Joint Health Overview & Scrutiny Committee (JHOSC)

Agenda

Thursday 20 February 2014
7.00 pm
COUNCIL CHAMBER
EALING TOWN HALL, NEW BROADWAY, EALING W5 2BY

MEMBERSHIP
Chair: Councillor Lucy Ivimy (LB Hammersmith & Fulham)

Vice Chair: Councillor Mel Collins (LB Hounslow)

Councillor Sheila D'Souza (Westminster City Council)
Councillor Mary Daly (LB Hounslow)
Councillor Pamela Fisher (LB Hounslow)
Councillor Robert Freeman (RB Kensington & Chelsea)
Councillor Abdullah Gulaid (LB Ealing)
Councillor Patricia Harrison (LB Brent)
Councillor Anita Kapoor (LB Ealing)
Councillor Vina Mithani (LB Harrow)
Councillor Will Pascall (RB Kensington & Chelsea)
Councillor Victoria Silver (LB Harrow)
Councillor Rory Vaughan (LB Hammersmith & Fulham)
Councillor Mary Daly (LB Brent)
Councillor Sue Jones (LB Richmond)
Councillor Maureen Chatterley (LB Richmond)

CONTACT OFFICER: Dwight McKenzie
Scrutiny Review Officer
Legal & Democratic Services
Ealing Council
Tel: 020 8825 8227
E-mail: mckenzied@ealing.gov.uk

Reports on the open agenda are available on the Council's website:
http://ealing.cmis.uk.com/ealing/Committees.aspx

Members of the public are welcome to attend.

Date Issued: 11 February 2014

Joint Health Overview & Scrutiny Committee (JHOSC)
Agenda

20 February 2014

Item

		Pages
1.	**WELCOME AND INTRODUCTIONS**	1- 3
2.	**APOLOGIES FOR ABSENCE**	
3.	**MINUTES OF THE PREVIOUS MEETING** a. To approve the minutes of the meeting held on 3 December 2013 b. To note the outstanding actions: Action Points	3 - 12
4.	**TERMS OF REFERENCE** The draft terms of reference are for consideration and approval.	13 -14
5.	**DECLARATIONS OF INTEREST**	
6.	**SHAPING A HEALTHIER FUTURE**	15 -16
7.	**IMPLEMENTATION**	17- 19
7.	**SHAPING A HEALTHIER FUTURE ENABLERS**	20 - 33
8.	**WHOLE SYSTEM INTEGRATED CARE**	34 - 39
9.	**PRIMARY CARE TRANSFORMATION**	40 - 44
10.	**MENTAL HEALTH TRANSFORMATION**	45 - 46
11.	**ACUTE RECONFIGUARTION**	47 - 68
12.	**LOCAL HOSPITAL UPDATE**	69 - 77
13.	**COMMUNICATIONS & ENGAGMENT UPDATE**	78 - 84
14.	**DATE OF NEXT MEETING** To be agreed. Proposed venue: London Borough of Westminster	

Joint Health Overview & Scrutiny Committee (JHOSC)
Minutes

Tuesday 3 December 2013

PRESENT

Members Present:
Councillors Lucy Ivimy (Chairman)
Councillor Mel Collins (LB Hounslow)
Councillor Sheila D'Souza (Westminster City Council) Councillor Mary Daly (LB Brent)
Councillor Pamela Fisher (LB Hounslow) Councillor Abdullah Gulaid (LB Ealing)
Councillor Will Pascall (RB Kensington & Chelsea)
Councillor Rory Vaughan (LB Hammersmith & Fulham) Ms Maureen Chatterly (Co-opted Member, LB Richmond)

NHS Representatives Present: Daniel Elkeles (Chief Officer, CWHH CCGs Collaborative and SaHF Senior Responsible Officer), Dr Mark Spencer (Associate Medical Director, NHS England and SaHF Clinical Lead) and Dr Susan McGoldrick (Hammersmith & Fulham CCG Vice-Chair)

Officers Present: Gareth Ebenezer (RBKC), Fola Irikefe (Harrow), Dwight McKenzie (Ealing), John Murphy (Hounslow) and Sue Perrin (Hammersmith & Fulham)

1. **WELCOME AND INTRODUCTIONS**

   Councillor Sheila D'Souza took the Chair.

2. **APOLOGIES FOR ABSENCE**

   Apologies were received from Councillors Freeman (RBKC), Kapoor (Ealing), Mithani (Harrow) and Silver (Harrow) and from Councillor Ivimy for lateness.

3. **MINUTES OF THE PREVIOUS MEETING**

   The minutes of the meeting held on 3 September 2013 were approved as an accurate record of the proceedings.

4. **TERMS OF REFERENCE**

   Members considered the terms of reference.

RESOLVED THAT:

(1) The first paragraph in respect of voting rights should be re-written to reflect the previous wording.

(2) The decision in respect of the final paragraph in respect of delegation of any of the functions or powers of the local authorities, either individually or jointly should be deferred to the next meeting.

It was proposed by Councillor Pamela Fisher and seconded by Councillor Mary Daly that Councillor Mel Collins be appointed Vice-Chairman.

RESOLVED THAT:

Councillor Collins be appointed Vice-chairman.

5. DECLARATIONS OF INTEREST

Councillor Collins declared an interest in that he is a member of the management committee of the Hounslow Bereavement Counselling Service.

6. SHAPING A HEALTHIER FUTURE UPDATE

Dr Mark Spencer and Mr Daniel Elkeles presented the Shaping a Healthier Future (SaHF) Update, which covered: the Secretary of State's acceptance of the advice from the Independent Reconfiguration Panel (IRP) and agreement of the changes to NHS services in North West London, including the move to five major hospitals; the Keogh Emergency Systems Review; the programme timeline; and the development of the capital business case.

Councillor Rory Vaughan queried the definition of 'immediate access to specialist consultant opinion'. Dr. Spencer responded that the emergency teams would work together, with support being provided by the Accident & Emergency (A&E) consultants at the major hospitals to Charing Cross and Ealing hospitals, in person or possibly by teleconference.

Dr. Spencer responded to Councillor Daly that the public would retain the statutory right to a consultant opinion.

Councillor Abdullah Gulaid referred to the Secretary of State's confirmation that Ealing and Charing Cross would continue to offer an A&E service, even if it was a different shape or size from that currently offered, and queried whether these departments would take blue light patients. Dr. Spencer responded that the five major hospitals would provide 24/7 A&E cover. Ealing and Charing Cross would be designated local hospitals and would provide a GP led

service connected to emergency care networks. They would not take blue light patients.

Dr Spencer responded to Councillor Daly that Central Middlesex would be a GP led Urgent Care Centre (UCC). There would be consultants on site, but not A&E consultants. A person with chest pains would currently and in future be taken directly to the Hammersmith Hospital Heart Centre.

Councillor Lucy Ivimy took the Chair

Dr Spencer clarified to Councillor Vaughan that paramedics would assess patients and decide on the appropriate hospital and commence treatment in the ambulance. Walk in patients would be assessed by GPs. There would be increased paramedic training.

Councillor Daly queried the number of patients transferred to Central Middlesex, when Northwick Park A&E has been closed.

Action: Dr Spencer to provide information.

Councillor Mel Collins raised concerns in respect of A&E departments closing before the major emergency centres were in situ, in view of the Secretary of State's support for the IRP recommendation that changes to A&E at Central Middlesex and Hammersmith hospitals should be implemented as soon as practical. Dr Spencer responded that work was currently being progressed to review these service transitions in greater detail. In addition, there was a review of: the potential impact on neighbouring A&Es; the level of readiness of UCCs to be stand alone sites; and the emerging network arrangements. It was anticipated that these changes would occur in summer 2014.

Dr Spencer and Mr Elkeles continued the presentation with the programme timeline and the development of the capital business cases. The SaHF major hospital outline business cases (OBC) which required sign off in early 2014, would be considered together, so that one hospital would not be penalised should there be insufficient capital.

Councillor D'Souza queried the absence of paediatric business cases. Mr Elkeles responded that there was sufficient capacity and expansion at the major hospitals was not required.

The capacity of the Northwick Park A&E was queried. Mr Elkeles responded that he understood that the department would be bigger and have 60/70 additional beds. Councillor Daly stated that she had been informed that capacity would not change.

Action: Mr Elkeles to confirm capacity and beds attached to the existing and the new Northwick Park A&E.

Mr Elkeles responded to a query that North West London would have no less than the current number of elective surgery beds. Numbers would be reduced only if there was an increase in day cases through medical technology.

Action: Mr Elkeles to provide information on the planned surgery and North West London services being transferred to Central Middlesex, and patient numbers.

Mr Elkeles outlined the St. Mary's site development and sale of land, which would make it affordable. Councillor Vaughan queried the short term plans to absorb capacity from Hammersmith. Mr Elkeles responded that wards were brought back into use to meet winter capacity at St. Mary's and these could be retained longer term. In addition, services could be moved from St. Mary's to Charing Cross. It was likely that Hammersmith A&E would be closed fairly soon after winter, as it was not possible to sustain a safe service. The date of the transition of Charing Cross to an Emergency Centre was not known. It would be necessary to clear enough of the Charing Cross site to build the new hospital, whilst maintaining existing services. There would be no service changes until the new building was complete.

Councillor Will Pascall queried whether more work could be done in respect of GP care to support the programme. Dr Susan McGoldrick responded that there was a strong focus on implementing the Out of Hospital (OOH) strategy, and it was intended to accelerate this programme over the following 12-18 months.

Mr Elkeles responded to a query in respect of the Imperial business plan that there were a number of low rise Victorian buildings at St. Mary's, which would be replaced with high rise buildings, which would be financed by the sale of land.

Mr Elkeles responded to Councillor Daly that the cost of the schemes was as shown in the Decision Making Business Case, and that the detailed work was ongoing. As agreed, the emerging work was being shared with the JHOSC, before being finalised.

Action: Mr Elkeles to re-send link to Decision Making Business Case.

Members noted an interest in planning discussions with Westminster City Council.

Mr Elkeles referred to the West Middlesex Hospital maternity business case, which considered a range of options from extending the current maternity facility to developing a new Women's and Children's building. Members queried the logic of disposing of a building which had been refurbished at a considerable cost. Mr Elkeles

responded that both options would be analysed, and that it was actually ten years since the existing building had been refurbished.

Dr Spencer highlighted the options being considered as a sustainable model for the Central Middlesex site : hub plus for Brent; elective orthopaedic centre; specialist rehabilitation services; re-housing mental health services; and relocating some or all of St Marks Hospital; and the closure of the site as a comparator. The presentation summarised the clinical evaluation of the options. The specialist rehabilitation service had a negative clinical evaluation and it had been recommended that this option should not be pursued. Whilst it had also been recommended that moving all or part of St Marks should not be pursued, the relocation of the regional genetics service from Northwick Park to Central Middlesex was an option. Disposal of the site and dispersal of services had been ruled out as non-deliverable.

Members noted that the hub plus for Brent had an impact on the viability of Willesden Hospital Councillor Collins commented on the importance of bereavement services (Brent & Hounslow bereavement services are based at Willesden Centre for Health & Care).

Dr Spencer responded to a query that there had not been engagement with local authorities as providers of social care, at this stage and assured members that the next stage would involve a wide engagement programme with stakeholders and the public.

Councillor Vaughan queried the word 'profitable' in relation to the relocation of regional genetics services. Dr Spencer responded that it was feasible for a number of services to use the space at Northwick Park, and therefore the chosen option must be profitable. In this context, the word did not relate to private patients.

Councillor Vaughan queried the impact of elective work at Central Middlesex on Charing Cross development as a large elective site. Dr Spencer responded that Central Middlesex would primarily be elective orthopaedics, allowing Charing Cross to develop other areas of elective care, for example urology.

Councillor D'Souza commented on patient choice and facilities across the whole of London. Dr McGoldrick responded that 'Choose and Book' informed patient of available hospitals, together with other information such as waiting times and performance. Councillor D'Souza noted that treatment might take place at a different location from the assessment, and this should be made known to patients at the time of their initial choice.

Mr Elkeles continued the presentation on local hospitals. The engagement events had identified a number of common themes that had helped to develop defining features for a local hospital. Councillor Gulaid noted the poor attendance at public engagement events, and

suggested that advance notification to councillors would be good publicity.

Councillor Gulaid queried the private provision of MRI scans. Dr McGoldrick responded that contracts could be placed with 'any qualified provider'. Hammersmith & Fulham GPs used a private provider for MRI scans and other diagnostic tests, as it provided a faster service than the NHS. Hearing aids and tests were another area where contracts were placed with a number of providers, giving patients the choice of a hospital, Specsavers or Boots.

Mr Elkeles responded to queries in respect of Ealing Hospital that the diabetic service would remain open, and there would be between 50 and 100 additional beds. However, a different service model for the provision of a bed was being considered, as the average cost of a hospital bed was £250 per night. The use of existing buildings and the building of a new hospital on the Ealing site to be funded by the sale of land, would be evaluated.

In respect of maternity care, delivery facilities would be provided at the five major hospitals and Queen Charlotte's. It was intended to increase community midwifery to support home deliveries. North West London currently had one of the lowest rates of home deliveries in the country.

In respect of Charing Cross, it was proposed that there would be 100 step down beds. If the new build option was selected, 40% of the current site would be retained. This was equivalent to the percentage of the existing site used for clinical services to treat Hammersmith & Fulham patients.

Mr Elkeles stated that once outline business cases had been approved, individual OSCs would be asked to advise on the level of consultation.

Dr McGoldrick presented 'Developing OOH Services', which set out the common features for each CCG model and the enablers: accessible care, proactive care and co-ordinated care. ICT and the sharing of information in a safe way was a key enabler. An integrated IT system would facilitate the integration across boundaries for both health and social care. Currently, Brent and Richmond were the only two CCGs not included. UCC and community staff, including mental health providers, would be able to use the same system as GPs, with patient consent.

Mr Elkeles responded to Councillor Daly that there was some new money for OOH. Dr McGoldrick confirmed that QIPP (Quality Innovation Productivity and Prevention) required efficiency savings. Hammersmith & Fulham had a target of 4%. Money would be invested in projects, which would create savings, such as GP practices networks.

7. CLINICAL COMMISSIONING GROUP: OUT OF HOSPITAL UPDATE

The CCG Update set out the 2013 successes, which included extending access to primary care. Mr Elkeles responded that from April 2013, three GP practices had opened at weekends for eight hours every Saturday and Sunday for walk in and booked appointments, and this would be extended to additional practices. Approximately, a third of the patients had said that they would have gone to A&E should the service not have been available, and two-thirds had a genuine health need for a weekend appointment. Extended hours services were also being offered in Brent (a practice in each of the five localities) and two schemes will be run in Ealing.

Dr McGoldrick noted the implementation of 'Co-ordinate My Care' and the progress in ensuring that support was in place to enable a person to die in their chosen place. She responded to Councillor Collins that practices were working to the gold standard framework, which involved contacting relatives.

Dr McGoldrick responded to comments in respect of paediatrics that the high rate of A&E attendances should be dealt with in primary care. As part of an initiative to upskill GPs. Inner NW London CCGs had arranged for a paediatric consultant to work in a community hub, with a GP present. The pilot work had produced encouraging results, with good patient satisfaction and some impact on out patient attendances and a significant impact on A&E attendances.

Mr Elkeles responded to queries in respect of a greater role for community pharmacists that a business case was being developed for GPs and pharmacists to meet jointly with patients in order to increase the compliance rate in respect of prescriptions. Mr Elkeles noted that the CCG was employing pharmacists to give the flu vaccination to patients and staff.

Mr Elkeles responded to comments in respect of signposting patients to the appropriate service that, in the following year, the NHS would be taking space in Council magazines and London newspapers to publicise the SaHF proposals and deliver the message in respect of services. The extended GP opening hours had been advertised on telephone boxes, as shown in the presentation.

RESOLVED THAT:

End of Life Care should be added to the work programme.

8. ACCIDENT & EMERGENCY PLANNING AND WINTER PRESSURES

Mr Elkeles outlined the priority actions of the A&E Recovery & Improvement Plan. £250 million additional funding had been allocated to areas deemed most at risk of problems in A&E to increase beds

and staff. A further £150 million from NHS England's expected surplus had been announced in November.

The presentation set out how the winter funding had been allocated. The CCGs had jointly allocated almost £4 million for a number of schemes. Hillingdon had not been awarded any monies from the £250 million winter funding, but was expected to receive funding from the additional £150 million.

The presentation indicated that NW London's A&E performance against the 95% target was the highest in London, achieving 96.92% to week ending 17 November, over quarter 3.

Ms Chatterly queried the accuracy of the figures on which the winter pressures planning had been based. Mr Elkeles responded that each of the Urgent Care Boards had analysed the number of beds and expected admissions, based on the previous winter, which had been severe, and had made bids against the winter pressures money to bring up to capacity. However, should there be a flu pandemic for example, elective surgery would have to be reduced.

North West London Joint Health Overview & Scrutiny Committee
Action Points

Information to be provided	NHS Response
Meeting Date: 3 December 2013	
Number of patients transferred to Central Middlesex, when Northwick Park A&E has been closed	Outstanding
The capacity and beds attached to the existing and the new Northwick Park A&E	Outstanding
Planned surgery and North West London services being transferred to Central Middlesex, and patient numbers	Outstanding
Link to Decision Making Business Case to be re-sent	Outstanding
Meeting Date: 20 February 2014	
Points raised by Councillor Collins (letter attached)	

Joint Health Overview & Scrutiny Committee, 20 February 2014
Questions from Councillor Mel Collins, Hounslow

Transport & Parking

1. Can clarification/details be provided on the 2.3% increase to be provided for ambulance services as highlighted by Daniel Elkeles at the JHOSC meeting which took place on the 3 Sept. 2013 as public perception is still that London Ambulance services will be subject to a 19% cut in funding as reported in the press?

2. Is there an integrated public transport plan/strategy that covers hospital access across the 8 boroughs?

3. Is there a consistent parking policy for patients across ALL hospital sites?

4. What provisions are being made for blue badge holders as patients & visitors are reporting a lack of available spaces, as a result of non-blue badge holders taking these spaces, and are subsequently receiving parking fines when they park outside blue badge designated spaces?

5. Patients are reporting having to wait very long times after discharge to receive their prescriptions and are accruing high parking charges as a result – can a policy be put in place so that this does not occur?

Medical Services

1. What will be the impact for West Middlesex University Hospital from the reconfiguration of gynaecology and obstetrics services at Ealing Hospital?

2. What consultant led services will remain at Charing Cross Hospital?

3. What outpatient services will remain at Ealing and Charing Cross Hospitals?

4. Can you provide a detailed specification for the services which will be provided by Urgent Care Centres under the planned reconfiguration including confirmation that these will operate on a 24/ 7 basis across North West London?

North West London Joint Health Overview and Scrutiny Committee

TERMS OF REFERENCE

Membership

One voting member, plus one non-voting member from each Council participating in the North West London Joint Health Overview and Scrutiny Committee (JHOSC). Current membership is attached as appendix 1.

The committee will require at least six members in attendance to be quorate.

Chairman and Vice Chairman

The JHOSC will elect its own Chairman and Vice chairman.

Elections will take place on an annual basis each May, or as soon as practical thereafter, such as to allow for any annual changes to the committee's membership. The current Chairman will remain as Chairman until the next election, in May 2014 (after the 2014 Local Government elections) or as soon as practical thereafter.

Duration

The JHOSC will continue until March 2018, to match the planned implementation timeframe for the Shaping a Healthier Future programme. During this period, the committee will also hold an annual review in May each year, or as soon as practical thereafter, where it will consider and decide whether there is a need for the JHOSC to continue or whether it has fulfilled its remit and should terminate earlier than 2018. This does not preclude individual local authorities from leaving the JHOSC before this date. Should there be any proposals for a JHOSC beyond this date, this would need to be considered by each participating authority in line with its own constitution and policies.

Terms of Reference

The JHOSC will perform the following functions:

1. To scrutinise the 'Shaping a Healthier Future' reconfiguration of health services in North West London; in particular the implementation plans and actions by the North West London Collaboration of Clinical Commissioning Groups (NWL CCGs), focussing on aspects affecting the whole of North West London.

2. To review and scrutinise decisions made or actions taken by NWL CCGs and/or other NHS service providers, in relation to the 'Shaping a Healthier Future' reconfiguration, where appropriate.

3. To make recommendations to NWL CCGs, NHS England, or any other appropriate outside body in relation to the 'Shaping a Healthier Future'

plans for North West London; and to monitor the outcomes of these recommendations where appropriate.

4. To require the provision of information from, and attendance before the committee by, any such person or organisation under a statutory duty to comply with the scrutiny function of health services in North West London.

The stated purpose of the JHOSC is to consider issues arising as a result of the Shaping a Healthier Future reconfiguration of health services, taking a wider view across North West London than might normally be taken by individual Local Authorities. Individual local authority members of the JHOSC will continue their own scrutiny of health services in, or affecting, their individual areas (including those under 'Shaping a Healthier Future'). Participation in the JHOSC will not preclude any scrutiny or right of response by individual boroughs.

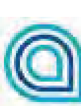
In particular, and for the sake of clarity, this joint committee is not appointed for and nor does it have delegated to it any of the functions or powers of the local authorities, either individually or jointly, under Section 23 of the local authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

NW London JOSC

20th February 2014

Agenda

1. Implementation
2. SaHF enablers:
   - 7 day services
   - Infomatics
   - Workforce transition
   - Travel
3. Whole system integrated care
4. Primary care transformation
5. Mental health transformation
6. Acute reconfiguration:
   - Ealing maternity transition
   - Hammersmith hospital emergency department transition
   - Future of Central Middlesex Hospital
   - Local and major hospital business case assurance process
7. Local hospital update
8. Communications & engagement



Implementation

To implement the changes we have established a whole system programme of change...

Shaping a healthier future – Led by 8 CCGs in NW London

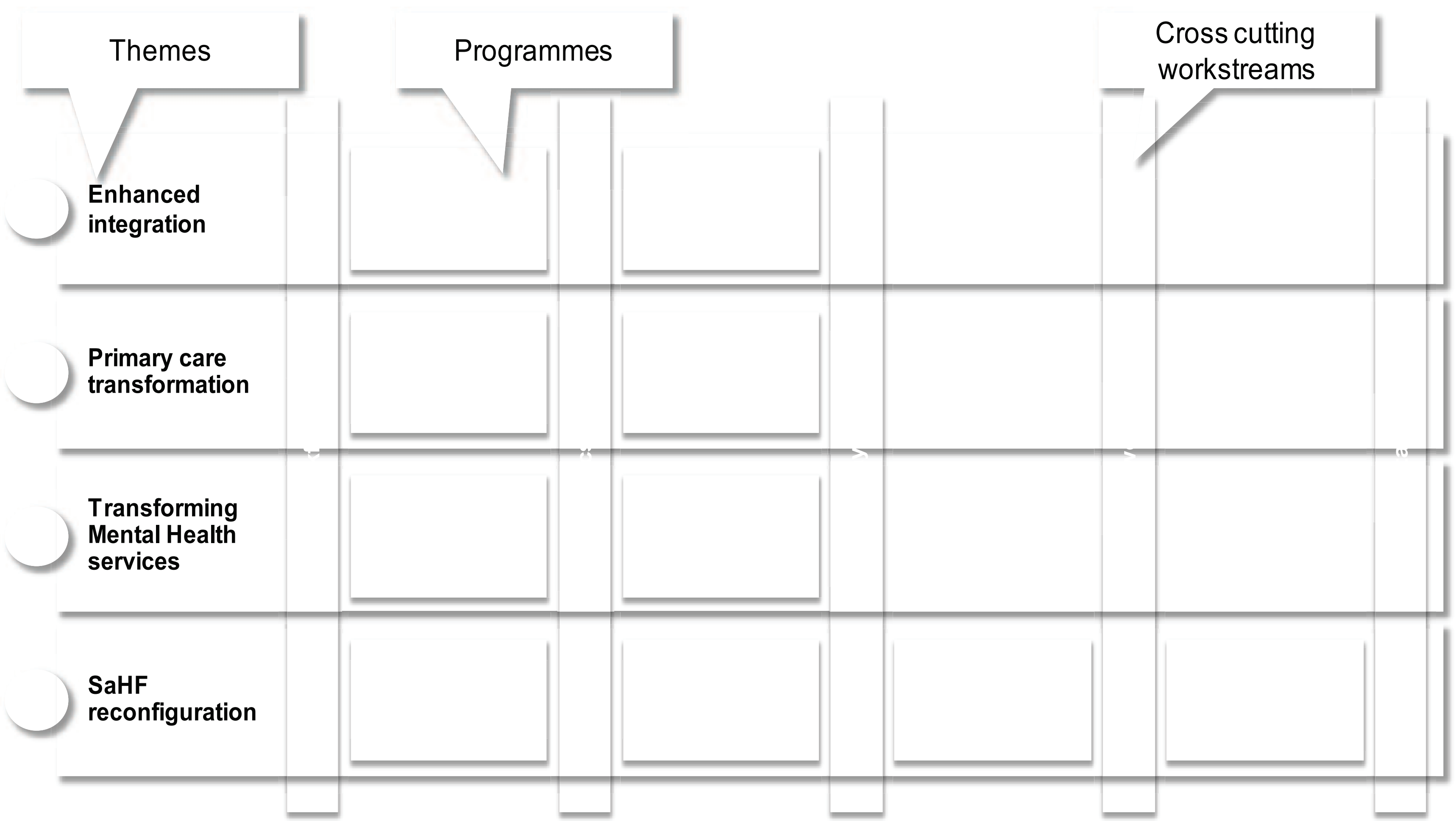
CCGs	Strategy & Transformation	Acute

- QIPP (CCGs)
- Whole systems
  - OOH transformation: Integrated care; Primary care transformation; Mental health transformation; Networks of care
  - *Provider transformation*: Primary care estates; Major hospitals; Local hospitals; Business cases
- Cross cutting:
  - Workforce: OOH and transition
  - Comms and engagement
  - Finance and modelling
  - Clinical pathways and quality
  - Equalities, travel and access, information management
- CIP (acute)

Monitoring delivery

IRP/ JR

... with the delivery of the vision managed through a portfolio of programmes that are grouped into four themes



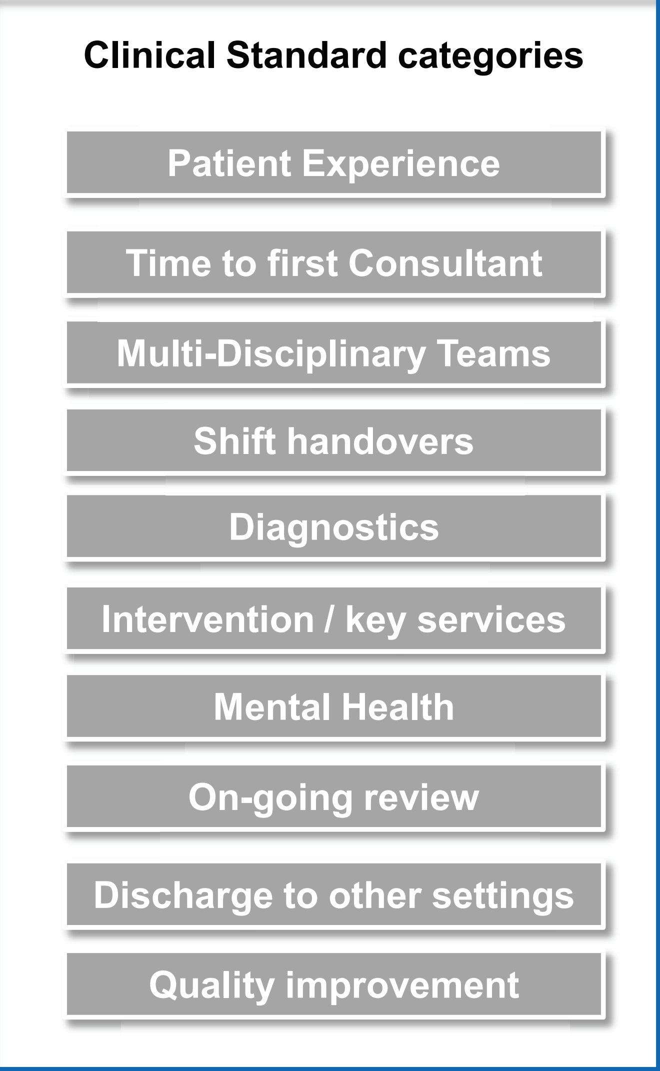
- Within each of the four themes there are a number of large scale programmes
- The delivery of programmes is enabled by a number of cross cutting workstreams

SaHF Enablers
7 Day Services

We are an Early Adopter for Seven Day Services, with a plan to meet the Seven Day Standards for Emergency Care at scale and pace

NW London is a NHS England/ NHS IQ 'Early Adopter' for the Seven Day Services Improvement Programme

- **Within five years** NHS IQ (*the NHS body providing improvement and change expertise*) expects early adopters to:
  - Be regarded as **experts** in delivering seven day services;
    - Delivering improved outcomes, including better experiences for patients, carers and the public
    - Tackling local cultural and organisational barriers
    - Realising savings and efficiencies
  - Have **demonstrated a range of approaches** and models involving whole system approaches to the delivery of seven day services;
  - Have demonstrated the scope to make **rapid progress** at scale and pace;
  - Have overcome the barriers to delivering coordinated care and support across pathways – **testing radical options** for delivering care differently;
  - Have **accelerated learning** locally, regionally and nationally; and
  - Have **improved the robustness of the evidence base** to support and build the value of the case for seven day services across the health and social care system.



Services will be provided 7 days per week in eight settings of care in NW London

Patients

ELECTIVE HOSPITAL
7 days
24 hours

MAJOR HOSPITAL
7 days
24 hours

HOME
7 days
24 hours

COMMUNITY AND RAPID RESPONSE
7 days
12 hours

CARE HOME
7 days
12 hours

111
7 days
24 hours

999
7 days
24 hours

GP PRACTICE
5 days
10.5 hours

HUBS AND GP NETWORKS
7 days
12 hours

LOCAL HOSPITAL
7 days
24 hours

SaHF Enablers
Informatics

North West London is developing a comprehensive Informatics Strategy to enable transformation

MUST DO **Interoperable NWL**	• Sharing information with service users • Sharing information between care professionals • Sharing information for system management and improvement
Pioneer: Informatics Club	• Rules of engagement – commitment to share (safeguards & controls) • Standard agreements and arrangements for NW London • NHS ID as the Universal Care ID
Functionality & Features	• Flexibility in accessing care • Shared care plans / records • Delivery – care across care settings (workflows) • Personalization • Self-management • Quality improvement/ planning & management / transactional tools
Driving up quality & supporting workforce	• Quality framework • Formulary for coding • Support, training and accreditation – workforce encourage use of technology
Encourage partnerships and innovation	• Supplier partnerships • Supporting provider innovation • Knowledge management community for informatics & innovation

SaHF Enablers
Workforce Transformation

The programme held a workshop jointly with Health Education NW London with over 100 stakeholders covering three areas:

I	**The future of health and care**	• What are the changes we are going to see and the new models of care • What integration is needed between providers in health and care
II	**Workforce transformation**	• The new skills and roles needed for the future • Strengthening existing roles • The new roles • Which of the core roles to be rapidly developed • How should we develop them
III	**Energising the workforce**	• What practical steps do we need to take • How do we energise the current workforce • How do we make the transition safe and attractive • What mechanisms do we use to keep and attract the best in NW London

The outputs of the session have laid the foundations for the workforce work-stream's work for the next 12-18 months

I - The Future of health and care

1. Delivering the right health care in the right place at the right time through a **focus on patient experience, kindness and patient centred coordinated care**
2. Further emphasis on **prevention** and the **educated and empowered patient**
3. An **integrated** health and care system with **multi-disciplinary working** and the **removal of organisational barriers** to collaborative working
4. **Commissioning on outcomes** and the removal of financial barriers between **health and social care to align incentives**
5. Greater freedoms of **staff moving between settings** and across organisations, **based on skills** and where the care is needed

II - Workforce transformation

1. Ensuring everyone has the **right skills to do the right job**
2. Creating **confidence and trust between providers**, breaking down traditional barriers, and supporting **clearer dialogue**
3. Supporting staff, **changing attitudes and developing the right behaviours**, winning hearts and minds
4. Creating **new training packages**, for example Multi Disciplinary Team training, training staff to **think in terms of the whole pathway**, providing rotation opportunities across settings
5. Developing **attractive community roles**, to support and coordinate and deliver care, **coaching and mentoring staff for empowerment** and more **autonomous working**

III - Energising the Workforce

1. Engage with staff, **be honest, listen, be kind and demonstrate that staff are valued**
2. Provide **strong leadership**, reduce bureaucracy and **demonstrate ongoing commitment**
3. Provide **exciting career and development opportunities** and education and training at an early stage to energise
4. **Understand barriers for staff**, for example recognise the high cost of living in NW London
5. The change management process needs to be **fully transparent and fair**

The workstream's packages of work for 2014/15

0. NWL Workforce Planning Overview (managed through the 'workstream coherence' work package)

- A overview report collating existing work and commitments across the programme a single place. This will provide a 'baseline' for all other work packages

1. Workforce HR Transition

- Develop the HR Transition framework for the multilateral movement of staff
- Plan the workforce transition for SaHF Priority One Projects (with initial concentration on CMH A&E, Hammersmith A&E and Ealing Maternity)

2. Business Case Assurance and Development

- Assurance of the local and major hospital Outline Business Cases (OBC)
- Support providers as required in the development of detailed workforce plans for the Full Business Cases (FBC)

3. Achieving Acute Clinical Standards

- Achievement of acute clinical standards as outlined in the Decision Making Business Case (DMBC) and London Quality standards
- Achievement of acute standards for Seven Day Services Programme

4. Primary Care Workforce Transformation

- Support the workforce aspects of Primary Care Transformation programme (inc. OD and ways of working)
- Develop career pathways for the transformed primary care workforce.
- Design training packages to support role development and transformation including GP trainees

5. Developing the Workforce for Integrated Care

- Develop workforce principles for the integrated care workforce.
- Support workforce aspects of the WSIC early adopters.
- Define and develop hybrid roles, at individual and team level.

6. Community Learning Networks

- Define, develop and implement community learning networks
- Develop multi-disciplinary training packages to support integrated care and community-based learning

Enablers

I. Programme Management – including analytics support across work packages.

II. Workstream Coherence

SaHF Enablers
Travel

Overview of TAG priorities and plan of work for 2014

- The Travel Advisory Group (TAG) was established during the decision making phase to provide travel and access expertise to the programme during the development of the Decision Making Business Case
- In concluding this work the TAG made 12 recommendations, summarised in their final report, and following this the TAG in that form was disbanded
- Following decision making, and during the mobilisation for implementation, it was agreed that the TAG would reconvene in order to:
    - Identify and mitigate travel and access issues arising during implementation of SaHF
    - Advise on the management of the travel implications / opportunities
    - Bring together relevant stakeholders to support this area of work
- The TAG, working with the programme, met on 30th January 2014 and has defined its priorities with a schedule of work to progress the previous TAG recommendations and achieve its objectives during implementation

The recommendations have been themed/summarised under five objectives to deliver the TAG's remit during implementation

TAG purpose

- Identify and mitigate travel and access issues arising during implementation of SaHF, provide assurance that travel implications of implementation have been identified and opportunities for improvements and mitigations have been considered
- Advise on the management of the travel implications / opportunities
- Bring together stakeholders to support this area of work and advise on actions to improve experience of travel to health services

OBJECTIVE	1: Establish TAG governance and networks	2: Monitor and assure health related transport challenges	3: Support the production of health transport solutions	4: Produce TAG related analytics and monitoring	5: Support travel related communications
TAG report recommendations	To support an ongoing forum similar to the TAG to support implementation	To monitor and seek assurance on hospital travel plans and patient transport services to agreed standards	To work together in assessing and improving access to local hospitals – across borough boundaries where required	To collect qualitative data on patient travel patterns to create a wider evidence base to inform development of specific proposals	To provide good, clear accessible information to patients and public on travel options to health facilities
	To ensure local NHS organisations are involved in public transport liaison groups	To consider access to health care sites in reviewing transport routes	To support primary and community providers in developing travel plans and addressing travel issues in the context of local out of hospital strategies	To recognise that travel to and from health facilities is an important part of measuring patient experiences and outcomes	
	Establish links with local authority public transport planning liaison groups/local authority transport planners to review strategic transport requirements/changes	To consider together the options for door-to-door transport to health facilities as part of an integrated response to people's travel needs	To develop/improve travel plans to best practice standards (e.g.: addressing key issues, covering staff, patients and visitors) and ensure annual review of plans by Trust Board	To undertake ad-hoc analysis to support implementation	

This wasn't a TAG recommendation but has been included as an emerging requirement for the TAG

A number of priorities were agreed at 30th January TAG meeting

*Objective	Activities to deliver task	Responsibility	Date	Status
1.5	• Agree programme of work and priorities for TAG	TAG	Jan ‘14	Ongoing
2.1	• Identify resources to review hospital travel plans and Patient Transport Service (PTS) policies and convene working group to oversee activity	TAG	Jan ‘14	Ongoing
2.2	• Request, collate and summarise trust transport plans and PTS policies	TBC	Jan ‘14	Ongoing
2.10	• Identify OBC Travel Working Group to support OBC assurance process	TAG	Jan ‘14	Ongoing
2.13	• Identify resources to support Phase 1 Priority Projects as they plan and implement changes at CMH and HH A&Es	TAG	Jan ‘14	Ongoing
3.1	• Receive briefing from LH and MH teams regarding considerations for travel in the context of local hospitals, specifically re. travel to LH, and between sites, e.g. emergency care and patient transport	TAG	Jan ‘14	Ongoing
4.1	• Identify resources to undertake the collection of qualitative data on patient travel patterns and convene working group to oversee activity	TAG	Jan ‘14	Ongoing
4.2	• Develop specification of requirements for patient travel patterns	TBC	Jan ‘14	Ongoing
4.9	• Identify resources to undertake work and convene working group to oversee activity	TAG	Jan ‘14	Ongoing
3.13	• Support Phase 1 Priority Projects as they implement changes at CMH and HH A&Es and seek assurance from those project groups that travel issues are being addressed	TAG	Jan to Oct ‘14	Ongoing

*Links to TAG recommendations report

Working groups were agreed (30/1/14) and set up to progress the priorities

Group 1

- Request/ Collate/ Review and summarise travel plans and make recommendations against 'best practice'
- Support OBC assurance process

Group 2a

- Support implementation of changes at Central Middlesex Hospital A&E department project

Group 2b

- Support implementation of changes at Hammersmith Hospital A&E department project

Group 3

- Review patient experience measures and make recommendations on measuring patient experiences
- Request/ Collate/ Review and summarise PTS policies and make recommendations

Being commissioned

- Patient travel patterns, review and make recommendations

Whole Systems Integrated Care

NWL is an Integrated Care Pioneer – our partners are supporting our transition towards whole systems integrated care

NHS
Brent
Clinical Commissioning Group

NHS
Central London
Clinical Commissioning Group

NHS
Ealing
Clinical Commissioning Group

NHS
Hammersmith and Fulham
Clinical Commissioning Group

NHS
Harrow
Clinical Commissioning Group

NHS
Hounslow
Clinical Commissioning Group

NHS
West London
Clinical Commissioning Group

NHS
Hillingdon
Clinical Commissioning Group

Brent

City of Westminster

Ealing
www.ealing.gov.uk

h&f

Harrow COUNCIL
LONDON

London Borough of Hounslow

KENSINGTON AND CHELSEA

Central London Community Healthcare NHS
NHS Trust

Central and North West London NHS
NHS Foundation Trust

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Ealing Hospital NHS
NHS Trust

Hounslow and Richmond Community Healthcare NHS
NHS Trust

Imperial College Healthcare NHS
NHS Trust

The Hillingdon Hospitals NHS
NHS Foundation Trust

The North West London Hospitals NHS
NHS Trust

West London Mental Health NHS
NHS Trust

West Middlesex University Hospital NHS
NHS Trust

IMPERIAL COLLEGE HEALTH PARTNERS

NIHR CLAHRC
for Northwest London

bucks
new university

NWL

NHS
Health Education
North West London

NHS
England

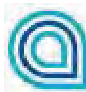
Our vision

Our shared vision of the WSIC programme …

We want to improve the **quality of care** for individuals, carers and families, **empowering and supporting** people to maintain independence and to **lead full lives** as active participants in their community

… supported by 3 key principles

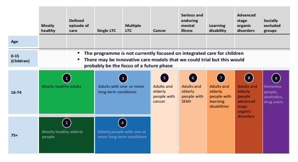
1. People will be empowered to direct their care and support and to receive the care they need in their homes or local community.
2. GPs will be at the centre of organising and coordinating people's care.
3. Our systems will enable and not hinder the provision of integrated care.



The WSIC Programme structure so far has concentrated on five areas of co-design underpinned by Embedding Partnerships

Embedding Partnerships

Population and outcomes

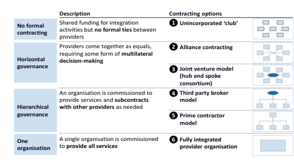


- How should we describe groups of people who need care?
- What are the opportunities to improve care for these groups?
- What goals do people in these groups want to achieve?

GP networks

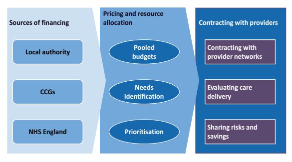
- What services could groups of practices working together provide for better care for people?
- How can these GP groups work with other care providers to deliver better services for people?

Provider networks



- What services could groups of providers working together provide for better care for people?
- What incentives do we need to ensure providers do the right and easy thing for people?
- How should different providers spend money in new ways without damaging existing care?

Commissioning and finance

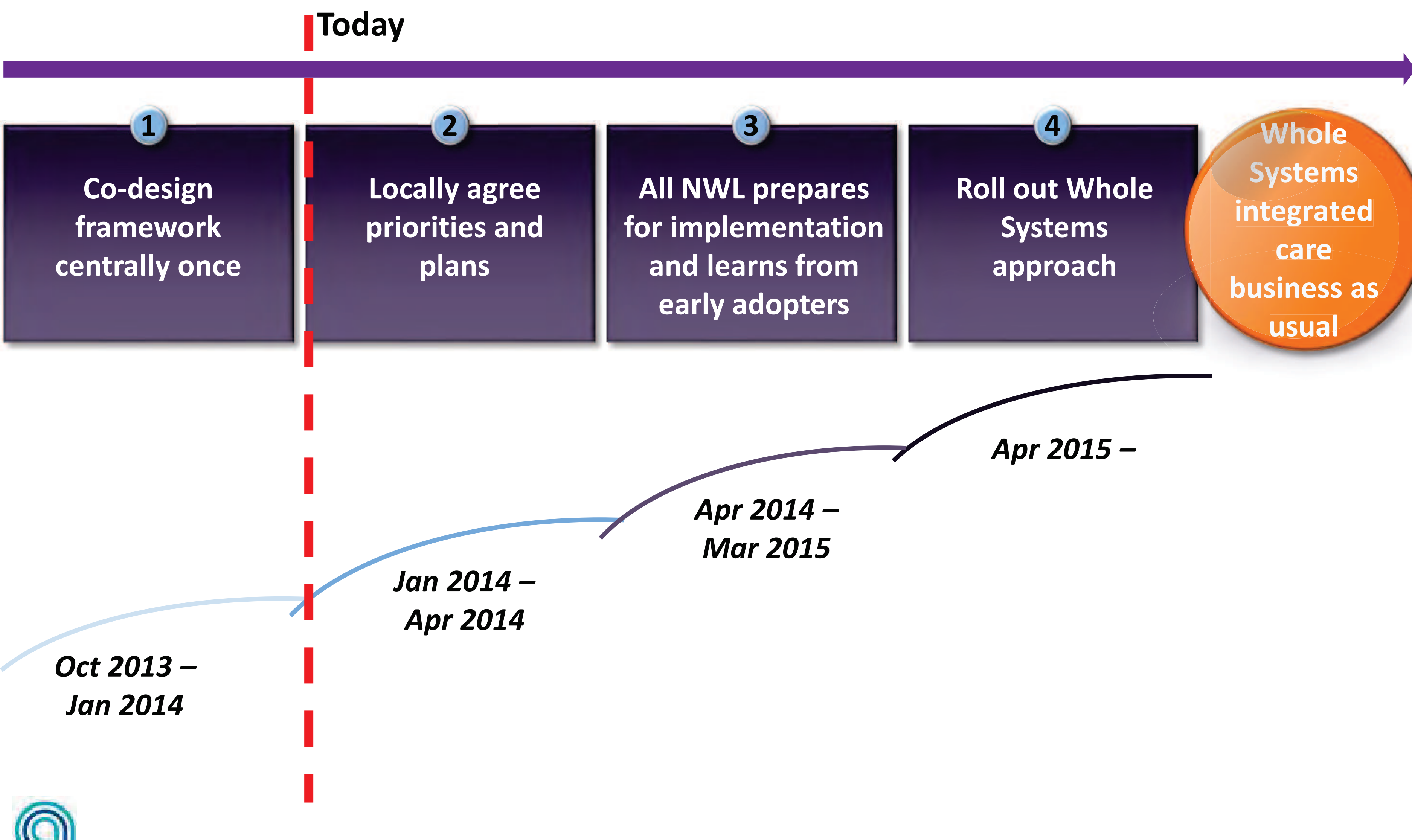


- How can people get better co-ordinated care by not having different organisations with separate budgets paying for care?
- If there was one pot of money how do different commissioners make sure that people are getting the care they want?

Informatics

- What information is needed to provide better services to people?
- What information do commissioners need to make sure people are getting the care they need?
- What information do we have and what information is missing today?

How we get from where we are today to where we want to be in 2015/16



Summary of the 25 expressions of interest

EOIs from commissioners
EOIs from providers

All NWL 12 19 24 25
- EOI for Cancer Commissioning
- EOI from LAS
- EOI from Mental Health Programme Board
- EOI from ICHP on COPD pathway

Harrow 23
- EOI for 6 emerging GP networks
- Supports 2+ LTCs

Brent 21
- EOI for 4 emerging GP Networks
- Supports 2-3% high risk and 1+LTCs

West London/K&C 1
- EOI from CCG and LMA GP Partners
- Supports elderly and 1+LTC

Hillingdon 22
- EOI for 2 GP networks
- Supports elderly

Imperial 9 10 11
- Adults admitted to hospital with **ChelWest** and **CLCH**
- Children
- Cancer with H&F and Hounslow

Ealing 20
- EOI from HWBB for all CCG
- Supports elderly and top 2% risk

CLCH 4 7 8
- EOI with H&F on Virtual Wards
- EOI with CLCCG for 'village delivery'
- EOI for integrated community services across Tri-borough

Hounslow 13 14 15 16 17 18
- EOIs from 4 GP Networks on elderly and LTCs
- EOI from GP Network on SMI
- EOI with WLMHT on dementia

H&F 3
- EOI for Virtual Ward for all patients

ChelWest 2
- EOI with H&F Network 2 supporting 1+LTCs, elderly and HIV

Central London/Westminster 5 6
- EOI for Victoria GPs LLP supporting elderly, homeless and 1+LTCs
- EOI for CLH CIC supporting LTCs and SEMI

Primary Care Transformation

Currently, a number of challenges face primary care

Transformation needed to deliver OOH

Increasing expectations of quality in primary care

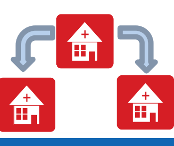
Higher requirements of the quality of practice estate

The common features of CCGs' plans primary care suggests major changes to how practices work

Registered GP Practice

Patients will be able to access from their <u>registered GP</u> practice:

- **Core opening hours**
- **Core general practice services**
- Standard suite of **out of hospital services**
- **Non-urgent** appointments within published timescales with named health professional.
- **Differentiated access** via telephone, email, etc.
- **Lead responsibility** for care planning
- **Online access** to practice registration, appointments booking, repeat prescription ordering, etc.



GP Network

Patients will be able to access from <u>a GP network hub</u> in their local area:

- **Extended opening hours**
- **Seven day access**
- **Standard suite of out of hospital services**
- **Urgent response** within 4 hours, and **same day appointments**
- **Convenient appointments** (with any health professional at a flexible time and location).
- **Differentiated access** via telephone, email and Skype.
- **Integrated community services** available from hubs

CCG level provision

Patients will be supported by the following <u>CCG-level enablers</u>:

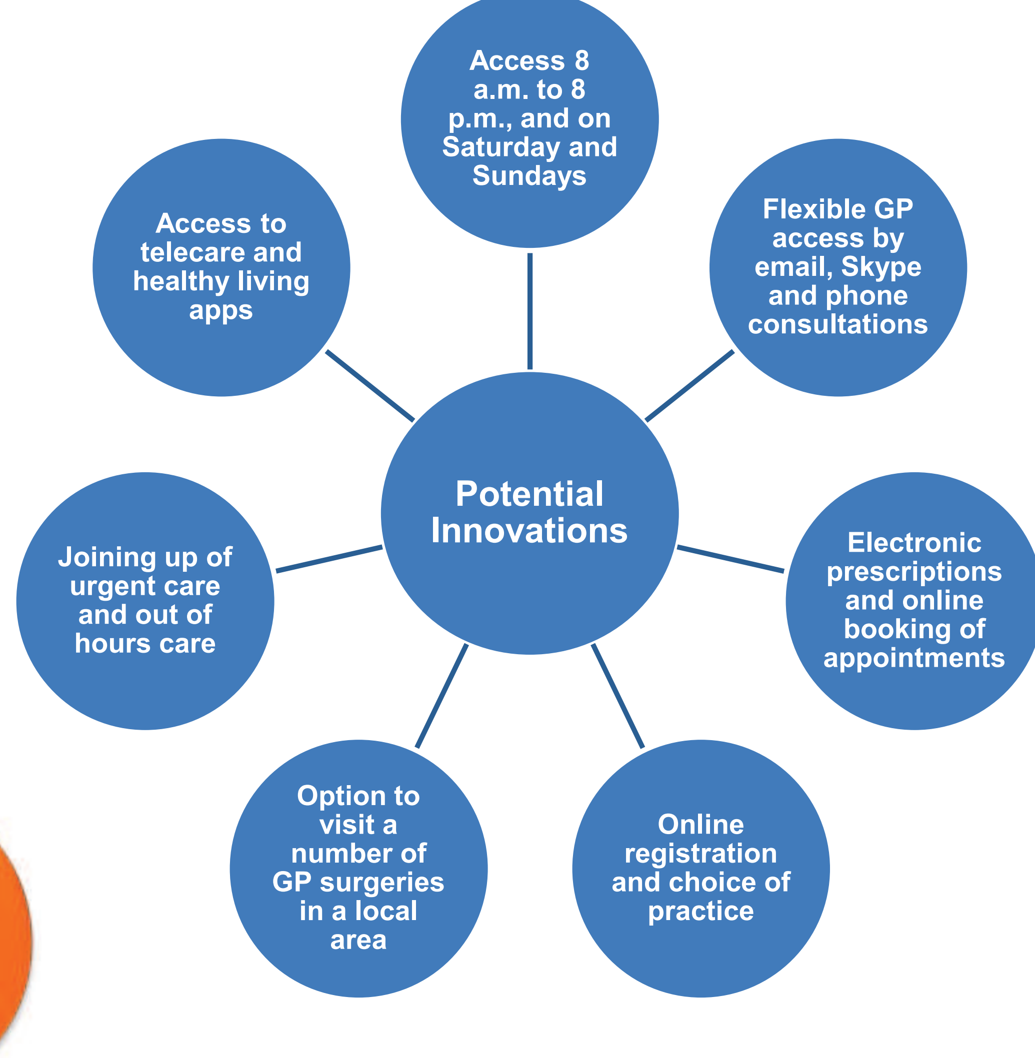
- **24/7 access** to urgent care.
- **111 service**
- **Out of hours GP service**
- **Walk-in centres / urgent care centres**]
- **Supporting ICT, data sharing and telephony**
- **Open patient lists** to allow wider patient access and inter-referrals between practices.

- **Continuity appointments** (with named health professional) for patients with long term care needs.
- **Longer appointments** for patients with long term care needs.

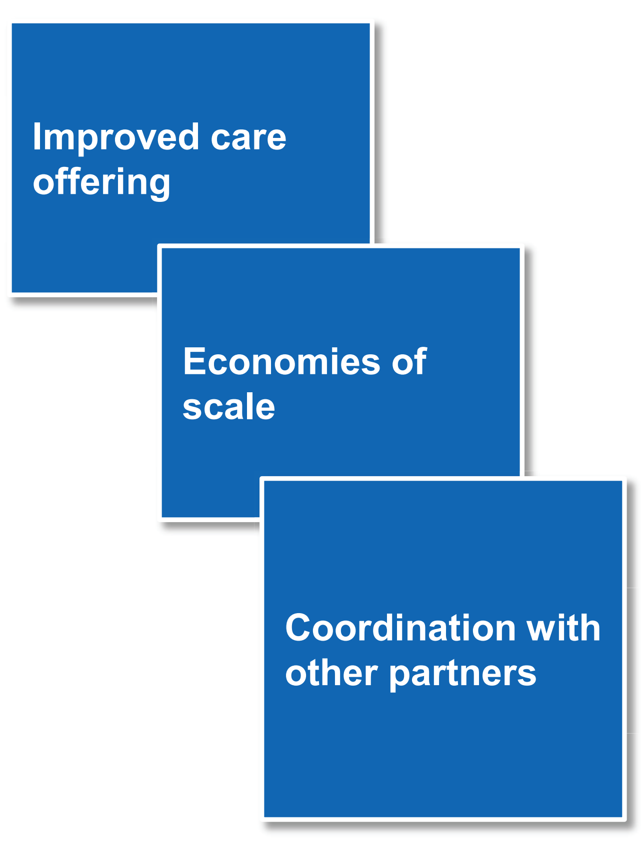
Prime Minister's Challenge Fund wants practices to test a range options for extending access to General Practice

- **£50m** available nationally
- **9** national pilot sites planned
- **14 February 2014** deadline for applications
- Focus on **new ways of working**, **innovation** and **technology**
- Supports **development of GP network** ways of working

The 8 CCGs in NW London are submitting a joint application



Formation of GP networks will allow primary care to better serve the population and to better coordinate with other providers



8 Hillingdon
- 6 networks
- 6-12 practices per network

1 Harrow
- 6 networks
- 5-7 practices per network

2 Brent
- 5 networks
- 10-15 practices per network

3 Central London
- 3 localities
- 10-12 practices per locality

4 West London
- 2 networks
- 10-15 practices per network

5 H&F
- 4-5 networks
- 6-8 practices per network

6 Hounslow
- 5 networks
- 8-12 practices per network

7 Ealing
- 7 networks
- 10-15 practices per network

Mental Health Transformation

The programme is focussing on three critical areas to modernise services...

Acute Reconfiguration

Ealing maternity transition

Verbal update

Acute Reconfiguration

Hammersmith Hospital Emergency Unit transition

Project overview

Objective: To ensure the safe closure of the Hammersmith Hospital Emergency Unit before December 2014, in line with the Secretary of State's decision on 30th October 2013

- Prior to the transfer of any services, changes will be managed through a robust service transition process, which will ensure operational readiness of all parties impacted by the transition
- Regular updates on the status and delivery of this project will be provided to the JOSC as required

Project scope

Objective: To ensure the safe closure of the Hammersmith Hospital Emergency Unit before December 2014, in line with the Secretary of State's decision on 30th October 2013

In scope	Out of scope
• Development and implementation of new **clinical pathways** • Implementation of changes to **Hammersmith UCC** • Development and implementation of the **closure plan**, including the necessary **assurance processes** • Local **communications and engagement activities** • **Workforce transition** • Any necessary **staff consultation** and **HR processes** • Changes to **training** programmes • Compliance with statutory **equalities responsibilities** • Changes to **infrastructure, travel and access** resulting from the closure of the Hammersmith Hospital Emergency Unit	• **Formal consultation** with patient and public • **Wider capital projects** within Imperial and other major hospitals

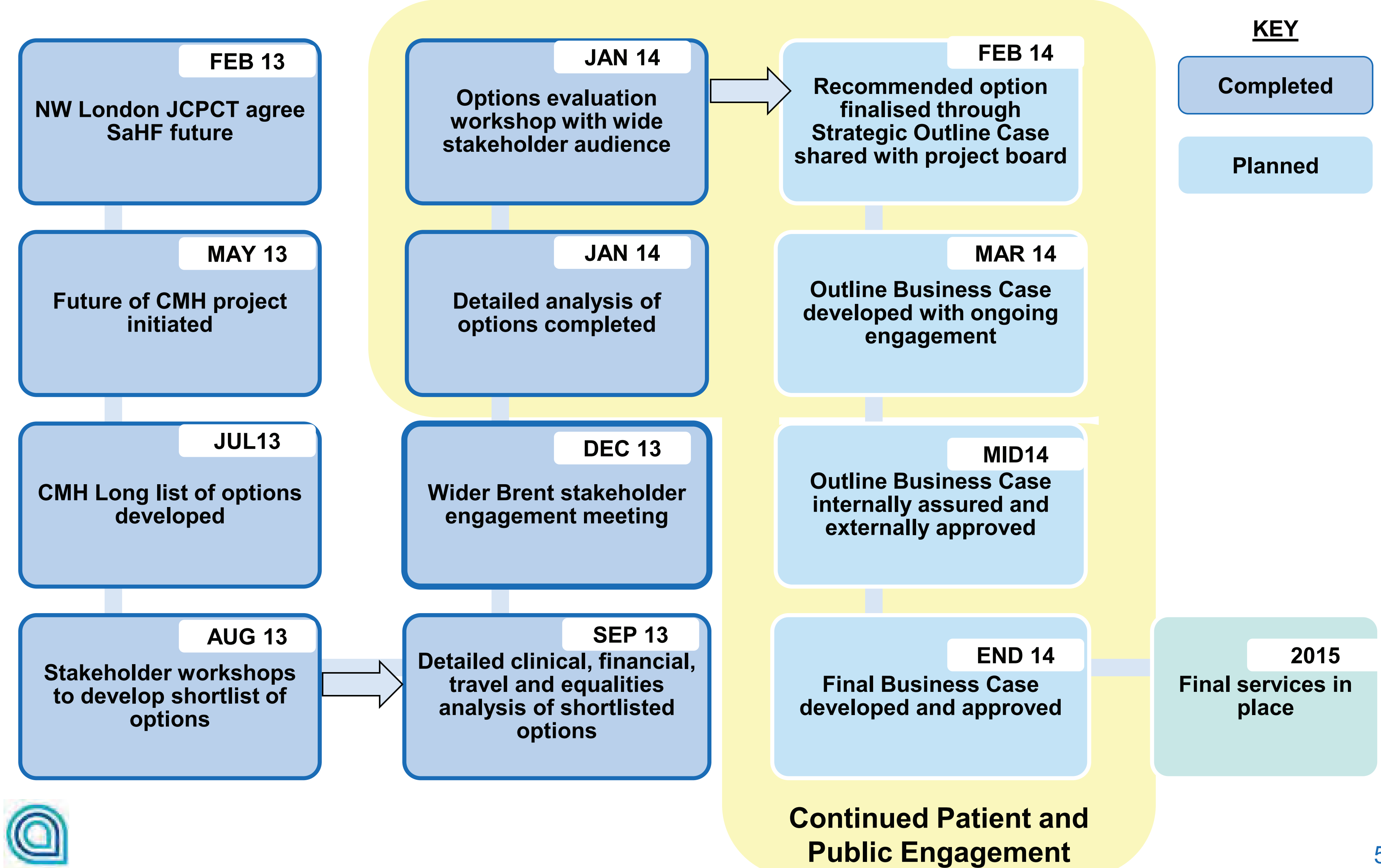
Acute Reconfiguration

Future of Central Middlesex Hospital

Options for additional services at Central Middlesex

- *Under the Shaping a healthier future* proposals the site would only be 35% full and would make a large financial loss. The site has excellent facilities and we committed to undertake further work to identify a range of services that would make best use of them.
- To fulfil our commitment a project has been established to look at what services could be delivered at CMH to fully utilise the site for the benefit of local residents and ensure it is financially sustainability for the long term.
- The project has considered four key areas to allow evaluation of different services:
  1. **Clinical evaluation** – quality of care, deliverability, research and education
  2. **Estates and Finance** – affordability and value for money
  3. **Access to Care** – access to care and impact of changed patient journeys
  4. **Equalities Impact** – any impact on protected patient groups

Process for developing a clinically viable and financially sustainable future for CMH



The clinical evaluation resulted in an additional optimised proposed list of services that will make full use of CMH

Option 2 | **Bundle of Services from multiple providers on CMH site**

Health centre | Local hospital | Elective hospital | Specialist hospital

- This 'bundle' of services option is the most viable option to provide the best range of health services for Brent residents and to maximise the use of the CMH site.
- These services would require a significant investment to be made on the site, which is being detailed in the estates and finance workstream.

Hub Plus for Brent – major hub for primary care and community services including additional out-patient clinics and relocation and expansion of community rehabilitation beds from Willesden

\+

Elective Orthopaedic Centre – a joint venture for local providers delivering modern elective orthopaedic services

\+

Brent's Mental Health Services from Park Royal Centre for Mental Health

\+

Regional genetics service relocated from Northwick Park Hospital

Impact of potential services that ‘bundle’ option offers

Hub Plus

- ✓ Improved quality – rehabilitation beds co-located with wider range of services and support
- ✓ More primary care and community services available on site
- ✓ Diagnostics services – improved direct access
- ✓ More out-patients clinics provided on site
- ✓ Co-located services support integration
- X Implication for Willesden Health Centre

Rehousing Mental Health Services

- ✓ Modern mental health facilities to ensure best practice care
- ✓ Improved mother and baby unit
- ✓ Shared pharmacy facilities between community acute and mental health

Elective Orthopaedic

- ✓ Dedicated planned/elective care with reduced length of stay and low infection and complication rate
- ✓ Proven model of care – SWLEOC receiving high patient satisfaction

Relocating regional genetics

- ✓ Moving lab services allows Northwick Park to expand major hospital services

Summary of draft evaluation presented at CMH Workshop - 14th January 2014

++ High evaluation
-- Low evaluation
/ Marginal

	Quality of Care		Access		Affordability & Value for Money					Deliverability			Research & Education	
	Clinical quality	Patient experience	Distance and time to access services	Patient choice	Capital cost to the system	Site viability	Surplus for the health economy	Transition costs	Value for Money	Work-force	Expect-ed time to deliver	Co-depend-encies with other strategies	Support current and developing research and education delivery	Total Evaluation
1a CMH bundle + Willesden bundle	++	+	/	/	- -	+	+	/	+	+	-	/	+	+5
1b CMH bundle + Willesden disposal	++	+	/	/	- -	+	+	-	+	+	-	/	+	+4
1c CMH bundle + partial Willesden disposal	++	+	/	/	- -	+	+	-	+	+	-	/	+	+4
2 CMH disposal and dispersal of services	-	/	+	-	- -	+	+ +	- -	+	/	-	- -	/	-4

Engagement with stakeholders

- GP Forum 30th October 2013
- Equality, Diversity and Engagement Committee (EDEN) 27th November 2013
- JHOSC 3rd December 2013
- Brent HOSC 4th December 2013
- Brent stakeholder focus meeting 12th December
- Brent Clinical Directors and Clinical Leads 8th January 2014
- CMH Workshop 14th January 2014
- Brent HOSC 28th January 2014
- Equality, Diversity and Engagement Committee (EDEN) 29th January 2014
- Brent stakeholder focus meeting *19th February 2014*
- JHOSC *20th February 2014*
- *Further engagement being planned throughout all stages*

Approvals process

Final Drafting of the Strategic Outline Case 19/2

Partnership Board 25/2
Agree final options evaluation and recommendation report and makes recommendation to develop business case(s) for confirmed options

CCG Collaboration Board 27/2
Commissioners to review proposals in advance of passing to implementation Programme Board and affected Commissioners and Providers

SaHF Implementation Programme Board 6/3
recommendation setting out:
- recommendation
- any deviations from the DMBC
- Impact on SaHF e.g. JHOSC engagement on need to consult
- Next steps and plan
- Option for NWLHT to progress with BC at risk

Approvals

Impacted:
CCG Governing bodies:
Brent 26/3
Harrow 25/3
Ealing 19/3
H&F 1/4
Approve proposal
NHSE 25/3
Approve proposal

Affected Trust's **Boards:**
NWLHT 26/3
CNWL 13/3
Imperial 27/3
EHT 27/3
Approve proposal

NHS Trust Development Authority Executive 24/3 Approve proposal

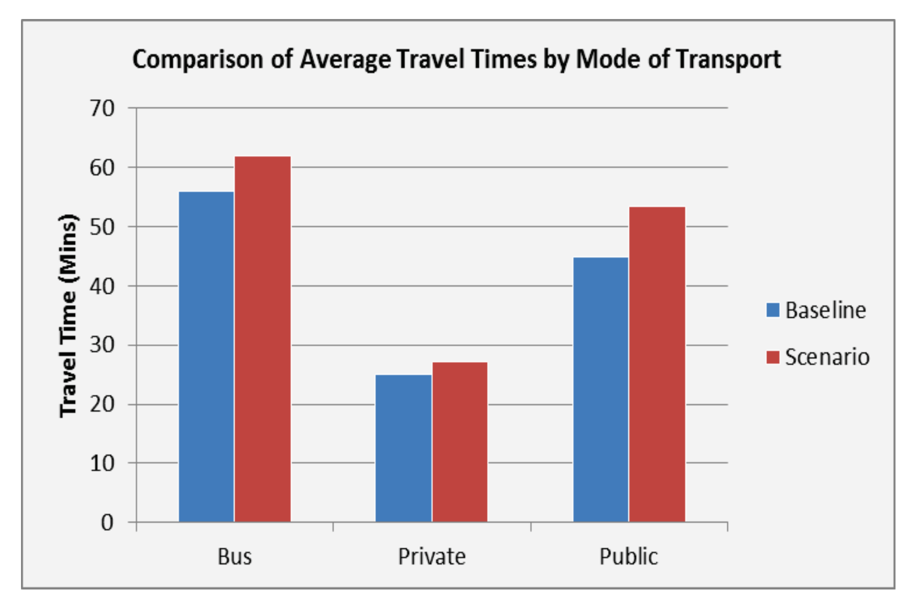
Partnership Board 3/4 confirms positive decision and forward action plan for all parties and work commences on OBC*

***Any proposals developed into an Outline Business Case will be progressed subject to any necessary or appropriate consultation**

Travel Considerations

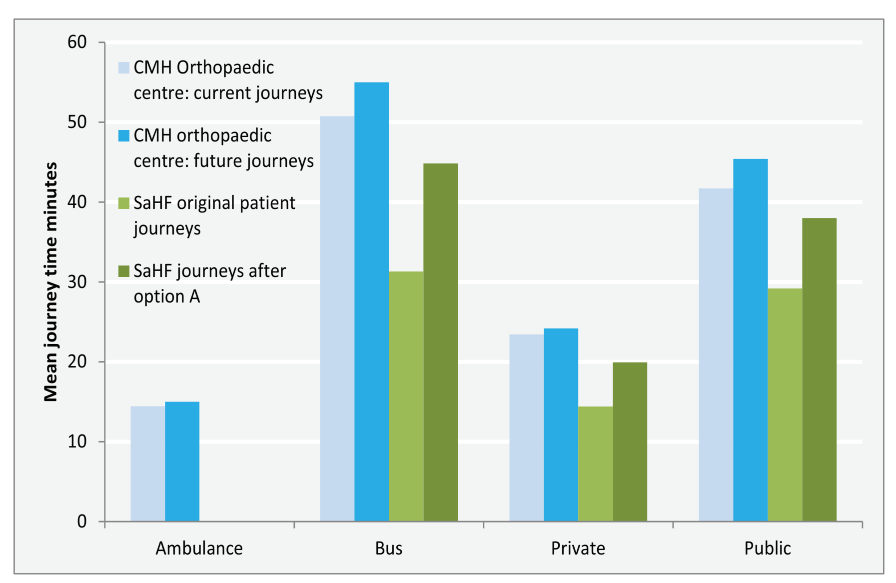
- Travel Conclusions:
  - Only three options involve major shifts of treatment location
  - A thorough analysis of journeys for the **Elective Orthopaedic Centre** option shows only small changes in journey times which, in our judgement, do not constitute a significant diminution of patient access
  - Analysis of the major inpatient and outpatient flows in **Closure** option suggests that the average travel time is marginally improved which strongly suggests there are no new barriers to access in this option
  - Analysis of the major flows relating to the **Brent Hub Plus** suggest that it also marginally improves the average patient journey time so cannot be considered to create significant access issues. A separate analysis may be required for routine GP activity based at Willesden and this is likely to require analysis of patient preferences not just activity.
  - No other options require travel analysis

The changes in average travel times for those orthopaedic patients moving to CMH are not large



- Our worst-case analysis takes the journey times of the patients to their current provider and compares it to the journey times to CMH. We test times for 3 key modes of transport, though in reality a mix of methods will be used (this has the advantage of being a worst-case for travel time).
- Note that in some options for the Orthopaedic Centre at CMH, patient transport is provided by the centre so this analysis is irrelevant and there are no relevant issues potentially reducing patient access.
- These are small changes in travel time and do not show significant affects on patient access.

Comparisons of orthopaedic centre option with the effect of SaHF changes shows the incremental change is much smaller



- The changes of treatment location as a result of the original SaHF plans were not regarded as creating significant problems for patient access. We show here a comparison of the incremental changes in average journey times for the CMH orthopaedic option compared to the equivalent analysis for SaHF.
- The average impacts can be seen to be much lower than the previous results which were themselves not though to be a significant barrier to access.
- NB the SaHF results are not significant in the context of the average patient journey times before the changes. Calculations are not directly comparable and involve different locations and case mixes.

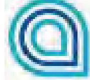
Acute reconfiguration

Local and major hospital business case assurance process

Before capital investment is approved, Trusts must develop the following SaHF business cases

	Maternity business cases	NEL major hospital business cases	Backlog business cases	Local Hospital business cases	Elective business cases
North West London Hospitals Trust	Northwick Park NEL, maternity & backlog BC				
					Central Mid LH/ elective BC
Imperial College Healthcare Trust	Imperial business case: St Mary's NEL, maternity & backlog BC				
				Charing Cross LH service spec and BC	
				Hammersmith LH/ specialist service spec and BC	
Chelsea & Westminster Foundation Trust	C&W hospital NEL, maternity & backlog BC				
West Middlesex University Healthcare Trust	West Middlesex University Hospital NEL, maternity & backlog BC				
Hillingdon Hospitals Foundation Trust	Hillingdon hospital NEL, maternity & backlog BC				
Ealing Hospital Trust				Ealing LH Service Spec and BC	

Single business case



Approach to securing commissioner support

- The SaHF hospital capital business cases will require review and approval during 2014.
- This is a complex process with a wide set of stakeholders but at the simplest level each business case requires:
  - Commissioner support from those with a *material* interest
  - Trust Board approval
  - NHS Trust Development Authority (NTDA) approval (& Monitor self-assessment)
  - Department of Health (DH) and HM Treasury (HMT) approval (for cases with higher capital requirements)
- Trusts, NTDA/Monitor, DH and HMT all have established approvals processes for capital business cases that will need to be followed.
- The remainder of this pack sets out the approach for securing commissioner support to the SaHF capital business cases.
- Given the number of business cases, this approach aims to provide commissioners with the necessary assurances in the most efficient manner.

Principles for assuring & approving SaHF major hospital capital business cases

- Letter of support required for each business case signed by all CCG Governing Bodies with a *material interest* in the case – this could include commissioners from outside NW London.
- Business case reviews will be conducted on a *per business case* as opposed to a *per CCG* basis.
- A single SaHF review and assurance process should be operated favouring commissioners with a material interest but seeking input from all stakeholders with a specific interest
- Where possible, existing quality assurance processes (NTDA/Monitor/HMT business case checklists) will be used and built upon to avoid creating unnecessary additional work
- Use of existing expertise should be maximised and any additional draw on already limited commissioner capacity minimised.
- Existing SaHF governance will be utilised wherever possible
- Early engagement and sight of the process is proposed with commissioners, programme, providers and other authorising bodies (NTDA, Monitor, NHS E, DH)

SaHF business case review will be broken down into five dimensions. These have been mapped against the NTDA's checklist for the HMT 5 case model

Dimension	Working group	Areas of assurance (To be developed further by the working groups)
Finance & activity	SaHF F&AM Group	• Assumptions, activity inputs and constraints applied to the business case(s) match the DMBC assumptions (or agreed deviations from these) • Affordability & sustainability (Standalone business case and across SaHF) • Transition costs • Fits SaHF overall bed and financial tolerances so SaHF outcome is met • Alignment with the Trust's LTFM and/or any merger business cases • Quality of business cases (5 case model)
Quality & Safety	SaHF Clinical Board	• Solutions are safe and reflect clinical standards. • Proposed solution meets hospital requirements and result in an acceptable patient pathway on-site & overall patient experience • Transition strategies laid out in the business cases will ensure a clinically safe transition of services and will maintain an acceptable level of quality and safety both in the lead-up to and immediately following transition. • Transition strategies align with transition plans for Zone(s) and NWL
Engagement & Equalities	PPRG & sub-committees	• Patient and other stakeholder engagement • Confirm that the Business case abides by all statutory provider and commissioner obligations regarding equality of protected groups
Workforce	Joint NWL Workforce Steering Group	• Confirm that the workforce assumptions within the business case(s) are aligned with the Programme position. • Stability of workforce in the lead-in to transition • Ensure the workforce estimates reflect the levels required to meet the clinical standards • Programme management and controls of the workforce transition
Implementation	SaHF Implementation steering groups	• Confirm that the implementation management approach and timetable is sensible and aligned with the programme requirements for transition

Business case next steps

- Draft Trust SaHF Outline Business Cases (OBCs) will be submitted to the SaHF Programme over the next 2 months for the purpose of assurance.
- The SaHF assurance process (as set out over the previous slides) will then commence with the aim of securing Trust Board approval for the OBCs during mid-2014.
- Once Trust Board approval has been secured, the OBCs will then progress to the NTDA (for non-Foundation Trusts) and ultimately Department of Health and Treasury.
- Following OBC development, work will commence on the Full Business Cases (FBCs). These will require approval, proposed to be through the same process, before construction works can commence.

Local hospital update

The Local Hospital project will produce three key outputs for Ealing and Hammersmith & Fulham CCGs

The SaHF Decision Making Business Case set out core models for the two new Local Hospitals in Ealing and Charing Cross.

The purpose of this project is to co-develop the visions for the Local Hospitals within the context of wider developments to Out of Hospital care. These visions will then be refined and reflected in agreed Outline Business Cases.

A suite of deliverables will be available from March 2014 for each of Ealing and Hammersmith & Fulham:

Out of Hospital Delivery Strategies that update on progress on the CCG *Better Care, Closer to Home* strategies, and **Strategic Service Delivery Plans** co-created with Ealing CCG and Hammersmith & Fulham CCG on estate options for the realisation of CCG strategic intentions for out of hospital care.

Co-created service models and specifications for the Local Hospitals, presented through two key outputs - a high level **Guided Tour** of each of the Local Hospitals and a more detailed **Design Guide**. The Guided Tour will provide an overview of the hospital services, patient benefits and out of hospital care services and settings, with high level estates, workforce and financial information; the Design Guide will set out how the Local Hospitals have been developed, with services, estates, workforce and financial information set out in detail.

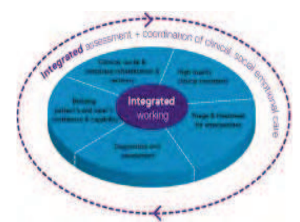
Outline and Full Business Cases for each of Ealing Local Hospital and Imperial Hospital NHS Trust, of which Charing Cross Local Hospital will be a part. The business cases will be completed by March 2014, with building works anticipated to start in 2015 and reach completion in 2018/19.

Defining features of the Ealing and Charing Cross Local Hospital Models

Patient-centred health and care principles for the Local Hospitals: Through engagement with patients, residents and health and care professionals eight principles for the local hospitals have been developed. These principles underpin the development of the service models and will be reflected in the delivery of services.

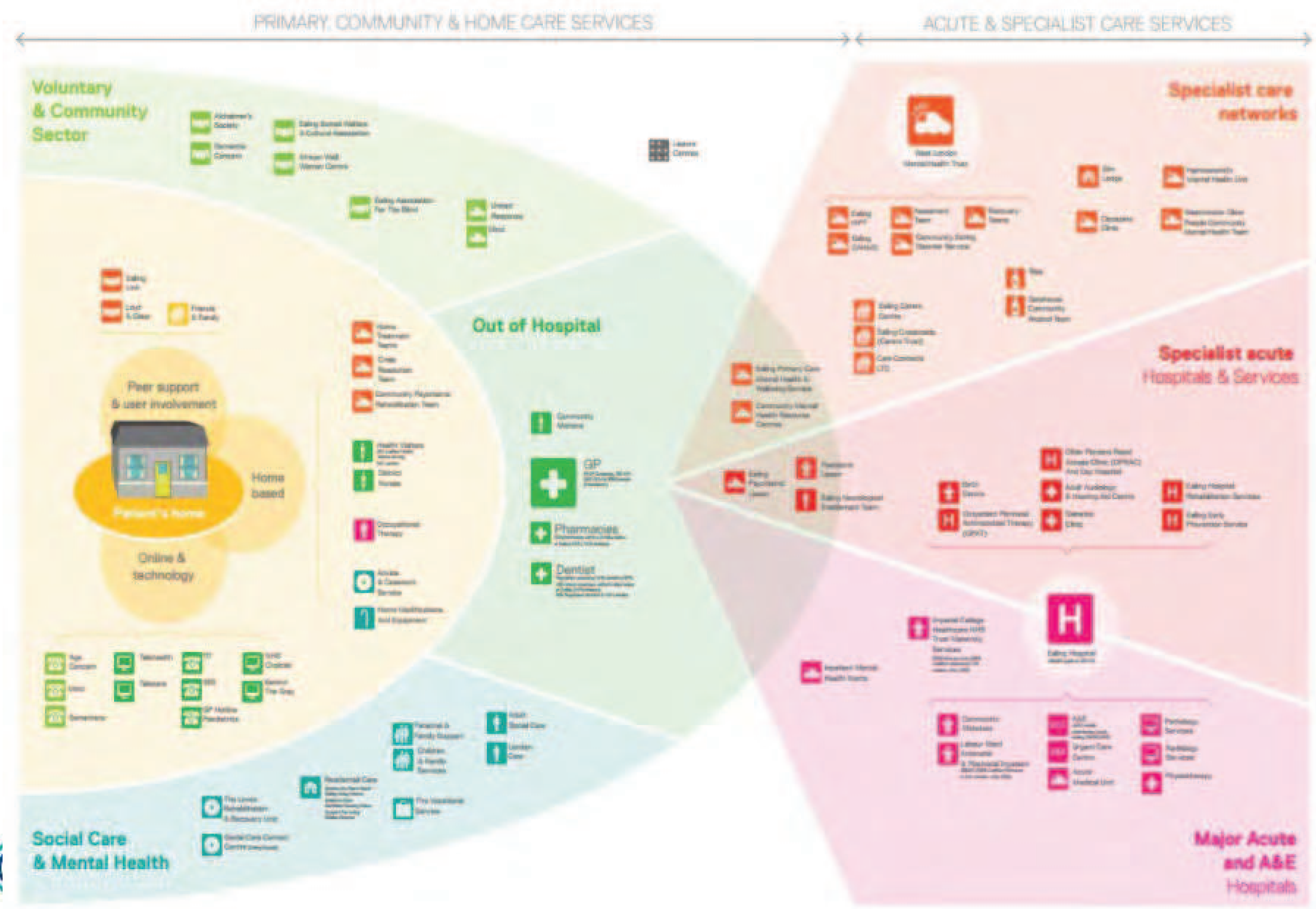
The Local Hospitals have a central role in delivering 21st Century care in NW London: The Local Hospitals support the wider re-configuration of health and care services across NW London and enable the CCGs to achieve their vision to localise, centralise and integrate services. The primary role of the Local Hospitals is to act as an intermediary and point of transition between primary and community care settings and specialist and specialist acute settings.

Multifunctional service to meet the needs of patients, carers and clinicians: To enable the Local Hospitals to meet the needs of patients, carers and clinicians they will provide a range of health and care functions. There are five core functions under which additional functions and services are aligned.



Model to enable innovative service delivery: The functions of the Local Hospitals will enable innovative service delivery models to be commissioned. These models will reflect the principles of a local hospital, support delivery of services across the borough and enable services that are both clinically viable and affordable.

Initial development of transformational models of care



Further development of transformational models of care for patients

The Local Hospitals will provide their communities with high quality, custom-designed services that are tailored specifically to the needs of the local community. This will include:

- **One stop care through specific services to match local needs:** This will include an integrated service of diagnostics, planning and social care assessment activities developed to support different patient groups and conditions.
  - In Ealing, there is a generally high prevalence of diabetes, but also specifically in the area closest to the Local Hospital. The CCG's vision is for the hospital to become recognised as a centre of excellence for diabetes, drawing on the services co-located on the site such as ophthalmology and cardiology to deliver a one-stop service. This will be underpinned by the provision of education and training for patients, carers and clinicians.
  - In Hammersmith and Fulham, the Local Hospital will align services with the strategic priorities of the CCG (such as diabetes and MSK care, the frail and elderly) and the known health needs of the borough. For example, the new Charing Cross Hospital design will include purpose built space for Frail and Elderly care to provide joined-up assessment reviews and support for patients with long-term conditions. Experts will be able to provide the best possible care on an ongoing basis.
- **A networked emergency care centre**: To make the urgent and emergency care system in NW London operate as effectively and efficiently as possible a networked approach will be introduced in which patients, along with all relevant information, will flow smoothly between the different components. This will ensure that patients who require acute care and arrive at the Local Hospital will be stabilised and transferred to the appropriate major hospital.

Ealing Hospital: Artists impression and subject to change

Further development of transformational models of care

contd.

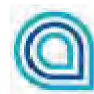
- **Holistic recovery & rehabilitation:** Post-treatment, patients will be referred from a specialist or acute hospital (or internally within the Local Hospitals) to be managed by the integrated community rehabilitation functions bringing together a range of services and support in and out of clinical settings; and

- **A Community zone:** Houses health, social and wellbeing services to support independent living including; Peer support and training, Services and respite support, online and offline education resource.

- The Local Hospitals will support the delivery of OOH care in the Boroughs. Patients will be able to:
  - Access specialist GP services;
  - Access rehabilitation and other therapies;
  - Receive diagnostic services which were once only offered in acute hospital settings;
  - Access consultant lead outpatient clinics at a location nearer to their home; and
  - Benefit from an integrated site where GPs, community services and teams from social care meet and manage their care.

- We expect that the Local Hospitals will also offer a rare opportunity for the greater consolidation of GP services in the Boroughs. Existing practices, some of which are currently in unsuitable premises, will be offered the opportunity to move into the Local Hospitals, delivering core, enhanced and out of hospital services in modern buildings which are fit for purpose.

- These new ways of working will ensure greater patient access and integrated services within the Local Hospitals, which overcome organisational boundaries – they will provide a base for community based health and social care workers in a variety of new and existing roles, facilitating the greater integration and co-ordination of care in the Boroughs.



Proposed services to be delivered from different settings of care in Ealing, including Ealing Local Hospital

- Our engagement with patients, residents and clinicians has informed the services that should be delivered from each setting of care in Ealing.
- The feasibility and viability of these services is being further assessed through the development of the outline business case.
- The Local Hospital will also operate as a Health Centre and will therefore deliver some services that will also be available in settings across the borough.
- The level of outpatient service may vary across each setting to reflect the needs of patients in each area of Ealing.

Services			LH	Hub / Network	GP
Core and Enhanced Primary Care	GP and nurse appointments	• GP practice(s)	✓	✓	✓
	High risk patients	• Long term care coordinators	✓	✓	
	Enhanced Primary Care	• Enhanced Primary Care Services and Community Contracts	✓	✓	✓
	Extended hours	• Evening and weekend operating	✓	✓	✓
	Other	• Hospital and community pharmacy	✓		
		• Education and research	✓		
Community and Hospital	Therapies	• Physiotherapy	✓	✓	
		• Speech therapy	✓	✓	
		• Occupational Therapy	✓	✓	
		• Deities	✓	✓	
		• Podiatry	✓	✓	
		• Audiology	✓	✓	
	Diagnostics	• X-ray	✓		
		• Ultra-sound (inc. Echo)	✓	✓	
		• CT	✓		
		• MRI	✓		
		• ECG (inc. Stress)	✓	✓	
	Transitional and rehabilitative care	• Assessment and Observation beds	✓		
		• Post-surgical rehabilitation beds	✓		
		• Transfer Beds	✓		
		• Palliative care beds (Meadow House)	✓		
	Other	• Integrated sexual health clinic	✓		
	Emergency Care Centre	• Urgent Care Centre	✓		
		• Ambulatory Care	✓		
	Outpatient services	• Cardiology	✓	✓	
		• Dermatology	✓	✓	
		• Diabetes	✓	✓	
		• ENT	✓		
		• Frail and Elderly	✓	✓	
		• Gastroenterology and Colorectal Clinic (GI)	✓		
		• General Medicine	✓		
		• General Surgery	✓		
		• Haemotology	✓		
		• Maternity (ante-natal and post-natal)	✓	✓	
		• MSK and Orthopedics	✓	✓	
		• Neurology	✓		
		• Paediatrics	✓		
		• Respiratory	✓	✓	
		• Rheumatology	✓	✓	
		• Urology	✓		
		• Vascular	✓		
		• HIV	✓		
	Specialist	• Renal	✓		
		• Chemotherapy	✓		
		• Ophthalmology	✓		
Mental Health	Mental Health	• MH Outpatients	✓	✓	
Other	Base for field teams and meeting space	• Base for field teams and meeting rooms	✓	✓	

Proposed services to be delivered from different settings of care in Hammersmith and Fulham, including Charing Cross Local Hospital

- Our engagement with patients, residents and clinicians has informed the services that should be delivered from each setting of care in Hammersmith and Fulham.
- The feasibility and viability of these services is being further assessed through the development of the outline business case.
- The Local Hospital will also operate as a Health Centre and will therefore deliver some services that will also be available in settings across the borough.
- The level of outpatient service may vary across each setting to reflect the needs of patients in each area of Hammersmith and Fulham.

				Out of Hospital Care Settings			
			Major Hospital	Charing Cross Local Hospital and Health Centre/ and Health Centre	GP Networks	GP Practices	Supported by clinically safe and feasible care at home
Core and enhanced primary care	GP and Nurse Appointments	GP Practices			4	4	
	High risk patients	Long term care co-ordinators		4	4	4	
	Enhanced primary care	Enhanced primary care services and community contracts			4	4	
	Extended hours	Evening and weekend operating			4	4	
	Other	Hospital and community pharmacy with medicines management services		4			
		Education and research		4			
Community and out patients	Therapies	Physiotherapy		4			
		Community Rehab		4			
		Podiatry		4			
		Speech and Language Therapy		4			
		Dietetics		4			
		Occupational Therapy		4			
	Diagnostics	X-ray		4			
		Ultrasound (incl. Echo)		4			
		CT		4			
		MRI		4			
		Endoscopy		4			
		ECG (incl. Stress)		4			
	Transitional and rehabilitative care	Assessment and observation beds		4			
		Post surgical rehabilitation beds		4			
		Transfer beds		4			
		Palliative care beds		4			
	Emergency care centre	UCC	4	4			
		Ambulatory care		4			
	Outpatients	Medical Oncology	4	4			
		Clinical Oncology	4	4			
		Gynaecological Oncology	4	4			
		Audiological Medicine					
		Paediatric Audiological Medicine					
		ENT		4			
		Oral Surgery	4	4			
		Sleep Studies					
		Trauma and Orthopaedics	4	4			
		Cardiology	4	4			
		Cardiac Rehabilitation	4	4			
		Transient Ischaemic Attack	4	4			
		Vascular Surgery	4	4			
		Neurosurgery	4	4			
		Urology		4			
		Breast Surgery		4			
		Gastroenterology		4			
		Colorectal Surgery	4	4			
		Ophthalmology		4			
		Thoracic Medicine	4	4			
		Rheumatology					
		Plastic Surgery	4	4			
		Diabetic Medicine		4			
		Endocrinology	4	4			
		Pain Management	4	4			
		Infectious Diseases	4	4			
		General Surgery	4	4			
		Dermatology		4			
		Geriatric Medicine	4	4			
		Nephrology	4	4			
		Clinical Haematology	4	4			
		Hepatology	4	4			
		Renal	4	4			
		Chemo		4			
	Other	Bedded services		4			
		Sexual Health	4	4			
Mental Health	Mental Health	Inpatient		4			
		Community		4			
		CAMHS		4			

We continue to focus on the service models for the Local Hospitals and understanding the estates needs to support the out of hospital work

Oct - Jan
Drafting of OBC & engagement with CCGs and Trusts

Oct
Draft criteria for identifying the preferred service model

24 Oct – 6 Nov
Public Engagement to develop vision for service model

2 Dec
Finance & Planning meeting

7 Nov
Vision defined & agreed by CCGs

Nov-Dec
Identify & agree commercial arrangements with CCG & providers

Nov-Dec
Governance & management arrangements and risks for delivery of service model identified & agreed with CCGs & providers

31 Jan
Final draft submitted to SaHF, CCGs & Provider

Feb
OBC reviewed by CCGs & letter of support sent to Trust

Feb
Trust Board Approval

Sep **Oct** **Nov** **Dec** **Jan** **Feb** **Mar**

31 Oct
Sharing of key outputs that impact other providers

12 Nov
Governing Body meeting

w/c 11&18 Nov
Service model & service specification defined with CCGs

Nov - Dec
Estates options & estates modelling agreed with CCGs & providers

14 Jan & 28 Jan
Governing Body meeting (14/1)
F&P meeting (28/1)

Feb
OBC discussed at Trust Board sub committees

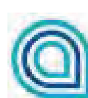
Mar
OBC approved by TDA & possibly HM Treasury

Sep – Dec: Activity & Financial modelling (including workforce). Agree activity to be modelled & financing mechanisms with CCG

Communications & engagement

Co-design & engagement

- Two large scale public and clinician engagement events attended by between 30-70 attendees each
  - H&F 5/11/13
  - Ealing 6/11/13
- Session with H&F Action on Disability with young people with disabilities, carers and volunteers
- Three full-day drop-in sessions: at the Lido Centre in Ealing, at Southall Market in Ealing and at Dawes Road in H&F
- Interviews at the Broadway homeless centre in H&F
- In-depth ethnographic interviews with 4 residents, in their homes and community settings



Co-design & engagement

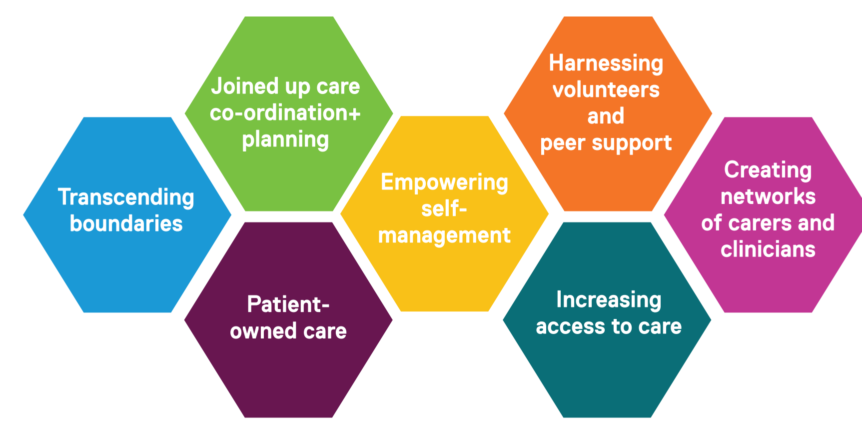
- One CCG Governing Body session in January for each of Ealing and H&F
- Two engagement sessions with Ealing Hospital on 16/12/13 and 8/1/14
- Weekly engagement with H&F and Ealing CCGs with clinical and managerial top teams
- Update to the Emergency and Urgent Care CIG
- Regular engagement with the SaHF PPRG forum
- Review of community groups & residents associations to inform future engagement

Emerging common themes have helped develop plans

Southall Market 01/11/13

Headlines

- *People value access to healthcare professionals who speak their language*
- *Health conversation and education outside of healthcare settings*
- *Flexibility of services*



'Drop in' Session Lido Centre 24/10/13

Headlines

- *Enable community champions*
- *Empower patients and carers to take control through education and accessibility*
- *Build cultural awareness of professionals*

H&F 'Drop in' Dawes Road Hub – 30/10/13

Headlines

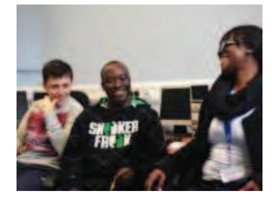
- *Enable community champions*
- *Need to be better, more comfortable spaces*
- *We need NHS system navigators*

Broadway Homeless Centre, H&F – 28/10/13

Headlines

- *Prejudice is a barrier to many homeless people*
- *Lifestyle makes it harder to stick to regular appointments and medication*

H&F Action on Disability – 28/10/13



Headlines

- *Difficult transition from young people to adult services*
- *Hard to communicate with clinicians*
- *Need to empower young people to take control*

Ongoing local hospital engagement

- H&F reablement workshop with CCG, Imperial, Social Services 10/2/14
- Ealing **HealthWatch** events on 14th Feb and 14th March to showcase the Ealing Hospital
- H&F **Healthwatch and CaVSA meetings** on 11th February – Healthwatch local committee; 27th Feb and 27th March – CaVSA Town Centre network meetings
- Following the completion of the outline business cases it will be agreed whether **additional co-design** will occur to drive development of the final business case.
- Working with the **SaHF and CCG equalities leads** to continue community outreach and engagement with local groups
- Continued engagement with **scrutiny bodies**
- **8 Focus groups** in Ealing and H&F, in February, to understand any misconceptions about service changes and to identify channels of communication for future activity
- **2-4 Borough roadshows** in Ealing and H&F in mid-2014 on health and social care improvements.

Ongoing NWL wide communications

- A letter to all **staff** has been circulated to trusts and CCGs for circulation. This provides a summary update of service wide improvements and changes.
- Double page **adverts** will be placed in one local paper per borough in late February. One side provides a SaHF overview and the other an update from the relevant CCG. This are in progress.
- Over the next few months we will be updating **public materials** such as factsheets, leaflets and posters as appropriate.
- Similarly, www.healthiernorthwestlondon.nhs.uk will be updated.
- We are looking to set up **information points** at the point of interaction with services, eg surgeries and hospitals, where patients can always pick up the latest information on SahF related changes.
- We continue to undertake proactive and reactive **media activity**.
- The next issue of the S&T wide **newsletter** is due to be distributed in early Feb.

Thank you