:

6,007 people answered this question. Of these respondents:

- 63% support Option A
- 30% opposed
- 7% of people either had ‘no views either way’ or responded ‘not sure/ don’t know.

Figure 9.33 summarises the results

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\(^1\) A number of campaigns provided recommended responses to both open and closed questions. In our analysis of responses to open-ended questions, we have been able to identify these campaign responses. We are aware of two campaigns which explicitly participated in the online and paper response channel: Chelsea and Westminster Hospital and West London Citizens.

Chelsea and Westminster Hospital distributed postcards and hosted an online form on their website. Both asked people to tick a box supporting Option A (under which Chelsea and Westminster would be a major hospital) and requesting consent for Chelsea and Westminster Hospital to complete the online response form on their behalf. For further information refer to the full MORI report in Appendix F.
Including the campaign responses for Option A 16,463 people answered this question. Of these respondents:

- 83% support
- 14% opposed
- 3% of people either had ‘no views either way’ or responded ‘not sure/ don’t know.

Figure 9.34 summarises the results.

<table>
<thead>
<tr>
<th>Agree</th>
<th>83%</th>
<th>13,697 people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>14%</td>
<td>2,309 people</td>
</tr>
</tbody>
</table>
The data above includes feedback from ‘campaigns’. Campaign responses and petitions (some with a large volume of signatories) were generally in support of particular hospitals.

We asked the same question for Options B and Option C. The results are as follows:

**Option B**

Excluding campaigns 23% of respondents to this question support Option B, 59% oppose. If we include campaign data then 4,718 people answered this question, of these respondents:

- 21% support
- 64% opposed
- 15% of people either had ‘no views either way’ or responded ‘not sure/ don’t know.

Figure 9.35 summarises the results

**Figure 9.35: Option B responses, including campaign data**

<table>
<thead>
<tr>
<th>Option B Responses</th>
<th>Strongly support (508)</th>
<th>Tend to support (464)</th>
<th>No views either way (297)</th>
<th>Tend to oppose (453)</th>
<th>Strongly oppose (2,564)</th>
<th>Not sure/ don’t know (432)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Agree</strong></td>
<td>21%</td>
<td>9%</td>
<td>11%</td>
<td>10%</td>
<td>54%</td>
<td>9%</td>
</tr>
<tr>
<td><strong>Disagree</strong></td>
<td>64%</td>
<td>10%</td>
<td>6%</td>
<td>10%</td>
<td>31%</td>
<td>10%</td>
</tr>
</tbody>
</table>

| Agree              | 21%                    | 972 people            |
| Disagree           | 64%                    | 3,017 people          |

**Option C**

Excluding campaigns 24% of respondents to this question support Option C, 64% oppose. If we include campaign data then 6,297 people answered this question, of these respondents:

- 31% support
- 59% opposed
- 10% of people either had ‘no views either way’ or responded ‘not sure/ don’t know.

Figure 9.36 summarises the results.
For full information on the factors underlying people’s responses please refer to the full MORI report in Appendix F.

**Petitions**

We received a total of 18 petitions and campaign responses during consultation. 12 of the petitions opposed the closure of A&E and other departments in hospitals, five were in support of Option A while one supported West Middlesex’s status as a major hospital. The petitions are summarised in the table below:

<table>
<thead>
<tr>
<th>Reference</th>
<th>Petition/campaign on behalf/in support of</th>
<th>Number of signatories</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Patients opposed to the proposed closure of the A&amp;E departments at Ealing Hospital, from Eastmead Surgery</td>
<td>76</td>
</tr>
<tr>
<td>B</td>
<td>Petition opposed to the closure of services at Charing Cross and Hammersmith hospitals and the closure of the hyper-acute stroke unit at Charing Cross, from Hammersmith and Fulham Council</td>
<td>492</td>
</tr>
<tr>
<td>C</td>
<td>Petition opposing the downgrading of hospitals in North West London</td>
<td>19</td>
</tr>
<tr>
<td>D</td>
<td>Email postcard petition registering support for Option A from Hounslow Council</td>
<td>47</td>
</tr>
<tr>
<td>E</td>
<td>Email petition supporting West Middlesex’s status as a major hospital in NW London from London Borough of Hounslow</td>
<td>643</td>
</tr>
<tr>
<td>F</td>
<td>Petition opposing the downgrading of services and the closure of the A&amp;E Department at Central Middlesex Hospital from Harlesdon Methodist Church</td>
<td>43</td>
</tr>
<tr>
<td>G</td>
<td>Email petition supporting Chelsea and Westminster Hospital being one of five major hospitals and Option A</td>
<td>6,611</td>
</tr>
<tr>
<td>H</td>
<td>Email petition registering support for Option A from West Middlesex Hospital patients</td>
<td>151</td>
</tr>
</tbody>
</table>
| I & J     | ‘Save Hammersmith Hospital’ petition calling for A&E and other clinical services to be retained at Hammersmith Hospital, from:  
- Hammersmith and Fulham Council  
- Number of signatories to online petition: 1,483 | 2,613                  |
<table>
<thead>
<tr>
<th>Reference</th>
<th>Petition/campaign on behalf/in support of</th>
<th>Number of signatories</th>
</tr>
</thead>
<tbody>
<tr>
<td>K &amp; L</td>
<td>‘Save Charing Cross Hospital’ petition calling for A&amp;E and other clinical services to be retained at Charing Cross Hospital, from:</td>
<td>9,388</td>
</tr>
<tr>
<td></td>
<td>● Hammersmith and Fulham Council</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Number of signatories to online petition: 6,084</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Number of signatories to paper petition: 3,304</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>‘Save Hammersmith &amp; Charing Cross Hospitals’ petition, calling for the Secretary State for Health to stop the closure of hospital services in West London, from Hammersmith and Fulham Council</td>
<td>15,263</td>
</tr>
<tr>
<td>N &amp; S</td>
<td>Chelsea and Westminster Hospital ‘Safe in Our Hands’ campaign. Postcard and online postcards in support of Option A, calling for Chelsea and Westminster Hospital to be a major hospital with a full A&amp;E</td>
<td>11,263</td>
</tr>
<tr>
<td></td>
<td>(9,927 of these responses were also submitted in the online form)</td>
<td></td>
</tr>
<tr>
<td>O</td>
<td>Petition calling for the A&amp;E department of Hammersmith Hospital to be retained, from residents of Hetley Road, W12</td>
<td>58</td>
</tr>
<tr>
<td>P</td>
<td>Petition registering support for Option A, from residents of the Heath Court Sheltered Scheme</td>
<td>92</td>
</tr>
<tr>
<td>Q</td>
<td>Petition calling for Ealing, Central Middlesex, Charing Cross and Hammersmith Hospitals to retain their status and keep all existing services, from Ealing Council</td>
<td>25,193</td>
</tr>
<tr>
<td>R</td>
<td>‘NHS Under the Knife’ campaign calling for the A&amp;E department of Central Middlesex Hospital to remain open and for no cuts to or privatisation of services</td>
<td>1,932</td>
</tr>
<tr>
<td>S</td>
<td>Please see Petition N</td>
<td></td>
</tr>
<tr>
<td>T</td>
<td>Petition calling for Secretary of State for Health to stop the closure of Hospital Services in west London, in particular the A&amp;E Departments of Hammersmith and Charing Cross Hospitals</td>
<td>1,332</td>
</tr>
<tr>
<td>U</td>
<td>Petition calling for the protection of A&amp;E departments in Hammersmith and Charing Cross Hospitals and opposing the closure of the stroke unit at Charing Cross</td>
<td>2,044</td>
</tr>
</tbody>
</table>

**Organisational support**

During consultation we received feedback supporting **Option A** from the following organisations:

- Brent Clinical Commissioning Group
- Chelsea and Westminster Hospital NHS Foundation Trust
- Governors of the Chelsea & Westminster Hospital NHS Foundation Trust
- Hammersmith and Fulham Clinical Commissioning Group
- Harrow Clinical Commissioning Group
- Harrow LINk
- Hillingdon Clinical Commissioning Group
- Hillingdon Council’s External Services Scrutiny Committee
- Hillingdon Hospitals NHS Foundation Trust
- Hounslow Clinical Commissioning group
- Imperial College Healthcare NHS Trust
- Jane Ellison, MP for Battersea, Balham and Wandsworth
- Kensington & Chelsea LINk
- London Borough of Richmond upon Thames’ Health, Housing and Adult Services Overview and Scrutiny Committee
- NHS Central London Clinical Commissioning Group
- NHS West London Clinical Commissioning Group
- Richmond Upon Thames LINk
- Royal Borough of Kensington and Chelsea Health, Environmental Health and Adult Social Care Scrutiny Committee
- Ruislip Residents Association
- Sir Malcolm Rifkind, MP for Kensington
- St George’s Healthcare NHS Trust
- The Community Voice
- The Royal Marsden NHS Foundation Trust
- User Panel, NHS Central London Clinical Commissioning Group
- West London Mental Health NHS Trust
- West Middlesex University Hospital NHS Trust
- Westminster and City of London Liberal Democrats
- Westminster City Council, Adult Services and Health Policy and Scrutiny Committee
- Westminster LINk

The following organisations supported **Option B**:

- Hammersmith NETWORK 2
- London Borough of Richmond upon Thames’ Health, Housing and Adult Services Overview and Scrutiny Committee

The following supported was noted for **Option C**:

- Ealing Clinical Commissioning Group’s poll of GPs found that a majority supported Option C
- Westminster City Council, Adult Services and Health Policy and Scrutiny Committee argued that Option C is better than Option B
- St George’s Healthcare NHS Trust, on the other hand, stated a preference for Option C over Option B.

What follows are examples of the organisational feedback about all three consultation options:

**Hillingdon Hospitals NHS Foundation Trust**

“We formally support the recommended option (option A) which, provided it is effectively implemented and backed by the requisite investment, has the potential to improve the quality of care, make good use of buildings and resources, and support research and education.”

**West Middlesex University Hospital NHS Trust**

“The West Middlesex University Trust supports Option A because it delivers the best use of estate, best value for money and minimises the level of disruption which such large scale change will generate.”

**Westminster City Council, Adult Services and Health Policy and Scrutiny Committee**

“Option A, the clinically recommended and preferred option, provides the best option for residents and the million visitors and commuters who come into Westminster daily. We have been assured that the option provides the safest, easiest and most cost effective result for the population of North West London.”

**Chelsea and Westminster Hospital NHS Foundation Trust**

“The Trust Board firmly believes that Option A is the best solution for the population of North West London in terms of the provision of health services within the available resources to ensure that we have a sustainable healthcare system for the future.”
West London Mental Health NHS Trust
“We support Option A...this provides an excellent opportunity to further integrate mental health and primary care as well as creating opportunities for new inpatient provision to replace older and outdated building stock that is no longer fit or appropriate for modern mental health services.”

Kingston Hospital NHS Trust
Confirmed that it could develop cost effective solutions to accommodate the additional activity in relation to Options A and C. Option C was described as more challenging and it would need to do further analysis of the implications of this option. Concerns were raised about the impact of Option B

London Ambulance Service NHS Trust
Supported the options presented in the consultation document predicated on additional investment in the London Ambulance Service to provide the increased staffing required.

Sir Malcolm Rifkind MP for Kensington
“A number of my constituents have written to me with their concerns about the possibility of Chelsea & Westminster Hospital being redesignated a 'local hospital', and after consultation with the hospital I am convinced that such a move, which would involve the loss of the hospital’s A&E and Maternity Unit, would make the hospital non-viable and under severe threat of closure.”

Jane Ellison, MP for Battersea, Balham and Wandsworth
“Given its proximity to Battersea, Chelsea and Westminster is used by many of my constituents. As well as the loss of specialist expertise and knowledge that would follow the downgrading of Chelsea and Westminster, it is likely that already stretched maternity services at St George’s in Tooting would come under increased pressure. Similarly, I understand that option C could see greater pressure put on Kingston Hospital, which is used by many some residents living in the western part of Wandsworth. For these reasons, I support option A.”

Richmond Clinical Commissioning Group
Prefers option A with the caveat that more needs to be done to accurately establish the best provision and distribution of hyper-acute stroke units to provide more even geographical access.

Brent Age UK
“The Champions of Older Peoples Network….indicate their preference is for Option A – with a proviso that the Central Middlesex Hospital continues to have an A&E department.”

Richmond Borough Council
“Richmond Council’s strong support for an option that retains West Middlesex as one of the major hospitals. There has been some discussion locally about the future location of hyper acute stroke units, and with this some debate about whether option A or B would be preferable. The consultation document makes a clear case for option A but at the time of writing, we do not have more detailed information about impact on journey times etc for Richmond residents. Assuming there is no adverse impact for Richmond residents, the Council will support option A.”

Ealing Hospital A & E Team
“Despite the preferred option A in SHF, the right model for Ealing, given its population, must be co-localised services with an A&E to ensure the safest care in this situation.”
Southall Black Sisters
“The closure will be catastrophic and irreversible; it will have a profoundly detrimental and life threatening impact on our users and more generally it will have a negative and disproportionate impact on the poor and vulnerable in Southall.”

Labour Group at Kensington and Chelsea Council
“Along with A&E, [Charing Cross] hospital would lose paediatric, maternity and general surgery in the first instance, as has happened across London in recent years. Other services follow as it becomes more difficult to recruit and retain staff, leading to the closure as ‘unviable’ of the remaining hospital services.”

Greg Hands, MP for Chelsea & Fulham
“Option A fails to reflect the impact on Chelsea & Westminster should the A&E at Charing Cross close, even if capital costs are incurred by expanding the current site. That site is severely constrained, placing a limit on what can be added. …I fear that the influx from Fulham, Hammersmith, and beyond, would create detrimental pressure on the service provided at Chelsea & Westminster under Option A. …Charing Cross Hospital is a world-class research and teaching facility. It is one of the few hospitals to have a sufficient number of beds under the consultation criteria and hosts regionally important services such as the hyper acute stroke unit. Given its size and quality, it seems extraordinary for it to be downgraded to become a minor local hospital, unrecognisable from the facility that exists today.”

Hammersmith & Fulham Council and its Health, Housing & Adult Social Care Scrutiny Committee (joint response)
“It is highly inappropriate to seek to transfer services away from Charing Cross and Hammersmith Hospitals…..the impact on Hammersmith & Fulham and Ealing is significantly greater than for any of the other boroughs. For both boroughs, it is essential that before any decisions are made, the impact of these changes is tested on a needs based population basis, rather than being primarily driven by the need to ensure NHS Trust organisational sustainability.”

Royal College of Midwives
“We are opposed to the proposal (option B) to move obstetric services from Chelsea and Westminster Hospital to Charing Cross Hospital. Aside from the cost of moving obstetric services from Chelsea and Westminster, we are also concerned that it will take time for the new unit at Charing Cross Hospital to build up demand for services and activity.”

Cystic Fibrosis Trust
“The CF Trust has a particular concern as to the possible impact on cystic fibrosis services at the Royal Brompton Hospital in the event that Option B were selected with the result that the Chelsea & Westminster Hospital would lose “major hospital” status.”

St George’s Healthcare NHS Trust
“Option B would have a major impact on patient flows into St George’s and we would not support it for this reason…Whilst Option C would not lead to significant flows to St George’s from NW London, there would be an impact on Kingston Hospital. Under the Better Services Better Value options, Kingston is proposed as a major hospital and would therefore, as St George’s, see increased patient flow if changes are implemented here. It is for Kingston Hospital to make their own response to this consultation, but from a SW London health economy perspective, a smaller impact from changes in NW London would be preferable.”

Guy’s and St Thomas’ NHS Foundation Trust
“This option would mean significant activity shifts to St Thomas’ Hospital and…the site does not have the spare capacity to absorb the extra activity.”
9.9 Stage 6 – The evaluation criteria (and sub-criteria)

This section describes the sixth stage of the process – the evaluation criteria and their sub-criteria. Figure 9.37 highlights the relevant step.

**Figure 9.37: Highlighting Stage 6 of the process described in this section**

9.9.1 The purpose and outcomes of the evaluation criteria

The purpose of the sixth stage is to test in detail the medium list of options identified in the previous stage using evaluation criteria agreed by clinicians and the public. The outcome is:

1. Identify a single recommendation for reconfiguration with the highest relative assessment

9.9.2 Developing evaluation criteria for to determine the short list of options for reconfiguration

Further analysis of the potential options was done using an agreed set of evaluation criteria. The criteria were developed by clinicians with involvement from providers, patients and their representatives and the public. An initial set of criteria were developed by clinicians and then tested by us at an engagement event on 15th February 2012. Participants were asked to rank the criteria they considered most important for evaluating options, Figure 9.38.
Quality of Care was the most important criteria for both the public and clinicians. There were not significant differences between the public and clinicians on other criteria, although the public ranked Patient Experience and Patient Choice slightly higher than clinicians.

Some additional criteria were suggested by both groups during the event, these are shown in Figure 9.39.

The Clinical Board reviewed these suggestions and developed them further where appropriate. From this, additional criteria were added and these are shown in Figure 9.40.
Figure 9.40: Additional criteria that have been included in the evaluation criteria

<table>
<thead>
<tr>
<th>Suggested criteria</th>
<th>Where this has been included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk to existing services</td>
<td>Incorporated into deliverability evaluation criteria</td>
</tr>
<tr>
<td>Impact on other co-dependent services</td>
<td>Part of deliverability criteria</td>
</tr>
<tr>
<td>Career experience</td>
<td>Included in quality criteria</td>
</tr>
<tr>
<td>Expertise – who, where is this</td>
<td>Addressed partially through the clinical standards and through workforce evaluation</td>
</tr>
<tr>
<td>Distribution of services meets local needs</td>
<td>Part of access criteria; primary and community care access being addressed as part of the out of hospital strategy</td>
</tr>
<tr>
<td>Flexibility across pathway</td>
<td>Addressed through patient choice</td>
</tr>
</tbody>
</table>

A number of the additional suggested criteria were not included; these are shown in Figure 9.41. These criteria are vitally important but they are not included as part of the final set of evaluation criteria because they do not differentiate between different options and so does not support us to identifying a recommendation.

Figure 9.41: Additional criteria that have not been included in the evaluation criteria

The final set of evaluation criteria as shown in Figure 9.42 were refined and agreed by the Clinical Board and Programme Board pre-consultation.
These criteria were used pre-consultation to identify the three consultation options.

It is important to note that the first two evaluation criteria, **Quality of Care** and **Access to Care**, have parallels with hurdle criteria 1 and 5 (as set out in Chapter 9b):

- **Hurdle criterion 1**: The correct care setting model to deliver high quality care
- **Hurdle criterion 5**: Ensure a good geographical spread of major hospitals across NW London

They are included within the evaluation criteria because:

- The earlier analysis indicates their importance to all stakeholders
- During this stage they are used to assess the relative merits between options, evaluating the criteria with more detailed metrics and analysis

### 9.9.3 Feedback received about the evaluation criteria during consultation

During consultation we sought feedback about the evaluation criteria we used to identify the consultation options. We wanted to understand if people agreed with the criteria and if people had any suggestions for how they could be improved. We asked people the following question in our response form:

**Question 22**: Please say how important you think each of these criteria (measures) should be in choosing which hospitals should be major hospitals, rating their importance on a scale where 10 means ‘absolutely vital’ and 0 means ‘not important at all.’

This data has been analysed in two ways:

1. Calculating a mean value for each criteria (i.e. an average score across all respondents answering the question).
2. Top three scores (10, 9 and 8) have been combined to determine the percentage of people rating the criteria as ‘important’, and similarly the bottom three scores (0, 1 and 2) are used to determine the percentage of people rating the criteria as ‘not important’.

Both sets of data are shown in Figure 9.43 for each criterion and provide a rank order of importance.

**Figure 9.43: Results for the importance of the evaluation criteria**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Not important</th>
<th>Important</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical quality (4,516)</td>
<td>12%</td>
<td>88%</td>
<td>9.42</td>
</tr>
<tr>
<td>Patient experience (4,488)</td>
<td>2%</td>
<td>98%</td>
<td>8.94</td>
</tr>
<tr>
<td>Workforce (4,152)</td>
<td>22%</td>
<td>78%</td>
<td>8.31</td>
</tr>
<tr>
<td>Distance/Time to access (4,512)</td>
<td>16%</td>
<td>84%</td>
<td>8.48</td>
</tr>
<tr>
<td>Patient Choice (4,484)</td>
<td>2%</td>
<td>98%</td>
<td>7.59</td>
</tr>
<tr>
<td>Developing research/education (4,438)</td>
<td>18%</td>
<td>82%</td>
<td>7.25</td>
</tr>
<tr>
<td>Expected time to deliver (4,426)</td>
<td>25%</td>
<td>75%</td>
<td>7.15</td>
</tr>
<tr>
<td>Viable trusts/sites (4,442)</td>
<td>3%</td>
<td>97%</td>
<td>6.93</td>
</tr>
<tr>
<td>Disruption (4,405)</td>
<td>3%</td>
<td>97%</td>
<td>6.48</td>
</tr>
<tr>
<td>Capital cost to system (4,458)</td>
<td>4%</td>
<td>96%</td>
<td>6.68</td>
</tr>
<tr>
<td>Transition costs (4,432)</td>
<td>4%</td>
<td>96%</td>
<td>6.59</td>
</tr>
<tr>
<td>Fitting in with other strategies (4,413)</td>
<td>4%</td>
<td>96%</td>
<td>6.27</td>
</tr>
<tr>
<td>Surplus for acute sector (4,370)</td>
<td>3%</td>
<td>97%</td>
<td>6.29</td>
</tr>
<tr>
<td>Net present value (4,367)</td>
<td>5%</td>
<td>95%</td>
<td>6.01</td>
</tr>
</tbody>
</table>

Figure 9.43 shows the highest ranked criterion for respondents in the decision making process is **clinical quality**: 88% cite this as ‘important’ and similarly the mean score is highest at 9.42 because most people have given it a score of nine or ten.

The second ranked criterion is **patient experience**, with 81% rating this highly and just one per cent saying it is not important.

The third highest ranked criterion is the **workforce**; the consultation document (at page 53) links this to the options that would provide the best workplace for staff. Here, 74% of respondents consider this aspect important and 2% say it is not important.

When ranked according to the percentage of respondents identifying each criterion as ‘important’, the **distance and time to access services** is in fourth place (57%), but is
ranked third according to the mean score calculation. This item focuses specifically on minimising the average or total time it takes people to get to hospital by ambulance, car (at off peak and peak times) and public transport and there are some groups where this seems to be particularly important.

During consultation we also received the following feedback about the evaluation criteria used in Stage 6:

**Ipsos MORI consultation analysis report (Appendix F)**

“Almost two in five respondents who answered this question made a comment relating specifically to the assessment criteria outlined in section 16 (p.52) of the consultation document. These covered a broad spectrum of comments, but (reflecting the criteria themselves) emphasised again concerns about travelling to access care, quality of care, capacity and ability to meet local needs, workforce issues, patient experience and costs. One in fourteen commented that the needs of the public and patients should be listened to.

“There is no criterion of general public acceptability, no requirement for majority support from clinicians and local healthcare providers, No mention of support from Health and Wellbeing Boards, no mention of impact on Public Health.”

More generally, one in five respondents said something about the consultation. A wide range of points were made about the evaluation criteria and the arguments in the consultation document, and these tended to be more negative than positive.”

**Westminster City Council, Adult Services and Health Policy and Scrutiny Committee**

“We consider that the criteria used to develop the proposals are fundamentally sound based on clinical evidence which we have been presented with by NHS North West London. On this basis we are able to support the direction of travel underlying the consultation paper.”

**Royal Borough of Kensington and Chelsea Health, Environmental Health and Adult Social Care Scrutiny Committee**

“We consider that the criteria used to develop the proposals are fundamentally sound. We are able to support the direction of travel underlying the consultation paper.”

**Independent report conducted by Tim Rideout Limited on behalf of the London Borough of Ealing Council**

“In order to evaluate the options, a number of criteria were developed, with reported input from clinicians and patients. While the final criteria are broadly sensible, interestingly a number of criteria suggested by clinicians and patients were not accommodated, including integration of services, health equality across NW London, and support for preventative care and help for patients to manage their own conditions. Notwithstanding the reasons given for their exclusion, this is potentially contentious and open to challenge. The inclusion of such criteria would go some way to addressing the inadequate population focus of the current proposals.”

**9.9.4 The implications of this feedback on the evaluation criteria**

The feedback we received about the evaluation criteria includes an alternative approach. We considered the feedback received as follows:

- **Response to feedback about including additional metrics in the MORI report:**
  The following criteria have not been included:
o **General public acceptability**: The pre-consultation engagement we undertook (see Chapter 6) is designed to understand the views of the public, and our public consultation is designed to elicit the views of the public. These substantial, and in the case of public consultation legal, processes for gathering the views of the public are more effective than a criterion.

o **Majority support from clinicians and local healthcare providers**: This is not a criterion for distinguishing between the options. However it would clearly be disconcerting if the recommended proposal (and the course of action decided upon) did not have majority support. In this case, all provider trust boards, all medical directors, all clinical commissioning boards and commissioning board chairs have stated their support for a reduction in the number of hospitals with an A&E. The boards and the CCGs will provide their views on the recommended proposal at the time of decision making.

o **Support from Health and Wellbeing Boards**: We worked with Health and Wellbeing Boards during the development of proposals, particularly OOH. Support for the proposals by Health and wellbeing boards is being considered as part of the consultation and continuing dialogue with the boards.

o **Impact on Public Health**: A key tenet of the programme is to improve the health of the public, so in that regard it is an overarching objective. However we do not have evidence that any of the options would impact more or less favourably than another on public health.

- **Response to feedback about excluding additional metrics in the Rideout report**: The criteria described in Figure 9.43 and referenced in the feedback received during consultation are important, but they are not used as part of the final set of evaluation criteria as they do not differentiate between sites where services may be located:

  o **Integration of services**: is central to the OOH strategies and is a key enabler, but it does not support the relative evaluation of options

  o **Health equalities**: reducing the inequalities described in the Case for Change (Chapter 4) is an overarching objective of the programme. How the proposals affect people with protected characteristic is addressed through the two equalities reviews we have undertaken (Chapter 13) and form the basis of an action plan for consideration during implementation. They do not differentiate between options.

  o **Managing long term conditions** is a key component of the OOH strategies; whilst this is an enabler to acute reconfiguration it is not within the scope of the process to define where to locate acute services.

Given the feedback, and the absence of any viable alternative, we reached the conclusion that the evaluation criteria used pre-consultation should be re-used post-consultation with one addition. As part of our evaluation of the research and education criterion we added an additional metric to complement the pre-consultation set. The rationale for this addition is described in detail in Section 9.9.52.

We confirmed this decision, and the evaluation criteria, with the following groups during the post consultation phase:

- Clinical Board
- Finance and Business Planning
- Programme Board.
9.9.5 **The analysis of the five evaluation criteria and their sub-criteria**

The following sections describe the purpose of each sub-criterion, how it was used, the question that was being answered and the measures that are being used as part of the evaluation to differentiate between the options on the medium list.

Northwick Park and Hillingdon have been included throughout the evaluation analysis to make sure that the full costs of implementing the reconfiguration are included.

For all evaluation criteria, it was noted that for some multi-site Trusts, such as Imperial College Healthcare NHS Trust (which has three sites; Charing Cross, Hammersmith and St Mary’s), it was not possible to obtain disaggregated information for their sites. In those instances it was assumed that that each site was equivalent to the overall Trust position.

9.9.6 **The purpose of the clinical quality sub-criterion**

Clinical quality is the first sub-criterion of quality of care. The purpose of the sub-criterion is to examine which options would provide better clinical quality in future using clinical surveys and indicators.

9.9.7 **Analysis of the clinical quality sub-criterion**

The analysis agreed by clinicians pre-consultation for this criterion was as follows:

- Review whether or not the option can deliver against the clinical standards:
  - assessment of ability of option to deliver access to experienced, skilled staff and specialist equipment
- Comparison of current clinical quality of sites which are expected to deliver future inpatient activity under each option.

The importance of quality should not be underestimated and it was variation in quality standards which provoked the reviews in Emergency and Paediatric Care, the results of which have informed the development of the reconfiguration.

Throughout the analysis described so far, clinicians have always required that each option under consideration must be of sufficient quality to meet the standards they have set out and indeed the first step in the fifth stage of this process (**determining the number of hospitals**) stated that major hospitals are required to ensure high quality care.

At this stage of the evaluation clinicians agreed to review further analysis on clinical quality data to see whether this would provide more detailed information to differentiate between the eight options being evaluated.

The data set out in the Dr Foster reports (shown in Figure 9.44) suggests that out of the NW London PCTs, Chelsea & Westminster achieved statistically better than expected results for all four mortality rates during 2010/11. Imperial also fared well with mortality rates better than the national average in three out of the four measures. However Hillingdon did not do better than expected against any of the measures and Ealing only did better against one. This set of data suggests that clinical quality is better, as measured by better performance of mortality rates, at Chelsea & Westminster and Imperial hospitals.
However, another useful source of data on clinical quality are the Quality Dashboards produced by the East Midlands Quality Observatory. A summary of the outputs of these Quality Dashboards is set out in Figure 9.45.

**Notes from Figure 9.44:**

1. Dr Foster standardised mortality rate for 3 years. The current three year HSMR is for the financial years 2008/09, 2009/10 and 2010/11; Summary Hospital-level Mortality Indicator (SHMI), and Deaths After Surgery, 2010/11, National average is 100
2. Includes Charing Cross, Hammersmith and St. Mary’s hospitals
3. Includes Northwick Park and Central Middlesex
4. Dr Foster Mortality Ratios 2010/11, Deaths in low risk conditions per 1,000 patients
In comparison to the Dr Foster data, according to the Quality Dashboard scores, Hillingdon is the top performer in NW London with better than national average performance against 62 of the metrics. Ealing has the lowest number of metrics that are above national average, however, the range between Ealing and Hillingdon is fairly small, with all the other Trusts having similar scores. It is not clear whether these scores help to sufficiently differentiate between the levels of clinical quality that are being achieved between the different Trusts.

As described at the start of this section, 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. The reconfiguration is being pursued to achieve the clinical standards and the improved clinical quality through the re-shaped clinical service delivery models set out in Chapter 7 a.

Prior to consultation, after reviewing the data available on clinical quality, 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 any significant information that allowed them to differentiate between options on this basis. Therefore all eight options were evaluated to provide high quality of clinical care. A summary is provided in Figure 9.46. This recommendation was approved by the Clinical Board and the Programme Board pre-consultation.

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1. The number of metrics that scored better for the Trust than national average, out of a total of 104 metrics (this takes into account metrics where a lower score is better (e.g. mortality) and metrics where a higher score is better (e.g. % patients seen within X weeks))
During consultation we received the following feedback related to the clinical quality sub-criterion:

**Independent reports conducted by Tim Rideout Limited on behalf of the London Borough of Ealing and Hammersmith & Fulham Council**

"Quantitative approaches to measuring quality of care were superseded by a qualitative approach that evaluated all eight options with an identical high scoring. The business case identified three methods of evaluating quality of care, the most highly ranked criterion according to the public and clinicians.

The first method used quantitative Dr. Foster clinical quality data to compare mortality rates (2010/11) by trust…The second approach looked at quantitative “quality dashboard” data, which only indicate with a binary Y/N whether 62 quality metrics are above national averages, rather than weighting metrics according to importance and looking at relative performance between trusts…The third approach, and the one adopted, sought qualitative agreement across clinicians that all eight options should be scored identically due to the fact that the eight options had been designed to achieve the highest levels of clinical quality…This is highly contentious and is open to challenge. Relative clinical quality is clearly of the utmost importance to patients, the public and clinicians. Should the current data really be inadequate for the purposes of site level comparisons, steps should have been taken to secure adequate data and for a detailed assessment to have been undertaken to inform the options appraisal. This undermines the credibility of the options appraisal."

**9.9.9 The implications of this feedback for the clinical quality sub-criterion**

We considered the feedback we received as follows:
**Response to feedback about the evaluation of quality referenced in the Rideout report:** It is not true to say our approach to assessing quality undermines the appraisal; for a proposal to become one of the recommended options it needed to satisfy stringent criteria that assessed whether it would improve the quality of care. The criteria do not include the current relative clinical quality of service because our clinicians explicitly recommended us not to do so:

- They believe that under the proposals all hospitals will be able to improve to the highest standard
- There is a risk that concentrating on current high performance would exacerbate inequality of access.

### 9.9.10 The outcome of the clinical quality sub-criterion

Given the feedback, and the absence of any viable alternative, we reached the conclusion that the evaluation of the clinical quality sub-criterion is still valid. We confirmed this decision with the Clinical Board and the Programme Board during the post consultation phase. This outcome is unchanged from that reached pre-consultation.

#### 9.9.11 The purpose of the patient experience sub-criterion

Patient experience is the second sub-criterion of the quality of care criterion. The purpose of the sub-criterion is to examine which options would provide a better experience for patients using patient experience surveys and looking at the quality of the buildings and facilities.

#### 9.9.12 Analysis of the patient experience sub-criterion

The measures agreed by clinicians for this sub-criterion were:

- **Patient experience data using Care Quality Commission (CQC) standardised scores** for the following measures:
  - How would you rate the care you received?
  - Did you feel you were treated with respect?
  - Were you involved as much as you wanted to be?

- **Quality of estates, looking at:**
  - Area of not functionally suitable NHS space
  - Estate dating post-1964

The first measure of patient experience is the data sourced from the National NHS Patient Survey Programme, carried out annually by the Care Quality Commission (CQC). The results are summarised in Figure 9.41.
Figure 9.47 shows that some Trusts in NW London had results from the National NHS Patient Survey that were statistically worse than the national average. Both Ealing and North West London Hospitals (Northwick Park and Central Middlesex) had two measurements that were worse than the national average. West Middlesex performed poorly against one indicator. However, the difference between all the scores is minimal and indeed the national scores have a very small range. Clinicians did not feel that using this data in isolation gave them sufficient basis to differentiate between the options.

The second measurement of patient experience was quality of estate. There is a growing body of evidence to support the view that the quality of the hospital or clinic where a person is treated is associated with their experience as a patient and the outcomes that are produced. This view was supported by the Clinical Board. In addition, there are a number of articles in the literature supporting this hypothesis, and Appendix E contains abstracts from these articles.

Figure 9.48 sets out an overview of the quality of the estate of the current nine acute hospital sites in NW London.

---

**Patient Experience data**

<table>
<thead>
<tr>
<th>Trust</th>
<th>How would you rate the care you received?</th>
<th>Did you feel you were treated with respect?</th>
<th>Were you involved as much as you wanted to be?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chelsea &amp; Westminster</td>
<td>75</td>
<td>85</td>
<td>68</td>
</tr>
<tr>
<td>Ealing</td>
<td>68</td>
<td>83</td>
<td>63</td>
</tr>
<tr>
<td>Hammer-Smith</td>
<td>77</td>
<td>88</td>
<td>66</td>
</tr>
<tr>
<td>Charing Cross</td>
<td>77</td>
<td>88</td>
<td>66</td>
</tr>
<tr>
<td>St Mary’s</td>
<td>77</td>
<td>88</td>
<td>66</td>
</tr>
<tr>
<td>West Middlesex</td>
<td>71</td>
<td>86</td>
<td>66</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>74</td>
<td>84</td>
<td>66</td>
</tr>
<tr>
<td>Northwick Park</td>
<td>71</td>
<td>84</td>
<td>62</td>
</tr>
<tr>
<td>Central Middlesex</td>
<td>71</td>
<td>84</td>
<td>62</td>
</tr>
</tbody>
</table>

\[Notes from Figure 9.47: \]

Chelsea & Westminster, West Middlesex and Central Middlesex are considered the sites with the highest quality of estate. These sites consist of very recently built buildings with space that is suitable for the current and future requirements. Ealing, St Mary’s and Northwick Park are considered to be sites with poor quality estate. St Mary’s and Northwick Park have high levels of floor space that is considered not functionally suitable NHS space. In addition 56% of St Mary’s estate was built pre-1964 and therefore suffers from issues typical of older buildings.

In Chapter 9d, consideration is given of the capital implications for each of these options to ensure that the quality of estate reaches the necessary levels to achieve the clinical standards. As evidence has shown, there will always be limitations when using estate that is older.

Combining these two elements of patient experience, clinicians agreed pre-consultation that some options were likely to offer patients a better experience than others. This is summarised in Figure 9.49.

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5 ERIC Site-level data, HEFS, 2010/11 ([http://www.hefs.ic.nhs.uk/DataFiles.asp](http://www.hefs.ic.nhs.uk/DataFiles.asp)). Notes from Figure 9.48:
2. Qualitative assessment
Options 1 and 5 achieved the highest evaluations. Both of these options included Chelsea & Westminster and West Middlesex, therefore achieving high evaluations for the quality of estate. Neither of these options contained Ealing which would have lowered its evaluation due to its poor quality of estate and the lower scores it achieved on the National Patient Survey.

Options 4 and 8 were given the lowest evaluations. Both of these options include Ealing but do not include one or both of Chelsea & Westminster and West Middlesex. The other hospitals do not impact any of the evaluations between the options. All options include Northwick Park as a major hospital and exclude Central Middlesex as a major hospital (as set out in Chapter 12), therefore they are all considered to be equally impacted by the low rated quality of estate at Northwick Park and the slightly lower than national average scores on the National Patient Survey for West Middlesex.

As described in Section 9.7.3 of this chapter, Central Middlesex has been designated as an elective hospital. This will ensure that the quality of its buildings will be utilised in all options.

Prior to consultation this evaluation was approved by the Clinical Board and the Programme Board.

**9.9.13 Feedback received about the patient experience sub-criterion during consultation**

During consultation we received the following feedback related to the patient experience sub-criterion:

**Independent report conducted by Tim Rideout Limited on behalf of the London Borough of Ealing**

“**The patient experience element of the quality criteria includes an assessment of the quality of the respective estates across the nine sites, based on the assumption that there is a correlation between the quality of the hospital or clinic where a patient is treated and their**...
experience. In order to use this as a comparative measure of patient experience the business case uses nationally collected site level information (from ERIC returns) in terms of the proportion of space deemed to be not functionally suitable as NHS space and the age of the estate. This does not take into account in any way current patients’ views of the respective sites. Therefore the information’s use in this way is somewhat open to challenge. In addition Ealing’s estate is assessed as “low” quality, despite the assessment indicating that all of the space is functionally suitable. The assessment appears to be based purely on the age of the estate, which in fact compares favourably with other trusts in NW London. This is considered further later in this report.

Much more appropriately, the patient experience criteria also incorporate recent patient experience data. It should be noted that Ealing, West Middlesex, Northwick Park and Central Middlesex score statistically below the national average in respect of the rating of the care received by patients. Ealing is the only NW London Trust that scores statistically below national average in terms of patients’ assessment of the respect with which they were treated. Ealing has the third best score in relation to patients’ desire level of involvement in their care. However, the business case states that “the difference between all the scores is minimal and indeed the national scores have a very small range. Local clinicians did not feel that using this data in isolation gave them sufficient basis to differentiate between the options”. This is open to challenge. Given its source and focus, this is a much better indicator of respective patient experience than the “proxy” estate indicator.”

9.9.14 The implications of this feedback on the patient experience sub-criterion

The feedback we received about the patient experience sub-criterion included a suggestion for alternatives. We considered the feedback received as follows:

- **Response to feedback about Patients’ views of sites referenced in the Rideout report**: Patient views are considered through the correlation between age and quality of estate. Evidence for the correlation is provided in the following articles:
  - Lawson B, Phiri M, Wells-Thorpe J (2004). The architectural healthcare environment and its effects on patient health outcomes report. NHS Estates. The study indicates that the architectural environment can contribute to the treatment of patients and significantly affect their health outcomes. The findings indicate patients are sensitive and articulate about their architectural environment and patients make better progress in purpose-designed modern buildings than in older ones
  - Enhancing the Healing Environment: A Guide for NHS trusts (2004). The Kings Fund. A growing body of evidence has found that an attractive, sensitively designed hospital environment can offer significant therapeutic benefits to patients and boost staff morale.

9.9.15 The outcome of the clinical quality sub-criterion

Given the feedback, and the absence of any viable alternative, we reached the conclusion that the evaluation of the patient experience sub-criterion is still valid. We confirmed this decision with the Clinical Board and Programme Board during the post consultation phase: This outcome is unchanged from that reached pre-consultation.
9.9.16 The purpose of the distance and time to access services evaluation sub-criterion

Distance and time to access services is the first sub-criterion of access to care. The purpose of the sub-criterion is to evaluate which options keep to a minimum the increase in the average or total time it takes people to get to hospital by ambulance, car (at off-peak and peak times) and public transport?

9.9.17 Analysis of the distance and time to access services sub-criterion

Distance and time to access services is among the chief concerns of the public and patients. Understandably, all patients want to access excellent NHS services as close to their homes as possible, therefore the distances and time taken to access services was key to the identification of options (this analysis was a fundamental part of hurdle criterion 5 to ascertain the best geographical distribution of major hospitals in NW London, described in Section 9.7.21 of this chapter).

The analysis agreed by clinicians for the distance and time to access services sub-criterion is as follows:

- Impact on population weighted average travel times for each option due to reconfiguration, based on activity volume and travel time estimations:
  - Blue light travel times
  - Off-peak car times
  - Peak car times
  - Public transport times

This analysis builds on the work described in Section 9.7.21. The model uses travel data from TfL’s HSTAT database which contains travel times by private car and public transport between a number of health service locations and LSOAs in London. We analysed each of the eight options to ascertain the population weighted average travel times by the four modes of transport specified by clinicians. The analysis is summarised in Figure 9.50.
The analysis indicates the average travel times in minutes are as follows:

- **Blue light**: 11.7-12.0, a difference between options of 0.3 minutes
- **Private car (off peak)**: 17.5-17.9, a difference between options of 0.4 minutes
- **Private car (peak)**: 21.4-22.2, a difference between options of 0.8 minutes
- **Public transport (peak)**: 36.0-36.6, a difference between options of 0.6 minutes

The analysis also indicates the maximum travel times in minutes are as follows:

- **Blue light**: 30.2, a difference between options of 0 minutes
- **Private car (off peak)**: 45.1, a difference between options of 0 minutes
- **Private car (peak)**: 54.0, a difference between options of 0 minutes
- **Public transport (peak)**: 93.0, a difference between options of 0 minutes

Prior to consultation clinicians gave all eight options a slightly negative evaluation. This reflects several factors:

- The analysis has not enabled any differentiation between the options so all options are evaluated identically.
- Reducing the number of sites that provide services as a major hospital, and as demonstrated in the earlier analysis (see Section 9.7.21 of this chapter), we know that for some residents in certain boroughs, moving to a configuration with five major hospitals rather than the current nine existing acute sites, will result in some additional distance and travel times to get to their nearest hospital.

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6 Transport for London: HSTAT travel time model. Notes from Figure 9.50:

1. Population Weighted average travel time to nearest Major hospital within NWL; population weighted travel times by postcode area (LSOA), morning peak 7-10am; hospitals outside of NWL included in analysis = Barnet, Guy’s, Kingston, Royal Free, St George’s, St Thomas’, St Peter’s, UCLH, Watford, Wexham Park and Wycombe
2. Blue Light travel time estimated as 67% of TfL HSTAT off-peak Private Car travel times
3. Longest travel time for Blue Light, Private Car and Public Transport is for a postcode area in Hillingdon Borough, which is unchanged in all options (including the current configuration)
• Travel analysis was used in the development of the options as part of the hurdle criteria process.

Distance and travel times are not the only important factors in terms of access. Other factors such as opening times and translation services are also important. However clinicians agreed that these factors are either driven by Out of Hospital services or are able to be provided equally under all the options.

The evaluation in Figure 9.50 was approved by the Clinical Board and the Programme Board pre-consultation.

9.9.18 Feedback received about sub-criterion distance and time to access services sub-criterion

During consultation we received the following feedback related to the distance and time to access services pertinent to the identification of the recommendation:

Paddington Green Health Centre Practice Patient Participation Group
“The key issue is public transport. Links to many hospitals are poor and complex and the time to improve links is too slow. Patients requiring immediate, urgent care don’t have transport issues but visitors and patients who need follow-up appointments have a great deal of difficulty.”

Onkar Sahota, London Assembly Member for Ealing and Hillingdon
“The proposed changes would lead to increased journey times to major hospitals for more than 174,000 people from key equality groups such as older people and pregnant women. These adverse effects would disproportionately affect people in deprived parts of the borough.”

Hammersmith and Fulham LINk
“Under the NWL NHS preferred ‘Option A,’ a significant number of local residents will have to travel to St Mary’s to access an ‘A&E’ department. The LINk 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.”

Ealing Council
“Concerns that travel times analysis does not accurately reflect the reality of travelling across the borough; neither does it account for the impact of planned regeneration developments in coming years. As a consequence there are significant concerns that this will result in delayed access to health services including emergency services.”

North West London Joint Health Overview and Scrutiny Committee
“There is insufficient analysis of the impact of the proposals on travel at a borough level, especially for the poorest and most vulnerable communities. Plans to reduce any negative impact on access to re-located services by some local populations are not yet identified.”

Ealing Hospital NHS Trust
“Access by public transport in the view of the Board needs to be reconsidered to ensure patient flows are not different to those modelled. If the modelling is incorrect some hospitals potentially could become overwhelmed and families or carers may have difficulty visiting patients in hospital.”

London Borough of Hounslow Health and Adult Care Scrutiny Panel
“Whilst total numbers of trips to each hospital have been clearly modelled, data on absolute and percentage increase in trips to hospital sites such as West Middlesex are not available.”
Rationalising provision across the sector would inevitably lead to significantly more trips from patients and staff. It is essential for the Council to have this information if we are to understand the transport impact of the programme on the borough."

Westminster City Council, Adult Services and Health Policy and Scrutiny Committee
“We note slightly longer Blue Light ambulance journey times to transport emergency cases to 5 instead of 9 sites. We consider it essential that London Ambulance Service gets the additional crews and vehicles it needs.”

North West London Critical Care Network
“We wish to declare our support for developing clinically necessary transfer pathways including mechanisms for safe, expedited transfer between sites.”

The College of Emergency Medicine
“We note the consolidation of the Emergency departments, the run time and number of ambulance transfers will increase. The College would suggest further detailed modelling and involvement of the London ambulance service for impact assessment is crucial. Clear pathways and standards for transfers from urgent care centres must be agreed.”

Independent report conducted by Tim Rideout Limited on behalf of the London Borough of Ealing
“All eight options scored the same for “Access to Services”. When evaluating “Access to Services” in the options appraisal, the business case states that all eight options have been rated the same in recognition that the time travel analysis has been used in the development of the options and that the analysis has not enabled any differentiation between the options. Access to services is differentially affected by the removal of different hospitals and this differentiation is demonstrated in the business case, which illustrate the varying impact on blue light and private car travel times when different hospitals are removed.

Consequently this aspect of the option appraisal is open to challenge. Access was rated as a highly important issue by patients and the public and it is not credible to suggest that there is no difference at all between the options.

It may, therefore, be argued that rather than developing options based on “Access to Services” and then subsequently discounting it from the options appraisal, it should instead be incorporated into the full options appraisal, particularly given its ranked importance from key stakeholders. On the basis of the aggregating the impacts of reconfiguration on maximum and average peak journey times, options without both Ealing and West Middlesex would have ranked lowest, options without two of West Middlesex, Ealing and St Mary’s would also have been ranked very low."

9.9.19 The implications of this feedback for the distance and time to access services sub-criterion

We have considered the feedback received as follows:

- London Ambulance Service (LAS) provided detailed feedback about extra resources they would need as a result of reconfiguration and this has been costed in full in the revised financial model (see Chapter 9D).
- Proposals are underpinned by a planned movement of work into primary and community care settings and practices and hubs making use of innovative technology (such as telehealth) to improve patient access. We have sought to mitigate the impacts on access by ambulance; in particular ensuring blue light travel times were safe, by ensuring a geographic spread of major hospitals. To this end our
options development process ruled out options that would significantly impact journey times during Stage 5, the hurdle criteria. We continue to work with LAS.

- During the post consultation phase we have undertaken additional travel analysis, supported by the programme’s Travel Advisory Group, to address feedback received during consultation, the outputs of this work are described in Chapter 12. This work supported the existing evaluation of the sub-criterion.
- We commissioned an additional Equalities Impact Assessment after consultation to consider the specific impacts on protected groups with relation to access on public transport, this work is described in Chapter 13 and again supports the current evaluation of the sub-criterion.
- We undertook further travel analysis after consultation, see Figure 9.51, to explore the travel implications of the consultation options. The development of the maps has enabled a detailed checking of the data and assumptions at each stage. The maps indicate the blue light journey time from each LSOA to the nearest major hospital under the three consultation reconfiguration options. The analysis of the maps further supports the pre-consultation conclusion that it is not possible to differentiate between the options on the basis of this sub-criterion. This is because the ‘pairings’ of the options have been designed in such a way as to minimise the affect on travel times.
Figure 9.51: Blue light travel times to nearest acute hospital for the three consultation options

Footnotes:
1. ‘Outside NW London’ means that the ‘nearest’ (as defined by travel time) major hospital for these LSOAs is to a non-NW London hospital.

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HSTAT data
Finally, the feedback we received about the sub-criterion did not include suggestions for alternatives.

### 9.9.20 The outcome of the distance and time to access services sub-criterion

Given the feedback received the Clinical Board agreed that any impact on travel times as a result of the proposed options would be clinically acceptable and the evaluation of the sub-criterion was unchanged.

We confirmed this decision with the Clinical Board and Programme Board during the post consultation phase. This outcome is unchanged from that reached pre-consultation.

#### 9.9.21 The purpose of patient choice sub-criterion

Patient choice is the second sub-criterion of access to care. The purpose of the sub-criterion is to examine which options would give people in NW London the greatest choice of hospitals for emergency care, maternity care and planned care across the greatest number of trusts.

#### 9.9.22 Patient choice sub-criterion analysis

Patient choice is one of the “4 Tests” set out by the Secretary of State as well as a principle within the NHS (refer to Chapter 11 for further details). The service reconfiguration options centralise specialist services, which is necessary to provide high clinical quality. Alongside this, NW London still aims to maximise the choice of high quality services available to its population.

The measures agreed by clinicians and used for the assessment of this sub-criterion were:

- The reduction in the number of sites delivering:
  - Emergency care
  - Obstetrics
  - Elective Care
  - Outpatients and diagnostics
- The number of Trusts with major hospital sites.

Patient choice is generally assumed to be greater if there are several suitable options for them to consider where they would like to use services. However, it is also recognised that the priority for patients is to receive the best care possible with the highest chance of a positive clinical outcome and a good patient experience.

Taking this into consideration clinicians agreed that all the options will provide better access due to the increased number of high quality services as well as increased access to specialists and diagnostics outside of the hospital environment, as set out in the Out of Hospital strategies (see Chapter 8).

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8 Emergency care and maternity care are excluded from the NHS Constitution and the scope of choice under the ‘Four Tests’ and for this reason are not included in our Choice paper in Appendix J, however we have included emergency and maternity care within this criterion due to its importance to patients as part of identifying a recommended option for reconfiguration.
Figure 9.52 shows the reduction in the number of sites delivering particular services according to each of the eight options.

**Figure 9.52: Review of patient choice**

<table>
<thead>
<tr>
<th>Proposed Option</th>
<th>Reduction in # of sites delivering...</th>
<th># of Trusts with major hospital sites</th>
<th>Evaluation</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Emergency Care¹</td>
<td>Obstetrics²</td>
<td>Elective Care³</td>
<td>O/P &amp; Diagnostics</td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
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<tr>
<td>8</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

Notes for Figure 9.52:
1. Does not include CMH as the site is not currently delivering 24/7 emergency care
2. Assumes that if C&W was not an major hospital site that CHX would provide new maternity service
3. Assumes that all major hospital and specialist hospital sites will provide some complex elective care however all sites may not provide non-complex elective care; Assumes CMH is an elective hospital under all options

Each of the options would see a reduction of three Emergency Care sites. All the options would also see a reduction in the number of sites providing Obstetrics and Elective Care services, however this would be slightly greater for Options 1 to 4, where they would lose two Obstetric sites and three Elective Care sites compared to a reduction of one Obstetric unit and two Elective Care sites under options 5 to 8. Under options 5 to 8, Hammersmith is not designated as a major hospital and would be designated as a Specialist Hospital. Under these options Hammersmith would retain Queen Charlotte’s Hospital, providing an additional obstetric unit. It would also retain an elective care unit. There would be no change under any of the options in the number of sites providing outpatient and diagnostic services.

A further consideration under patient choice is the range of Trusts with major hospital sites that patients could access under the different options. Those options that locate a major hospital at Chelsea & Westminster rather than at Charing Cross result in five Trusts having a major hospital. Where Charing Cross is designated a major hospital then only four Trusts have major hospitals, and Imperial Trust would contain two major hospitals instead of one.

After reviewing this analysis on patient choice, clinicians agreed that options 5 and 7 should be given the highest evaluation. These two options result in a lower reduction of sites in obstetric and elective care as well as leading to five Trusts having major hospitals. Options 2 and 4 were given the lowest evaluation as these options both lose two obstetric sites and three elective care sites, as well as the options leaving only four Trusts with major hospitals.
This evaluation was agreed by the Clinical Board and the Programme Board pre-consultation.

9.9.23 Feedback received about the patient choice sub-criterion during consultation

During consultation we received the following feedback related to the patient choice sub-criterion:

**Kensington & Chelsea LINk**

“Where services are to be specialised there is a removal of choice for the patient, therefore it is important that these services are monitored to ensure that they are run in a sensitive manner, are accessible, and that all staff are trained in accordance with a robust equality delivery strategy.”

**Independent report conducted by Tim Rideout Limited on behalf of the London Borough of Ealing**

“In terms of patient choice (included within the access criteria), the business case gives the highest rating to the “two options [that] result in a lower reduction of sites in obstetric and elective care as well as leading to five Trusts having major hospitals”. Indeed, emphasis is placed on patient choice benefitting from a greater number of Trusts (not sites) offering services. This argument is open to challenge on two counts. Firstly, no evidence is provided to support the proposition that patient choice is enhanced by the number of trusts as opposed to sites offering services to patients. Secondly, the distribution of sites between NHS organisations is not fixed and can be changed.”

9.9.24 The implications of this feedback for the patient choice sub-criterion

We have considered feedback received about the sub-criterion as follows:

- **Response to feedback about how patient choice relates to the number of trusts referenced in the Rideout report:** The Co-operation and Competition Panel set up by DH and Monitor to advise Secretary of State and Monitor, and the Office of Fair Trading (OFT), work from a presumption that it is the number of providers (trusts) that impact on patient choice and competition. We recommend that the JCPCT makes that same presumption.

The feedback we received did not include suggestions for an alternative.

9.9.25 The outcome of the patient choice sub-criterion

Given the feedback, the absence of any suggested alternative, we reached the conclusion that the evaluation of the sub-criterion is robust and valid for decision making.

We confirmed this decision with the following groups during the post consultation phase:

- Clinical Board
- Finance and Business Planning
- Programme Board.

This outcome is unchanged from pre-consultation. The complete analysis of patient choice can be found in Chapter 11.
9.9.26 **The purpose of the value for money criterion**

The purpose of the third stage of the process is to ascertain which options present the best value for money. The value for money criterion is assessed using five sub-criteria:

1. Capital Costs
2. Transition Costs
3. Site viability
4. Total surplus / deficit
5. Net Present Value

The financial analysis completed as part of the pre consultation phase has been refreshed using data on beds, activity, income and expenditure, for commissioners and providers, for the financial year 2012/13. As part of this phase of the work, we have undertaken a more detailed appraisal of the impact of the changes to options A, B and C (options 5, 6 and 7 in the pre-consultation phase), particularly with regard to estates solutions and the impact on capital requirements. This updated analysis is set out in more detail in Part D of Chapter 9.

9.9.27 **Feedback received about value for money criterion during consultation**

During consolation we received the following feedback about the value for money evaluation:

**JHOSC**

“The money available in the system reduces and hence there is neither the capital nor the revenue available to implement the plan or that the finances no longer flow in the way envisaged.”

**Westminster HOSC**

“There must be absolute guarantees that capital is available so that major estate and infrastructure issues at St Mary’s are addressed in time to accommodate the extra service and capacity requirements to provide specialist health services in the 21st century. Decanting Western Eye Hospital and Hyper Acute Stroke Services into the site requires major investment in the current infrastructure, accessibility and facilities.”

**Independent reports conducted by Tim Rideout Limited on behalf of the London Borough of Ealing and Hammersmith & Fulham Council**

“The overall value for money assessment in the business case gives the highest rating to Option 5 and the second highest rating to Options 6 and 7. However this is open to challenge. The differentiation between Options 1 to 4 and Options 5 to 8 is primarily a function of the capital costs estimate. As suggested above, the capital estimates work needs to be significantly strengthened to arrive at the true capital cost of each of the estimates. The differentiation between Options 5 to 8 is entirely a function of the impact on site and Trust viability and the NPV calculation. Both the methodology and the application are open to challenge, as this does not give a sufficiently accurate differential value for money assessment between the options.”

9.9.28 **The implications of this feedback for the value for money criterion**

We have considered the feedback received about the value for money evaluation as follows:
- **Response to feedback about capital costs:** Our F&BP group and Programme Board agreed the initial financial modelling work pre-consultation to support the evaluation of options and the JCPCT’s decision to proceed to consultation. The F&BP group has since updated the financial models as part of the post consultation phase and they include detailed cost requirements, this work is reflected in the post consultation analysis that follows in the next section of this document.

With respect to securing capital, Trusts are required to secure capital funds through the standard Department of Health and Treasury processes, the programme is committed to supporting this work.

- **Response to feedback about site viability as referenced in the Rideout report:** The financial viability of trusts is an important factor for local people. If trusts are not viable, then the trust cannot continue in that state. This work has also been revisited by the F&BP group during the post consultation phase. Details follow in the next section.

- **Response to feedback about Net Present Value as referenced in the Rideout report:** NPV is the best overall indicator available to assess the financial impact of an option over a number of years because it takes into account both capital and revenue consequences of each option. It does use data that is contained in other financial measures but uses it in a different way to calculate the overall financial benefit of the option. This evaluation has also been revisited post-consultation.

As stated, we re-evaluated the ‘value for money’ criteria post-consultation. We noted the concerns regarding the capital estimates and as a result have worked closely with providers to review and refine the three consultation options and used this updated analysis post-consultation. We focused on the three consultation options because the feedback we received during consultation did not include any viable alternative to these options.

**4 Deliverability: Workforce**

### 9.9.29 The purpose of the workforce sub-criterion

Workforce is the first sub-criterion of deliverability. The purpose of the sub-criterion is to examine which options will provide the best workplace for staff using staff satisfaction surveys.

### 9.9.30 Workforce sub-criterion analysis

The availability of sufficient workforce with the right skills was a significant factor in determining the number of major hospitals needed in NW London (see Chapter 9b). Once this number was established, the programme wanted to assess whether there was any further differentiation between options based on workforce. For this to be the case, we therefore needed to assess qualitative rather than quantitative measures and these were based on whether staff performed well and were satisfied in their work.

A qualitative assessment was undertaken based on the number of better performing Trusts expected to be part of the future configuration, as assessed by the following staff metrics:

- Staff turnover rates
- Staff sickness rates
- Staff recommendation as a place to work or receive treatment
- Staff job satisfaction
- Staff satisfied with the quality of work and patient care.

The Programme Board recommended that clinicians use the outputs of the National NHS Staff Survey to understand current levels of staff satisfaction, as shown in Figures 9.53 and 9.54.

**Figure 9.53: Workforce data**

<table>
<thead>
<tr>
<th>Site</th>
<th>Turnover rates</th>
<th>Sickness rates</th>
<th>Staff recommendation</th>
<th>Staff job satisfaction</th>
<th>Staff satisfied with the quality of work and patient care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chelsea &amp; Westminster</td>
<td>9.3%</td>
<td>3.3%</td>
<td>3.89</td>
<td>3.58</td>
<td>82</td>
</tr>
<tr>
<td>Ealing</td>
<td>4.5%</td>
<td>3.8%</td>
<td>3.43</td>
<td>3.51</td>
<td>74</td>
</tr>
<tr>
<td>Hammersmith</td>
<td>9.2%</td>
<td>3.1%</td>
<td>3.66</td>
<td>3.47</td>
<td>80</td>
</tr>
<tr>
<td>Charing Cross</td>
<td>9.2%</td>
<td>3.1%</td>
<td>3.66</td>
<td>3.47</td>
<td>80</td>
</tr>
<tr>
<td>St Mary’s</td>
<td>9.2%</td>
<td>3.1%</td>
<td>3.66</td>
<td>3.47</td>
<td>80</td>
</tr>
<tr>
<td>West Middlesex</td>
<td>13.1%</td>
<td>1.5%</td>
<td>3.07</td>
<td>3.37</td>
<td>61</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>7.7%</td>
<td>2.9%</td>
<td>3.53</td>
<td>3.45</td>
<td>78</td>
</tr>
<tr>
<td>Northwick Park</td>
<td>6.8%</td>
<td>2.5%</td>
<td>3.54</td>
<td>3.47</td>
<td>84</td>
</tr>
<tr>
<td>Central Middlesex</td>
<td>6.8%</td>
<td>2.5%</td>
<td>3.54</td>
<td>3.47</td>
<td>84</td>
</tr>
<tr>
<td>National Average</td>
<td>2.4%</td>
<td>4.0%</td>
<td>3.50</td>
<td>3.47</td>
<td>74</td>
</tr>
</tbody>
</table>

Clinicians agreed that data on turnover and sickness rates did not provide sufficient basis to determine whether staff at any given site were more satisfied on others. The turnover rates in particular are affected by the presence of staff in training roles, and so teaching hospitals typically have much higher levels of staff turnover compared to the national average. London is also considered to have differing working patterns compared to the majority of the country and its population tends to be more transient than in other areas.

The outputs from the National NHS Staff Survey (2011) indicate that Chelsea & Westminster achieves the best scores for two of the three metrics and is the second best placed hospital in NW London for the third metric. West Middlesex has the lowest scores across all the metrics. Excluding West Middlesex, there is little difference in the scores for all the other Trusts in NW London.

**Figure 9.54: Staff survey confidence intervals**

10 Notes for Figure 9.53:
1. NHS Information Centre, NHS Hospital & Community Health Service (HCHS) monthly workforce statistics turnover, between Oct 2010 and Oct 2011, % leaving rate. National average estimated based on Sep 2010 to Sep 2011 figures. 1 = unlikely to recommend and 5 = likely to recommend
2. NHS Information Centre (workforce section), July-September 2011 Sickness Absence Rates in the NHS
3. 2011 National NHS staff survey – National NHS Staff Survey Co-ordination Centre, DH, Staff recommendation of the trust as a place to work or receive treatment, where 1 = unlikely to recommend and 5 = likely to recommend
4. 2011 National NHS staff survey – National NHS Staff Survey Co-ordination Centre, DH, Staff job satisfaction, where 1 = unsatisfied and 5 = satisfied
5. 2011 National NHS staff survey – National NHS Staff Survey Co-ordination Centre, DH, Staff feeling satisfied with the quality of work and patient care they are able to deliver, where 1 = unsatisfied and 5 = satisfied

11 2011 National NHS staff survey
Only a small proportion of staff from each trust participate in the survey (due in part to the survey methodology which means it is sent to randomly selected group of Trust staff). However, confidence intervals can be calculated that take account of the sample size and distribution of responses. Chelsea & Westminster can be seen to have scores that are statistically better than the scores achieved by other Trusts, whilst scores for West Middlesex are statistically worse.

On the basis of the analysis detailed above, clinicians agreed that the analysis on workforce provided only small differentiating factors between each of the eight options. Options 1, 3, 4, 5, 7 and 8 were given a slightly more positive evaluation compared with options 2 and 6. Options 2 and 6 were the only options that included West Middlesex, which had the lowest set of staff satisfaction scores, but did not include Chelsea & Westminster, which had the highest set of staff satisfaction scores. Options 3 and 7 included Chelsea & Westminster but not West Middlesex and so scored slightly more highly. Options 4 and 8 do not include either Chelsea & Westminster or West Middlesex and so scored positively due to the good overall scores for staff satisfaction compared with the national average. Options 1 and 5 included both Chelsea & Westminster and West Middlesex and so were rated more positively due to the better scores for Chelsea & Westminster. This evaluation is summarised in Figure 9.55.

**Figure 9.55: Summary of workforce evaluation**
This analysis was agreed prior to consultation (November 2011 to July 2012) by clinicians and approved by the Clinical Board and the Programme Board.

9.9.31 Feedback received about sub-criterion workforce during consultation

During consultation we received the following feedback related to the workforce sub-criterion:

Westminster City Council, Adult Services and Health Policy and Scrutiny Committee
“There is a clear issue in relation to workforce strategy which needs further detailed consideration, since out-of-hospital services need to be built up before surplus staff are released from the acute sector for re-deployment.”

Richmond Clinical Commissioning Group
“See clear plans to deliver the necessary workforce and estate configurations to facilitate the out of hospital care expectations that underpin many of the delivery assumptions behind the options.”

Kensington & Chelsea LINk
“Moving services and human resources to an out of hospital setting will involve retraining large numbers of staff to work in a different environment requiring a different skillset, greater independence and responsibility. We have not seen any studies on the feasibility of this, and seek assurances that existing staff are willing to make this transition.”

Independent reports conducted by Tim Rideout Limited on behalf of the London Borough of Ealing and Hammersmith & Fulham Council
“The deliverability criteria include an assessment of the workforce using recent national workforce date and staff survey results as a proxy indicator. The appropriateness of this as a proxy is open to challenge. The business case states that “Chelsea and Westminster can be seen to have scores that are statistically better than the scores achieved by other Trusts”. This too is open to challenge. Ealing’s scores are generally good and are all better than those of West Middlesex with the exception of the sickness absence rate. Indeed the business case notes that West Middlesex’s scores “are statistically worse”. Consequently options that include West Middlesex as a “Major Hospital” are rated lower in terms of the evaluation of the workforce.”

9.9.32 The implications of this feedback for the workforce sub-criterion

The feedback we received about the workforce sub-criterion did not include suggestions for alternatives. We have considered the feedback received as follows:

- **Response to feedback about the use of staff survey results as a proxy in the Rideout report**: The feedback about the use of staff survey results as a proxy indicator did not include a suggestion for alternatives. The Clinical and Programme Board were content that this measure was the most suitable available.

- **Response to feedback about turnover and sickness rates referenced in the Rideout report**: Section 9.8.48 described how clinicians agreed that turnover and sickness rates did not provide sufficient robust differentiation of the options. Chelsea & Westminster are statistically better than the scores achieved by the other trusts on two of the remaining three measures, and very close to the best on the third.

- **Response to feedback about Ealing’s scores referenced in the Rideout report**: Ealing’s score are rated more highly than West Middlesex because they score more highly on the three measures that are being used. The impact on options with West Middlesex is described in Figure 9.55.
9.9.33 The outcome of the workforce sub-criterion

Given the feedback and the absence of any alternative, clinicians concluded that the pre-consultation evaluation of workforce is still valid. We confirmed this decision with the Clinical Board and Programme Board during the post consultation phase. This outcome is unchanged from pre-consultation.

9.9.34 The purpose of the expected time to deliver sub-criterion

Expected time to deliver is the second sub-criterion of deliverability. The purpose of the sub-criterion is to examine how long it will take to deliver the proposed changes in each option. A shorter delivery time means that benefits can be delivered earlier.

9.9.35 Analysis of the expected time to deliver sub-criterion

During Stage 5 one of the hurdle criteria used by clinicians used to determine the number of major hospitals needed in NW London was the length of time it would have taken to deliver (see Chapter 9b). Within the remaining options there are still a range of delivery timescales that are all acceptable. Therefore we want to assess the likelihood of delivery for each option (a proxy for the management case in business case terms) and whether this is different for each option.

The measures used for the assessment were:

- Qualitative assessment of ease of delivering option within 3-5 years based upon the following measures:
  1. Number of sites that are already delivering relevant services
  2. Additional capacity required
  3. Required movements of beds within the system
  4. The volume of maternity beds that would be moved.

Clinicians and programme leaders have agreed that for Shaping a healthier future to be successful it needs to be delivered within the next 5 years. This recommendation was made by the Programme Board.

Figure 9.56 summarises the pre-consultation assessment of each of the four measures described above.
Pre-consultation options 3, 4, 7 and 8 were all given a strongly negative evaluation. In all of these options, at least two Trusts are forecast to be in deficit. It is very difficult for Trusts facing such financial difficulties to make the changes in services as part of reconfiguration.

Options 1 and 2 were given a slightly negative evaluation. Both these options include Hammersmith as a major hospital, which would require a significant amount of change to services to make this happen. It is likely that the scale of change to make Hammersmith a major hospital would be difficult to achieve in the 3-5 year timeframe.

Options 5 and 6 were given slightly positive evaluation as neither of these options face the same degree of financial difficulties or the scale of change to services as compared with the options. Both of these options require fewer beds to be moved and less additional capacity.

Movement of maternity beds is also an indication of the degree of change required. Options 2, 4, 6 and 8 would need higher numbers of maternity beds to be moved compared to options 1, 3, 5 and 7. Options 1, 3, 5, and 7 all include Chelsea & Westminster which has a large obstetric unit. If Chelsea & Westminster was not designated as a major hospital, these beds would need to be moved elsewhere.

Pre-consultation this evaluation was confirmed by the Clinical Board and the Programme Board.

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12 Notes for Figure 9.56:
1. Includes – Adult general and acute, adult daycare, critical care at Major hospitals and Elective Centres (not at Local hospitals). Excludes – Pediatric, maternity, rehabilitation and other beds, and neonatal cots
2. Assumption that Elective activity would move based on travel time used to estimate Elective bed capacity requirements
3. Major hospital Critical Care beds numbers include Specialist Critical Care beds (numbers required from ICHT, C&W and WMUH)
9.9.36 Feedback received about sub-criterion expected time to deliver during consultation

During consultation we received the following feedback related to the expected time to deliver sub-criterion:

North West London Hospitals NHS Trust
“These changes will take time to deliver so the pace of change required by SaHF is an important consideration. Given the scale of change required across eight clinical commissioning groups, we are concerned that the implementation date of March 2016 may be too optimistic.”

Ealing Hospital NHS Trust
“The scale of change envisaged in SaHF in the timeframe suggested is very ambitious and the Board hoped this would be reviewed prior to any reconfiguration.”

Brent North Constituency Labour Party
“2 to 3 years for delivery of enhanced community health services is overly optimistic.”

Roadshow event, ‘universal themes’, Ipsos MORI report
“…Concerns about the timescales for change…”

Hospital site event, ‘key concerns’, Ipsos MORI report
“…Timescales…”

User Panel, NHS Central London Clinical Commissioning Group
“We think that the timescales are not long enough to enable sufficient investment to go into community services to ensure that these services work well, are able to meet the demand, and are able to reduce demand on A&E services.”

North West London Joint Health Overview and Scrutiny Committee
“There are concerns over the readiness and capacity of out of hospital services, the realism of timescales for change and the likelihood of cost transfer from the NHS to others.”

Independent reports conducted by Tim Rideout Limited on behalf of the London Borough of Ealing and Hammersmith & Fulham Council
“The deliverability criteria also include an assessment of the expected time to deliver each option. This assessment should be challenged. It includes again (double counting) information from the financial base case based on the premise that “it is very difficult for Trusts facing such financial difficulties to make the changes in services as part of the reconfiguration”. No evidence is provided in support of this statement and it doesn’t take account of other proposed actions, most notably including the merger between Ealing Hospital NHS Trust and North West London Hospitals NHS Trust. The assessment also uses again the assessment of new capacity required (a double count). Finally, it incorporates an assessment of the movement of adult and maternity beds. Currently, in overall terms this assessment of expected time to deliver ranks options 5 and 6 as equal highest.”

9.9.37 The implications of this feedback for the expected time to deliver sub-criterion

We have considered the feedback received during consultation as follows:
Response to feedback about implementation timescales: We noted the concerns regarding the implementation timetable and as a result have worked closely with providers to review and refine the three consultation options. As a result, we now plan to implement changes within five years, please refer to Chapter 17.

Response to feedback about double counting in the Rideout report: The assessment does use data that is contained in other criteria but uses it in a different way to calculate the overall deliverability of the option.

Response to feedback about the transaction referenced in the Rideout report: It may be the case that the merger between Ealing Hospital NHS Trust and North West London Hospitals NHS Trust delivers additional productivity benefits, but to date the merger business case has been unable to identify a strong enough case to proceed.

Following the decision to implement over five years we revisited the deliverability evaluation for options A, B and C (originally options 5, 6 and 7 respectively).

4 Deliverability: Expected time to deliver – post consultation

Figure 9.57 shows the re-evaluation of the expected time to deliver sub-criterion using the analysis we undertook during the post-consultation phase.

Figure 9.57: Evaluation of expected time to deliver using analysis created post consultation

The figure shows:

- Options A and B (originally options 5 and 6 respectively) continue to receive the highest ranking, because they result in the lowest number of trusts in financial deficit.
- Option C (originally option 7), would result in three trusts being in financial deficit (West Middlesex, NWL hospitals and Hillingdon).
- More detailed work has been undertaken with the providers on options A, B and C to understand bed requirements based on actual provider estate. As a result, estimates of the number of beds and new capacity required has increased (e.g. number of
paediatric beds required may drop but not all of those beds can be replaced directly with adult beds)

**9.9.38 The outcome of the expected time to deliver sub-criterion**

Given the feedback, the updated evaluation and the absence of any alternative, clinicians concluded that the pre-consultation ranking of options was still valid. We confirmed this decision with the following groups during the post consultation phase:

- Clinical Board
- Finance and Business Planning group
- Programme Board.

| 4 | Deliverability: Co-dependencies with other strategies |

**9.9.39 The purpose of the sub-criterion co-dependencies with other strategies**

Co-dependencies with other strategies is the third sub-criterion of deliverability. The purpose of the sub-criterion is to examine how well each option fits with what is happening, or may happen, nationally or in London?

**9.9.40 Analysis of the co-dependencies with other strategies sub-criterion**

Clinical practice and demands on the health system are constantly evolving. Therefore we prefer options that are most likely to enable us to respond to future changes.

The measures used for the assessment were:

- Fit with previous Major Trauma designation
- Fit with previous stroke designation for Hyper-Acute Stroke Units and Stroke Units
- Fit with national initiatives:
  - Transparency agenda
  - Enhancing and improving out of hospital care
  - Integrated care
  - Driving improvements in acute services, particularly out of hours
  - National QIPP challenge.
- Fit with broader London initiatives:
  - Primary care
  - Integrated care.
- Fit with local strategies in place or in development:
  - Inner NW London Integrated Care Pilot (ICP)
  - Mental Health ICP
  - Pathology modernisation programme
  - Ongoing work by cancer, cardiac and other networks.

Clinicians agreed that their recommendations needed to take account of other work and initiatives going on within the region as well as across London and in surrounding areas. They agreed that our proposals should not go against other changes being made that support improvements in clinical quality and patient experience.

The key initiatives that the Clinical Board agreed needed to be taken into consideration alongside the proposed reconfiguration were:
• Changes to the designation of the Major Trauma Centre at St Mary’s
• Current location of stroke units (Ealing is the only site in NW London without a stroke unit)
• Changes to the location of the HASU at Charing Cross.

Clinicians agreed that options 3 and 4 had the lowest scoring as both of these options would require the Major Trauma Centre at St Mary’s to be moved and the lack of stroke unit (and therefore one would need to be ‘moved’ from another site) at Ealing. Options 5 and 6 scored the most positively compared to the other options as both of these options designate St Mary’s as a major hospital, therefore requiring no change to the Major Trauma Unit (MTU), and have West Middlesex rather than Ealing as a major hospital, therefore there would be no requirement to ‘move’ a stroke unit. As the Hyper-Acute Stroke Unit consultation designated the location of the unit to Charing Cross, but said that co-location with a MTU would be considered in future, then any potential re-location of the HASU from Charing Cross to St Mary’s (where the MTU is located) is possible within the different options and does not differentiate between options 5 and 6 (option 5 including Chelsea & Westminster as a major hospital with option 6 having Charing Cross).

Options 1, 2, 7 and 8 all have a slightly negative rating. Options 1 and 2 would see a change in the MTU from St Mary’s as both of these options designate Hammersmith as a major hospital rather than St Mary’s. Both options 7 and 8 designate Ealing as a major hospital rather than West Middlesex which would require changes to the stroke units.

Clinicians agreed that other initiatives did not sufficiently impact or give cause for differentiation between the options. These initiatives included:

• National initiatives: Transparency agenda, Enhancing and improving OOH care, Integrated Care, Driving improvement in acute services, particularly out of hours, National QIPP challenge
• Broader London Initiatives: Primary Care and Integrated Care
• Local Strategies in place or in development: Inner NWL Integrated Care Pilot (ICP), Mental Health ICP, Pathology modernisation programme, on-going work by networks e.g. Cancer network, Cardiac network.

This evaluation is summarised in Figure 9.58.
This evaluation was agreed by the Clinical Board and the Programme Board during the pre-consultation phase.

9.9.41 Feedback received about the sub-criterion co-dependencies with other strategies during consultation

During consultation we received the following feedback about the co-dependencies with other strategies sub-criterion:

Independent reports conducted by Tim Rideout Limited on behalf of the London Borough of Ealing

“Finally, in terms of deliverability, the assessment includes a consideration of co-dependencies with other strategies, to take account of other work and initiatives going on within NW London and beyond...The business case’s assessment gave Options 5 and 6 the highest rating. Options that contain Ealing over West Middlesex are scored slightly worse due to the Stroke Unit at West Middlesex and the fact that Ealing is the only site without a stroke unit.”

9.9.42 The implications of this feedback for the co-dependencies with other strategies sub-criterion

We have considered feedback received about the sub-criterions. Given the feedback, the absence of any alternative, clinicians concluded that no response was required.

9.9.43 The outcome of the co-dependencies with other strategies sub-criterion

Clinicians agreed the pre-consultation evaluation was still valid. We confirmed this evaluation with the Clinical Board and Programme Board during the post consultation phase. This outcome is unchanged from pre-consultation.
The research & education criterion is constituted of two sub criteria; disruption and support current and developing research and education delivery.

9.9.44 The purpose of the disruption sub-criterion

Disruption is the first sub-criterion of research and education. The purpose of the sub-criterion is to examine which options best fit with current research and education to minimise disruption in these areas.

9.9.45 Analysis of the disruption evaluation sub-criterion

The NHS in NW London has a strong reputation for Research and Education and clinicians agreed that it was important that any proposals would allow for continued opportunities to grow and enable an innovative environment to support further work in this area. Therefore minimising disruption to research and education during any service change is important. The assessment of this criterion depends as much on what happens to sites not designated as major hospitals as much as those that are.

Pre-consultation clinicians considered the outcome of the National Training Survey. All current 9 acute sites in NW London have scored well in the recent National Training Survey, with Hammersmith and St Mary’s scoring particularly well being rated in the top quartile nationally; see Figure 9.59 for the results.

Figure 9.59: Results from 2011 National Training Survey

13 General Medical Council, National Training Surveys, 2011
During Stage 5 clinicians agreed that in options where Hammersmith was not designated as a Major Hospital, it would be designated as a Specialist Hospital and would therefore be able to retain its teaching.

Due to the results in Figure 9.59 it was agreed that those options with St Mary’s as a Major Hospital and Hammersmith as a Specialist Hospital would be evaluated slightly higher to reflect this retention of teaching.

Clinicians did not feel that the National Training Survey results allowed for any further differentiation between the different options. Therefore the measures used for the assessment of this sub-criterion were as follows:

- Research spend at non-major hospital and non-specialist hospital sites
- Education spend at non-major hospital and non-specialist hospital sites.

**Research and education spend**

Figure 9.60 sets out the pre-consultation analysis of planned levels of spending for 2014/15 that would be ‘located’ at hospitals that had not been designated as either major hospitals or specialist hospitals. For example, in option 1, where West Middlesex, Hammersmith, Chelsea & Westminster have been designated Major Hospitals (alongside Northwick Park and Hillingdon), and all other sites are either local hospitals or elective hospitals, then £21 million of research spend would be ‘located’ at the local or elective hospitals and £46 million of education spend would be ‘located’ at the local or elective hospitals. This is in comparison with option 8, where only £6 million of research spend and £29 million of education spend would be ‘located’ at the local or elective hospitals.

Pre-consultation clinicians agreed that options 1, 2, 3 and 4 should be rated lower than options 5, 6, 7 and 8. Clinicians agreed that it is critical for research to be co-located with clinical delivery to optimise the transfer of treatments from the academic environment to ‘real-life’. Additionally in NW London, the majority of research is currently carried out at Hammersmith, St Mary’s and Chelsea & Westminster (excluding Northwick Park and specialist hospitals which are the same in all options). All of options 1-4 designate Hammersmith as a Major Hospital and assumes that St Mary’s would become a local or specialist hospital, and would therefore ‘lose’ its research capability. Whereas in options 5-8, Hammersmith is assumed to become a specialist hospital whilst St Mary’s is a Major Hospital, leading to the continuation of research at both Hammersmith and St Mary’s, therefore minimising disruption.
Chelsea & Westminster already carries out research and could do more because they have the capacity to do so (although this scenario isn’t unique to Chelsea & Westminster), but the amount of research work is much smaller compared to the research undertaken at Hammersmith and St Mary’s. It therefore has a negligible effect in being able to differentiate between options.

This evaluation was agreed pre-consultation by clinicians. This recommendation was approved by the Clinical Board and the Programme Board.

9.9.46 Feedback received about the disruption sub-criterion during consultation

During consultation we received the following feedback about the disruption sub-criterion:

**Independent report conducted by Tim Rideout Limited on behalf of the London Borough of Ealing**

“The last element of the option appraisal was an assessment of the impact on research and education. In terms of potential disruption, no differentiation was made between the options beyond seeking to protect the position at Hammersmith and St Mary’s (as they scored particularly well in the 2011 National Training Survey). The ultimate conclusion of this element is that it is critical for research to be collocated with clinical delivery and therefore Options 5 to 8 were ranked the highest.”

**Imperial AHSC**

“Currently Charing Cross (CXH) is the major centre for undergraduate medical education, housing two major lecture theatres (> 300 students) not available elsewhere, major teaching

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14 Notes for Figure 9.60:
1. ICHT site split provided by the Trust. Research split as 20% Charing Cross; 60% Hammersmith and 20% St Mary’s; Education split as 38% Charing Cross; 23% Hammersmith and 39% St Mary’s
2. Where Hammersmith is not an Major hospital site, it is assumed to retain all Research and Education as an Specialist centre (Specialist) site
facilities, including anatomy, skills labs and computer rooms, communication teaching suites and various student laboratories…Should CXH become a local hospital then it will be necessary to relocate the medical school, re-providing the current teaching facilities, as well as relocating doctors in training.”

9.9.47 The implications of this feedback for the disruption sub-criterion

We have considered feedback received about the disruption sub-criterion. We have responded as follows:

- **Response to feedback about relocating teaching at Charing Cross**: We have worked closely with the College and Hammersmith & Fulham CCG to develop proposals for services for Charing Cross and understand the impacts of proposals on teaching. It is anticipated that consolidating teaching to St Mary’s will add to the high quality of teaching provision for Imperial. To reflect the movement of undergraduate teaching from Charing Cross to St Mary’s the scoring for options that do not retain Charing Cross as a major hospital now attracts a more negative evaluation.

5 Research and Education: Disruption – post consultation

Figure 9.61 shows the re-evaluation of the disruption sub-criterion using the analysis we undertook during the post-consultation phase.

**Figure 9.61: Evaluation of disruption using analysis post consultation**

<table>
<thead>
<tr>
<th>Proposed Option</th>
<th>Disruption to Research and Education</th>
<th>Evaluation</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Research spend at non Major hospital/Specialist centre sites</td>
<td>Education spend at non Major hospital/Specialist centre sites</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Em. 2014/15</td>
<td>Em. 2014/15</td>
<td></td>
</tr>
<tr>
<td>1 West Middlesex</td>
<td>21</td>
<td>46</td>
<td>--</td>
</tr>
<tr>
<td>2 West Middlesex</td>
<td>17</td>
<td>46</td>
<td>--</td>
</tr>
<tr>
<td>3 Ealing</td>
<td>20</td>
<td>49</td>
<td>--</td>
</tr>
<tr>
<td>4 Ealing</td>
<td>16</td>
<td>49</td>
<td>--</td>
</tr>
<tr>
<td>5 West Middlesex</td>
<td>11</td>
<td>26</td>
<td>-</td>
</tr>
<tr>
<td>6 Ealing</td>
<td>8</td>
<td>26</td>
<td>+</td>
</tr>
<tr>
<td>7 Ealing</td>
<td>10</td>
<td>28</td>
<td>-</td>
</tr>
<tr>
<td>8 Ealing</td>
<td>6</td>
<td>29</td>
<td>+</td>
</tr>
</tbody>
</table>

The figure shows:

- Options 1 and 3 were negative pre-consultation and are now strongly negative.
- Options 5 and 7 were positive pre-consultation and are now negative.
9.9.48 The outcome of the disruption to education sub-criterion

Given the feedback, clinicians agreed the post-consultation ranking of options during the post consultation phase. This decision was confirmed by the Programme Board.

9.9.49 The purpose of the sub-criterion support for current and developing research and education delivery evaluation

Support for current and developing research and education delivery is the second sub-criterion of research and education; it also the final sub-criterion of the evaluation of Stage 6. The purpose of the sub-criterion is to examine which options best support what is happening in research and education across NW London.

9.9.50 Analysis of the sub-criterion support for current and developing research and education delivery

The analysis agreed by clinicians for this sub-criterion pre-consultation included:

- Qualitative assessment of whether each configuration option supports current and developing research and education delivery, this includes:
  - Fit with government R&D strategy;
  - Support for Academic Health Science Partnership and Imperial College’s strategy to concentrate research activity onto the Hammersmith and St Mary’s sites;
  - Alignment with GMC trainee plans;
  - Fit with emerging Local Education and Training Boards (LETBs) strategy and plans
- Quantitative assessment of the space allocated to research on each site.

The analysis undertaken pre-consultation was as follows.

Qualitative assessment of support for current and developing research and education delivery

The Imperial College Faculty of Medicine’s current strategy is to concentrate its research activity onto the sites at Hammersmith and St Mary’s. Clinicians agreed that options 5-8 would continue to support this strategy by designating St Mary’s as a Major Hospital and Hammersmith as a Specialist hospital, thereby supporting the actions undertaken by Imperial. Therefore options 1, 2, 3 and 4 have been rated slightly lower than options 5, 6, 7 and 8 for support to current research and education delivery.

Quantitative assessment of space allocated to research

We undertook an assessment of the amount of space allocated to research. This is a proxy for research activity. The assessment indicated:
- Hammersmith has ~60% of Imperial College space (39,000m²) and received the majority of major research infrastructure investment over recent years\(^\text{15}\)
- St Mary’s has 17,000m² of research space with the development of the new surgical innovation centre
- Imperial College is investing in new White City Health Research Campus

Therefore options that included St Mary’s received a higher evaluation than options that didn’t. Figure 9.62 details the evaluation undertaken by clinicians for this sub-criterion.

**Figure 9.62: Evaluation of support to current research and education delivery\(^\text{16}\)**

<table>
<thead>
<tr>
<th>Proposed Option</th>
<th>Evaluation</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hammersmith</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Chelsea &amp; Westminster</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>St Mary’s</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Chelsea &amp; Westminster</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Hammersmith</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Chelsea &amp; Westminster</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

\(-\) Low evaluation  
\(\text{\textbullet\textbullet}\) High evaluation

- Imperial College London strategy to concentrate research activity onto the Hammersmith and St. Mary’s site
- Hammersmith has ~60% of Imperial College space (39,000m²) and received the majority of major research infrastructure investment over recent years
- St Mary’s has 17,000m² of research space with the development of the new surgical innovation centre
- Imperial College is investing in new White City Health Research Campus

- Education can move with clinical activity, and therefore there would be no difference between options in the ability to develop teaching

Prior to consultation clinicians agreed the ranking detailed in Figure 9.62. They also stated that they believed education was not a differentiating factor as education can move with clinical activity, and the ability to develop teaching will be maintained regardless of the option recommended. The recommendation was approved by the Clinical Board and the Programme Board pre-consultation.

**9.9.51 Feedback received about the support for current and developing research and education delivery sub-criterion during consultation**

During consultation we received the following feedback about the sub-criterion:

**Hillingdon Hospitals NHS Foundation Trust**

“We formally support the recommended option (option A) which, provided it is effectively implemented and backed by the requisite investment, has the potential to improve the quality of care, make good use of buildings and resources, and support research and education”

\(^\text{15}\)This allocation focuses on the Faculty of Medicine and excludes the wider Imperial College space at the South Kensington campus

\(^\text{16}\)Notes from Figure 9.62:
1. Hammersmith has ~60% of Imperial College space (39,000m²) and received the majority of major research infrastructure investment over recent years; St Mary’s has 17,000m² of research space and the ability to recruit patients for Imperial College trials through their outpatient clinics
Greg Hands, MP for Chelsea & Fulham
“…..Charing Cross Hospital is a world-class research and teaching facility…..”

Petition H by users of the West Middlesex University Hospital, Ipsos MORI report
“Support research and education: West Middlesex Hospital has the research facilities and some of the most important research in NW London is currently carried out a WMUH

Imperial AHSC
“The implications of the proposals on education and research need to be addressed”

Charing Cross staff event on 17th July 2012
“Potential impact on medical research at Charing Cross”

Excerpt from letter received from Dr McRobbie (2nd October 2012), Charing Cross Hospital
“On reading your detailed business case, it appears that your measure of research and education activity is the “space available”. You have not used any recognised indicator of research or educational output e.g. the number of clinical trials conducted, the number of research patients enrolled on studies, the research income through grants, the number of publications produced. These are data easily accessible and are un-ambiguously quantifiable, but you have chosen to invent your own indicator of activity, which you have presented to the public as fact.

In particular, you have stated as factual and without evidence, to support your preferred option A, that “most important medical research and education is carried out at Hammersmith, St Mary’s and Chelsea and Westminster Hospitals”. This is very misleading. At a recent open meeting at Charing Cross Hospital your team admitted that “in terms of publications etc. Charing Cross does more research than Chelsea and Westminster.”

9.9.52 The implications of this feedback for the support for current and developing research and education delivery sub-criterion

We have considered the feedback received during consultation as follows:

- In summarising the pre-consultation business case for the consultation document, some of the detailed explanations for these criteria have been over simplified. The statements regarding research & education in the consultation document state the positive effect that each of the options would have. Other issues that need to be considered are ICHT’s stated intention to concentrate research in particular on the St Mary’s and Hammersmith sites, along with the advantage in continuing research & education provided at Chelsea & Westminster as this Trust has fewer opportunities to move its research & education facilities elsewhere. There was no intention to dismiss or overlook the value of the research & education currently undertaken at Charing Cross.
- We have revisited the original evaluation against the two research & education sub-criteria to check its validity in light of the feedback received and are content that the original evaluation was correct.
- We are aware that research is often multi-site, suggesting research could be done out of an alternative site should the other site cease to be a research facility following reconfiguration. We also realise that much of the research undertaken will be training driven and will be revisited if training is relocated.
We have considered the suggestion of an additional evaluation sub-criteria relating to research publications and we asked the Clinical Board to consider this – see Section 9.9.53.

**9.9.53 Proposed additional evaluation sub-criteria metrics for consideration**

Given the feedback we believe the evaluation criteria used in the original options analysis could be strengthened by the incorporation of an additional recognised indicator of research output. We added the following sub-criterion:

- **Quantitative assessment of the quality and impact of research published by institutions**

Research is often conducted by multidisciplinary teams across a number of sites. Therefore this measure is a proxy and uses the assumption that the principal investigator is based at the site making the most significant contribution to the research being published, be that reputational, institutional or resource based. We evaluated this criterion in the following way:

1. Quantify the number of published research papers at each institution
2. Evaluate the quality and impact of the research undertaken at those hospitals by multiplying the number of published research papers by institution by the Journal Impact factor (JIF) of the journal in which the papers are published.

We have applied the analysis outlined in the first step of the evaluation to the following hospitals:

- Charing Cross
- Chelsea & Westminster
- Ealing
- West Middlesex
- Hammersmith
- St Mary’s.

Hammersmith and St Mary’s hospitals are included in this preliminary analysis for reference purposes due to the large volume of research & education undertaken at these institutions. Hillingdon and Northwick Park hospitals are excluded from this analysis as they do not differentiate between options, refer to Section 9.9.50 of this chapter for more details.

Imperial College do not support the methodology described above. However we believe this is the most appropriate methodology to address the feedback from Dr McRobbie.

Please note that the data presented in the subsequent sections is taken from PubMed (with JIF taken from internet searches).

**Analysis of the volume of published research papers at each institution**

The number of papers published by each institution was determined using the PubMed search engine database (www.ncbi.nlm.nih.gov/pubmed). Maintained by the United States national Library of Medicine (NLM) at the National Institutes of Health, the PubMed database

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17 Journal Impact Factor (JIF) is a measure reflecting the average number of citations to recent articles published in the journal. It is frequently used as a proxy for the relative importance of a journal within its field, with journals with higher impact factors deemed to be more important than those with lower ones. JIFs used in this paper were obtained through internet searches and will be validated with the Trusts where appropriate through the Clinical Board and Programme Board.
comprises more than 22 million citations for biomedical literature from MEDLINE, life science journals and online books. The database was searched using date and medical institution name filters (e.g. 01/01/2012- 31/12/2012 and Charing Cross). A manual refinement of the generated publication list was performed to verify content and to exclude any captured research papers published by institutions other than the stated hospital e.g. affiliated locations, primary care locations, PCTs etc. Research papers co-published with another institution aside from the stated hospital were retained in the list. The number of research papers published by each institution in 2010, 2011 and 2012 is outlined in section 3.2.1.

Analysis of the quality/impact of research undertaken at each institution

Whilst the analysis outlined in section 3.1.1 above provides an understanding of the volume of research papers published by each institution, accepting the limitation that multi-site research cannot be accurately identified, the quality of the research undertaken cannot be interpreted from the data. One way to determine this is to identify the number of papers published in well read (high impact) journals and use this as a proxy.

Journal Impact Factors (JIFs) are a standard measure reflecting the average number of citations to recent articles published in the journal. They are frequently used as proxies for the relative importance of a journal within its field, with journals with higher JIFs deemed to be more important than those with lower ones. JIFs are calculated annually, and for all scientific and medical journals they are based on the Journal Citation Report generated by Thomson ISI (Institute for Scientific Information). A collated list of scientific and medical JIFs is available at a cost, and so, JIFs for 2012 retrieved from an internet search (http://impactfactor.weebly.com) were used for this exercise.

The list of research papers published by Charing Cross and Chelsea & Westminster in 2011 and 2012 (the output to section 3.1.1) was used as the basis for this analysis. For each institution and year (e.g. Charing Cross, 2012), the number of papers published in a specified journal was multiplied by the JIF (2012) for that journal to give an individual quality/impact score. These individual quality/impact scores were added together to reach a final quality/impact score for each institution in that year. An overview of this calculation can be seen in figure 9.63 below.

Figure 9.63: Calculation of Quality/Impact score

For ease, only those research papers published in higher impact journals (JIF>5) were included in the analysis. This analysis was repeated for both institutions for 2011 and 2012 and the quality/impact scores for both institutions are outlined in section 3.2.2.

The volume of published research papers at each institution

A preliminary assessment of the number of research publications by institution is shown in Figure 9.64.
The data indicates that over the past three years:

- Hammersmith and St Mary’s hospitals have published more papers than either Charing Cross or Chelsea & Westminster hospitals.
- To date this year, Chelsea & Westminster have produced 18% more research papers than Charing Cross.
- Ealing and West Middlesex hospitals have published less research papers than the other institutions.

For the remainder of the analysis we have focused on Chelsea & Westminster and Charing Cross. We do not analyse Hammersmith any further because it is designated a specialist hospital under all the options being analysed in Stage 6. Ealing and West Middlesex are excluded from further analysis due to the small number of research publications. Finally St Mary’s is excluded because it was designated as a major hospital under all three consultation options.

The additional analysis focuses on clarifying the ‘quality’ of the research completed at both Charing Cross and Chelsea & Westminster hospitals to enable a direct comparison to be made, using the JIF factor as a proxy.

**Evaluating the quality/impact of research undertaken at each institution**

A proxy for the quality of the research undertaken by Charing Cross, and Chelsea & Westminster was determined by identifying the number of research papers published this year to date in medical journals with a JIF of over 5.

This year to date, Charing Cross and Chelsea & Westminster Hospitals have published 12 and 18 research publications respectively, in journals with a JIF>5. Factoring in actual JIFs for those publications (i.e. sum of the JIFs for the 12/18 publications) gives a score for Charing Cross of 133 and for Chelsea & Westminster of 174 (shown in Figure 9.65).
These findings together with those outlined in section 3.2, demonstrate that in 2011 and 2012 to date, Chelsea & Westminster publish a larger volume of research papers in journals with a higher impact factor (JIF).

**The implications of this analysis on the evaluation of research and education**

This additional analysis undertaken in response to feedback received during consultation supports the higher relative ranking of options that designate Chelsea & Westminster as a major hospital over those that designate Charing Cross as a major hospital.

This has the following impact on the evaluation of research and education, see Figure 9.66:

**Figure 9.66: The post consultation evaluation of support to current research and education delivery**

<table>
<thead>
<tr>
<th>Proposed Option</th>
<th>PCBC Evaluation</th>
<th>DMBC Evaluation</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Middlesex, Hammersmith, Chelsea &amp; Westminster</td>
<td>-</td>
<td>-</td>
<td>St Mary’s produces a substantial volume of research papers, therefore options where St Mary’s is not designated as a major hospital attract a lower ranking</td>
</tr>
<tr>
<td>Hammersmith, Chelsea &amp; Westminster, Northwick Park</td>
<td>-</td>
<td>-</td>
<td>Chelsea &amp; Westminster produces a higher volume of research with a higher impact factor, therefore options that designate Chelsea &amp; Westminster a major hospital are ranked higher</td>
</tr>
<tr>
<td>Hammersmith, Chelsea &amp; Westminster, Northwick Park</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Ealing, Hammersmith, Chelsea &amp; Westminster, Northwick Park</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Hammersmith, Chelsea &amp; Westminster, Northwick Park</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>West Middlesex, St Mary’s, Chelsea &amp; Westminster, Northwick Park</td>
<td>+</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>St Mary’s, Chelsea &amp; Westminster, Northwick Park</td>
<td>+</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>St Mary’s, Chelsea &amp; Westminster, Northwick Park</td>
<td>+</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td>St Mary’s, Chelsea &amp; Westminster, Northwick Park</td>
<td>+</td>
<td>++</td>
<td></td>
</tr>
</tbody>
</table>

Figure 9.65 Research Publication Quality/Impact scores by institution (2012)
We confirmed this decision with the Clinical Board and Programme Board during the post consultation phase. This evaluation is different from pre-consultation, but the relative ranking is the same.
9. Decision making analysis – stage 6 (Value for Money) and stage 7

This section describes the value for money component of Stage 6 and Stage 7 the sensitivity analysis.

9.10 Pre-consultation evaluation

The purpose of this criterion is to ascertain how options compare financially. As part of the pre-consultation work, a financial evaluation was undertaken and during post-consultation this evaluation has been updated.

The financial appraisal from pre-consultation assessed options over five sub-criteria:

1. Capital Costs
2. Transition Costs
3. Site viability
4. Total surplus / deficit

In the pre-consultation work the five sub-criteria contributed towards an overall evaluation of options under the ‘value for money’ heading. The same framework, method and approach has been applied as part of the post-consultation analysis, focussing on the three short-listed options.

As part of the development of the recommendation, we have updated the baseline data and undertaken more work on the impact on the estate and the requirements for capital. We also propose to place greater focus on the Net Present Value calculation, as set out later in this chapter.

As part of the development of the options for consultation the financial work entailed:

- Commissioner Strategic Plans including allocation and spend forecasts, and QIPP savings 2012/13 to 2014/15
- Out of hospital strategies for Clinical Commissioning Groups (CCGs) setting out their approach to delivering the QIPP plans, including estimates of the changes to activity and spending priorities proposed
- Trust ‘do nothing’ (i.e. current configuration) activity and income and expenditure (I&E) forecasts 2012/13 to 2014/15, including delivery of productivity savings (Cost Improvement Plans) and length of stay reductions
- Trust reconfiguration modeling under different options in terms of activity, capacity requirements, capital investment, capital receipts and I&E impact on site viability and total surplus or deficit
- An assessment of the costs of transition
- A comparison of the Net Present Value (NPV) of the potential reconfiguration options.

In the pre-consultation work, eight options were financially assessed against the five sub-criteria. The results are summarised in Figure 9.67.
The analysis concluded that options 5 and 6 were the only two options that have an overall positive evaluation, with Option 5 being the strongest. The only negative evaluation for Option 5 was given for transition costs. Option 6 received an additional negative evaluation for overall surplus/deficit. Options 5, 6, and 7 were evaluated positively for their Net Present Value.

Sensitivity testing was undertaken on the results of the evaluation. A total of 17 scenarios were tested and in all cases Option 5 (now Option A) was ranked first outright or in one case, joint first.

On the basis of this evaluation, along with that for the other criteria, **Options 5, 6 and 7 were taken forward and consulted on (as Options A, B and C respectively).**

9.11 **The approach used to undertake the assessment post-consultation**

To oversee the financial analyses the approach taken (as with the work undertaken pre-consultation) was to convene a group of all commissioner and provider Finance Directors, together with a patient representative and finance staff from NHS London.

This Finance and Business Planning (F&BP) group was tasked with overseeing the 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 also 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 group met approximately every two weeks from September 2012 to January 2013.
There were six distinct parts of the analysis:

- Commissioner forecasts including the allocation and forecast spend for all commissioning in NW London from 2012/13 to 2017/18
- QIPP analysis, including the planned savings (by acute/non-acute, and by ‘point of delivery’ within acute) and associated reinvestment over 3 (2015/16) and 5 (2017/18) years. This is based on high level assumptions reflecting the detailed plans in the out of hospital strategies, as agreed with Chief Financial Officers for the NWL CCGs. The year-by-year phasing of these plans have not been modelled, only the 3 and 5 year points. It is not possible to compare actual in year commissioner QIPP plans with these numbers, however over the 3 and 5 year time horizons the total should be consistent
- Trust activity, beds, income and expenditure forecasts in the ‘do nothing’ and 3 reconfiguration options for the nine acute sites in NW London: St. Mary’s, Charing Cross, Hammersmith (including Queen Charlotte’s), Chelsea & Westminster, West Middlesex, Ealing hospital (excluding community care services), Central Middlesex, Northwick Park & St. Mark’s (reported as one site), Hillingdon Hospital (does not include Mount Vernon)
- Estates plans and capital requirements for acute hospital sites to accommodate the reconfiguration changes
- Value for Money evaluation of three acute reconfiguration options, including sensitivity analysis
- Out of hospital estates and capital investment required to deliver the proposed changes.

The F&B group confirmed that the analyses use reasonable assumptions based on the best information available during the course of this work, and provides an assessment of the relative value of the reconfiguration options, and an overall assessment of the differential revenue and capital implications for commissioners and providers.

9.12 Commissioner forecasts

The commissioner model is based on PCT unified allocations and expenditure. From 2013/14 the split of commissioning responsibilities and allocations between CCGs, the National Commissioning Board, public health and others will come into force but is not expected to change the strategic intention of rebalancing acute and out of hospital services, nor the QIPP impact on acute Trusts and re-investment in OOH services modelled here. The impact of changes to overall allocation uplifts and QIPP delivery are both covered in sensitivity analyses.

The pre-consultation modelling has been updated over a 5-year period from 2012/13 to 2017/18. Key planning assumptions include:

- Allocation growth assumes closing Distance from Target with 2% ‘floor’ from 2014/15
- Spend growth in line with demographic and non-demographic trends (as per the pre-consultation modelling)
- Price changes, including tariff deflator (as per Monitor).

The work has tested these assumptions to ensure that the modelling is consistent with the latest (2011) Census, as shown in Figure 9.68.
Commissioners have the strategic intention to rebalance their spending from acute to out of hospital while maintaining a minimum 1% surplus over the next 5 years. To do so, commissioners plan £365 million net savings and £190 million investment, resulting in £555 million gross savings by 2017/18.

The gross QIPP of £555 million and the planned investment of £190 million are distributed across the eight CCGs as shown in Figure 9.69.

---

1 Source: Comparison of the 2010 sub-national population projections1 (SNPP) with 2011 Census-based projections.
This is a mid-year estimate produced by ONS based on the 2001 Census and “known” components of change in the intervening years, i.e. births, deaths, internal migration and estimates of net international migration. From this “known” base year ONS then project.
Figure 9.69: 5 year gross savings, investment and net savings breakdown by PCT

12/13 to 17/18, £m

<table>
<thead>
<tr>
<th></th>
<th>Gross QIPP savings</th>
<th>Investments</th>
<th>Net QIPP savings</th>
<th>Average net QIPP as % of annual allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brent</td>
<td>-74</td>
<td>30</td>
<td>-44</td>
<td>1.5%</td>
</tr>
<tr>
<td>Harrow</td>
<td>-91</td>
<td>30</td>
<td>-61</td>
<td>3.4%</td>
</tr>
<tr>
<td>Ealing</td>
<td>-88</td>
<td>31</td>
<td>-57</td>
<td>1.8%</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>-83</td>
<td>28</td>
<td>-55</td>
<td>2.6%</td>
</tr>
<tr>
<td>Hounslow</td>
<td>-64</td>
<td>23</td>
<td>-42</td>
<td>1.9%</td>
</tr>
<tr>
<td>H&amp;F</td>
<td>-57</td>
<td>17</td>
<td>-40</td>
<td>2.1%</td>
</tr>
<tr>
<td>K&amp;C</td>
<td>-50</td>
<td>15</td>
<td>-35</td>
<td>1.8%</td>
</tr>
<tr>
<td>Westminster</td>
<td>-49</td>
<td>16</td>
<td>-33</td>
<td>1.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>-555</strong></td>
<td><strong>190</strong></td>
<td><strong>-365</strong></td>
<td><strong>2.0%</strong></td>
</tr>
</tbody>
</table>

£344 million (62%) of gross savings are planned to come from the acute sector as shown in Figure 9.70.

Figure 9.70: 62% of gross savings are planned to come from the acute sector

The breakdown of this by Point Of Delivery (POD) is shown in the Figure 9.71.

2 Total 5 year net QIPP saving divided by 5, as percentage of 2012 total allocation (recurrent and non-recurrent)
3 Source: NWL Commissioner forecast model
Commissioner forecast assumptions and plans developed for modelling purposes based on extrapolation from existing out of hospital plans. High level findings agreed with CCG finance leads as representing the best available estimates at the time of the analysis
1. 'Other' savings cover a range of initiatives not analysed by setting
Figure 9.71: Breakdown of 5 year gross acute QIPP savings by POD

£m

<table>
<thead>
<tr>
<th>Gross acute savings by POD</th>
<th>Investments to deliver savings by POD</th>
<th>Net saving to commissioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>145</td>
<td>67</td>
</tr>
<tr>
<td>Non elective</td>
<td>134</td>
<td>40</td>
</tr>
<tr>
<td>Elective</td>
<td>23</td>
<td>7</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>18</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>24</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>344</td>
<td>126</td>
</tr>
</tbody>
</table>

The breakdown of the £344 million gross savings by Trust and POD is shown in Figure 9.72.

Figure 9.72: Breakdown of 5 year gross acute QIPP savings by POD and site

£m, %

<table>
<thead>
<tr>
<th>Gross QIPP by Trust and POD 12/13 to 17/18</th>
<th>Percent of 12/13 income</th>
<th>Demand growth (% of 12/13 income)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-elective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A&amp;E</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imperial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chelsea &amp; Westminster</td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Middlesex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ealing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North West London Hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hillingdon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (incl. outsides NWL)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total from NWL commissioners only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total acute QIPP for NWL commissioners</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The overall effect of the commissioning modelling used post-consultation is summarised in the Figure 9.73.

---

4 Source: NWL Commissioner forecast model
Note: Commissioner forecast assumptions and plans developed for modelling purposes based on extrapolation from existing OOH plans. High level findings agreed with CCG finance leads as representing the best available estimates at the time of the analysis

5 Source: NWL Commissioner forecast model
1. QIPP from outside NWL assumed to be proportional to income from outside NWL, except Imperial where no QIPP was assumed for non-London income due to specialist nature of the work
**Figure 9.73: Commissioners intend to rebalance spending from acute to non-acute while maintaining 1% surplus over the next 5 years**

Commissioner I&E bridge 12/13 to 17/18

<table>
<thead>
<tr>
<th>12/13 spend</th>
<th>Activity growth</th>
<th>Change in price</th>
<th>Gross QIPP</th>
<th>Investment</th>
<th>Non-healthcare spend change</th>
<th>17/18 spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>3,694</td>
<td>253 (7%)</td>
<td>363</td>
<td>307</td>
<td>-33</td>
<td>-58</td>
<td>3,025</td>
</tr>
<tr>
<td>1,864</td>
<td>253 (50%)</td>
<td></td>
<td></td>
<td>-33</td>
<td>+211</td>
<td>1,482</td>
</tr>
<tr>
<td>1,577</td>
<td>253 (43%)</td>
<td></td>
<td></td>
<td>-33</td>
<td>-41</td>
<td></td>
</tr>
</tbody>
</table>

9.13 Acute Trusts

9.13.1 Overall approach

The approach has been to use the current position regarding the income and expenditure (I&E) of acute trust sites in NW London and model the impact of the changes on the activity, beds and overall financial position of those sites:

- 12/13 income and expenditure forecast forward five years to 17/18:
  - Income changes based on commissioner spend on acute services, including demand growth, tariff deflator and QIPP
  - Cost changes based on changes in activity volumes, cost inflation, and productivity savings (CIP)

- 12/13 activity and occupied beds forecast forward three years to 15/16:
  - Activity and beds are based on 3 year forecasts and not extended to 5 years as a prudent assumption

---

6 Source: NWL Commissioner forecast model

Commissioner forecast assumptions and plans developed for modeling purposes based on extrapolation from existing out of hospital plans. High level findings agreed with CCG finance leads as representing the best available estimates at the time of the analysis:

1. Commissioner model based on PCT unified allocations/expenditure. From 2013/14 the split of commissioning responsibilities and allocations between CCGs/NCB/PHE, etc., is not expected to change the strategic intention of rebalancing acute and out of hospital services, nor the QIPP impact on acute Trusts and re-investment in out of hospital services modelled here

2. The £190m covers reprovision of all QIPP, as well as the £0.5m recurrent spend required to fund the 10 additional paramedics for the London Ambulance Service; For modelling purposes, none of this investment is assumed within acute Trusts income

3. Surplus is carried forward but not included in the spend

4. Trusts I&E models include acute and Trust –specific proportion of specialist commissioning
9d. Decision making analysis stage 6 and stage 7

- 15% length of stay reduction partially offset through 5% additional ‘headroom’ – the headroom effectively serves to reduce current Trust occupancy level by 5%.

9.13.2 Financial Outlook in the ‘Pre-Reconfiguration’ scenario

Key planning assumptions include inflation at 2.7% in 2013/14 and 2014/15 and 4% thereafter, improvements in the Average Length of Stay (assumed at 15%) and productivity improvements (based on the opportunity at each Trust, ranging from 4% per annum to 5.4% per annum). In addition a downside was run with an additional 1% cost inflation and only 90% of efficiencies delivered. This resulted in five sites in deficit in the base case, and all bar Charing Cross in the downside. The overall impact in the base case is a zero surplus and in the downside a deficit of £89 million per annum (Figure 9.74).

Figure 9.74: I&E base case pre-reconfiguration, forecasted 17/18 and downside forecast 17/18

The baseline for Trusts in terms of the numbers of beds has also been updated. Trusts provided details of their current beds in terms of those beds available and those occupied – the difference being those available to be opened but effectively mothballed at this present time. Modelling this for the reductions to required beds that would occur as a result of the impact of QIPP and the reductions to the length of stay, we have calculated that under the ‘Do Nothing’ scenario, we would have a surplus of 930 beds, as shown in Figure 9.75.

---

7 Source: Trusts, reconfiguration modelling
1. Downside includes base case assumptions, with additional 1%pt cost inflation until 14/15 and Trust achieve only 90% of planned efficiency savings prior to mitigation
2. Only includes acute business for the specific site – i.e. excludes community services and services at sites not specifically listed (e.g. Mount Vernon)
### Figure 9.75: Beds bridge: 2012/13 to 2015/16

#### Total adult, CC, maternity & paediatrics beds (excludes mothballed)

<table>
<thead>
<tr>
<th>Site</th>
<th>Available beds</th>
<th>Required beds</th>
<th>Bed capacity surplus</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total available(^1) beds (incl. mothballed)</td>
<td>Current used beds 2012/13</td>
<td>Change due to demand &amp; commissioner strategy</td>
</tr>
<tr>
<td>St Mary's</td>
<td>418</td>
<td>418</td>
<td>-16</td>
</tr>
<tr>
<td>Hammersmith</td>
<td>373</td>
<td>373</td>
<td>-4</td>
</tr>
<tr>
<td>Charing Cross</td>
<td>443</td>
<td>443</td>
<td>-25</td>
</tr>
<tr>
<td>Chelsea &amp; Westminster</td>
<td>559</td>
<td>498</td>
<td>-27</td>
</tr>
<tr>
<td>West Middlesex</td>
<td>442</td>
<td>420</td>
<td>-56</td>
</tr>
<tr>
<td>Ealing</td>
<td>373</td>
<td>312</td>
<td>-31</td>
</tr>
<tr>
<td>Central Middlesex</td>
<td>235</td>
<td>197</td>
<td>-19</td>
</tr>
<tr>
<td>Northwick &amp; St. Mark's</td>
<td>739</td>
<td>739</td>
<td>-71</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>508</td>
<td>508</td>
<td>-97</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,090</strong></td>
<td><strong>3,908</strong></td>
<td><strong>-345</strong></td>
</tr>
</tbody>
</table>

This analysis focuses on the number of beds ‘required’ based on activity, length of stay and headroom. However, the actual number of beds at the site under reconfiguration options may be higher due to retaining more surplus beds – see reconfiguration options for specific details.

### 9.13.3 Modelling the impact of reconfiguration

The approach to the analysis is to focus on the three options that were consulted on. The assessment covers five criteria as set in Figure 9.76.

---

\(^8\) Source: Trust submissions 2012; Base case “base case” forecast model

1. Includes - Adult general and acute, adult day case, critical care, pediatric and maternity; Excludes – Rehabilitation and other beds, and neonatal cots
2. Net reduction in beds of 10% due to improved bed utilisation, modeled as an average length of stay reduction of 15% by 15/16 and a 5% head room for seasonal variations, above current occupancy
3. Only includes acute business for the specific site – i.e. excludes community services and services at sites not specifically listed (e.g. Mount Vernon).
Figure 9.76: Value for Money evaluation criteria for acute reconfiguration

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Notes</th>
<th>Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Capital costs</td>
<td>▪ Up front capital required to implement acute reconfiguration</td>
<td>▪ Cost of backlog maintenance/ major hospitals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Cost of changes at major hospitals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Cost of new local hospitals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Net receipts from selling land</td>
</tr>
<tr>
<td>ii. Transition costs</td>
<td>▪ One off costs (excluding capital build and receipts) to implement changes</td>
<td>▪ Double running (staff)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Redundancy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Training</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Excess travel</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Double running (estate)</td>
</tr>
<tr>
<td>iii. Site viability</td>
<td>▪ Assessment of the ongoing viability of individual hospital sites</td>
<td>▪ Financial gap for all sites to achieve at least 1%3 annual net surplus after reconfiguration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Number of sites below 1% surplus</td>
</tr>
<tr>
<td>iv. Total surplus/ deficit</td>
<td>▪ Total surpluses generated across the acute providers within North West London</td>
<td>▪ Sum of the annual surplus / deficits across the 9 NWL sites after reconfiguration</td>
</tr>
<tr>
<td>v. Net present value</td>
<td>▪ Total value of each option incorporating future capital and revenue implications and compared on like-for-like basis</td>
<td>▪ Up front capital investment and receipts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Ongoing cost to operate and replace new assets</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Benefits from consolidation and reduction in fixed costs</td>
</tr>
</tbody>
</table>

The assessment metrics used in both the modelling pre-consultation and post-consultation are set out in Figure 9.77.

Figure 9.77: Overview of the Value for Money scoring

<table>
<thead>
<tr>
<th>Major hospitals</th>
<th>++</th>
<th>-</th>
<th>--</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Capital cost to the system</td>
<td>Capital cost same as ‘do nothing’ or less</td>
<td>Capital cost less than £100m above ‘do nothing’</td>
<td>Capital cost between £110m-£200m above ‘do nothing’</td>
</tr>
<tr>
<td>ii. Transition costs</td>
<td>NA</td>
<td>NA</td>
<td>F&amp;BP judgment for relatively lower costs (&lt;£65m)</td>
</tr>
<tr>
<td>iii. Site viability</td>
<td>All sites are within £1m of 1% surplus</td>
<td>The gap to bring all sites to 1% surplus is less than £20m, and Fewer than 3 sites are below 1%</td>
<td>The gap to bring all sites to 1% surplus is between £20m - £30m, and Fewer than 3 site are below 1%</td>
</tr>
<tr>
<td>iv. Surplus for acute sector</td>
<td>Net surplus as percent of income more than 3%</td>
<td>Net surplus as percent of income between 2-9%</td>
<td>Net surplus as percent of income between 1-2%</td>
</tr>
<tr>
<td>v. Net present value</td>
<td>NPV more than £200m above ‘do nothing’ scenario</td>
<td>NPV £101m-£200m above ‘do nothing’ scenario</td>
<td>NPV £0m-£100m above ‘do nothing’ scenario</td>
</tr>
</tbody>
</table>

Notes from Figure 9.76:
1. NPV is calculated on future cash flows over 20 years discounted at 3.5% per annum. The decision to assess NPV over 20 years is a matter of judgement, and was selected by the F&B board to strike a balance between accounting for the ongoing benefits post-reconfiguration, while not giving undue weighting to the long term forecasts that are necessarily less accurate (which may be the case with a longer period.) Note that the out of hospital investment is assumed to be the same in the ‘do nothing’ scenario and all reconfiguration options, so is excluded from the NPV calculations comparing the acute reconfiguration options.
2. Evaluation focuses on acute business only – excludes non-acute parts of Trusts (e.g. Ealing CHS)
3. Assessment against ‘1% net surplus’ has been used as the minimum requirement. However, for ongoing viability as a Foundation Trust, hospitals would require higher surpluses.

Sites are deemed to be ‘below 1%’ if they are more than £1m below 1%
The key modelling assumptions applied during the pre consultation phase have also been used in the post consultation analysis. For example, the approach to how variable, semi-variable and fixed costs change through the reconfiguration. The detailed assumptions are modelled in Appendix N.

The effect on activity of the changes to patient flows that would occur under the options is then modelled in terms of the impact on beds. The bed requirements drive the need for capital to create new estate solutions to both acute hospitals and local hospitals. The bed requirements under each option along with the total number of new beds required is shown in Figure 9.78.

Figure 9.78: Revised bed requirement under Options A, B and C

<table>
<thead>
<tr>
<th>Site</th>
<th>12/13</th>
<th>Option A</th>
<th>Option B</th>
<th>Option C</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Mary's</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hammersmith</td>
<td>418</td>
<td>479</td>
<td>427</td>
<td>498</td>
</tr>
<tr>
<td>Charing Cross</td>
<td>373</td>
<td>386</td>
<td>383</td>
<td>381</td>
</tr>
<tr>
<td>Chelsea &amp; Westminster</td>
<td>559</td>
<td>572</td>
<td>556</td>
<td>537</td>
</tr>
<tr>
<td>West Middlesex</td>
<td>442</td>
<td>474</td>
<td>443</td>
<td>421</td>
</tr>
<tr>
<td>Ealing</td>
<td>373</td>
<td>373</td>
<td>373</td>
<td>421</td>
</tr>
<tr>
<td>Central Middlesex</td>
<td>235</td>
<td>73</td>
<td>60</td>
<td>71</td>
</tr>
<tr>
<td>Northwick Park &amp; St. Mark’s</td>
<td>799</td>
<td>730</td>
<td>730</td>
<td>685</td>
</tr>
<tr>
<td>Hillingdon Hospital</td>
<td>508</td>
<td>417</td>
<td>417</td>
<td>382</td>
</tr>
<tr>
<td>Flow outside NWL</td>
<td></td>
<td>30</td>
<td>145</td>
<td>127</td>
</tr>
<tr>
<td>Total</td>
<td>4,090</td>
<td>3,160</td>
<td>3,160</td>
<td>3,160</td>
</tr>
</tbody>
</table>

### Value for money: Capital cost to the system

#### 9.13.4 Capital Investment

Capital investment estimates have been assessed in accordance with NHS capital guidance for the development of a Strategic Outline Case. The technical definition adopted was ‘do minimum’ which defines the lowest capital cost to deliver the agreed solution. This approach has been overseen by the F&BP group and a sub-group of all Estate Directors of acute Trusts. The principles followed were as follows:

- Add capacity and/or reconfigure current facilities to accommodate the changes in activity due to the reconfiguration

11 Source: North West London reconfiguration
1. Difference between available and used beds is the number of mothballed beds
2. Includes mothballed capacity
3. Dispose EMS beds currently in EMS ward
4. New build at bed activity (e.g., cannot re-purpose mothballed paed's beds for adults); 4 Totals subject to rounding errors
- Build new Local Hospital facilities
- Dispose of estate when changing the site to a Local Hospital (net receipts from disposal)
- Cover high risk and significant risk backlog maintenance (this is included because backlog maintenance is assumed to be one off additional spend over and above the ongoing programmes to replace assets and the requirement differentiates the options as it is not required for sites becoming Local Hospitals).

The capital estimates for Options B and C were derived from the extensive work done on Option A by pro-rating costs and values as appropriate, except for Ealing under Option C and Charing Cross under Option B where an estimated range was provided by the estate advisors.

In options where Imperial College is impacted by changes (Charing Cross in Option A and C, and Chelsea and Westminster in Option B), a capital cost equivalent to the estimated NHS contribution to relocating the College in acute premises has been included (this excludes additional potential NHS capital contributions to provide teaching space in out of hospital hubs and GP practices). This amounts to £35 million in Options A and C and £18 million in Option B.

Based on consultation feedback for Trusts impacted, capital has been estimated for activity flowing out of NW London sector. Estimates of activity flows were used to estimate the requirement for new beds and the feedback from Trusts from out of sector who responded to the consultation was applied to assess the cost.

Land and capital receipts have been estimated on the basis of market value assuming planning permission for residential use. To be prudent, an additional 20% risk adjustment discount has been applied.

With these planning assumptions, revised capital estimates have been assessed for the three shortlisted options as set out in Figure 9.79.
Figure 9.79: DMBC NHS net capital estimates for Options A, B and C\textsuperscript{12}

<table>
<thead>
<tr>
<th>Site\textsuperscript{a}</th>
<th>Do nothing</th>
<th>DMBC option A</th>
<th>DMBC option B\textsuperscript{1}</th>
<th>DMBC option C\textsuperscript{1}</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Backlog maintenance</td>
<td>Required new investment</td>
<td>Net land receipt</td>
<td>Net total capital spend</td>
</tr>
<tr>
<td>Ealing</td>
<td>6</td>
<td>0</td>
<td>19</td>
<td>-21</td>
</tr>
<tr>
<td>Charing Cross</td>
<td>8</td>
<td>0</td>
<td>15\textsuperscript{i}</td>
<td>-136</td>
</tr>
<tr>
<td>Central Middlesex</td>
<td>0</td>
<td>0</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>Chelsea &amp; Westminster</td>
<td>1</td>
<td>1</td>
<td>26</td>
<td>0</td>
</tr>
<tr>
<td>Northwick park</td>
<td>28</td>
<td>28</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>and St. Mark’s</td>
<td>West Middlesex</td>
<td>1</td>
<td>1</td>
<td>22</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>19\textsuperscript{i}</td>
<td>17</td>
<td>17\textsuperscript{i,3}</td>
<td>0</td>
</tr>
<tr>
<td>Hammersmith</td>
<td>2</td>
<td>2</td>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td>St Mary’s</td>
<td>3</td>
<td>3</td>
<td>132\textsuperscript{i}</td>
<td>-10</td>
</tr>
<tr>
<td>NHS contribution to Imperial College\textsuperscript{e}</td>
<td>-</td>
<td>-</td>
<td>35</td>
<td>-</td>
</tr>
<tr>
<td>Out of sector</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>69</td>
<td>52</td>
<td>320</td>
<td>-167</td>
</tr>
</tbody>
</table>

\textsuperscript{12} Source: Trusts, reconfiguration modelling, DJD
1. Excludes cost of college reprovision
2. Land receipt across all options include £10m from Western Eye
3. Options B and C estimated at a lesser level of granularity than option A
4. Only includes acute business for the specific site – i.e., excludes community services and services at sites not specifically listed (e.g., Mount Vernon)
5. Median of estimated range £32-46m
6. High range of estimated range £95-111m given feedback of higher cost to create a new NICU/PICU on a site that does not currently have maternity nor paediatrics
7. Includes £14m rehousing pathology labs currently at Charing Cross
8. Estimated NHS contribution to relocating the College in acute premises; excludes additional potential NHS capital contributions to provide teaching space in OOH hubs and GP practices
9. Subject to revised condition survey report to be published end of 12/13; 10 Includes £2.4m of MRI equipment for which I&E impact is assumed to replace current cost of service outsourcing
Under the ‘do nothing’ scenario the capital costs would be £69 million. All options are compared with this baseline as part of the value for money assessment.

The table below (Figure 9.80) shows that all 3 options evaluated in the post-consultation phase have been given a lower evaluation score than at the pre-consultation phase due to the increased costs of implementing the estate solutions.

Figure 9.80: Capital cost to the system evaluation and rating

3

Value for money: Transition costs

9.13.5 Impact of the Changes – Transitional Costs

Transitional costs were considered as those costs that will occur as services transfer. The Finance and Business Planning Group considered five dimensions, as set out in Figure 9.81.

---

13 Source: Trusts, reconfiguration modelling, DJD

1. Evaluation: ‘do nothing’ or less (++); <=£100m from ‘do nothing’ (+); £101m-£200m from DN (+); >£200m from DN (--) 
2. High and significant risk backlog maintenance
Although this is a more detailed methodology, the evaluation assessment remains unchanged from pre-consultation, as summarised in Figure 9.82.

### Figure 9.82: Evaluation of transition costs

<table>
<thead>
<tr>
<th>Option</th>
<th>Major hospitals</th>
<th>Double Running (staff)</th>
<th>Redundancy estimate</th>
<th>Training costs</th>
<th>Excess travel costs</th>
<th>Double Running (estate)</th>
<th>Total £m</th>
<th>VfM evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>West Middlesex, St Mary's, Chelsea &amp; Westminster, Northwick Park &amp; St Mark's, Hillingdon</td>
<td>10</td>
<td>15</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>18</td>
<td>-53 (−)</td>
</tr>
<tr>
<td>B</td>
<td>West Middlesex, St Mary's, Charing Cross, Northwick Park &amp; St Mark's, Hillingdon</td>
<td>11</td>
<td>16</td>
<td>5</td>
<td>5</td>
<td>22</td>
<td>−58 (−)</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Ealing, St Mary's, Chelsea &amp; Westminster, Northwick Park &amp; St Mark's, Hillingdon</td>
<td>10</td>
<td>15</td>
<td>4</td>
<td>4</td>
<td>22</td>
<td>−55 (−)</td>
<td></td>
</tr>
</tbody>
</table>

**Evaluation**
- Revised transition costs are approximately £10m more for each option than in the PCBC
- Options A, B and C have comparable levels of transition costs, so methodology is to evaluate each option against this criteria, as in the PCBC

---

**Notes from Figure 9.81:**
1. ‘Staff impacted’ is the proportion of staff working in services moving from one site to another. This is estimated based on assumptions on pay cost by service line
2. WAAP – Weighted average annual pay for staff members at the hospital. Double Running (staff) includes consultant pay, other elements exclude consultant pay
3. Fixed costs include establishment, premises and fixed plant, depreciation and PDC, estimated at 10% of costs for all sites except for PFI sites where it is estimated at 15% of costs

14 Notes from Figure 9.81:
1. ‘Staff impacted’ is the proportion of staff working in services moving from one site to another. This is estimated based on assumptions on pay cost by service line
2. WAAP – Weighted average annual pay for staff members at the hospital. Double Running (staff) includes consultant pay, other elements exclude consultant pay
3. Fixed costs include establishment, premises and fixed plant, depreciation and PDC, estimated at 10% of costs for all sites except for PFI sites where it is estimated at 15% of costs

15 Reconfiguration modelling
9.13.6 Impact of the Changes – site viability

The financial impact of the changes to sites has been assessed by considering the key drivers to costs. These changes are summarised in Figure 9.83.

Figure 9.83: Drivers of change in Income and Expenditure due to reconfiguration options

<table>
<thead>
<tr>
<th>Components</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay cost changes</td>
<td></td>
</tr>
<tr>
<td>Consolidation savings</td>
<td>Efficiency gains through consolidating clinical services and reducing duplication</td>
</tr>
<tr>
<td>Meet service standards through consolidation</td>
<td>Moving from 9 to 5 Major acute sites and consolidating teams allows for full consultant cover to be provided with current staffing levels, which would otherwise require an increase in the numbers across the current sites. This is reflected in conservative assumption for consolidation savings</td>
</tr>
<tr>
<td>Fixed cost changes</td>
<td></td>
</tr>
<tr>
<td>Net change due to local hospitals</td>
<td>Net reduction in fixed costs when current sites are replaced by Local Hospital. These are assumed to have lower costs due to reduced footprint and removal of support services and equipment that would be required on an acute site</td>
</tr>
<tr>
<td>Operating costs and depreciation on new assets</td>
<td>Additional premises and other fixed costs (e.g. depreciation) for the increased capacity at those Major Hospital sites that increase under the reconfiguration option</td>
</tr>
<tr>
<td>Avoid backlog maintenance</td>
<td>Avoid backlog maintenance on sites that become new Local Hospitals as these are assumed to be major refurbishments or new builds, with the fixed costs included in the relevant fixed cost driver</td>
</tr>
<tr>
<td>Other effects</td>
<td></td>
</tr>
<tr>
<td>Flows out of NWL – loss of contribution margin</td>
<td>Flows out of sector for activity that is currently provided by NWL hospitals leading to loss of contribution margin on the activity for the NWL Trusts</td>
</tr>
<tr>
<td>Income change due to MFF differences</td>
<td>Differences in MFF for the Trusts leading to increase/decrease in MFF payments in the sector</td>
</tr>
</tbody>
</table>

Using this methodology the surplus or deficit for each site that would occur under each option has been assessed and compared with the ‘do nothing’. The outcome is summarised in Figure 9.84.
Figure 9.84: Summary of net surplus at site level in 2017/18\(^{16}\)

<table>
<thead>
<tr>
<th>Site</th>
<th>Income (I)</th>
<th>Cost (C)</th>
<th>Net Surplus / Deficit (S/D)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do nothing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I</td>
<td>C</td>
<td>S/D</td>
</tr>
<tr>
<td>St Mary's</td>
<td>326</td>
<td>320</td>
<td>-6</td>
</tr>
<tr>
<td>Hammersmith</td>
<td>327</td>
<td>325</td>
<td>2</td>
</tr>
<tr>
<td>Charing Cross</td>
<td>245</td>
<td>231</td>
<td>-14</td>
</tr>
<tr>
<td>Chelsea &amp; Westminster</td>
<td>332</td>
<td>323</td>
<td>8</td>
</tr>
<tr>
<td>West Middlesex</td>
<td>122</td>
<td>130</td>
<td>-8</td>
</tr>
<tr>
<td>Ealing</td>
<td>110</td>
<td>111</td>
<td>-1</td>
</tr>
<tr>
<td>Central Middlesex</td>
<td>65</td>
<td>76</td>
<td>-10</td>
</tr>
<tr>
<td>Northwick Park &amp; St. Mark’s</td>
<td>247</td>
<td>255</td>
<td>-8</td>
</tr>
<tr>
<td>Hillingdon(^{1})</td>
<td>135</td>
<td>140</td>
<td>-4</td>
</tr>
<tr>
<td>NWL Total(^{2})</td>
<td>1,910</td>
<td>1,910</td>
<td>0</td>
</tr>
</tbody>
</table>

Options A and C evaluation results are as per pre-consultation. Option B evaluation has reduced. This results in the evaluation for site viability as shown in Figure 9.85.

Figure 9.85: Evaluation of site viability\(^{17}\)

<table>
<thead>
<tr>
<th>Options</th>
<th>Major hospitals</th>
<th>Gap to get all sites to 1% net surplus, £m</th>
<th># Sites below 1% net surplus(^3)</th>
<th>VFM evaluation(^2), (not used for evaluation)</th>
<th># Trusts below 1% net surplus based on current organisations(^3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>West Middlesex, St Mary’s, Chelsea &amp; Westminster, Northwick Park &amp; St. Mark’s, Hillingdon</td>
<td>14</td>
<td>2</td>
<td>Central Mid, Northwick Park (+)</td>
<td>1 NWL Hospitals</td>
</tr>
<tr>
<td>B</td>
<td>West Middlesex, St Mary’s, Charing Cross, Northwick Park &amp; St. Mark’s, Hillingdon</td>
<td>15</td>
<td>3</td>
<td>West Middlesex, Central Mid, Northwick Park (-)</td>
<td>2 NWL Hospitals, West Middlesex</td>
</tr>
<tr>
<td>C</td>
<td>Ealing, St Mary’s, Chelsea &amp; Westminster, Northwick Park &amp; St. Mark’s, Hillingdon</td>
<td>35</td>
<td>4</td>
<td>West Middlesex, Central Mid, Northwick Park, Hillingdon (-)</td>
<td>3 NWL Hospitals, West Middlesex, Hillingdon</td>
</tr>
<tr>
<td>Do nothing</td>
<td></td>
<td>39</td>
<td>5</td>
<td>West Middlesex, Ealing, Central Middlesex, Northwick Park, Hillingdon (-)</td>
<td>4 West Middlesex, Ealing, North West London Hospitals, Hillingdon</td>
</tr>
</tbody>
</table>

\(^{16}\) Source: Trusts, Reconfiguration modelling
1. Hillingdon hospital site only – does not include Mt Vernon
2. Difference in total income in Options A, B and C compared to do nothing scenario due to additional effect of (i) activity flowing out of sector, (ii) differences in MFF for each Trust and (iii) income going to UCC providers.

\(^{17}\) Source: Reconfiguration modelling
1. Forecast surpluses in 2017/18 after all reconfiguration changes have taken place and transition costs and income loss occurred in previous years.
2. £30m subsidy or >=3 sites requiring subsidy (- -); £20m-£30m and <3 sites (-); £20m and >=1 sites (+); all sites >1% (+ +)
3. Only sites and Trusts with forecast deficits of £1m+ less than 1% are counted, due to margin of error. The assessment against 1% net surplus has been used as the minimum requirement, however for on-going viability as a Foundation Trust, hospitals would require higher surpluses.
This analysis leaves Northwick Park in surplus but below the target 1% surplus in Options A and B (in deficit in option C). Central Middlesex would be in deficit at £11 million for all three options. All other Trusts achieve the 1% surplus although the result for Hillingdon (not including Mount Vernon) is marginal.

Further work will be undertaken in respect of Northwick Park and Central Middlesex.

For Northwick Park:

- The base modelling assumes 5.4% per annum productivity savings for the 5 years to 2017/18. This results in £1 million net surplus, below the £3 million required to achieve 1% surplus
- However, further work with NWLH Trust indicates additional savings opportunities, potentially increasing up to 5.6% per annum to 2017/18. If the Trust were to deliver this higher productivity gain, it would reach a surplus of approximately £3 million, achieving 1% surplus.

For Central Middlesex Hospital, under all scenarios it fails to reach the threshold for financial viability. This was also true at the time of the pre consultation phase. We will develop a plan by autumn 2013 to address this.

The key reason for this is a long term Private Finance Initiative (PFI) contract that cannot be flexed as activity patterns change. This is not related to Shaping a healthier future, but is a part of the longer term issues with the site. All reconfiguration options that increase the range of acute services provided at the site, add capital cost that would be needed to allow the site to provide those additional acute services, and so there are acute reconfiguration options that address the fundamental issue with financial viability.

Further work should consider the options for additional services on the site, including:

- Primary and community hub activities
- Further elective non-complex activity
- Rehabilitation beds
- Mental Health beds.

These options will continue to be investigated to find a viable long-term clinical and financial strategy.

This further work will need to be consistent with any decision of the JCPCT, consider clinical and financial sustainability, involve relevant stakeholders, and assess the capital requirements to implement the service changes. We would expect further work to be undertaken over the next approximate six months.

### 3 Value for money: Surplus for acute sector

#### 9.13.7 Impact of the Changes – Trust Surplus

As shown above the total surplus calculated is £42 million per annum for Option A, £26 million for Option B and £25 million for Option C. This annual surplus generates the following evaluation score, as shown in Figure 9.86.
Figure 9.86: Evaluation of total surplus / deficit across NW London providers

<table>
<thead>
<tr>
<th>Options</th>
<th>Major hospitals</th>
<th>Total annual surplus/ deficit across NWL acute sites, £m</th>
<th>Percent of income, %</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>G</td>
<td>West Middlesex</td>
<td>42</td>
<td>2.2%</td>
<td>(+)</td>
</tr>
<tr>
<td></td>
<td>St Mary’s</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chelsea &amp; Westminster</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Northwick Park &amp; St. Mark’s</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hillingdon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>West Middlesex</td>
<td>26</td>
<td>1.5%</td>
<td>(-)</td>
</tr>
<tr>
<td></td>
<td>St Mary’s</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Charing Cross</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Northwick Park &amp; St. Mark’s</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hillingdon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>Ealing</td>
<td>25</td>
<td>1.3%</td>
<td>(-)</td>
</tr>
<tr>
<td></td>
<td>St Mary’s</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chelsea &amp; Westminster</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Northwick Park &amp; St. Mark’s</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hillingdon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do nothing</td>
<td></td>
<td>0</td>
<td>0.0%</td>
<td></td>
</tr>
</tbody>
</table>

The evaluations are unchanged from pre-consultation.

3 Value for money: Net Present Value

9.13.8 Impact of the Changes – Net Present Value

The Net Present Value brings together capital and revenue changes into an overall measure. All NPV values are lower than pre-consultation and the evaluation scoring reflects this.

Figure 9.87 shows the calculation of the NPV and the evaluation scoring attributed.

---

18 Source: Reconfiguration modelling
1. Forecast surpluses in 2017/18 after all reconfiguration changes have taken place and transition costs and income loss occurred in previous years
2. Scores determined based on net surplus as percent of income: <1% (- -); 1-2% (-); 2-3% (+); >3% (++)
**Figure 9.87: Evaluation of Net Present Value**

Net present value (£m), absolute and relative to ‘do nothing’

<table>
<thead>
<tr>
<th>Option</th>
<th>Major hospitals</th>
<th>Investment and costs</th>
<th>Benefits</th>
<th>NPV</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>West Middlesex</td>
<td>-222</td>
<td>135</td>
<td>17</td>
<td>(+)</td>
</tr>
<tr>
<td></td>
<td>St Mary’s</td>
<td>-31</td>
<td>132</td>
<td>114</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chelsea &amp;</td>
<td>-49</td>
<td>384</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Westminster</td>
<td>-47</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Northwick Park &amp; St Mark’s</td>
<td>-232</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hillingdon</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>West Middlesex</td>
<td>-288</td>
<td>166</td>
<td>-74</td>
<td>(-)</td>
</tr>
<tr>
<td></td>
<td>St Mary’s</td>
<td>-49</td>
<td>190</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Charing Cross</td>
<td>-16</td>
<td>466</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Northwick Park &amp; St Mark’s</td>
<td>-297</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hillingdon</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Ealing</td>
<td>-273</td>
<td>120</td>
<td>-266</td>
<td>(--)</td>
</tr>
<tr>
<td></td>
<td>St Mary’s</td>
<td>-13</td>
<td>269</td>
<td>-170</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chelsea &amp;</td>
<td>-31</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Westminster</td>
<td>-55</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Northwick Park &amp; St Mark’s</td>
<td>-49</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hillingdon</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do Nothing</td>
<td></td>
<td></td>
<td>-96</td>
<td></td>
</tr>
</tbody>
</table>

- Net present value is calculated over 20 years (2012/13 to 31/32) at 3.5% discount and no terminal value, and values are reported relative to the NPV of the ‘do nothing’ scenario. The decision to assess NPV over 20 years is a matter of judgement, and was selected by the F&B board to strike a balance between accounting for the ongoing benefits post-reconfiguration, while not giving undue weighting to the long term forecasts that are necessarily less accurate (which may be the case with a longer period.) The sensitivity analyses look at the relative impact on the NPV for the options if this timeframe were extended to 60 years.
- ‘Do nothing’ scenario includes backlog maintenance and the ongoing capex to maintain these increased assets.
- Evaluation ratings based on £100m increments between above the ‘do nothing’ scenario: <£0m (-); £0m-£100m (-); £101m-£200m (+); >£200m (++)

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19 Source: Reconfiguration modelling
1. NPV calculation on cash flows for capital investment and receipts based on implementation timeline
9.13.9 Impact of the changes: Updated evaluation

The result of the evaluation is that Option A remains the best option under the financial appraisal with a score of +1 (from +4 from the pre consultation analysis). Option B remains second with a score of -6 (from +1) and Option C has moved to -7 (from -2). This is shown in Figure 9.88.

Figure 9.88: Post-consultation Value for Money evaluation

<table>
<thead>
<tr>
<th>Option</th>
<th>PCBC</th>
<th>DMBC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Capital cost</td>
<td>Transition costs</td>
</tr>
<tr>
<td>A</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>B</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>C</td>
<td>+</td>
<td>-</td>
</tr>
</tbody>
</table>

The changes to the Value for Money evaluation from pre-consultation to the post-consultation phase are summarised below:

**Total net capital required to deliver the reconfigurations has increased by £94 million - £155 million** and the gross costs and capital receipts by a larger amount. The following describes the net capital required by option:

- Option A: £112 million (PCBC) vs. £206 million (DMBC)
- Option B: £153 million (PCBC) vs. £253 million (DMBC) assuming £139 million net receipt at Chelsea & Westminster NHS Foundation Trust can be used to fund development at other non Foundation Trusts, otherwise capital requirement increases to £388 million
- Option C: £113 million (PCBC) vs. £268 million (DMBC)

**Improvement in total I&E across the sector has reduced by £11 million - £13 million** consistently across all options due to higher gross capital investment to make changes to the estates:

- Option A: £55 million (PCBC) vs. £42 million (DMBC)
- Option B: £37 million (PCBC) vs. £26 million (DMBC)
- Option C: £38 million (PCBC) vs. £25 million (DMBC)

---

20 Source: Reconfiguration modelling
NPV of the options relative to ‘do nothing’ have decreased due to higher gross capital investment. Options B and C are particularly affected because of the two reasons listed below:

- **Option A:** £271 million (PCBC) vs. £114 million (DMBC) due to higher build costs
- **Option B:** £192 million (PCBC) vs. £22 million (DMBC) due to higher build costs and capital for activity flowing outside of the sector
- **Option C:** £100 million (PCBC) vs. -£170 million (DMBC) due to higher build costs and capital for activity flowing outside of the sector.

In conclusion:

- **Option A remains the highest scoring** in terms of the Value for Money assessment, but the overall score has reduced from +4 to +1 due to higher capital requirements (reducing 2 points) and the impact of this on the NPV (reducing 1 point)
- **The gap to Option B has widened** as Option B has reduced by 7 points from +1 to -6, due to higher capital costs (2 points), more sites remaining unviable (3 points), and the impact of this on the NPV (reducing 2 points)
- **The gap to Option C has widened** as Option C has reduced by 5 points from -2 to -7, due to higher capital costs (2 points) and lower NPV (3 points).

The application of the evaluation metric accentuates the gap between A and B because B falls below just below the threshold, particularly for Site Viability where the improvement in one Trust would improve the score of B by three. Consequently it was agreed by the F&BP that further work should be undertaken on the absolute values focussed on the Net Present Value of the options.

**9.14 Expanded NPV**

The NPV assessment focuses on the specific factors that influence NHS costs, distinguishes between reconfiguration options and is consistent with the pre consultation work. During the post consultation work the F&BP Group agreed that an expanded NPV in line with the requirements of the Generic Economic Model (GEM) should be calculated. The key differences are as shown in Figure 9.89.
These changes have the effect of significantly improving the NPV for all options and the ranking of options is unchanged. This result is shown in Figure 9.90.

Notes from Figure 9.89:
1. NPV is calculated over 20 years (2012/13 to 2031/32 inclusive) with 3.5% discount rate and no terminal value. The cost of new service standards is assumed to come in during 2013/14 (50% full year effect in 2013/14 with 100% by 2014/15). The PDC reductions in Local Hospitals is assumed to come in 2016/17 (so apply for 15 of the 20 year period)
2. Total net cost of £71m under options A and C assume that all College activity is reprovided within local or major hospitals. There is an option for Imperial College to reprovide some teaching space from OOH hubs, which would reduce capital needs by £5-8m. Under this scenario, all NPV evaluations for options A and C (base case and sensitivities) would decrease by the corresponding amount.
Figure 9.90: Expanded NPV of acute reconfiguration (20 years)\(^2^2\)

Expanded net present value (£m), absolute and relative to ‘do nothing’

<table>
<thead>
<tr>
<th>Option</th>
<th>Major hospitals</th>
<th>Year to complete reconfig. (by end of year)(^1)</th>
<th>Investment in local hospital</th>
<th>NHS contribution to Imperial College move</th>
<th>Backlog Maintenance</th>
<th>Transitory Costs</th>
<th>Fixed costs for activity flowing outside NWL</th>
<th>Fixed cost of major hospital investment</th>
<th>Net Receipts from land sale</th>
<th>Consoliation savings</th>
<th>Avoid cost of new service standards</th>
<th>Net savings from conversion to local hospital</th>
<th>Total NPV, 20 years (relative to “do nothing”)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>West Middlesex</td>
<td>2017/18</td>
<td>-190</td>
<td>-26</td>
<td>-51</td>
<td>-49</td>
<td>-33</td>
<td>-23</td>
<td>-232</td>
<td>135</td>
<td>132</td>
<td>228</td>
<td>298</td>
</tr>
<tr>
<td></td>
<td>St Mary’s</td>
<td></td>
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<tr>
<td></td>
<td>Chelsea &amp; Westminster</td>
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<td>Northwick Park &amp; St Mark’s</td>
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<td></td>
<td>Hillingdon</td>
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<td>St Mary’s</td>
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<td></td>
<td>Charing Cross</td>
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<td>Northwick Park &amp; St Mark’s</td>
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<td>Chelsea &amp; Westminster</td>
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<td>Northwick Park &amp; St Mark’s</td>
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</table>

\(^2^2\) Reconfiguration modelling
1. NPV calculation on cash flows for capital investment and receipts based on implementation timeline
9.15 Stage 7 - Sensitivity Analysis

This section describes the seventh stage of the process – sensitivity analysis. Figure 9.91 highlights the relevant step.

Figure 9.91: Highlighting Stage 7 of the process described in this section

Sensitivity analysis has been used to test the options to establish whether the ranking changes under testing. 22 sensitivities have been run as summarised in Figure 9.92.
### Figure 9.92: Outline of the sensitivity analyses

<table>
<thead>
<tr>
<th>Sensitivity tests</th>
<th>Description</th>
<th>High level effect</th>
</tr>
</thead>
</table>
| **a) Demand growth I:** 1%pt pa higher than plan, trust income allowed to grow | - Demand is higher than exptact leading to increased activity (+1%pt per year)  
- Trusts are reimbursed for this additional activity | - Higher income, activity and costs (scaled with increase in activity)  
- More beds needed, leading to higher capital spend and ongoing costs to replace and operate the assets |
| **b) Demand growth II:** 1%pt pa higher than plan, trust income fixed as per baseline | - Same as (a) except Trusts are not reimbursed for additional activity through contractual arrangements or block contracts | - Same as (a) except income does not increase leading to a worse financial position for the Trusts |
| **c) QIPP plans I:** 60% of plans achieved, trust receive income | - QIPP initiatives do not deliver the planned level of reduction in acute activity (only 60% achieved)  
- Trusts are reimbursed for this additional activity | - Same as (a) except the new activity is focused on services targeted by QIPP initiatives (mainly non-elective and outpatients) |
| **d) QIPP plans II:** 60% of plans achieved, trust income is capped | - Same as (d) except Trusts are not reimbursed for additional activity through contractual arrangements or block contracts | - Same as (c) except income does not increase leading to a worse financial position for the Trusts |
| **e) QIPP plans III:** 110% of QIPP achieved (Trusts recover costs) | - QIPP initiatives deliver 10% more reduction than planned in acute activity (110% achieved), with the associated reduction in income and in activity  
- Trusts adapt by reducing variable and semi-variable costs accordingly | - Lower income, activity and costs (scaled with decrease in activity)  
- Less beds needed, leading to lower capital spend and ongoing costs to replace and operate the assets |
| **f) Tariff efficiency I:** Monitor guidance on tariff efficiency, and 90% productivity savings | - 5% tariff efficiency (i.e. difference between cost inflation and tariff deflator) instead of 4% for 12/13 and 13/14 (modelled by varying cost inflation); 14/15 onwards remains 4.2%  
- Trusts achieve only 90% planned productivity savings in 12/13-17/18 | - Increased cost inflation, and less cost saving from productivity, leading to a worse financial position |
<table>
<thead>
<tr>
<th>Sensitivity tests</th>
<th>Description</th>
<th>High level effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>g) <strong>Tariff efficiency II</strong>: Monitor downside on tariff efficiency</td>
<td>- 5.5% tariff efficiency in 12/13 and 14/15&lt;br&gt;- 5% efficiency in 15/16 onwards</td>
<td>Increased costs inflation leading to a worse financial position</td>
</tr>
<tr>
<td>h) <strong>LOS reduction I</strong>: 10% reduction achieved (instead of 15%)</td>
<td>- Trusts achieve only 10% reduction in average length of stay, compared to 15% assumed in the main analysis</td>
<td>More beds needed, leading to higher capital spend and ongoing costs to replace and operate the assets</td>
</tr>
<tr>
<td>i) <strong>LOS reduction II</strong>: no ALOS reduction on maternity, paediatrics nor critical care</td>
<td>- Trusts keep average length of stay for maternity and critical care constant, and achieve 15% reduction for other categories</td>
<td>15% more beds needed in maternity and critical care, leading to higher capital spend and ongoing costs to replace and operate the assets</td>
</tr>
<tr>
<td>j) <strong>Transition costs</strong>: 20% higher than plan</td>
<td>- Higher revenue impact from reconfiguration (e.g., due to more expensive or extended transition period)</td>
<td>Increased one-off transition costs</td>
</tr>
<tr>
<td>k) <strong>Consolidation savings</strong>: 50% of the consolidation savings achieved</td>
<td>- Only 50% of the modelled savings in pay costs due to consolidating services are achieved (i.e., 2.5% of pay costs when consolidated on Hammersmith site; 5% for all other sites)</td>
<td>Less cost saving delivered when consolidating services</td>
</tr>
<tr>
<td>l) <strong>Higher new build cost</strong>: 30% higher than plan</td>
<td>- Higher capital costs to add new capacity</td>
<td>Increased capital requirements and ongoing costs to operate and replace assets</td>
</tr>
<tr>
<td>m) <strong>Lower net land receipts</strong>: 30% lower than plan</td>
<td>- Lower net disposal value for unused land (e.g., due to restrictions or difficulties selling land, or higher exit and demolition costs)</td>
<td>Increase in net capital requirements</td>
</tr>
<tr>
<td>n) <strong>Higher cost of capital</strong>: NPV discount rate of 4.5% instead of 3.5%</td>
<td>- Decease the relative value of long term benefits compared to short term costs when evaluating NPV to reflect the cost of up front capital, and the risk of future returns</td>
<td>Reduces NPV, particularly for medium-to-long term benefits and costs</td>
</tr>
<tr>
<td>Sensitivity tests</td>
<td>Description</td>
<td>High level effect</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>o) Time to deliver reconfiguration</td>
<td>Acute reconfiguration changes take 2 years longer to implement (than originally planned; e.g., delays due to planning or delivering required QIPP or LOS reductions)</td>
<td>Extends the time for which current trading deficits need to be covered, and delays the benefit of reconfiguration – reduces the NPV of options</td>
</tr>
<tr>
<td>p) Lower outpatient activity: Local Hospitals retain 40% rather than 85% of outpatient activity</td>
<td>Less outpatient activity retained at Local Hospitals (40% compared to base assumption of 85%) reducing income and variable/semi-variable costs, but with the same fixed costs</td>
<td>Reduces the contribution margin for Local Hospitals, potentially impacting site viability</td>
</tr>
<tr>
<td>q) Period for NPV assessment</td>
<td>Period for NPV assessment increases from 20 years (no terminal value) to 60 years (no terminal value)</td>
<td>Increases the NPV of options</td>
</tr>
<tr>
<td>r) Theatre efficiency</td>
<td>Theaters assumed to run 50 hours per week instead of 40 hours</td>
<td>Less new theatres needed, leading to lower capital spend and ongoing costs to replace and operate the assets</td>
</tr>
<tr>
<td>s) Lower new build cost: 30% lower than plan</td>
<td>Lower capital costs to add new capacity</td>
<td>Decreased capital requirements and ongoing costs to operate and replace assets</td>
</tr>
<tr>
<td>t) Reduced fixed cost savings at Local Hospitals: Only 75% of net savings delivered</td>
<td>Reduced net savings in fixed costs at local hospitals to 75% of modelled savings</td>
<td>Increases cost at Local Hospitals (potentially impacting viability) and reduces cost saving benefit in NPV</td>
</tr>
<tr>
<td>u) Imperial College I: NHS contributes 100% of capital; no net revenue impact</td>
<td>Increases NHS capital contribution; no change to on-going revenue cost assuming these costs are already incurred for the existing services</td>
<td>Increases capital cost and reduces VfM NPV. No change to expanded NPV as total capital already included</td>
</tr>
<tr>
<td>v) Imperial College II: NHS contributes 100% of capital; full revenue impact added to ongoing costs (est. 11.5% of capital)</td>
<td>Increases NHS capital contribution; on-going revenue costs increased by 11.5% of capital costs</td>
<td>Increases capital and revenue costs, and decreases total VfM and expanded NPV</td>
</tr>
</tbody>
</table>
Figure 9.93 summarises the impact on the expanded NPV for all three options in comparison with the ‘do nothing’ case for both 20 and 60 years.

Changes in the NPV are compared in Figure 9.94.

The sensitivity analyses were run prior to final adjustments to the expanded NPV calculation. The result is that NPV figures in Figure 9.93 are understated:

- Option A: £62 million (20 years) and £119 million (60 years);
- Option B: £67 million (20 years) and £114 million (60 years);
- Option C: £67 million (20 years) and £94 million (60 years)

This does not change the relative impact of the sensitivities, so does not affect the conclusions.

The results of the sensitivity testing have been assessed in terms of the ranking of the three options using the criteria set out earlier in this chapter. The F&BP group considered the sensitivity of sites falling below 1% surplus as this appeared to be a particularly sensitive part of the evaluation. The group also reviewed the financial value of bringing all sites to a 1% surplus. The results of this work are shown in Figure 9.95.
### Figure 9.93: Summary of sensitivity analyses – Expanded NPV

#### Sensitivity tests

<table>
<thead>
<tr>
<th>Sensitivity tests</th>
<th>Op A</th>
<th>Op B</th>
<th>Op C</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Base modelling outputs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Demand growth I: 1% pt pa higher, trust income allowed to grow</td>
<td>183</td>
<td>124</td>
<td>-77</td>
</tr>
<tr>
<td>b) Demand growth II: 1% pt pa higher, trust income fixed</td>
<td>183</td>
<td>124</td>
<td>-77</td>
</tr>
<tr>
<td>c) QIPP plans I: 60% of plans achieved, trust receive income</td>
<td>96</td>
<td>21</td>
<td>-161</td>
</tr>
<tr>
<td>d) QIPP plans II: 60% of plans achieved, trust income is capped</td>
<td>96</td>
<td>21</td>
<td>-120</td>
</tr>
<tr>
<td>e) QIPP plans III: 110% of QIPP achieved (Trusts recover costs)</td>
<td>253</td>
<td>168</td>
<td>-8</td>
</tr>
<tr>
<td>f) Efficiencies I: Monitor inflation and 90% CIPs</td>
<td>246</td>
<td>192</td>
<td>-8</td>
</tr>
<tr>
<td>g) Efficiencies II: Monitor downside</td>
<td>260</td>
<td>214</td>
<td>4</td>
</tr>
<tr>
<td>h) LOS reduction I: 10% reduction achieved</td>
<td>104</td>
<td>-1</td>
<td>-146</td>
</tr>
<tr>
<td>i) LOS reduction II: no reduction on maternity, paeds &amp; critical care</td>
<td>117</td>
<td>9</td>
<td>-147</td>
</tr>
<tr>
<td>j) Transition costs: 20% higher than plan</td>
<td>160</td>
<td>80</td>
<td>-80</td>
</tr>
<tr>
<td>k) Consolidation savings I: 50% of consolidation savings achieved</td>
<td>77</td>
<td>-33</td>
<td>-180</td>
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<tr>
<td>l) Consolidation savings II: 30% higher than plan</td>
<td>184</td>
<td>88</td>
<td>-74</td>
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<tr>
<td>m) Lower net land receipts: 30% lower than plan</td>
<td>187</td>
<td>107</td>
<td>-52</td>
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<tr>
<td>n) Higher capital cost: NPV discount rate of 4.5% instead of 3.5%</td>
<td>200</td>
<td>129</td>
<td>-36</td>
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<tr>
<td>o) Time to deliver reconfiguration: 2 year delay</td>
<td>235</td>
<td>148</td>
<td>-33</td>
</tr>
<tr>
<td>p) Lower outpatient activity: 40% of activity retained in stead of 80%</td>
<td>224</td>
<td>138</td>
<td>-38</td>
</tr>
<tr>
<td>q) Period for NPV assessment from 20 years to 60 years</td>
<td>278</td>
<td>210</td>
<td>49</td>
</tr>
<tr>
<td>r) Theatre efficiency: run 50 hours a week instead of 40 hours</td>
<td>371</td>
<td>288</td>
<td>104</td>
</tr>
<tr>
<td>s) New build/refurbishment cost I: 30% lower than plan</td>
<td>128</td>
<td>21</td>
<td>-105</td>
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<tr>
<td>t) Lower fixed cost saving from local hospital: 75% of plan</td>
<td>224</td>
<td>138</td>
<td>-38</td>
</tr>
<tr>
<td>u) Imperial College I: NHS contributes 100% capital; no revenue impact</td>
<td>156</td>
<td>121</td>
<td>-106</td>
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<tr>
<td>v) Imperial College II: NHS contributes 100% capital; full revenue impact (est. 11.5% of capital)</td>
<td>653</td>
<td>496</td>
<td>167</td>
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#### NPV relative to ‘do nothing’ – 20 years

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<th>Op C</th>
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<tr>
<td>a) Demand growth I: 1% pt pa higher, trust income allowed to grow</td>
<td>224</td>
<td>138</td>
<td>-38</td>
</tr>
<tr>
<td>b) Demand growth II: 1% pt pa higher, trust income fixed</td>
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<td>124</td>
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<td>21</td>
<td>-161</td>
</tr>
<tr>
<td>d) QIPP plans II: 60% of plans achieved, trust income is capped</td>
<td>96</td>
<td>21</td>
<td>-120</td>
</tr>
<tr>
<td>e) QIPP plans III: 110% of QIPP achieved (Trusts recover costs)</td>
<td>253</td>
<td>168</td>
<td>-8</td>
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<tr>
<td>f) Efficiencies I: Monitor inflation and 90% CIPs</td>
<td>246</td>
<td>192</td>
<td>-8</td>
</tr>
<tr>
<td>g) Efficiencies II: Monitor downside</td>
<td>260</td>
<td>214</td>
<td>4</td>
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<tr>
<td>h) LOS reduction I: 10% reduction achieved</td>
<td>104</td>
<td>-1</td>
<td>-146</td>
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<tr>
<td>i) LOS reduction II: no reduction on maternity, paeds &amp; critical care</td>
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<td>9</td>
<td>-147</td>
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<tr>
<td>j) Transition costs: 20% higher than plan</td>
<td>160</td>
<td>80</td>
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<tr>
<td>k) Consolidation savings I: 50% of consolidation savings achieved</td>
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<td>-33</td>
<td>-180</td>
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<tr>
<td>l) Consolidation savings II: 30% higher than plan</td>
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<td>m) Lower net land receipts: 30% lower than plan</td>
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<td>-52</td>
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<tr>
<td>n) Higher capital cost: NPV discount rate of 4.5% instead of 3.5%</td>
<td>200</td>
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<tr>
<td>o) Time to deliver reconfiguration: 2 year delay</td>
<td>235</td>
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<td>-33</td>
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<tr>
<td>p) Lower outpatient activity: 40% of activity retained in stead of 80%</td>
<td>224</td>
<td>138</td>
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<tr>
<td>q) Period for NPV assessment from 20 years to 60 years</td>
<td>278</td>
<td>210</td>
<td>49</td>
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<tr>
<td>r) Theatre efficiency: run 50 hours a week instead of 40 hours</td>
<td>371</td>
<td>288</td>
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<tr>
<td>s) New build/refurbishment cost I: 30% lower than plan</td>
<td>128</td>
<td>21</td>
<td>-105</td>
</tr>
<tr>
<td>t) Lower fixed cost saving from local hospital: 75% of plan</td>
<td>224</td>
<td>138</td>
<td>-38</td>
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<tr>
<td>u) Imperial College I: NHS contributes 100% capital; no revenue impact</td>
<td>156</td>
<td>121</td>
<td>-106</td>
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<tr>
<td>v) Imperial College II: NHS contributes 100% capital; full revenue impact (est. 11.5% of capital)</td>
<td>653</td>
<td>496</td>
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#### NPV relative to ‘do nothing’ – 60 years

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<tr>
<td>a) Demand growth I: 1% pt pa higher, trust income allowed to grow</td>
<td>653</td>
<td>496</td>
<td>167</td>
</tr>
<tr>
<td>b) Demand growth II: 1% pt pa higher, trust income fixed</td>
<td>605</td>
<td>500</td>
<td>125</td>
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<tr>
<td>c) QIPP plans I: 60% of plans achieved, trust receive income</td>
<td>480</td>
<td>356</td>
<td>71</td>
</tr>
<tr>
<td>d) QIPP plans II: 60% of plans achieved, trust income is capped</td>
<td>480</td>
<td>356</td>
<td>71</td>
</tr>
<tr>
<td>e) QIPP plans III: 110% of QIPP achieved (Trusts recover costs)</td>
<td>693</td>
<td>537</td>
<td>211</td>
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<tr>
<td>f) Efficiencies I: Monitor inflation and 90% CIPs</td>
<td>697</td>
<td>609</td>
<td>229</td>
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<tr>
<td>g) Efficiencies II: Monitor downside</td>
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<td>h) LOS reduction I: 10% reduction achieved</td>
<td>470</td>
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<tr>
<td>i) LOS reduction II: no reduction on maternity, paeds &amp; critical care</td>
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<tr>
<td>j) Transition costs: 20% higher than plan</td>
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<td>485</td>
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<tr>
<td>k) Consolidation savings I: 50% of consolidation savings achieved</td>
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<td>346</td>
<td>47</td>
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<tr>
<td>l) Consolidation savings II: 30% higher than plan</td>
<td>439</td>
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<td>41</td>
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<tr>
<td>m) Lower net land receipts: 30% lower than plan</td>
<td>613</td>
<td>446</td>
<td>131</td>
</tr>
<tr>
<td>n) Higher capital cost: NPV discount rate of 4.5% instead of 3.5%</td>
<td>495</td>
<td>364</td>
<td>95</td>
</tr>
<tr>
<td>o) Time to deliver reconfiguration: 2 year delay</td>
<td>610</td>
<td>463</td>
<td>156</td>
</tr>
<tr>
<td>p) Lower outpatient activity: 40% of activity retained in stead of 80%</td>
<td>676</td>
<td>518</td>
<td>177</td>
</tr>
<tr>
<td>q) Period for NPV assessment from 20 years to 60 years</td>
<td>653</td>
<td>496</td>
<td>167</td>
</tr>
<tr>
<td>r) Theatre efficiency: run 50 hours a week instead of 40 hours</td>
<td>735</td>
<td>606</td>
<td>299</td>
</tr>
<tr>
<td>s) New build/refurbishment cost I: 30% lower than plan</td>
<td>867</td>
<td>714</td>
<td>374</td>
</tr>
<tr>
<td>t) Lower fixed cost saving from local hospital: 75% of plan</td>
<td>451</td>
<td>251</td>
<td>25</td>
</tr>
<tr>
<td>u) Imperial College I: NHS contributes 100% capital; no revenue impact</td>
<td>653</td>
<td>496</td>
<td>167</td>
</tr>
<tr>
<td>v) Imperial College II: NHS contributes 100% capital; full revenue impact (est. 11.5% of capital)</td>
<td>512</td>
<td>461</td>
<td>25</td>
</tr>
</tbody>
</table>

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Sensitivity U - This is already included in the expanded NPV and will only impact VFM evaluation
### Figure 9.94: Change in expanded NPV vs baseline

Change in expanded NPV due to sensitivity, £m

<table>
<thead>
<tr>
<th>Sensitivity tests</th>
<th>Change in NPV – 20 years</th>
<th>Change in NPV – 60 years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Base modelling outputs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Demand growth I: 1%pt pa higher, trust income allowed to grow</td>
<td>-41</td>
<td>-14</td>
</tr>
<tr>
<td>b) Demand growth II: 1%pt pa higher, trust income fixed</td>
<td>-41</td>
<td>-14</td>
</tr>
<tr>
<td>c) QIPP plans I: 80% of plans achieved, trust receive income</td>
<td>-129</td>
<td>-117</td>
</tr>
<tr>
<td>d) QIPP plans II: 80% of plans achieved, trust income is capped</td>
<td>-129</td>
<td>-117</td>
</tr>
<tr>
<td>e) QIPP plans III: 110% of QIPP achieved (Trusts recover costs)</td>
<td>29</td>
<td>30</td>
</tr>
<tr>
<td>f) Efficiencies I: Monitor inflation and 90% CIPs</td>
<td>21</td>
<td>54</td>
</tr>
<tr>
<td>g) Efficiencies II: Monitor downside</td>
<td>35</td>
<td>76</td>
</tr>
<tr>
<td>h) LOS reduction I: 10% reduction achieved</td>
<td>-120</td>
<td>-138</td>
</tr>
<tr>
<td>i) LOS reduction II: no reduction on maternity, paediatrics &amp; critical care</td>
<td>-107</td>
<td>-129</td>
</tr>
<tr>
<td>j) Transition costs: 20% higher than plan</td>
<td>-9</td>
<td>-10</td>
</tr>
<tr>
<td>k) Consolidation savings I: 50% of consolidation savings achieved</td>
<td>-64</td>
<td>-71</td>
</tr>
<tr>
<td>l) New build/refurbishment cost I: 30% higher than plan</td>
<td>-147</td>
<td>-150</td>
</tr>
<tr>
<td>m) Lower net land receipts: 30% lower than plan</td>
<td>-40</td>
<td>-50</td>
</tr>
<tr>
<td>n) Higher cost of capital: NPV discount rate of 4.5% instead of 3.5%</td>
<td>-37</td>
<td>-30</td>
</tr>
<tr>
<td>o) Time to deliver reconfiguration: 2 year delay</td>
<td>-15</td>
<td>-9</td>
</tr>
<tr>
<td>p) Lower outpatient activity: 40% of activity retained instead of 80%</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>q) Period for NPV assessment: from 20 years to 60 years</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>r) Theatre efficiency: run 50 hours a week instead of 40 hours</td>
<td>54</td>
<td>73</td>
</tr>
<tr>
<td>s) New build/refurbishment cost II: 30% lower than plan</td>
<td>147</td>
<td>150</td>
</tr>
<tr>
<td>t) Lower fixed cost saving from local hospital: 75% of plan</td>
<td>-96</td>
<td>-116</td>
</tr>
<tr>
<td>u) Imperial College I: NHS contributes 100% capital; no revenue impact</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>v) Imperial College II: NHS contributes 100% capital; full revenue impact (est. 11.5% of capital)</td>
<td>-68</td>
<td>-17</td>
</tr>
</tbody>
</table>

24 Source: sensitivity modelling
Figure 9.95: Summary of sensitivity analyses – Value for Money

<table>
<thead>
<tr>
<th>Sensitivity tests</th>
<th>VfM evaluation (rank out of 3)</th>
<th>VfM evaluation (rank out of 3)</th>
<th>Sites below 1% surplus after reconfiguration (%)</th>
<th>Recurrent amount required to bring all sites within £1m of 1% surplus (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base modelling outputs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Demand growth I: 1% pt pa higher, trust income allowed to grow</td>
<td>-1</td>
<td>-2</td>
<td>-3</td>
<td>1</td>
</tr>
<tr>
<td>b) Demand growth II: 1% pt pa higher, trust income fixed</td>
<td>-7</td>
<td>-8</td>
<td>-9</td>
<td>1</td>
</tr>
<tr>
<td>c) QIPP plans I: 60% of plans achieved, trust receive income</td>
<td>-1</td>
<td>-2</td>
<td>-3</td>
<td>1</td>
</tr>
<tr>
<td>d) QIPP plans II: 60% of plans achieved, trust income is capped</td>
<td>-9</td>
<td>-9</td>
<td>-9</td>
<td>1</td>
</tr>
<tr>
<td>e) QIPP plans III: 110% of QIPP achieved (Trusts recover costs)</td>
<td>-2</td>
<td>-3</td>
<td>-4</td>
<td>1</td>
</tr>
<tr>
<td>f) Efficiencies II: Monitor inflation and 90% CIPs</td>
<td>-5</td>
<td>-6</td>
<td>-7</td>
<td>1</td>
</tr>
<tr>
<td>g) Efficiencies II: Monitor downside</td>
<td>-8</td>
<td>-8</td>
<td>-8</td>
<td>1</td>
</tr>
<tr>
<td>h) LOS reduction I: 10% reduction achieved</td>
<td>-8</td>
<td>-8</td>
<td>-8</td>
<td>1</td>
</tr>
<tr>
<td>i) LOS reduction II: no reduction on maternity, paeds A&amp;E care</td>
<td>-8</td>
<td>-8</td>
<td>-8</td>
<td>1</td>
</tr>
<tr>
<td>j) Transition costs: 20% higher than plan</td>
<td>-8</td>
<td>-9</td>
<td>-9</td>
<td>1</td>
</tr>
<tr>
<td>k) Consolidation savings I: 50% of consolidation savings achieved</td>
<td>-9</td>
<td>-9</td>
<td>-9</td>
<td>1</td>
</tr>
<tr>
<td>l) New build/refurbishment cost I: 30% higher than plan</td>
<td>-9</td>
<td>-9</td>
<td>-9</td>
<td>1</td>
</tr>
<tr>
<td>m) Lower net land receipts: 30% lower than plan</td>
<td>-1</td>
<td>-2</td>
<td>-3</td>
<td>1</td>
</tr>
<tr>
<td>n) Higher cost of capital; NPV discount rate of 4.5% instead of 3.5%</td>
<td>-1</td>
<td>-1</td>
<td>-1</td>
<td>1</td>
</tr>
<tr>
<td>o) Time to deliver reconfiguration: 2 year delay</td>
<td>-2</td>
<td>-3</td>
<td>-4</td>
<td>1</td>
</tr>
<tr>
<td>p) Lower outpatient activity: 40% of activity retained instead of 80%</td>
<td>-2</td>
<td>-3</td>
<td>-4</td>
<td>1</td>
</tr>
<tr>
<td>q) Period for NPV assessment from 20 years to 60 years</td>
<td>-2</td>
<td>-3</td>
<td>-4</td>
<td>1</td>
</tr>
<tr>
<td>r) Theatre efficiency run 52 hours a week instead of 40 hours</td>
<td>-2</td>
<td>-3</td>
<td>-4</td>
<td>1</td>
</tr>
<tr>
<td>s) New build/refurbishment cost II: 30% lower than plan</td>
<td>-3</td>
<td>-4</td>
<td>-5</td>
<td>1</td>
</tr>
<tr>
<td>t) Lower fixed cost saving from local hospital: 75% of plan</td>
<td>-6</td>
<td>-7</td>
<td>-8</td>
<td>1</td>
</tr>
<tr>
<td>u) Imperial College I: NHS contributes 100% capital; no revenue impact</td>
<td>-1</td>
<td>-2</td>
<td>-3</td>
<td>1</td>
</tr>
<tr>
<td>v) Imperial College II: NHS contributes 100% capital; full revenue impact (est. 115% of capital)</td>
<td>-3</td>
<td>-4</td>
<td>-5</td>
<td>1</td>
</tr>
</tbody>
</table>

Notes from Figure 9.95

1. The gap to reaching net surplus within £1m of 1% of income (in line with the criteria used to assess financial viability of sites). Note that this is slightly less than the calculation in VfM metric (iii) which quantifies the gap to achieving net surplus of at least 1% of income
The sensitivity analysis supports the conclusion that Option A is the leading option in financial terms. It has the highest expanded NPV values under all 22 sensitivity tests and is also the highest in terms of VfM scores under all tests (joint first with Options B or C in three of them).

However, as highlighted pre-consultation 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. Pre-consultation, a negative NPV over 20 years occurred if the top four sensitivities occurred at the same time. The analysis now suggests that the top two sensitivities would have this impact. Similarly whilst Option A delivers an improved I&E position over ‘do-nothing’, a combination of the two worst sensitivity impacts would reduce this by approx 50%.

The highest risk sensitivities are listed below. These risks need to be very carefully managed in order for any reconfiguration to be successful and for improvements in acute sector finances to be delivered. Some of these adversely affect the ‘do nothing’ and all reconfiguration options, whereas others reduce the benefits of all options with respect to ‘do nothing’ and potentially differentially impact the options relative to each other:

**Sensitivities that affect the ‘do nothing’ and all reconfiguration options:**

- Two of the key risks highlighted in the pre-consultation analysis remain significant risks in this review: These both involve higher activity than planned, but where Trusts are not reimbursed for the additional activity
  - Sensitivity B: 1% higher demand, but Trusts not reimbursed
  - Sensitivities D: Only 60% of QIPP delivered, but Trusts not reimbursed
- Two other sensitivities on tariff efficiencies (F and G) were not explicitly tested pre-consultation, but were shown to be high risk through the pre-consultation downside scenario. These demonstrate that higher tariff efficiency (through higher experienced cost inflation) or under-delivery of CIP is a significant risk for providers

**Sensitivities that reduce benefits of all options relative to ‘do nothing’ and potentially differentiate options:**

- Sensitivity T: Reducing fixed costs (defined as establishment, premises & fixed plant, depreciation and PDC) at local hospitals was highlighted as a key sensitivity in the pre-consultation analysis. Failure to reduce these costs (e.g. by retaining more buildings than the estate plans indicate is required) would result in unviable sites and under-delivery of the cost saving benefits from the proposed changes (reflected in the sensitivity analysis through the number of sites in deficit and the reduced NPV, respectively)
- Sensitivities on bed capacity and capital build costs did not have a large impact in the PCBC analysis, but now emerge as significant risks. These all involve increases to the capital expenditure for adding new capacity, and now have larger impact because of the revised higher capital costs per bed and because the analysis now accounts for step changes when adding capacity that have been identified through the more detailed estates work. Note that these sensitivity analyses model the case where all of the additional capacity is built at the Major Hospital sites; the additional capacity could be mitigated through the better use of spare beds at Central Middlesex, or out of hospital capacity.
  - Sensitivity H: Only 10% ALOS reduction achieved
  - Sensitivity I: No ALOS reduction in maternity, paediatrics and critical care (new sensitivity analysis)
  - Sensitivity L: New build capital costs 30% higher than modeled
● Sensitivity K (50% of the consolidation savings through merging into larger clinical teams) has a larger impact on the Value for Money assessment than in the pre-consultation analysis because Option A is now closer to the scoring thresholds, particularly on total I&E and Site Viability.

There are also potential upsides that would improve the outlook for the reconfiguration options, including reduced capital costs or improved operational efficiency requiring less capacity at the major hospital sites (e.g. theatre productivity or further ALOS reductions).

9.16 Ranking of Options

In conclusion, the results of the work post-consultation have confirmed the ranking of Option A as the best financial option.
Chapter 10

The proposed future configuration of hospitals in NW London
10. The proposed future configuration of hospitals in NW London
10. The proposed future configuration of hospitals in NW London

This chapter summarises the results of the decision making analysis and sets out the programme’s proposed future configuration of hospitals in NW London. This is based on Option A in the consultation and has been refined following feedback from the consultation and the analysis in response to this feedback. The recommendation is for a local hospital (including an Urgent Care Centre operating 24 hours a day, 7 days a week) and major hospital (24/7 A&E with co-located obstetrics and maternity unit and inpatient paediatrics) 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.

10.1. Results of the decision-making analysis

Chapter 9 describes how the decision-making analysis was refreshed following feedback from the consultation. In particular, we updated the value for money analysis through Stage 6 and the sensitivity analysis. We also updated the assessment of both the sub-criteria under Research and Education.

The assessment across all five evaluation areas, including their sub-metrics, was brought together onto a single evaluation grid, shown in Figure 10.1. Note that the Value for Money evaluation has only been updated for options 5, 6 and 7, which is denoted by darker shading in the diagram.
### Figure 10.1: Summary of the decision-making analysis of the eight medium list options

<table>
<thead>
<tr>
<th>Quality of Care</th>
<th>++ High evaluation</th>
<th>-- Low evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical quality*</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Patient experience</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Access</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distance and time to access services</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Patient choice</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Value for Money</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital cost to the system</td>
<td>--</td>
<td>++</td>
</tr>
<tr>
<td>Transition costs</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Viable Trusts and sites</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Surplus for acute sector</td>
<td>+</td>
<td>--</td>
</tr>
<tr>
<td>Net Present Value</td>
<td>-</td>
<td>--</td>
</tr>
<tr>
<td>Deliverability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workforce</td>
<td>+</td>
<td>--</td>
</tr>
<tr>
<td>Expected time to deliver</td>
<td>-</td>
<td>++</td>
</tr>
<tr>
<td>Co-dependencies with other strategies</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Research &amp; Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disruption</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Support current and developing research and education delivery</td>
<td>-</td>
<td>++</td>
</tr>
<tr>
<td>Pre-consultation score</td>
<td>-2</td>
<td>-7</td>
</tr>
<tr>
<td></td>
<td>-11</td>
<td>-16</td>
</tr>
<tr>
<td></td>
<td>+14</td>
<td>+7</td>
</tr>
<tr>
<td></td>
<td>+2</td>
<td>-4</td>
</tr>
<tr>
<td>Post-consultation score</td>
<td>-3</td>
<td>-7</td>
</tr>
<tr>
<td></td>
<td>-12</td>
<td>-16</td>
</tr>
<tr>
<td></td>
<td>+10</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>-4</td>
<td>-4</td>
</tr>
</tbody>
</table>

Changes from pre-consultation:
- West Middlesex
- Hammersmith
- Chelsea & Westminster
- Northwick Park
- Hillingdon
- Ealing
- Hammersmith
- Chelsea & Westminster
- Northwick Park
- Hillingdon
- West Middlesex
- St Mary's
- Charing Cross
- Northwick Park
- Hillingdon
- Ealing
- St Mary's
- Chelsea & Westminster
- Northwick Park
- Hillingdon
- West Middlesex
- St Mary's
- Charing Cross
- Northwick Park
- Hillingdon
- Ealing
- St Mary's
- Chelsea & Westminster
- Northwick Park
- Hillingdon

Quality of Care
- Clinical quality* REVIEWED AND NO CHANGE
- Patient experience REVIEWED AND NO CHANGE

Access
- Distance and time to access services REVIEWED AND NO CHANGE
- Patient choice REVIEWED AND NO CHANGE

Value for Money
- Capital cost to the system UPDATED
- Transition costs UPDATED
- Viable Trusts and sites UPDATED
- Surplus for acute sector UPDATED
- Net Present Value UPDATED

Deliverability
- Workforce REVIEWED AND NO CHANGE
- Expected time to deliver REVIEWED AND NO CHANGE
- Co-dependencies with other strategies REVIEWED AND NO CHANGE

Research & Education
- Disruption UPDATED
- Support current and developing research and education delivery UPDATED
The changes to the scoring before and after consultation have primarily decreased because of the refreshed value for money analysis for the three consultation options. Additional analysis undertaken on research and education in response to feedback received during consultation supports the higher relative ranking of options that designate Chelsea and Westminster as a major hospital over those that designate Charing Cross as a major hospital, and strengthens the data collated to support designation of reconfiguration option A. Note that although the score for the other options has not decreased, this may be due to the value for money analysis not being refreshed for these options. The sensitivity analysis confirmed that Option A (Option 5 in the table above) remains the strongest.

As a result of the decision-making analysis, the Clinical Board agreed that Option A (Option 5 in the table above) should be the recommendation. The Finance & Business Planning Working Group agreed that Option A 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.

10.2. The recommended configuration

Based on the pre-consultation options evaluation, Option A was our preferred option at the start of the consultation. During consultation we received feedback about the process of reaching this preferred option and about the evaluation itself. Post-consultation, we have responded to the feedback and refreshed the options evaluation. Option A remains our recommended option for configuration.

The evaluation and post-consultation analysis did not change the high level configuration in the preferred option. However, it did enable us to consider additional services that could be located as part of local hospital sites and this meant some lower-level changes to the configuration of the Charing Cross site.

The recommended 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
- **Ealing** – a local hospital
- **Hammersmith** – a specialist hospital with obstetric-led maternity unit and a local hospital

Five specialist hospitals in NW London are not affected by these proposals. These are Harefield, Mount Vernon, Royal Brompton, Royal Marsden and RNOH.
Figure 10.2 Map illustrating the recommended configuration

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

10. The proposed future configuration of hospitals in NW London
10.3. Why this is the recommendation

All configuration options have been considered and detailed analysis has been carried out on the eight strongest of these options. The recommended option is felt to be significantly superior (demonstrated through the evaluation detailed in Chapter 9) than all of the others.

This configuration provides an improved quality of care as it reduces the number of sites providing major hospital services to five, which will mean there will be more specialist and experienced doctors available for more of the time, and that they will be able to build and maintain the skills and expertise they need to deliver high quality care. Compared with the other options it would deliver the greatest benefits for NW London:

- A high quality patient experience. Chelsea & Westminster and West Middlesex both consist of very recently built buildings, with space that is suitable for both current and future requirements. Given what we have demonstrated about the need to manage and maintain NHS buildings in NW London, and the difficulty of finding or building new ones, this is a key factor
- Value for money. The least amount of capital expenditure (on buildings and equipment) would be required to implement this option and it would leave NW London with a projected overall financial surplus. This option is predicted to provide the best return on investment of all the options. In other words, it means the NHS in NW London would be in a much better financial position than if nothing changes
- Relatively easy to deliver. This option corresponds most closely with services already being delivered at particular sites, and with other changes taking place outside of this reconfiguration. The scale of the change required would be smallest under this option
- Supports research and education. The majority of important medical research in NW London is currently carried out at Hammersmith, St Mary’s and Chelsea & Westminster. Under this option, Hammersmith becomes a Specialist Hospital and St Mary’s a Major Hospital, which allows for the continuation of research at both those sites. The impact of this recommendation on undergraduate education has been built in to the decision-making analysis.

Throughout the evaluation, Option A has been consistently strong and local clinicians recommend that it will lead to the greatest improvement in quality of care and patient choice. The distance and time to access the different sites is clinically acceptable. Around 25% of patients would have to travel a little further for their care under any of the eight options, but the increase in blue-light travel time would be less than 10 minutes and, as noted previously, it is more important that those patients receive higher quality care. This option provides the highest confidence for deliverability and supports wider work on research and education. The alternative proposals for Charing Cross and Ealing Hospitals (referred to in 10.4.2 and 10.4.4 respectively) are consistent with and supportive of the recommendation for NW London as a whole.

10.4. Services at each site

The services that will be offered by each site where changes are proposed under the recommended configuration are shown in Figure 10.3. The specialist hospitals that are not affected by the proposals are not shown in the table but are covered in the following subsections.
Figure 10.3 Services to be offered at each site after reconfiguration\(^1\)

<table>
<thead>
<tr>
<th>Core services</th>
<th>Local Hospital</th>
<th>Major Hospital</th>
<th>Elective hospital</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Central Middlesex</strong></td>
<td>Future</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐</td>
</tr>
<tr>
<td><strong>Charing Cross</strong></td>
<td>Future</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐</td>
</tr>
<tr>
<td><strong>Chelsea &amp; Westminster</strong></td>
<td>Future</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐</td>
</tr>
<tr>
<td><strong>Ealing</strong></td>
<td>Future</td>
<td>☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐</td>
<td>☐ ☐</td>
</tr>
<tr>
<td><strong>Hammersmith(^1)</strong></td>
<td>Future</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐</td>
</tr>
<tr>
<td><strong>Hillingdon</strong></td>
<td>Future</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐</td>
</tr>
<tr>
<td><strong>Northwick Park</strong></td>
<td>Future</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐</td>
</tr>
<tr>
<td><strong>St Mary’s</strong></td>
<td>Future</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐</td>
</tr>
<tr>
<td><strong>West Middlesex</strong></td>
<td>Future</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐</td>
</tr>
<tr>
<td><strong>Harefield</strong></td>
<td>Future</td>
<td>☐</td>
<td>☐ ☐ ☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

\(^1\) The nomenclature in Figure 10.3 does not exactly match to that used in Figure 2.5 in Chapter 2, due to the different requirements for the recommended models of care

\(^1\) (incl. Queen Charlotte’s)

L = limited service on site

S = specialist services on site
In the rest of this section, the services that would be on each site are outlined in more detail.

10.4.1 Central Middlesex

Central Middlesex will have an Urgent Care Centre and provide outpatient and diagnostic services. It will deliver non-complex elective surgery and medicine with the associated High Dependency beds.

Brent CCG is considering whether additional services could be provided on the same site. These would include primary care services (delivered by GPs, nurses and pharmacists), community therapies, community diagnostics, neurological rehabilitation beds and specialist renal services.

10.4.2 Charing Cross

Charing Cross will have an Urgent Care Centre and provide outpatient and diagnostic services. It will provide mental health services (inpatient and outpatient). It will also deliver undergraduate and postgraduate training for local hospital services.

Hammersmith and Fulham CCG is considering whether Charing Cross could be developed into a specialist health and social care hospital. This would provide primary care services (delivered by GPs, long term care coordinators, pharmacists and social workers), community therapies and beds, sexual health clinics and specialist renal and ambulatory cancer care. 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.

10.4.3 Chelsea & Westminster

Chelsea & Westminster will have a 24/7 A&E with associated emergency surgery. It will also deliver complex medicine and surgery and have Intensive Care beds. It will have specialist inpatient paediatric services and consultant-led and midwife-led maternity units. It will also have an Urgent Care Centre and provide outpatient and diagnostic services.

10.4.4 Ealing

Ealing will have an Urgent Care Centre and provide outpatient and diagnostic services. West London Mental Health Trust will continue to provide mental health services from this site.

Ealing CCG is considering whether additional services could be provided on the same site. These include primary care services (delivered by GPs, long term care coordinators and pharmacists), community therapies and beds, sexual health clinics, mental health services (inpatient) and specialist renal and chemotherapy services. This model adopts the local hospital model together with enhanced primary and community services that reflect Ealing CCG’s out of hospital strategy.

10.4.5 Hammersmith

Hammersmith will continue to deliver specialist cardiothoracic, colorectal, urology, transplantation, gynaecology and cancer services. It will have a consultant-led maternity unit. It will also have a local hospital with an urgent care centre and outpatient and diagnostic services.
10.4.6 Hillingdon

Hillingdon will have a 24/7 A&E with associated emergency surgery. It will also deliver complex medicine and surgery and have Intensive Care beds. It will have inpatient paediatric services and consultant-led and midwife-led maternity units. It will also have an Urgent Care Centre and provide outpatient and diagnostic services.

10.4.7 Northwick Park

Northwick Park will have a 24/7 A&E with associated emergency surgery. It will also deliver complex medicine and surgery and have Intensive Care beds. It will have inpatient paediatric services and consultant-led and midwife-led maternity units. It will also have an Urgent Care Centre and provide outpatient and diagnostic services. It will continue to have a Hyper-acute Stroke Unit.

10.4.8 St Mary’s

St Mary’s will have a 24/7 A&E with associated emergency surgery. It will also deliver complex medicine and surgery and have Intensive Care beds. It will have inpatient paediatric services and consultant-led and midwife-led maternity units. It will also have an Urgent Care Centre and provide outpatient and diagnostic services. It will continue to be the Major Trauma Centre for NW London and will have a co-located Hyper-acute Stroke Unit. It will deliver specialist ophthalmology services.

Details of the rationale for the HASU and the Western Eye Hospital moving to the St Mary’s site can be found in Chapter 15, section 15.2.4.

10.4.9 West Middlesex

West Middlesex will have a 24/7 A&E with associated emergency surgery. It will also deliver complex medicine and surgery and have Intensive Care beds. It will have inpatient paediatric services and consultant-led and midwife-led maternity units. It will also have an Urgent Care Centre and provide outpatient and diagnostic services.

10.4.10 Specialist Hospitals where no change is proposed

With the exception of Hammersmith Hospital and the movement of the Western Eye Hospital onto the St Mary’s site, the services provided by other specialist hospitals in NW London are unchanged. The other specialist hospitals will be:

- Harefield – providing specialist heart and lung services
- Mount Vernon – providing specialist cancer services
- Royal Brompton – providing specialist heart and lung services
- Royal Marsden – a cancer hospital providing secondary and specialist cancer services
- RNOH – providing specialist and routine orthopaedic services.