

# North West London Joint Health Overview and Scrutiny Committee

**Monday 16 May 2016 at 11.00 am**

Conference Hall - Brent Civic Centre, Engineers Way,  
Wembley, HA9 0FJ

## Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members.

Item	Page
<b>1 Welcome and Introductions</b>	
<b>2 Apologies for Absence</b>	
To receive apologies for absence (if any).	
<b>3 Declarations of Interest</b>	
To receive declarations of disclosable pecuniary or non-pecuniary interests, arising from business to be transacted at this meeting, from: (a) all Members of the Joint Committee; (b) all other Members present in any part of the room or chamber.	
<b>4 Minutes</b>	1 - 10
That the minutes of the meeting held on 14 October 2015 be taken as read and signed as a correct record.	
<b>5 North West London Winter Performance for Accident and Emergency</b>	11 - 20

**6 Shaping a Healthier Future**

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- Update on recent developments including Implementation Business Case
- Use and scale of consultants to support the programme
- Local Services Strategy (Out of Hospital)
- NW London Sustainability and Transformation Plan
- Outcome measurements
- Review of 2015 North West London Maternity and Neonatal Transition

**7 Arrangements for next municipal year**

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**8 Any other business**

Which the Chair has decided is urgent and cannot otherwise be dealt with.

# **NORTH WEST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE MINUTES**

## **14 OCTOBER 2015**

### **Chairman:**

Councillor Mel Collins (Hounslow)

### **Councillors:**

Councillor Rekha Shah (Harrow)  
Councillor Mrs Vina Mithani (Harrow)  
Councillor Rory Vaughan (Hammersmith and Fulham)  
Councillor John Coombs (Richmond)  
Councillor Dan Filson (Brent)  
Councillor Barbara Arzymanow (Westminster)  
Councillor Charles Williams (Kensington and Chelsea)  
Councillor Sharon Holder (Hammersmith and Fulham)

### **1. Welcome and Introduction**

Councillor Rekha Shah welcomed members to the London Borough of Harrow.

### **2. Apologies for Absence**

Apologies for absence were received from Councillor David Harvey (Westminster), Dr Sheila D'Souza (Westminster), Councillor Will Pascal (Kensington & Chelsea), Councillor Theresa Mullins (Ealing), Councillor Myra Savin (Hounslow)

### 3. **Declarations of Interest**

#### Agenda Item 6 – Shaping a Healthier Future Update

Councillor Mel Collins declared a non-pecuniary interest in that he was involved with the Willesden Centre for Health and Care.

### 4. **Minutes**

The Assistant Director of Communications, CCG commented that the minutes from the meeting held on 16 June 2015 had indicated that a wide ranging consultation would be taking place with communities, patients and local authorities on the development of Charing Cross and Ealing Hospitals into Local Hospitals. He commented that this had not been stated at the meeting.

The Committee were advised that the business case for the proposal was required to go through internal governance processes before a workshop event was conducted with partners, stakeholders etc.

The Committee believed that the minutes were a correct record but the clarification provided was noted.

**RESOLVED:** That the minutes of the previous meeting of the Committee held on 16 June 2015 be taken as read and signed as a correct record.

### 5. **London Ambulance Service Update**

A presentation was conducted for the Committee by representatives from the London Ambulance Service NHS Trust (LAS). They made a number of points as follows:

- London had been divided into 7 sections for the operation of the LAS;
- The LAS had undergone a service transformation which had included a management restructure. A new Chief Executive of the service had also been appointed;
- A new set of purposes and values had been adopted by the LAS to modernise the Trust;
- Demand for the LAS increased year on year. In 2014/15 over 1.7 million requests were received;
- The operating budget for the LAS was £316 million;
- The LAS had about 5,000 staff. Approximately 71% of these staff operated on frontline services;
- There were 70 Ambulance stations across London;

- Retention of staff had been a big challenge for the LAS. Opportunities for paramedics outside the NHS had increased dramatically;
- The LAS were focusing on national and international recruitment drives;
- The contract for the LAS included 9 Commissioning for Quality and Innovation schemes (CQUIN). These were a contractual requirement for NHS providers and offered financial incentives to the innovative development of services;
- The LAS produced a suite of reports as a requirement of the commissioning contract;
- The LAS and the NHS faced a number of financial challenges. The LAS income was dependent of demand and performance. Money was being spent on private ambulances and overtime payments but the LAS were striving for value for money;
- There were three major challenges for the LAS which related to staffing, demand and culture;
- There was an increased emphasis from the LAS to make it a better place to work. This involved the launch of a LAS academy, filling all front line vacancies, creating 500 band six senior paramedics and continuing with VIP awards;
- The LAS were not achieving the 75% target response rate. However reports and reviews undertaken had demonstrated that a safe service was being provided;
- A detailed improvement programme had been developed. Some of the actions identified were the reduction of absences from front line staff relating to sickness and reducing the out of service hours relating to people and vehicles;
- In relation to front line recruitment of staff, processes had been redesigned to include revised training and supervision to allow staff to work on the front line as safely and quickly as possible. University places had increased and a media campaign had been launched ;
- There was closer work being undertaken with Emergency Department leads to improve Hospital handover processes;
- There was greater work being done on standardising referral pathways.

Councillor Filson queried what was being done regarding vehicle utilisation which was currently at 85%. This provided very little flexibility for the LAS. Councillor Filson also asked whether vehicle serving and maintenance facilities could be shared with the Fire Services. Councillor Filson also asked whether filling vacancies only up to 95% created extra stress for staff.

Additionally was the level of training being proposed from October 2016 realistic given that proportionally it was small.

The representatives from the LAS responded that the level of current vehicle utilisation was not desired. However it was expected that some of the actions as part of the improvement programme would help to reduce the levels of vehicle utilisation.

There was currently work being done by the Government on collaborative working between the LAS and the Police on equipment and vehicles although it was not believed that vehicle maintenance was one of the issues being addressed.

The recruitment of staff up to 95% was a result of feedback from existing staff who expressed a wish to have the ability to work overtime.

There would be reflection on the issue raised in relation to the training of staff and a separate response would be provided.

Councillor Filson also asked why there was not a greater emphasis on recruiting staff from London. The representatives from the LAS responded that there was a significant amount of time required to qualify fully as a paramedic. Another challenge was that upon qualification there were usually other career opportunities for paramedics given the unique set of skills which they possessed. It was also stated that the 32 CCGS across London all commissioned the LAS services and recruitment and retention of staff was recognised as an issue.

Councillor Mithani asked whether the 500 band six senior paramedics had all been provided with relevant training.

The LAS responded that the 500 band 6 senior paramedics had all received this promotion as a result of the retention programme. Funding had been made available to promote 500 of the most senior and experienced paramedics and they had been provided with tailored training to develop their skills.

Councillor Mithani also asked whether frontline staff were well trained in answering calls and dealing with delays. The representatives from the LAS employed a robust triage process and this operated well.

Councillor Williams asked for some further information regarding the benefits provided to recruitment from overseas and also asked for information regarding the standardised referral pathways across North West London. The representatives from LAS responded that the package offered to overseas recruits was the same as that offered to national recruits.

The referral pathways involved getting all relevant parties together and developing new and efficient pathways. It had been identified that the previous pathways were not as effective as it would have been liked.

Councillor Vaughan asked when response times from the LAS would improve. Councillor Vaughan also asked what factors relating to the cost of living in London were affecting retention rates and whether any further rewards were offered for performance.

The LAS had a trajectory to improve its performance in relation to response times. Whilst its performance was not where it wished for it to be, the trajectory pathway for improvement was being met.

The main issue for the retention of staff appeared to be other career paths which paramedics could embark on due to the skills that they possessed. It was sometimes difficult to compete with these other roles due to their differing natures and salary.

The Chair thanked the representatives from the LAS for their presentation.

**RESOLVED:** That the presentation be noted

## **6. Shaping a Healthier Future Update**

The Committee were advised that there were separate papers for different topics relating to these items.

### Paper 1 – Out of Hospital Update

The Medical Director – Shaping a Healthier Future Programme introduced the report and explained that there was a great deal of hospital activity taking place and a number of common themes across the 8 boroughs. This included the following:

- Extended GP opening hours would be been introduced;
- There was visible progress toward hubs;
- Far less difference between out of hospital and in hospital care;
- Rapid access to service change on assessments;
- Lots of partnership working with other organisations like the London Ambulance Service;
- There was a great amount of work being conducted in moving to a co-ordinated service in and out of hospital.

The Chair – Harrow CCG reported to the Committee that there had been a lot of work taking place on supported living to help promote independent lives.

Councillor Filson stated that the Scrutiny Committee at Brent Council had recently conducted a review into extended GP hours and it was hoped that the recommendations made would be adopted by the relevant CCGs.

Councillor Filson also raised an issue where a community organisation (Brent Bereavement Service) had its rent increased on a property owned by the NHS despite it providing a service to which the NHS signposted residents to. This organisation received no financial assistance yet provided a valuable service to residents. It was queried why this was allowed to happen and whether the CCG had an input into these issues.

It was responded that the CCG did not own estates. However the issue raised would be investigated.

Councillor Mithani queried how the 2 walk in centres in Harrow had helped to ease the pressure on the Accident and Emergency Department at Northwick Park Hospital.

It was responded that there had been a change in the attendance at Accident and Emergency as a result of the 2 walk in clinics. It was also being proposed that a walk in clinic be established on the east side of Harrow. It was hoped that this would be operational from 2016 although the exact site was still to be determined.

Councillor Vaughan queried how availability for the out of hours GP service was being communicated and whether the services provided would be consistent across the 8 boroughs. Councillor Vaughan also queried when the business case for the implementation of out of hospital care would be made available

In relation to the extended opening for GP practices, there was a real issue to determine whether the same model should be used across North West London. It was important to assess the patterns that were faced and the size of each facility.

It was also responded that not all out of hospital would be exactly the same. These could be different depending on the building used. Services that could have been offered locally in a hospital can now be offered closer to patients' homes.

Councillor Collins queried whether the proposals for out of hospital services had factored in that it was anticipated that approximately 50,000 new homes were being proposed to be built across the boroughs. Councillor Collins also queried whether relevant section 106 monies earmarked for health services were being utilised by the CCG.

It was responded that proposed increase in population had been taken into account when developing the out of hospital care proposals. Work had taken place with the Greater London Authority (GLA) project future population estimates and this would be kept up to date. This work did not pre-empt the proposed closure of 2 Accident and Emergency departments within North West London as the work conducted was based on a number of different scenarios. It was important to also understand the impact of the increase in population to determine the correct size of the hospital.



In relation to the section 106 monies the amounts were relatively small. However staffs in the estates department were currently investigating this and were looking to use the funds available.

### Paper 2 – NHS 111 / GP Out of Hours Integrated Services

The Accountable Officer – BHH Federation introduced the paper and reported that the 111 service was provided by Care UK and LCW. The contract for the provision of this service in London was due to expire in 2016 and a process had been commenced with the intention of identifying a future provider. These services were subject to a national procurement process by the Department of Health. Communication about the services for 111 needed to be better and it was anticipated that a new provider would be identified by the beginning of 2016.

A vision for urgent care was also being developed based on better understanding of local needs and demands.

### Paper 3 – Implementation Business Case Briefing

The Accountable Officer, CWHHE Collaborative introduced the report and explained that within it contained the current status, timescales, overview of the approvals process and the outline and full business case in primary care settings.

It was reported that the paper also highlighted the success criteria that would be utilised. It was also highlighted that there were huge financial challenges and so value for money was a key component. Inflation of the construction industry was also influencing the costs involved.

The programme will be arranging workshops on the Implementation Business Case to which the Committee would be invited.

### Paper 4 – Maternity Update

It was reported that the Ealing CCG Governing Body had agreed to endorse the transition of the Maternity and Neonatal service at Ealing Hospital with effect from 1 July 2015. At the time 969 women were booked to give birth at Ealing Hospital. Out of these 15 women were not able to be offered their first alternative choice of unit.

All staff had been transitioned to their new units. Extra staff had been being recruited. Additionally the issue of travelling to Maternity Services would be reviewed in a formal way to understand how women have found their patient experience on this subject.

The report also contained information on the Quality and System Monitoring Dashboard. This only provided the first month of data following transition and so there were a few gaps. This was being monitored on a regular basis to identify if there were any adverse impacts.

Unbooked deliveries, especially at Hillingdon Hospital, had increased as expected in the first month due to the agreed process to deliver women at whichever unit they attended. There had also been an increase in post partum haemorrhages although this increase was due to a change in its definition.

#### Paper 5 – Paediatrics Update

The Medical Director – Shaping a Healthier Future Programme introduced the report and advised that the changes centered on more consultant cover over the entire week. The benefit of this would be reflected in outcomes such as lower admission rates and an increase in patient satisfaction.

#### Paper 6 – Benefits Tracker

The Accountable Officer – CWHHE Collaborative introduced the paper and reported that the North West London Transformation and Benefits Tracker had been created to track improvements across health and care. This would help to promote greater transparency.

The Tracker would be presented on a single page and pick up key measures. The Tracker would then be supplemented with a further series of dashboards to provide a comprehensive and detailed view on transformation and benefits realisation.

Councillors were asked to advise on what they would want to see in the tracker.

#### Paper 7 – Accident and Emergency (A & E) Data

The Accountable Officer – BHH Federation introduced the report and explained that this represented the performance of A & E departments over the last 12 months. This described the actions being taken to improve performance where appropriate.

North West London was the only sector in London to have achieved the national standard for 3 consecutive months. The report provided information on type 1 performance which was a local measure which described the setting of care.

North West London had more urgent care facilities (10 across 8 CCG catchment areas). Patients who are less acutely ill are being seen in Urgent care centres, so that the proportion of more severely ill patients in the A&Es is higher making the target harder to achieve. However it was acknowledged performance was not at a standard which was desired.

Members then asked various questions on papers 2 to 7.

Councillor Filson questioned a gap on the Transformation and Benefits Tracker in that it did not identify issues at Northwick Park Hospital in terms of it's a & E performance. More information was also required on what the interpretation of the figures referred to.

It was responded that the national standards dictated that 95% of patients attending A & E would be seen within 4 hours. Performance at Northwick Park Hospital was not where it was hoped it would be. More beds were expected to be installed at Northwick Park Hospital to provide greater capacity to help to address this issue.

Councillor Vaughan asked in relation to the Implementation Business Case whether early sign off was expected in early 2016 and whether it would be after this that this could be viewed. Councillor Vaughan also commented that there was work required in educating and signposting the public on how to use the NHS in the correct manner. It was also commented that there needed to be a better reflection of the issues facing A & E Departments within the reports presented.

It was acknowledged that greater work was required in educating the public on using the NHS effectively. This would involve greater work between the NHS and their partners to promote this.

It was also acknowledged that there were issues facing the NHS but clinically the best formats for A & E departments in local hospitals were still being devised. It was important to offer a range of clinical services as close to home as possible.

Councillor Collins queried whether the information provided meant that there would be no further closures of A & E Departments. It was responded that consideration would be given to what services were offered from A & E Departments in local hospitals before forming an opinion on future provision.

Councillor Filson expressed concern that the basic principle of A & E departments was being diluted by proposals to offer only certain services. He believed that they should offer specialities in all relevant medical areas.

It was responded that a different model of care was required and for those cases which did not require acute care, these could be dealt with at different centres. There would be special consideration given to those who were frail and elderly.

The Chair thanked all of the representatives in attendance.

**RESOLVED:** That the report be noted.

## **7. Scoping Mental Health Item**

The Committee were advised that there had been indications at the last meeting that it consider a more specific item in relation to mental health. The Committee had previously made a commitment to focusing on the 'Shaping a Healthier Future Initiative' so any consideration would be made with this context in mind.

Members of the Committee felt that at this point it would be better focusing on the 'Shaping a Healthier Future' item.

**RESOLVED:** That the Committee does not consider an item on mental health at this stage.

**8. Health Commission Update**

The Committee were advised that a report of the Healthcare Commission had not yet been published. It was expected that the report would be published towards the end of November 2015 and a briefing session for the Committee would be arranged as soon as possible after that.

**RESOLVED:** That the item be noted.

**9. Date of Next Meeting**

The Chair advised that at the next meeting of the Committee there would be consideration of a new Chair and Vice Chair. It was also agreed that the next Committee meeting should be arranged after the Implementation Business Case had been published in January / February 2016.



## NW London JHOSC

North West London Collaboration of  
Clinical Commissioning Groups

April 2016

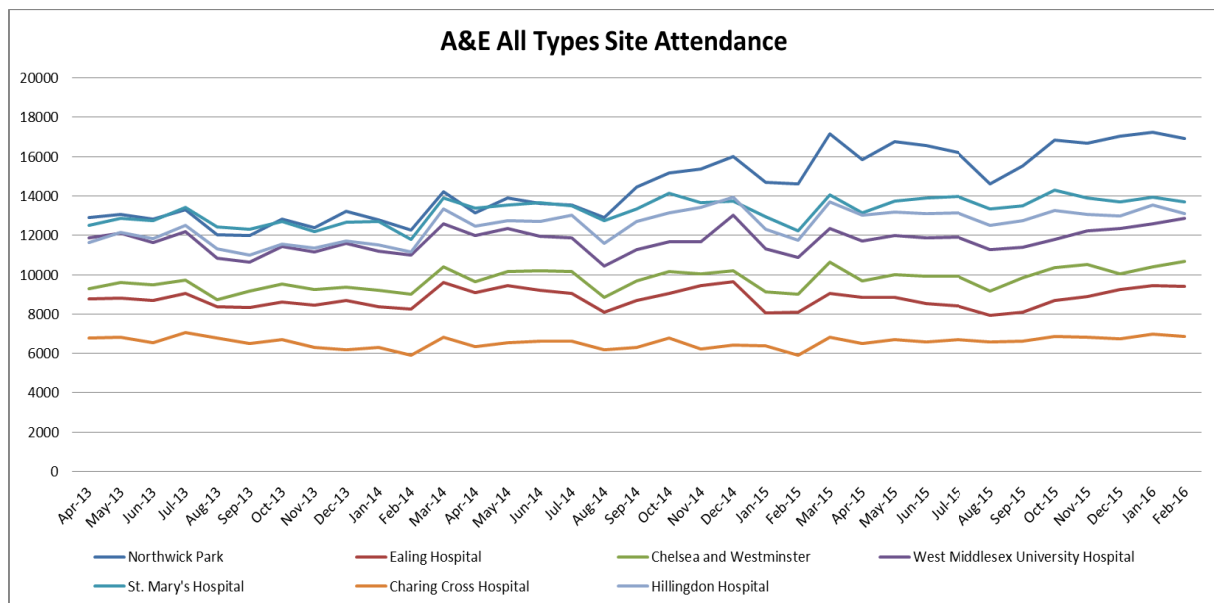
### Purpose

This briefing has been provided to the NW London JHOSC to provide an update on North West London winter performance for accident and emergency. This paper will summarise the performance of our local urgent and emergency care system over the winter of 15/16 and the challenges that have been identified in meeting performance targets. It will also outline the range of actions planned for 16/17 to improve the patient experience and recover performance.

### North West London Winter Performance for Accident and Emergency

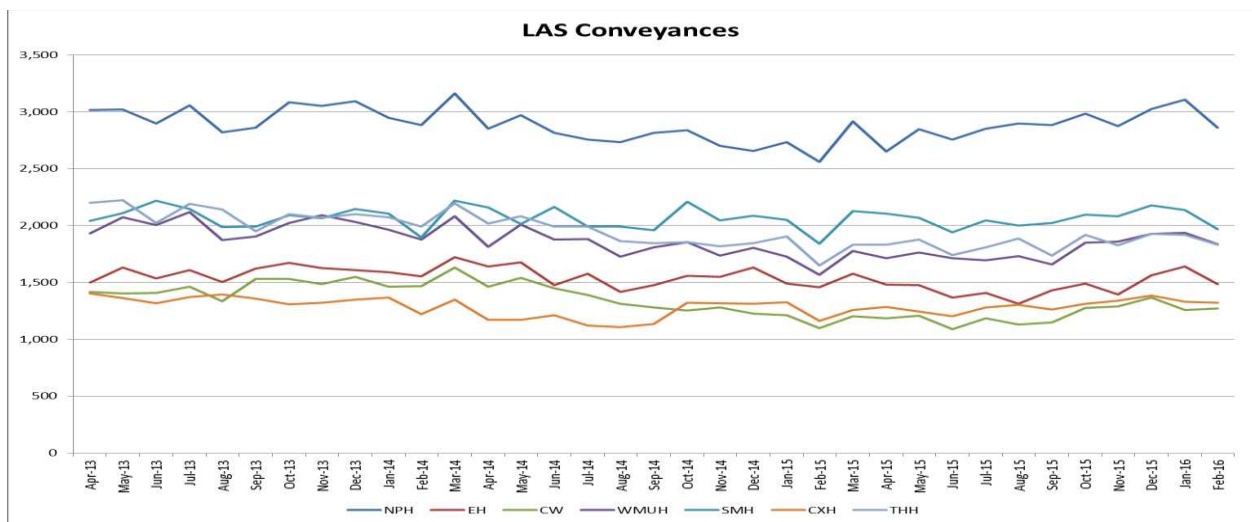
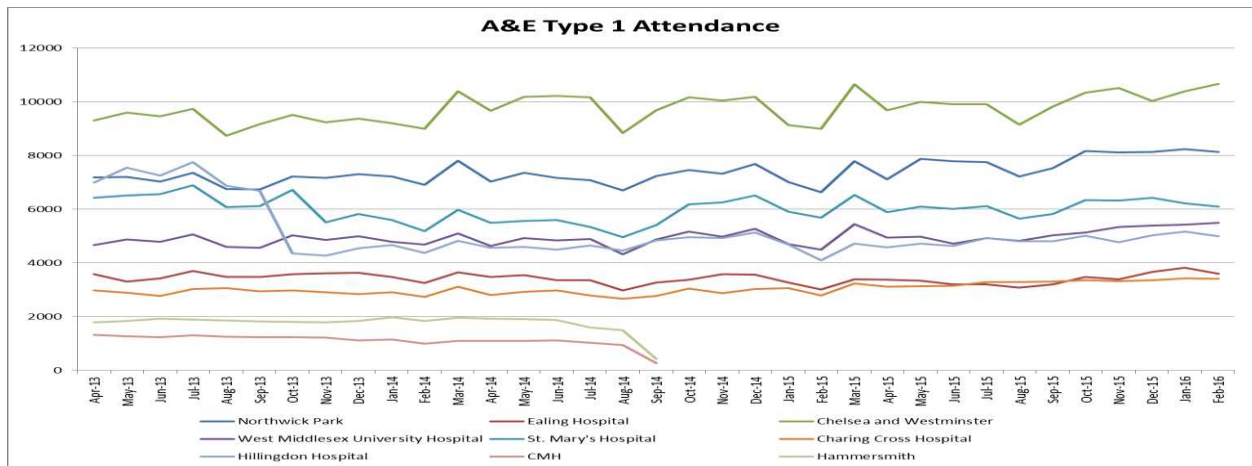
#### Demand

Demand for A&E services across North West London has risen during the winter of 15/16. In particular the Northwick Park system has seen an increasing number of A&E and UCC attendances over the period.



As planned, Northwick Park and St. Mary's both saw a rise in the Type 1 A&E demand (activity treated within a type 1 (major) facility) in September 2014 when Central Middlesex and Hammersmith Hospital A&E departments closed. However demand has continued to rise at Northwick Park during the winter of 2015/16. London Ambulance Service Conveyance has remained relatively consistent throughout the period.

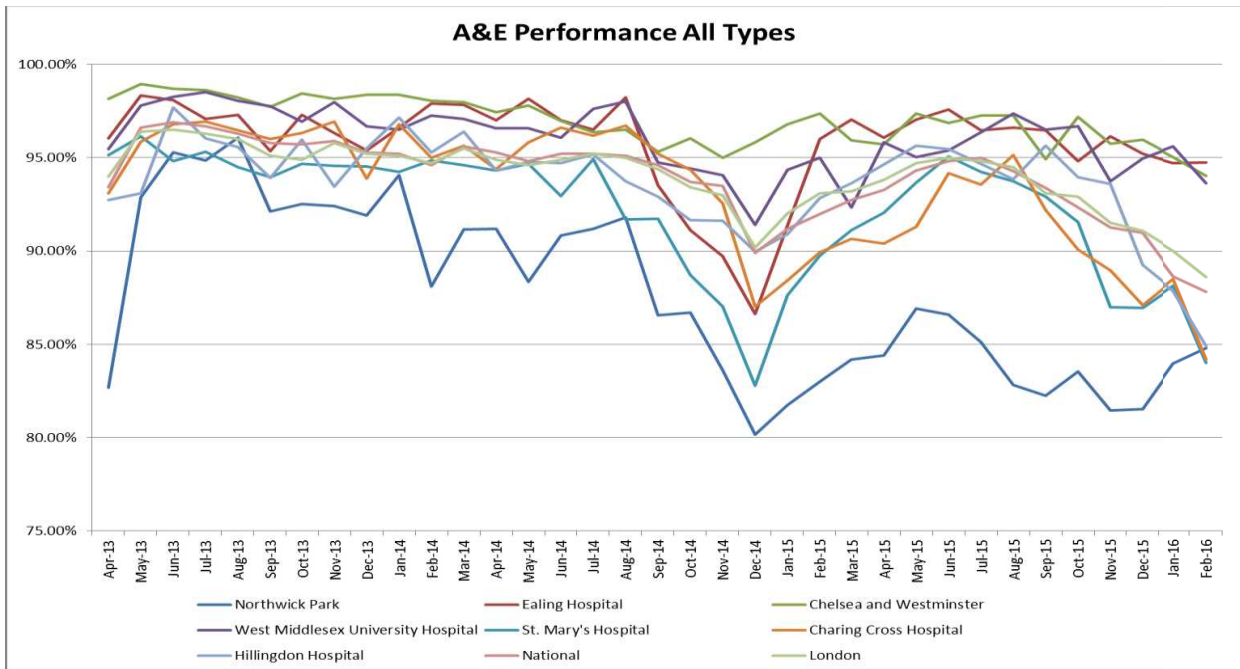
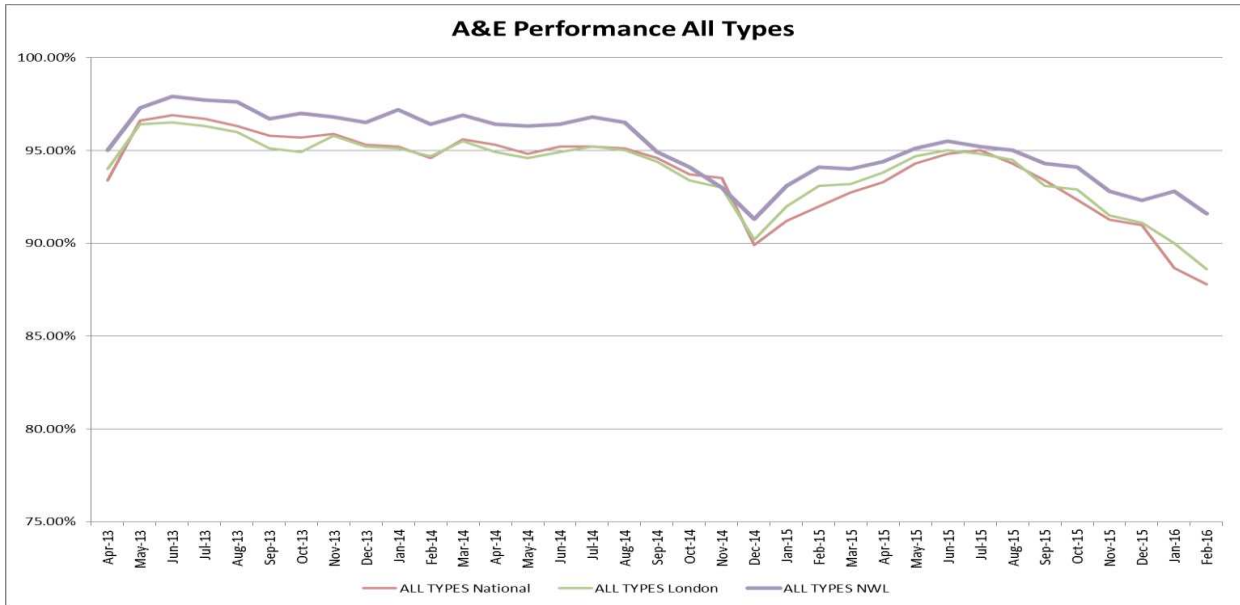
In terms of Type 1 attendance whilst Northwick has, again seen a rise, activity at other sites has remained fairly steady over time though some sites have seen a rise in the last 3 months.



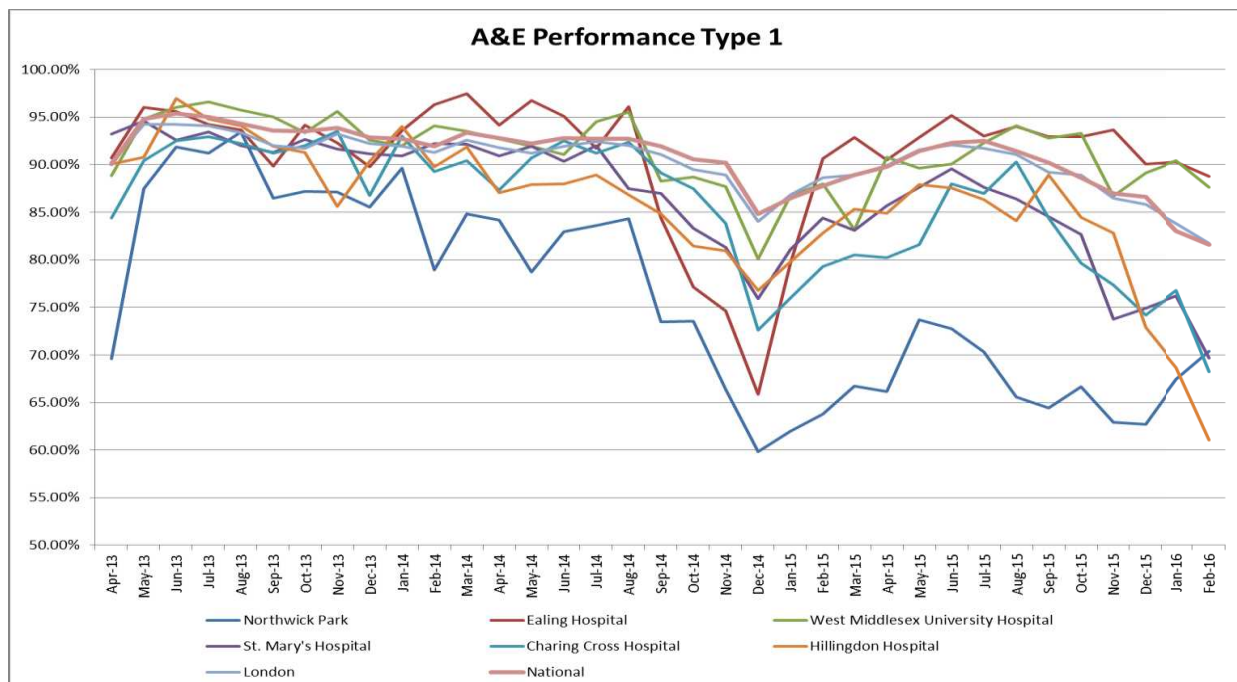
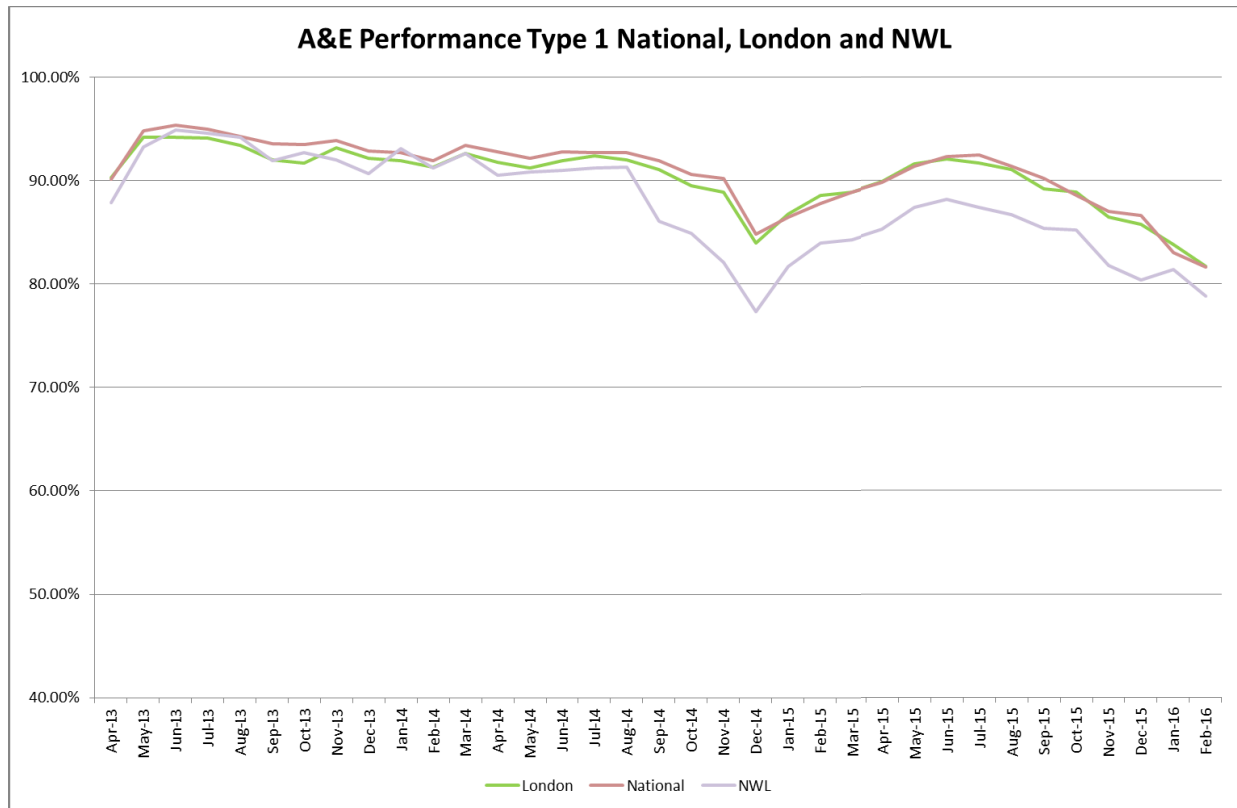
**Performance**

NWL continues to perform consistently higher than the national and London average for ‘all types’ of Accident and Emergency Performance. National A&E Performance during the winter of 2015/16 was consistently below the target of 95% of patients admitted or discharged within 4 hours. In North West London the majority our hospital sites tracked above or close to national performance for the majority of the winter. London North West Hospital’s Ealing site has consistently delivered the standard whilst the larger Northwick Park site has under-delivered for nearly three years. The Trust have an agreed recovery trajectory with the local commissioners and NHS Improvement (the replacement body for the Trust Development Authority) in order to improve performance over the coming months. The reasons for this include limited bed capacity across the site which has been improved through the opening of 48 additional beds and increased local co-ordination to improve flow.

All sites saw an improvement in performance during the summer of 16/17, however as we moved into winter performance reduced again as it had the previous year. Both the Charing Cross and Mary’s sites of Imperial NHS Trust have also under delivered over the winter. A number of initiatives have been identified as part of the 16/17 contracting round to improve delivery during the coming year, including estates changes which are outlined later in this paper.

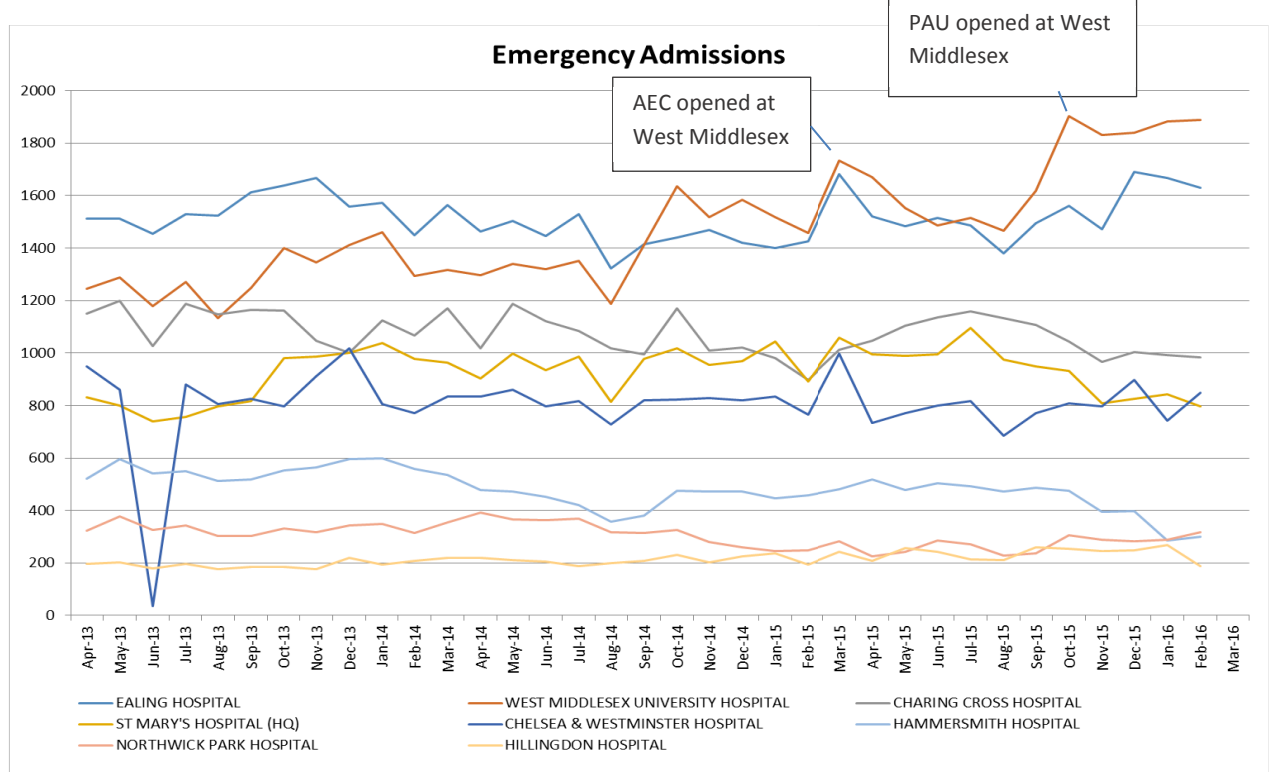


North West London has a high number of urgent care services across the area to reduce unnecessary demand on the A&E departments. This results in greater appropriate use of our A&Es and a higher proportion of the patients attending the facilities who are seriously ill, resulting in reduced performance in comparison to the London or National position. The measurement of type 1 attendance and performance by different hospitals is inconsistent which means that comparison is not possible.



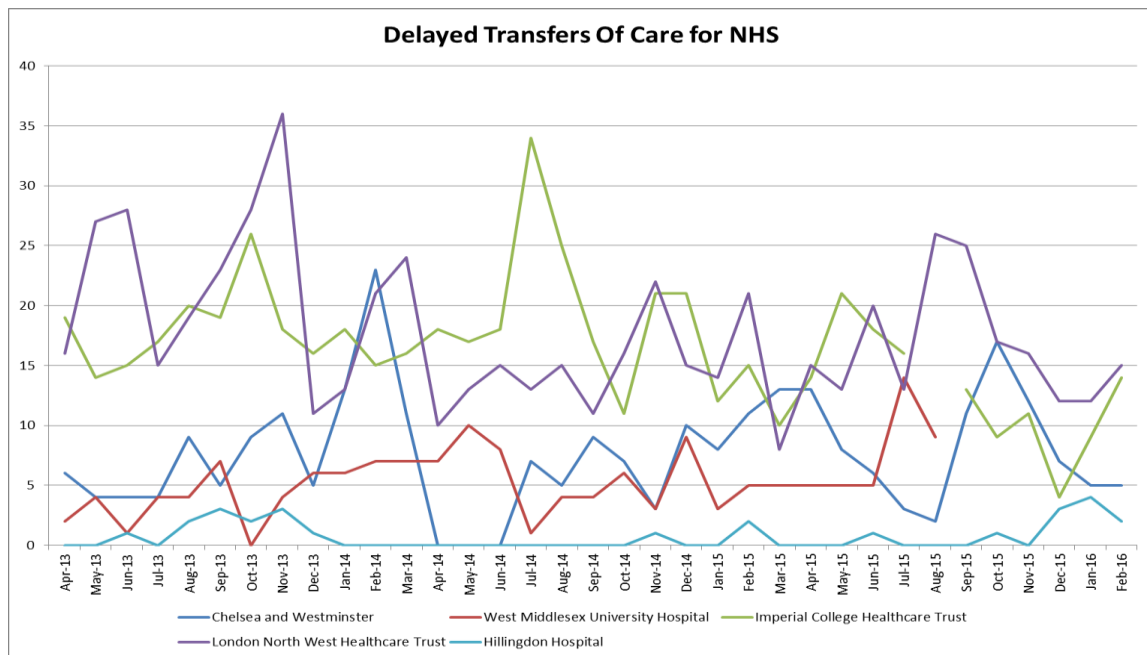


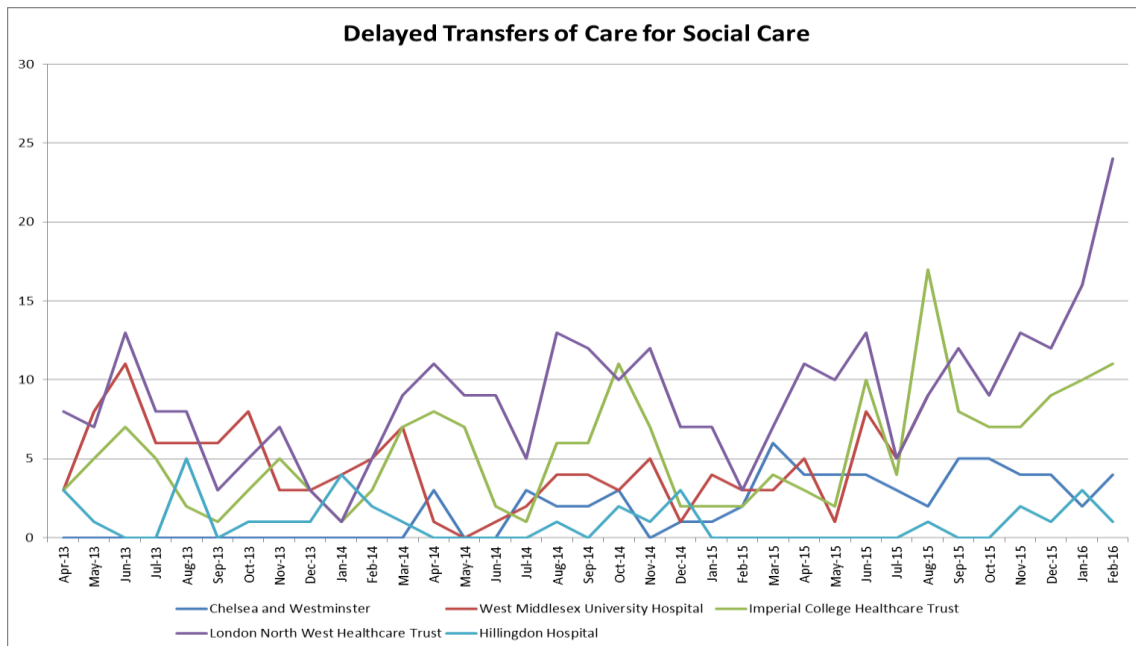
## Emergency Admissions



Emergency admissions over the period have remained mostly consistent whilst reflecting seasonal variations. West Middlesex has seen a rise in demand in the later half of 15/16 due to a coding issue with the opening of the paediatric and ambulatory assessment units. This has not driven up admissions rather the assessment has been coded as an admission incorrectly. This has been rectified for 16/17.

## Delayed Transfers of Care

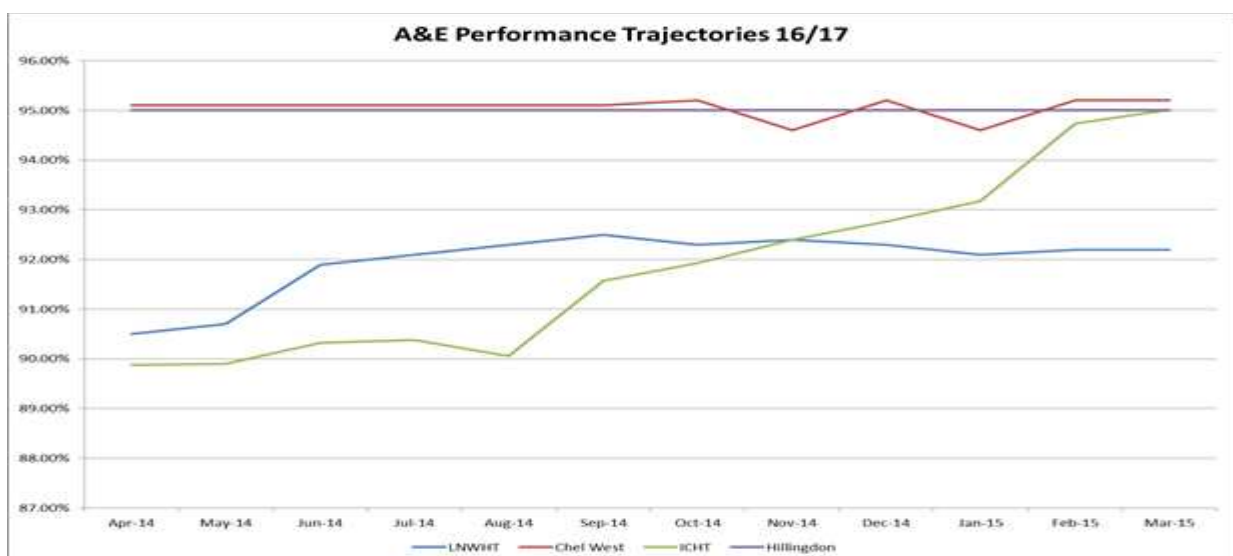




Improved cross organisational working between commissioners, Trusts and social care have continued during the winter of 15/16. Delayed transfers continue to be an issue for Trusts however overall there is an improvement. Availability of nursing home placements for routine and fast track packages; social care housing delays and family delays as part of choosing nursing homes are the causes of the majority of longer delays. Nursing home placements continue to be a challenge due to the reduction of capacity for care home beds as a result of the suspension of providers as a result of quality concerns. Additional interim neuro rehabilitation beds were purchased over the winter and new permanent beds opened in April 2016 to reduce delays for these patients.

### Performance Trajectories for 16/17

Contracts are currently being finalised with our acute Trusts for 16/17 and include an average of c5% increase in demand from demographic and non-demographic growth. This growth and our demand mitigation plans have been factored in to the following A&E trajectories for 16/17.



A number of demand mitigation schemes are planned and are in place to reduce non-elective activity by offering a number of services OoH (Out of Hospital) as well as Trust actions to improve capacity and flow.

- Rapid Response Services (Hillingdon)
  - These provide a single point of contact for patients experiencing a health crisis who could be safely cared for in the community instead of being admitted to hospital.
- The Community Independence Service (CIS Tri-Borough)
  - Spans the Tri-Borough CCGs and offers an increase in rapid response activity will prevent a number of NEL admissions and an associated level of AE activities. Although there is more activity in the community under within the rapid response service it is not a like for like intervention, therefore shown here as a reduction within the system.
- Homeward (Ealing)
  - This service aims to give a more responsive OOH service that maximises admission avoidance through managing a wide range of patients in a sub-acute setting.
- Community Response Service (Hounslow)
  - Integration of Health and Social Care by bringing together four existing OoH services; the Community rehabilitation Service, Neuro Rehabilitation Service, LBH reablement and LBH OT. These are redesigned into the Community Recovery Service.
- Nursing Home schemes (Brent)
  - Falls education, including care bundles to prevent falls
  - GP Network Contracts, to provide care to nursing home patients
- Whole Systems Integration (Brent)
  - Case managing complex patients in the community
- End of Life (Harrow)
  - Proactive signposting for patients along with redesigned pathways to ensure plans are in place to manage patients the most appropriate setting to their needs
- Nursing Home Support (Harrow)
  - Admission Avoidance by supporting Nursing Homes and Falls Prevention

Further to the above Estates work has already been undertaken to increase the capacity at the ChelWest site and Northwick Park as part of Shaping a Healthier Future. Additional estates work is planned for West Middlesex, Hillingdon, St. Mary's and Charing Cross.

All the Trusts plan to undertake a number of internal initiatives during 16/17 to develop sustainable improvement.

At Imperial these include actions to improve early discharge, improve specialty response times, reduce delayed transfers of care, develop ambulatory care further and reduce mental health breaches. which is to be monitored at a fortnightly joint steering group. These will be enhanced through additional local estates work which includes the opening of two enhanced discharge lounges at St. Mary's and Charing Cross; refurbishment of the Charing Cross and St. Mary's site A&E to increase capacity; increased referral of patients from St. Mary's A&E to the Urgent Care Centre; development of surgical, medical and paediatric assessment units to reduce delays in decision making.

At London Northwest Healthcare NHS Trust work will be undertaken to support the emergency care services and pathway: LNWT will work with LAS on frequent attenders and turnaround times; senior decision makers will be on ward rounds to aid timely discharge; the development of a Frailty Unit;

increase ambulatory care provision at Ealing Hospital; recruitment & retention initiatives across the clinical workforce and review of clinical pathways across sites.

At Hillingdon, Ambulatory care via the Acute Medical Unit (AMU) has increased by > 200% from 14/15. The AMU clinics accept community GP heralded patients and also work proactively to 'pull' patients from the ED. During February these clinics have started to run at the weekend. The discharge lounge now remains open until 2000 hrs Monday to Friday and is able to accept both ambulance and non ambulance patients. Additionally senior ED nurses are undertaking full triage including diagnostic requests to ensure that once seen by a medic all necessary information is available to make safe, clinical decisions, and where possible discharge patients home/make timely referrals to specialities. System wide working is also a priority working with Hillingdon CCG to commission step down/interim bed provision in the community.

North West London as a sector accepted the opportunity to be a national First Wave Delivery Site for the new 7 day services programme (as launched by the PM at the conservative party conference). As part of this programme, our acute trusts have agreed to achieve delivery of the 4 prioritised Clinical Standards by April 2017:

#### **Time to First Consultant Review**

All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours of arrival at hospital.

#### **Access to Diagnostics**

Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:

- Within 1 hour for critical patients
- Within 12 hours for urgent patients
- Within 24 hours for non-urgent patients

#### **Access to Consultant-directed Interventions**

Hospital inpatients must have 24 hour access, seven days a week, to consultant-directed interventions either on-site or through formally agreed networked arrangements with clear protocols, such as:

- Critical care
- Interventional radiology
- Interventional endoscopy
- Emergency general surgery

#### **On-going Review**

All patients on the AMU, SAU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate. To maximise continuity of care consultants should be working multiple day blocks.

Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

### **Conclusion**

In line with the rest of the country, A&E performance fell in the winter of 2015/16 compared to 2014/15. However all type performance remained above the national and London averages. All providers and commissioners are committed to returning performance to the 95% target and 3 or the 4 Trusts have agreed trajectories to achieve this during 2016/17. There are detailed plans at Trust level to support these trajectories and we will continue to engage with local scrutiny committees during the year to report on progress.

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NWL JHOSC

North West London Collaboration of  
Clinical Commissioning Groups

April 2016

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## Shaping a healthier future - transforming health care in NW London

In North West London, the NHS is working together to improve healthcare services for the two million residents who live in the area. Our vision is that we will deliver care that is:

- **Personalised:** Care is to be personalised, enabling people to manage their own care themselves and to offer the best treatment to them. This ensures care is unique.
- **Localised:** Care is to be localised where possible, allowing for a wider variety of services closer to home. This ensures care is convenient.
- **Integrated:** Delivering care that considers all the aspects of a person's health and wellbeing and is coordinated across all the services involved. This ensures care is efficient.
- **Specialised:** Centralising services where necessary for specific conditions ensuring greater access to specialist support. This ensures care is better.

By CCGs in [North West London](#) working together to realise this vision, we can achieve patient-centred care in all our care settings, ensuring reduced inequality of care outcomes and delivery of services that are tailored to the needs of the local population.

That means being able to get appointments with a GP quickly and conveniently; making sure more specialist doctors are available, no matter what day of the week it is; that your mental health is considered at the same time as your physical health, with a single, coordinated approach by health and voluntary sector organisations; and that when you need longer term care from different people, it is joined up and you don't need to keep repeating your story.

We're also making sure the public helps shape care, involving them from an early stage in the design of services, and listening to their feedback along the way. Through this joint approach, we will improve people's health and wellbeing, giving them a better quality of life. In North West London,

To improve health care and mental health and wellbeing across North West London, the local NHS agreed two programmes of work covering all eight boroughs. One is Shaping a Healthier Future (SaHF), the other is Like Minded, which looks at improving mental health and wellbeing. The SaHF case for change has been discussed many times, and fully consulted on and so we won't repeat this here, though it is worth highlighting that the fundamental challenge facing the health service in NW London – a growing, ageing population living with more long term conditions – becomes ever more acute.

SaHF consists of two main parts: out of hospital or local service improvements, which includes primary care transformation, whole systems integration and other local service improvements; and changes to our hospitals. Our aim is to ensure expertise is in the right place to make the biggest difference to local people.

### Benefits

The programme is clinically led and aims to provide the best possible outcomes and experience for the people of NW London, 24 hours a day, seven days a week, 365 days a year. The services our hospitals' provide need to change to match the needs of our population, including more specialisation and technology, and with more services provided closer to peoples' homes.

As well as improving the quality of care and bringing in much needed investment, our work helps tackle the biggest factors in dissatisfaction with NHS services according to the latest British Social Attitudes patient satisfaction survey. These are waiting times for GP and hospital appointments, not enough staff and under-funding.



Our plans will see an extra £190m invested in local services (out-of-hospital care) by 2017-18. We are also investing in five major hospitals, all of which would have an A&E and consultant-led maternity service (at: Chelsea and Westminster; Hillingdon; Northwick Park; St Mary's; and West Middlesex).

All nine hospitals in NWL also have 24/7 urgent care centres which can treat the majority of patients needing A&E care. To increase expert care, Central Middlesex Hospital is being developed as a specialist hospital for planned (elective) care such as hip operations, and Hammersmith will specialise in areas including cancer care and as a heart attack centre.

### **Our plan**

Our plan was to:

- make progress in local services as quickly as possible to improve care for patients and take pressure off hospital services, especially A&E
- at the same time, there were a number of key hospital changes that needed to take place on safety grounds
- we would then move to secure the capital funding needed to modernise our hospital and primary care facilities, through the Implementation Business Case.

### **Progress against the plan**

We are making good progress against our plan, but much of this is overlooked as it is happening in the areas which are used most but are less visible and emotive - primary care and mental health.

Hospitals, and especially A&E and maternity services, are often seen as a barometer for the health of the NHS. Our hospitals are totemic, the most visible sign of the NHS. Yet GPs and primary care see over 90 percent of patients and this is where SaHF is making the biggest difference to patients most quickly.

Current estimates show that failure to implement SaHF would lead to:

- An estimated £500m gap across the region
- Patients not receiving planned clinical benefits and longer waits for diagnosis and treatment
- All trusts and CCGs in deficit and an £834m maintenance backlog not addressed

In short, doing nothing is not an option.

## Hospital changes

Hospital changes are always controversial, but the NHS has always adapted the way it works to ensure patients benefit from new medicines, technology and diagnostics. Better data collection means doctors have more evidence than ever before to design the best way to provide care and to stop services that are under-performing or unsafe. SaHF gave clinicians the opportunity to work together to re-shape services, leading to difficult but essential changes to improve care for patients:

### Maternity Services

To improve the quality of care for mothers and babies across North West London, maternity services in the region underwent significant change in July 2015, including the closure of Ealing Hospital's maternity unit and development of community services. These clinically-led changes were essential to: respond to the increasing number of women with complex health needs during pregnancy; provide consistent high-quality maternity care by concentrating staff, expertise and resources in fewer centres and; increase the number of midwives and the hours of senior consultant cover. The changes mean that:

- 778 women had their maternity care safely transferred from Ealing to a new maternity unit, with no incidents reported.
- Across NW London we have improved the midwife to birth ratio so that on average we are meeting the London Quality Standards minimum staffing ration of one midwife to thirty birth ratio standards of one midwife to thirty births (1:30).
- Prior to the change, Ealing Hospital was achieving 60 hours of consultant cover – lower than all neighbouring hospitals. Across NW London pre-transition there was on average 101 hours consultant cover. NW London set out to achieve 123 hours in 2015/16 and we are now at 122 hours.
- 100 new midwives have been recruited to North West London as a result of these changes
- Hospital trusts worked together to review their catchment boundaries for maternity care to help improve continuity of care. Since the transition, 79% of women now receive their postnatal care from the same hospital trust that provides their antenatal care, an increase of 21% from the 58% before the transition.

Antenatal and postnatal care is still available at Ealing Hospital and locally in 30 sites across Ealing and the number of community midwives has also increased. There has also been more investment in the home birth team supporting mothers in Ealing.

A recent review of the North West London Maternity and Neonatal Services Transition (Appendix A) found that:

- North West London has managed a complex service change safely and with clear benefits to patients, mothers and their babies.
- New community services have been developed, facilities at the receiving hospitals invested in, a significant number of new midwifery staff appointed and the maternity and neonatal units closed safely.
- The majority of women who had their care transferred felt supported and well-communicated with. While it has been a major change for staff who worked at Ealing hospital, they are now settled in their units and through the strong head of midwifery network that has been formed, they will continue to be actively supported.

- The changes in North West London are aligned with the national maternity review, meaning North West London is already delivering the majority of the standards of care outlined in the review.

At Ealing Council's Health and Adult Social Services Standing Scrutiny meeting on the 26 April 2016, the Royal College of Midwives endorsed the transition and congratulated North West London NHS on the model of care and the detail in the transition.

See Appendix A Review of the North West London maternity and neonatal service transition of July 2015.

### **Paediatric inpatient services transition**

We have developed an improved model of paediatric care for children in North West London

On 30 June 2016, inpatient paediatric services (for children who require emergency treatment or an overnight stay in hospital) will move from Ealing Hospital onto five other hospital sites in North West London, all of which have expanded their capacity by either increasing their number of inpatient beds or increasing the size of their paediatric A&E units. They will also have more senior doctors on site for longer hours, seven days per week, and have more paediatric nurses.

The changes will see new Paediatric Assessment Units (PAU) in place at five receiving hospital sites by the end of June 2016. St Mary's PAU will initially be based in the children's ward at the hospital from the end of June and will move alongside the A&E in December when building work is complete.

The PAU is designed to provide the right clinical environment for children to be cared for. The units provide ambulatory care, which is care during the day for children who don't need to be admitted to hospital, but need a period of observation and treatment. This will provide better care and means less children will need stay in hospital overnight. It will also help reduce pressure on inpatient ward areas.

Following the launch of the PAU at West Middlesex Hospital in September 2015, early data shows that for the months of October, November and December 2015 on average 30 per cent of children were treated in the PAU rather than the emergency department.

These changes will ensure that children receive consistently high-quality seven-day care, with more specialist senior doctors available to treat children for longer times. This will improve the quality of clinical care and patient experience in our hospitals, and get children back to health more quickly.

The changes do not mean that all children's services are moving from Ealing Hospital – nearly three quarters (73%) of existing children's services will continue on the Ealing Hospital site and elsewhere in the borough.

Services that will remain include:

- Routine appointments and treatments that do not require an overnight stay such as Day Care Unit activity, meaning most children will be seen in the same place they are now.
- Urgent care for minor injuries/out of hours GP appointments will also remain at Ealing Hospital. Currently the majority of children who are brought to Ealing's A&E by their family or friends are already being treated in the Urgent Care Centre (UCC). If children arrive at

Ealing's A&E that need more specialist care than the Urgent Care Centre can provide, they will be assessed, stabilised and transferred safely as required.

- Services for children with long-term conditions (such as asthma, diabetes and epilepsy) and child and adolescent mental health services will also remain unchanged.

The decision to move inpatient paediatric services from Ealing was taken by the JCPCT in 2013 and subsequently approved by the Secretary of State in October 2013, and is supported by independent bodies such as the Independent Reconfiguration Panel and London Clinical Senate. The transition will go ahead as planned on 30 June 2016 provided NHS England, NHS Improvement and Ealing CCG GB is assured that sufficient capacity exists at the receiving hospital sites and that the transition can be delivered safely.

## Seven day services update

We believe everyone should receive consistent high quality hospital care every day of the week. The NHS already provides care 24 hours a day, seven days a week, for emergencies including heart attacks, strokes and serious injuries. However, this is not always the case for less serious conditions and the level of care is not always the same at weekends. In hospitals there are fewer senior doctors, nurses and other health professionals at the weekend. This can leave staff feeling less supported and without access to all the diagnostics and tests that are available during the week. This can affect patient care, sometimes meaning patients remain in hospital unnecessarily over the weekend.

We want to ensure that patients receive the best possible care and that our staff are supported and equipped to do so, regardless of the day of the week. This is why North West London has been chosen as one of the few early adopter sites as part of the National 7 Day Services programme.

The NHS has co-produced with patients and clinicians, a set of National Clinical Standards designed to improve patient care and patient experience while in hospital every day of the week. We are focusing on delivering five of these standards, all of which will have a significant impact on care in hospitals by April 2017 as indicated below.

North West London as a sector accepted the opportunity to be a national First Wave Delivery Site for the new 7 day services programme. As part of this programme, our acute trusts have agreed to achieve delivery of the four prioritised Clinical Standards by April 2017. We have already enabled more patients to be seen by a consultant within 14 hours of admission to hospital. For patients, this means that you can expect to be seen by a consultant within a few hours and at the latest by the morning after your arrival in hospital. Our focus for the next year will be:

### **Standard 2: Time to first consultant review**

All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours of arrival at hospital.

### **Standard 5: Access to diagnostics**

Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:

- Within 1 hour for critical patients
- Within 12 hours for urgent patients
- Within 24 hours for non-urgent patients

### **Standard 6: Access to consultant-directed interventions**

Hospital inpatients must have 24 hour access, seven days a week, to consultant-directed interventions either on-site or through formally agreed networked arrangements with clear protocols, such as:

- Critical care
- Interventional radiology
- Interventional endoscopy
- Emergency general surgery

**Standard 8: On-going review**

All patients on the Acute Medical Unit (AMU), Acute Surgical Assessment Unit (SAU), Intensive Care Unit (ICU) and other high dependency areas must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate. To maximise continuity of care consultants should be working multiple day blocks.

Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

In addition to the four standards set out below, we have been working with council colleagues on a seven day discharge programme which goes live on 3 May. From a health perspective, this involves the movement away from multiple referral forms into different community services (over 25 across North West London) to a single approach based on the assessment of need, supported by a single assessment form and a single point of access for non bedded community services within each borough. This is a significant step forward that is expected to reduce length of stay and smooth the patient pathway, as well as ensuring that they receive services that are best tailored to their individual needs.

We would welcome the opportunity to brief the Committee further on the progress of the seven day programme of work during 2016/17.

Programme overview:

Project Title	Project Objective	Deliverables for FY 16/17
<b>Inpatient Model of Care Standards #2 &amp; #8</b>	To deliver a new model of care that will deliver; time to first Consultant review within 14 hours for all emergency admission via any route and a Consultant led, on-going twice daily, inpatient reviews for acute and high dependency units and daily 24 hour review for all other inpatients unless deemed it will not affect the patients pathway (standards 2 & 8)	<ul style="list-style-type: none"> <li>• <b>Model of Care:</b> Engage stakeholders in the development of the clinical outcomes that standards 2 &amp; 8 aim to deliver and design a new inpatient model of care from March to May 2016</li> <li>• <b>Consultant Job Planning:</b> Ensure Consultant job plans and ward configurations are fit for purpose to support the new models of care from June 2016 to March 2017</li> <li>• <b>Implementation:</b> Pilot and Trust implementation of new inpatient model of care and track benefits from September to February 2016</li> </ul>
<b>Radiology and Diagnostics Standard #5</b>	To deliver the 7D diagnostic standard which includes scanning and reporting of inpatient investigations in one hour for emergency, 12 hours for urgent and 24 hours for non urgent patients.	<p>Trust Level:</p> <ul style="list-style-type: none"> <li>• <b>Trust Imaging Capacity:</b> Trust level deep dive, action planning &amp; implementation to deliver 7 day scheduled inpatient imaging</li> </ul> <p>NWL Level:</p> <ul style="list-style-type: none"> <li>• <b>Clinical Decision Support (CDS):</b> Implementation of a CDS IT system in primary care to reduce clinical variation in diagnostic radiology requests and manage outpatient demand</li> <li>• <b>NWL Radiology Network:</b> Joining up of exiting Radiology IT systems (RIS/PACS) to enable cross-provider transfer of images, increasing reporting capacity and reducing repeated exams</li> <li>• <b>NWL Radiology Workforce Strategy:</b> Development of a career framework for Radiographers &amp; Sonographers to recruit, train and retain staff across NWL</li> <li>• <b>Interventional Radiology Pathways:</b> Agree robust pathways to ensure patients have access to emergency radiology interventions 24/7</li> </ul>
Project Title	Project Objective	Deliverables for FY 16/17
<b>Interventions Standard #6</b>	Provide project assurance that robust pathways are in place for inpatient access to interventions in place for 24 hours a day, 7 days a week (Critical care, interventional radiology, interventional endoscopy, emergency general surgery, renal replacement therapy, urgent radiotherapy, thrombolysis, PCI and cardiac pacing)	<ul style="list-style-type: none"> <li>• <b>Protocol &amp; Pathway Development:</b> Assurance that for the 73 emergency interventions that exist, <b>protocol documents</b> and <b>supporting protocol governance structures</b> are in place and have been signed off by required stakeholders</li> </ul>
<b>Discharge Standard #9</b>	A consistent and streamlined North West London wide process covering the discharge of patients with a new or changed need for community healthcare support in their home on discharge from a hospital ward, including those that cross CCG boundaries. Introducing a standardised discharge referral form will improve the quality of information provided to community services, reducing paperwork pressure and ensure that patients are allocated to the appropriate service on discharge. Benefits are expected for CCGs, acute trusts and community providers including: improved information to plan and purchase community services, a reduction in the average length of stay for patients discharged cross-borough to equal that of patients discharged within-borough and improved bed availability within acute trusts.	<ul style="list-style-type: none"> <li>• <b>Single Point of Access:</b> SPA in place per CCG to cover (at a minimum) services provided by community health trusts in patients' homes including: intermediate care, rapid response, early supported discharge, district nursing, specialist nursing, rehab, etc.</li> <li>• <b>NWL-wide needs-based assessment form</b> that is accepted by all of the Single Points of Access described above</li> <li>• <b>Patients referred and accepted into the new Single Points of Access</b></li> </ul>

## The Implementation Business Case (ImBC)

The Implementation Business Case (ImBC) is the request for the capital needed to implement the changes to buildings that support some of the clinical service changes which the Secretary of State for Health endorsed in October 2013. It is the necessary step to deliver the parts of the Decision making Business Case that cannot be funded through usual operating budgets and forms the Strategic Outline Case (SOC) for the capital developments. The current position is:

- We plan to provide a draft ImBC to NHS England in July 2016 as part of the review and assurance process
- We plan to submit the ImBC to the NHSE Investment Committee on 13 September 2016. It is also expected to reference two 'business as usual' bids for Northwick Park Hospital and Central Middlesex Hospital for essential maintenance and modernisation (examples include boilers and pharmacy – updating and expanding both to meet current need and be more efficient in future)
- NWL CCGs and hospital trusts are currently working together to finalise the level of capital that will be needed.

Clearly it has taken longer than we would have liked to produce the ImBC – a major factor has been changes in trust finances across the country in last 12-18 months which has meant a reworking of the financial case. SaHF has always been driven by the need to improve the quality of care and patient experience, but we must equally ensure that financial sustainability is achieved.

The capital needed must be credible in the current financial context and it must be available and it must be affordable. This means the ImBC will not be made public before it has been assured by NHS England and NHS Improvement and recommended by the NHS England Investment Committee.

The ImBC builds on the aims of the DMBC published in 2013, and includes no major changes in services on each site that the DMBC described. As per previous public engagement, local hospitals will still have a range of services, and on each site a range of different options will be considered for the physical estate. These include doing nothing (as a comparator with the options for change); making the minimum capital changes necessary to support the service model; refurbishing existing estate; and building new facilities.

The Committee has previously expressed concerns that the ImBC will not reflect latest activity and population figures. The activity baseline has been updated to reflect the expected outcomes for 2015/16 and the section below sets out our approach to population planning.



## Population planning

Our population planning figures include the current populations in each borough based on the 2011 census, Office of National Statistics projections, latest NHS activity figures and information from the Greater London Authority. Across NW London, we are modeling average annual growth for SaHF of 1.2%, against the GLA number of 0.8% growth. We also have regular meetings with council colleagues in planning and other departments where we discuss issues such as population growth linked to housing and property development.

As an extra check, we have written to colleagues in each local authority for their input into our population figure projections from now until 2025/26. **We value your input into this process and ask for you to work with us to ensure we have the most accurate data possible to plan for our future health services.** The detailed population planning assumptions by borough are shown in Appendix 2.

Looking forward beyond 2026, our current thinking is that growth will continue to track the current trend of c 1-1.5%, but we will continue to update our planning projections regularly. We will continue to discuss these projections regularly with London's councils to make sure all relevant factors, such as housing projects and major infrastructure developments, are included. We will also factor in the potential impact of the latest breakthroughs in medicine and technology, which may change how and where clinicians provide services and treatment to their patients in the years ahead.

The question of population growth is especially important in relation to the number of major hospitals that we have planned. When reaching the recommendation in the DMBC to move to five major hospitals, our planning considered guidance from the Royal College of Surgeons (RCS), which recommends that the minimum population levels needed to sustain a full emergency hospital are between 450,000 - 500,000 per A&E. This gives a population for North West London of at least 2.25m as the minimum level for five major hospitals, and would need a population of at least 2.7m before even the minimum level required to safely deliver services across six major hospitals, with a much larger population that could be safely accommodated. We are therefore confident that five major hospitals are sufficient to meet the needs of the North West London population.

## Moving care out of hospital and the resultant impact on hospital bed numbers

Building on previous analysis, we have recently conducted a detailed review of the opportunity to reduce the number of non-elective admissions to hospitals across North West London, by preventing unnecessary admissions and discharging patients more quickly when appropriate to do so. The analysis used a patient level dataset and focused particularly on admissions that indicate a likelihood of being able to provide treatment in a non-hospital setting, such as those where:

- Length of stay was recorded as zero days
- The patient has a long-term condition or ambulatory care sensitive condition
- No procedures were undertaken following admission.

In addition to admission avoidance, we also looked closely at length of stay in hospital. This used benchmarking data at a specialty level to estimate those who needed to be in an acute hospital, and those who could be cared for in other settings if available. Both the admission avoidance and length of stay analysis considered opportunity proactively (i.e. those patients whose needs could be met through case management) and reactively (i.e. those patients for whom an immediate alternative type of care could be provided to meet their needs). We applied assumptions based on best practice by patient type to estimate the admissions that could be avoided and the potential for length of stay reductions.

We also looked at actual experience and data from our providers.

- Across our hospitals, there is a very small cohort of patients occupying beds for long periods. For non-elective admissions this equates to 3% of admissions utilising 33% of the bed base across North West London.
- We know that delayed transfers of care have increased across the system by 45% from 2012/13 to 2014/15. These are patients that no longer need an acute care setting.
- As part of auditing bed use, some of our hospitals have conducted bed audits and considered why the patient is still in hospital. In approximately 30% of the cases, there is no further need for that patient to be in an acute hospital bed, but some would need different care arranged to be able to be discharged from hospital.
- We have a group of patients across our hospitals who do not meet the categorisation of delayed transfer of care but are medically fit for discharge. This can be up to 10% of patients, and ensuring services in the community are available to accept these patients would reduce acute bed use.
- Due to differences in community service provision, we know that patients who are admitted to hospitals outside of their borough have slightly longer lengths of stay. Improving community services and balancing this across the system can contribute to a more efficient use of hospital beds.

The analysis identified significant opportunity to reduce acute beds. Even with a cautious approach to the analysis, there is an opportunity equivalent to reduction of nearly 900 beds across North West London (based on the 2014/15 dataset). Around two thirds of this bed reduction is from admission avoidance (equivalent to c. 55,000 avoided admissions) and one third is from length of stay reduction. These opportunities exclude efficiencies from implementation of 7 day diagnostics within 24 hours (for which the estimated further opportunity is 50 – 100 beds across the system). There are also wider opportunities from 7 day working that have not been included, and there are other areas of opportunity (such as new technology) that can support reductions over and above this analysis.

Taking into account both demographic and non-demographic growth, our plan is for an overall reduction of 500-600 acute hospital beds (figure currently being finalised). This is slightly lower than the DMBC estimate of 769 fewer beds.

To enable this reduction we will need to invest in a range of out of hospital services, including non-acute beds such as rehabilitation or intermediate care beds. Our financial planning currently assumes a reinvestment rate of approximately 50% of the current acute bed cost to pay for these new services.

## Consultancy spend

We have significantly reduced spending on consultancy this year, reducing it by around seventy-five per cent compared to the previous year. Our position at the end of the 2015/16 financial year is spend of just over £5m (£5.17m), against £20m in 2014/15. This reduction is due to projects finishing and more permanent staff being recruited for longer-term work. We are also currently undertaking a review of the VFM of our consultancy usage in 2015/16 and we will share it when completed.

Please find below the details of specific organisations that have supported the development and implementation of service improvements across North West London, through the Strategy and Transformation Directorate, during the financial years of 2013/14, 2014/15 and 2015/16. The tables below are broken down into the main streams of work that are going on across North West London.

<b>2016</b>	
<b>Provider</b>	<b>Break down of support provided to projects</b>
<b>Acute Reconfiguration</b>	
365Response	<i>Consultancy support has been provided for programmes of work including:</i> <ul style="list-style-type: none"> <li>• The refresh of the Implementation Business Case</li> <li>• Support for the CCG 5 year planning to underpin the Implementation Business case</li> <li>• Maternity Services Review</li> <li>• Support to Paediatric services transition.</li> </ul>
Carnall Farrar	
Deloitte LLP	
GE Healthcare Finnamore	
McKinsey and Company	
Moorhouse	
<b>Local Services</b>	
GE Healthcare Finnamore	<i>Consultancy support has been provided for programmes of work including:</i> <ul style="list-style-type: none"> <li>• Support to CCG out of hospital plans</li> <li>• Support to Whole Systems Integrated Care Programme</li> <li>• Development of Outline business cases for local estates hubs.</li> </ul>
McKinsey and Company	
PA Consulting	
<b>Mental Health</b>	
Anna Freud Centre	<i>Consultancy support has been provided for programmes of work including:</i> <ul style="list-style-type: none"> <li>• Needs Assessment to support the development of Children and Young People's mental health services.</li> </ul>
<b>Programme Management</b>	
PA Consulting	<i>Consultancy support has been provided for programmes of work including:</i> <ul style="list-style-type: none"> <li>• Needs Assessment to support the development of Children and Young People's mental health services.</li> </ul>
<b>Programme Management</b>	
PA Consulting	<i>Consultancy support has been provided for programmes of work including:</i> <ul style="list-style-type: none"> <li>• Programme and Portfolio Management support to Strategy &amp; Transformation team.</li> </ul>
<b>Workforce</b>	
OSCA agency	<i>Consultancy support has been provided for programmes of work including:</i> <ul style="list-style-type: none"> <li>• Health Coaching.</li> </ul>

2013 – 2015	
Provider	Break down of support provided to projects
<b>Acute Reconfiguration</b>	
Baker Tilly	Consultancy support has been provided for programmes of work including: <ul style="list-style-type: none"> <li>• The development of the Implementation Business Case (IMBC)</li> <li>• The closure of A&amp;E services at Central Middlesex and Hammersmith Hospitals in September 2014</li> <li>• The development of community and consolidation of inpatient maternity services across NW London in July 2015</li> <li>• Planning for the transition of paediatric services across NW London in June 2016.</li> </ul>
Consortium led by McKinsey & Company	
Fennimore/ GE Healthcare	
M&C Saatchi Group	
McKinsey & Company	
PA Consulting	
Private Public Ltd	
PwC	
Consolidated PR/LCA	
Freshwater UK	
Qi Consulting	
<b>Mental Health</b>	
Fennimore/ GE Healthcare	Consultancy support has been provided for programmes of work including: <ul style="list-style-type: none"> <li>• NW London's '<i>Like Minded</i>' strategy, which sets out the future of mental health services in NW London</li> <li>• New models of care across primary, community and acute settings to support patients with serious and long term mental health conditions</li> <li>• New models to support perinatal care and to those with learning disabilities.</li> </ul>
McKinsey & Company	
PA Consulting	
Private Public Ltd	
<b>Primary Care</b>	
McKinsey & Company	Consultancy support has been provided for programmes of work including: <ul style="list-style-type: none"> <li>• Seven day services – this work has improved access to GP services, seven days a week, across NW London</li> <li>• Co-commissioning, between our clinical commissioning groups and NHS England</li> </ul>
PA Consulting	
Private Public Ltd	
Finnamore/ GE Healthcare	
Methods Consulting Ltd	
<b>Whole Systems Integrated Care</b>	
McKinsey & Company	Consultancy support has been provided for programmes of work including: <ul style="list-style-type: none"> <li>• An individual patient record for everyone across NW London to speed up care and improve patient experience</li> <li>• Early adopters- areas within NW London that are working to create a more integrated care system, with increased coordination between</li> <li>• Primary, community and acute care. This largely involves the movement of services out-of-hospital into community settings. This work is supported by an education and training programme for staff (called the Change Academy).</li> </ul>
PA Consulting	
Private Public Ltd	

For your convenience we have supplied below the breakdown of costs for each of these four work streams. The costs incurred for mental health support the joint work with local authorities on the 'Like Minded' strategy. The Whole Systems Integrated Care workstream is also a joint programme of work between health and local government.

<b>Work stream title</b>	<b>Total spend 2013-2014 £000's</b>	<b>Total spend 2014-2015 £000's</b>	<b>Total spend 2015-2016 £000's</b>
Acute reconfiguration	5,120	7,138	3,109
Mental health	358	*3,654	353
Primary care development		3,218	
Whole systems integrated care	2,602	2,050	
Communications (support across all work streams)	57	2,365	
Strategy/infrastructure (Support across all work streams)	3,538	*2,148	864
Local Services			757
Workforce			87
	<b>12,188</b>	<b>20,572</b>	<b>5,170</b>

The table below also provides information regarding single tender waivers and contracts that were competitively procured. Please see below the breakdown of contracts, single tender waivers and secondments for the financial years of 2013/14, 2014/15 and 2015/16 for spending across the Strategy and Transformation Directorate.

<b>Type</b>	<b>2013-2014 £000's</b>	<b>2014-2015 £000's</b>	<b>2015-16 £000</b>
Contract following procurement	10,107	13,621	3,171
**Single tender waiver	325	3,837	2,016
Secondments	1,756	3,115	
<b>Total</b>	<b>12,188</b>	<b>20,572</b>	<b>5,188</b>

*\*\*Please note that much of the spend incurred following single tender waivers was associated with the extension of a competitively procured contract.*

## Local services strategy

All eight CCG in NW London have started to deliver improvements and changes to local services. And there are a number of programmes in train to help the delivery of this including whole systems integrated care, self-care, data & informatics, developing accountable care partnerships, primary care transformation, last phase of life programme, the 'Like Minded' mental health strategy and the Better Care Fund.

### Summary

More detailed information summaries of these are provided in Appendix C as well as priorities for the year ahead, but some of the key investments for our patients are:

- GP practices across North West London now offer extended opening weekday hours (8am-8pm) and weekend access to over a million people in NW London.
- To provide easier access for patients, investment in new technology at 80 GP practices means they now offer online, email, video or telephone consultations to over half a million patients.
- Eleven primary care hubs are already providing access to primary care and social care services in one place
- Rapid access services in all NW London boroughs to help keep patients with long term conditions out of hospital where possible, and discharged quickly from hospital when they have needed to be admitted - this has helped more than 3,000 people in **Harrow** and prevented 2,700 hospital admissions in **Brent** alone
- Many more community services now in place across all eight boroughs meaning more patients can be seen closer to home.

We are also working hard to increase seven day working and to better integrate care so patient care is properly coordinated and we run our services as efficiently as possible. All of these improvements should help relieve pressures for hospital beds, freeing up space for the most urgent cases and allowing hospitals to run planned surgery more effectively.

### Whole Systems Integrated Care

The Whole Systems Integrated Care (WSIC) programme has been operating for 3 years, and is currently shifting from an initial 'co-design phase' into an implementation phase across NWL. The programme is underpinned by 3 core principles:

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

Recent updates include the following:

#### Self-care

The patient activation measure (PAM) tool gives clinicians a better understanding of the knowledge, confidence, and skills a patient can bring to managing their own care. The tool is to be piloted in approximately 200 practices during 2016/17. In addition, plans are in place to produce a menu of self-care programmes for patients; training for staff; and work to empower third sector partners to deliver self-care support.

### **Data & informatics**

Around 250 of 389 GP practices are now signed up to an information sharing agreement to allow data extraction of care records in order to produce dashboards to support integrated care. Data linkages are now complete for acute, community, and mental health providers. Loading of data from GP practices is currently underway, and the aim is to start loading social care data in the coming months. Plans are in place for full dashboard rollout to all practices within 12-16 months.

Local developments: New models of care are currently being implemented by 'early adopters' in each CCG for specific population segments. Examples include Kensington & Chelsea (West London CCG), where two integrated care 'hubs' have been opened, offering the highest risk patients over 65 access to longer appointments with their GP alongside a multi-disciplinary team.

### **Developing 'accountable care partnerships'**

Accountable Care Partnerships (ACP) are groups of providers that collectively hold a single contract with commissioners, taking shared responsibility for the entire care needs of a population. The aim is to improve patient outcomes by reducing the misaligned incentives that arise when different providers are accountable for and paid for separate parts of the patient pathway. ACP structure also incentivised more proactive care that helps people to stay as well as possible.

Commissioning intentions for the 8 NWL CCGs in September stated that we intend to commission from ACPs from April 2018. ACP development discussions are taking place across NWL, as providers begin to form increasingly sophisticated collaborations and commissioners begin to specify the outcomes they wish to see for the population and how they would like to see the ACPs emerge.

For example, in Hillingdon providers, including the 3<sup>rd</sup> sector, have formed 'Hillingdon Health & Care Partners', a shared entity through which they hope to take increasing shared accountability patient care, evolving into a full ACP. Discussions are underway with commissioners about how this transition could best take place.

To support local ACP development, workshops are taking place in Hillingdon, Hammersmith & Fulham, and Westminster throughout April/May, with support from NHS England. The aim is to support providers to work through some of the technical aspects of closer collaboration (e.g. shared decision-making, shared finances), and to produce outputs that can be used by partners across NWL and nationally.

Over the coming months we expect to set out our transition paths towards ACPs across NWL.

### **Primary care transformation**

Primary care is at the centre of our ambitions to improve out of hospital care in NWL. Thanks to NWL action as part of the Prime Minister's Challenge Fund over 2014 and 2015, 1.9m people in North West London now have weekend access to GP services. Many patients in NWL can now also book appointments online, access their records online, and benefit from alternative forms of access for consultations (including telephone, email and video consultations). GP practices have come together across NWL to form federations and networks, aiming to deliver higher quality services and more efficient administration, and to provide a strong voice for general practice within the Accountable Care Partnerships (ACPs) now being developed across NWL.

The PMS review is designed to ensure that money spent through PMS contracts on services above and beyond core general practice continues to represent value for money. It is being led by NHS England as part of a national programme and, in London, is now due to be completed in the summer of 2016. Although challenging for many practices, this represents a step towards equalising the



patient offer within CCGs and delivers a series of incentives to increase proactive screening and immunisations. Practices losing income will be supported through transitional financial support, which NHS England and the CCGs are now finalising. The CCGs designed their new local PMS premium specifications as part of their co-commissioning role.

NWL CCGs are also working on the development of a broader new model of primary care. This must at least meet the requirements of the Strategic Commissioning Framework (SCF), which is a London-wide vision for what general practice should deliver to patients by 2019. Monitoring its delivery will become part of the NHS England (London) assurance process for CCGs.

### **Last phase of life programme**

The last phase of life programme is the first of the *Shaping a Healthier Future* 'Delivery Architecture' programmes, which are all to be sponsored by provider Trust Chief Executives. The purpose of these programmes is to accelerate the implementation of consistent services across North West London and to deliver financial savings to support the ongoing sustainability of the system.

The Senior Responsible Owner of the last phase of life programme is Lesley Watts, Chief Executive at Chelsea and Westminster Foundation Trust, and the clinical lead is Tim Spicer, chair of Hammersmith & Fulham CCG.

The Last Phase of Life programme follows work undertaken in the autumn of 2015 to scope opportunities in this area, which included representatives from acute trusts, community providers, London Ambulance Service, GPs, mental health providers, commissioners, Co-ordinate My Care, Macmillan, patients, carers, and the public.

The group defined the Last Phase of Life as the last 1-2 years of life and focussed on the frail elderly, defined as patients over 75 years of age with two or more emergency admissions in the last 18 months.

Five main challenges were identified that reduce the quality of care delivered at the end of life:

- Identification of frail, end of life patients at high risk of unnecessary admission
- The sensitivity of the subject and lack of difficult conversations between health professionals and patients
- NWL stakeholder groups not working together
- 'Now-ist' culture in acute hospitals preventing sufficient communication with other providers
- Relevant, consistent education is lacking across the system

The group recommended a number of initiatives and interventions which could be put in place to address many of the above issues. These included both cross-cutting initiatives (e.g. creating a directory of end of life services) and also initiatives related to specific types of providers (e.g. completion of and better access to care plans).

The benefit potential of this work, focussing particularly on the nursing home population, is believed to be substantial, both in terms of improving outcomes and saving beds days by investing in community end of life care (including primary, social and palliative care).

A detailed programme plan and implementation plan will be designed to reflect the recommendations of this work. This will include an audit of existing initiatives in each CCG patch, and define and measure specific interventions to enable delivery. The scope will initially focus upon admissions avoidance for patients in nursing homes, but across all eight CCGs.

## The 'Like Minded' mental health strategy

In North West London, a population of 2m, it is estimated that there are 37,000 people living with serious and long term mental health needs and 250,000 people with common mental health needs.

To improve mental health and wellbeing across North West London, we've established a new strategy called '**Like Minded**', which is all about working in partnership to look at how we can deliver excellent, joined up services that improve the quality of life for individuals, families and communities who experience mental health issues.

The strategy has been co-produced with patients, carers, doctors, voluntary organisations and charities and other experts. It's about everyone who provides any aspect of mental health care joining together so that we can all learn best practice and share innovative approaches. Good health means good mental health and, by working in partnership to promote wellbeing, we can equip people to help themselves.

The Like Minded Case for Change received endorsement from all eight Health & Wellbeing Boards and CCG Boards in NWL, as well as our two main mental health providers West London Mental Health Trust (WLMHT) and Central and North West London NHS FT (CNWL), in autumn 2015. Our vision is for North West London to be a place where people say:

- My wellbeing and happiness is valued and I am supported to stay well and thrive
- As soon as I am struggling, appropriate and timely help is available
- The care and support I receive is joined-up, sensitive to my own needs, my personal beliefs, and delivered at the place that's right for me and the people that matter to me

The Like Minded Strategy is a 'whole systems' strategy – throughout the programme we recognise the critical role that services provided by Local Authorities have in supporting mental health and wellbeing – prevention and maintaining recovery being examples. As a programme we are aware that any developments need to be jointly supported across health and social care – to avoid the risk that changes in services commissioned by health have a negative knock on effect on social care teams.

Local Authority leads, CCG leads, Trust leads, Healthwatch, Health Education England NWL, NHS England, Metropolitan Police are members of Like Minded Boards. A NWL alliance of service users and carers called Making a Difference (MAD) Alliance provide input at governance and design/implementation groups at NWL level and local areas.

The Like Minded Case for Change identified a number of priority areas for focus including Serious & Long Term Mental Health Needs, Common Mental Health Needs, Children & Young People, Workplace Wellbeing, Perinatal Care and Learning Disabilities.

Work is in progress with health (including public health), social care, criminal justice, third sector and lay partners to both:

- Monitor the implementation of projects agreed to deliver the Shaping Healthier Lives strategy 2012 - 2015.
- Develop and implement new models of care to deliver on the Like Minded Whole Systems Mental Health & Wellbeing strategy 2015 - 2020.

Projects in progress include:

Children & Young People's Transformation Plan in response to 'Future in Mind', 2015 (NWL and local plans; NHSE approved December 2015):

- Local Needs Assessment
- Training & Development Needs Assessment
- Child and Adolescent Mental Health Services (CAMHS) pathway redesign

Transforming Care Plan for people with learning disabilities, autism and challenging behaviour (NWL and local plans; final plan submitted to NHSE 11 April). The plan is overseen by the Transforming Care Partnership Board and builds on work in progress in NWL to improve the mental health care of people with learning disabilities, projects in train include:

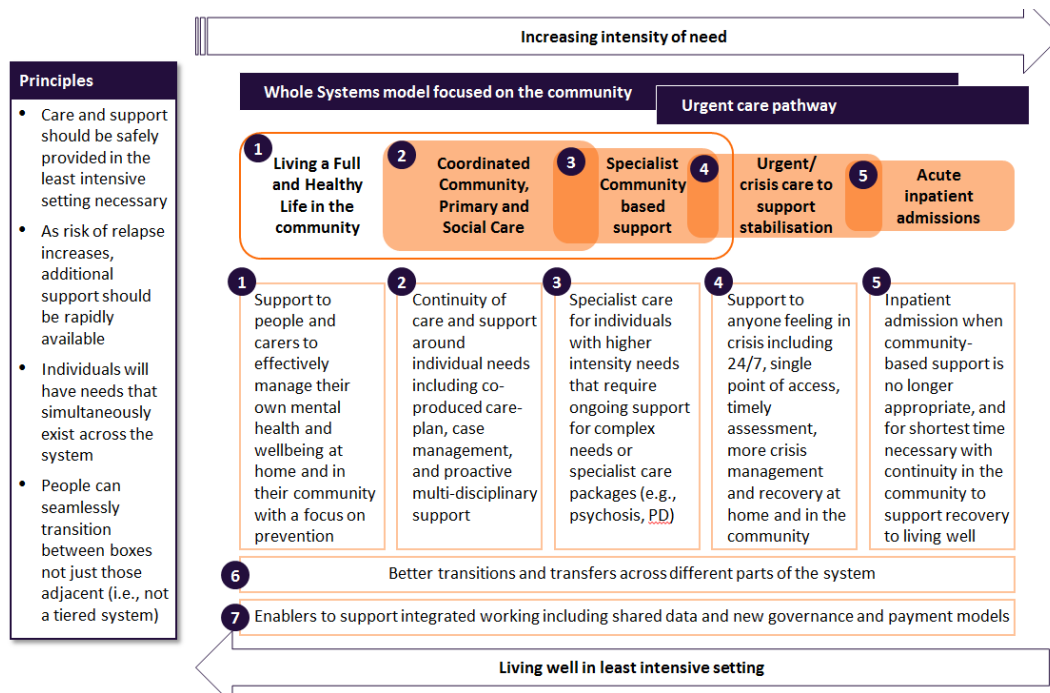
- Kingswood Centre service specification
- Service specifications for Community Learning Disability Teams
- NWL leadership for local Greenlight action plans

A co-produced, integrated perinatal service launched for Ealing, Hammersmith & Fulham and Hounslow at the end of February 2016, feedback has been very positive to date. Improvements have been made at St Mary's in collaboration with West London and Central London CCGs and the clinical pathway is being developed through co production. The work will inform planning for Brent, Harrow and Hillingdon CCGs.

The NWL Urgent Care & Assessment redesign has addressed key priorities set out in NWL Crisis Care Concordat (signed by 25 agencies in November 2014) as well as delivering a key enabler for the Shifting Settings of Care agenda agreed in 2012:

- The redesign has delivered 24/7 Single Point of Access (advice and referral) hubs run by CNWL and WLMHT, and rapid response home treatment teams. The CNWL service went live from November 2015, WLMHT service from April 2016.
- In addition the redesigned Child and Adolescent Mental Health Services (CAMNHS) Out of Hours service for NWL went live January 2016.
- An improved pathway for Early Intervention in Psychosis to meet NICE/NHSE Access targets from April 2016 is being launched at CNWL and WLMHT.

These redesigned services will be evaluated during 2016 to inform contracting and the new Model of Care & Support for people with Serious & Long Term Mental Health Needs. This is at draft business case stage, being refined and developed for each of the eight local areas with CCG and Local Authority colleagues and expected to go to CCG Governing Bodies in the summer.



*NWL Model of Care & Support for people with Serious & Long Term Mental Health Needs*

### The Better Care Fund

Better Care Fund (BCF) programmes across NWL are due to be finalised in early May. They are expected to be broadly consistent in priority from the previous plans across NWL and to focus on reducing the need for acute care by looking after people better in the community, and where acute care is required making sure that people return to their community setting as quickly as possible. We expect progress will be measured against to two main metrics: reducing non-elective admissions (NELs) and delayed transfers of care (DTocS).

There is work being done to achieve this both within the BCF programmes and elsewhere. With regard to non-elective admissions, 7 day working now is operational across health (mental, as well as physical) and social care services in the community, which reduces the likelihood of visits, by default, to A&E. We have the first steps in place to join up social care data and health data using the NHS number with the vast majority of social care customers' records now having a NHS number. Care and attention is being delivered more locally and with greater timeliness by widening the use of multi-disciplinary working and by continuing with pro-active care planning for high risk patient groups.

We will be benchmarking our work to prevent delayed transfers of care prevention against the model promoted by the Local Government Association and the Association of Directors of Adult Social Services, and will aim to identify other improvement areas. We would be pleased to provide further updates once local BCF plans have been finalised.

## NW London Sustainability and Transformation Plan

The NHS Five Year Forward View, published in October 2014, considers the progress made in improving health and care services in recent years and the challenges that we face leading up to 2020/21. In December last year the NHS asked local health care services to develop their blueprints for delivering the Five Year Forward View – Sustainability and Transformation Plans (STPs).

In common with the NHS Five Year Forward View we face big challenges over the next five years:

- There is a 17 year difference in the life expectancy between the wealthiest and poorest parts of our boroughs
- 21% of the population is classed as having complex health needs
- NW London's 16-64 employment rate of 71.5% was lower than the London and national average.
- If we do nothing there will be a £1billion financial gap in our health and social care system and potential failure in some sectors.

Our nine emerging priorities addresses the gaps in the Five Year Forward View and have the triple aim of improving health and wellbeing, improving care and quality , and improve productivity and close the financial gap:

- Supporting people who are mainly healthy to stay mentally and physically well , enabling and empowering them to make healthy choices and look after themselves
- Reduce social isolation
- Improve children's mental and physical health and well-being
- Ensure people access the right care in the right place at the right time
- Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population
- Improve the overall quality and of care for people in the last phase of life and enabling them to die in the place of their choice
- Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed
- Reducing unwanted variation in the management of long-term conditions – diabetes, cardiovascular disease and respiratory disease
- Reduce health inequalities and disparity in outcomes for the three top killers: cancer, heart diseases and respiratory illnesses

### **Communicating and engaging with patients and local residents, staff and the wider stakeholder community**

To make the most of our STP it is essential we engage patients and local residents, staff and the wider stakeholder community in North West London in its development, giving them the opportunity to help shape the strategy and agree priorities for the next five years.

**We are already working closely with you on the STP. We would like your input on the on-going engagement with our local community.**

We will:

- 1) Hold a series of public meetings to get feedback on the emerging priorities. We have started this process and had successful meetings in both Brent and Harrow;

2) Use social media platforms to continue the conversation with residents of NW London.

**We would request partners support in communicating and engaging with local people and stakeholders and would welcome their positive contribution and ideas as to how we could do so.**

## Outcomes measurement

A range of outcomes and metrics have been introduced or are in development including Whole Systems Integrated Care (WSIC) and mental health care. We are also in the process of developing a dashboard to measure local service developments.

The shared vision of the WSIC programme is 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. The Outcomes and Metrics project focuses on developing a core set of metrics for the over 65 population which supports this vision. The project aims to support and stimulate local discussions about more detailed specific outcomes and metrics for use when commissioning of local integrated services. Responsibility for these local metrics remains within individual CCGs and Local Authorities.

The outcomes and metrics are set out in the table below. They were developed by a working group comprising individuals from the eight boroughs across North West London representing health, social care, third sector and lay partners. They identified outcomes domains that reflect an integrated care environment:

- People have a high quality of life.
- Care is safe, effective and people have a good experience.
- Professionals experience an effective integrated environment.
- Care is financially sustainable.
- Care delivery is efficient

The metrics were developed through a series of engagement processes. These included:

- Initial identification of alignments across NWL through review of the Early Adopter March 2014 Outline business plans.
- Use of National Voices<sup>1</sup> 'I statements' to develop the outcome patient descriptions.
- Research of national best practice, including PIRU (2014)<sup>2</sup>.
- Alignment with key programmes, including CWHHE Better Care Fund Patient Experience work stream and Seven Day Standards.
- Service user forums including care home residents, carer groups and NWL WSIC Lay Partner Forum
- Engagement with WSIC Lay Partner Advisory Group (LPAG) in development of patient description and identification of metrics.
- Engagement with staff in each local 'early adopter' to scope localised developments.
- Review of core metrics at local integrated care steering groups for feedback and endorsement

Next steps for the WSIC outcomes and metrics workstream include:

- Annual review date of NWL WSIC core metrics, reflecting emerging local models of integrated care and the increasing use of data across health and social care through the release of the data warehouse. Examples of potential developments include the evolution of the 'days at hospital' metric into 'days at home', additional social care metrics, and introduction of the Patient Activation Measure (PAM) score to evaluate impact on patient empowerment.

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<sup>1</sup> <http://www.nationalvoices.org.uk/principles-integrated-care>

<sup>2</sup> Raleigh. V et al; Policy Innovation Research Unit (PIRU): Integrated care and support Pioneers: Indicators for measuring the quality of integrated care: Final report (2014)

- Development of the data warehouse dashboard to support the communication of metrics.
- Centralised administration of the staff survey, and support for local tailoring of questions.
- Development of North West London contribution to National Staff and GP survey consultation process to ensure a focus on the increasing focus of integration across traditional health organisations.

Outcome domain	Outcome patient description	Core Metrics	Measurement	Data Source
<b>1. People have an overall quality of life</b>	"Taken together, my care and support gives me the opportunity to contribute and help me live the life I want to the best of my ability"	1A: GP National Survey: How confident are you that you can manage your own health? *	% responding very confident/fairly confident	National GP Patient Survey: Ipsos MORI
		1B: Social care-related quality of life	Aggregated score across 8 survey questions	ASCOF
		1C: Number of days in hospital. (Planned evolution into 'Days at Home' dependant on availability of data)	Average days for population	SUS
		1D: GP National Survey: Did you help put your written care plan together?	% responding yes	National GP Patient Survey: Ipsos MORI
<b>2. Care is safe, effective and people have a good experience</b>	"I feel safe, in control and well informed. I am respected for my own experience and knowledge. I know people are there when and where I need them"	2A: GP National Survey: In the last 6 months, have you had enough support from local services, or organisations to help you manage your long term condition?	% responding yes	National GP Patient Survey: Ipsos MORI
		2B: Patients with all of the following: care plan/goals set/ crisis plan within previous 12 months	% with all 3	EMIS SystemOne
		2C: A&E activity for ambulatory sensitive conditions	Per 100,000 population	SUS
		2D: Safety metric: In development; proposal for aggregated metric across whole system.	TBC	TBC
<b>3. Professionals experience an effective integrated environment</b>	"The professionals involved with my care talk to each other. We all work as a team."	3A: WSIC staff survey: Professionals who agree they are working in an integrated way to support service users and carers.	% responding strongly agree/agree	NWL Survey (comparison with National Staff Survey)
		3B: WSIC staff survey: Professionals able to deliver the patient care they aspire to.	% responding strongly agree/agree	NWL Survey (comparison with National Staff Survey)
		3C: WSIC staff survey: Professionals who would recommend their integrated care partnership as a place to work.	% responding strongly agree/agree	NWL Survey (comparison with National Staff Survey)
<b>4. Care is financially sustainable</b>	"The care I receive is part of a service built on long term sustainability"	4A: Spend within set capitated budgets for target population	+/- agreed capitated budget	Financial reporting
		4B: Shift in spend/activity from acute to out of hospital	Definition of out of hospital/acute TBC	Financial reporting
<b>5. Care team is efficient</b>	"I am supported by people who respect my time and I am not being admitted into hospital unnecessarily."	5A: Emergency readmissions within 30 days of discharge from hospital	% of total discharges from hospital	SUS
		5B: Weekend discharge rate	% comparison with weekday discharges	SUS
		5C: Non-elective admissions	Per 100,000 population	SUS

We will provide a further update as to progress when we are able.



# Review of the North West London maternity and neonatal service transition of July 2015

March 2016

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# Executive summary

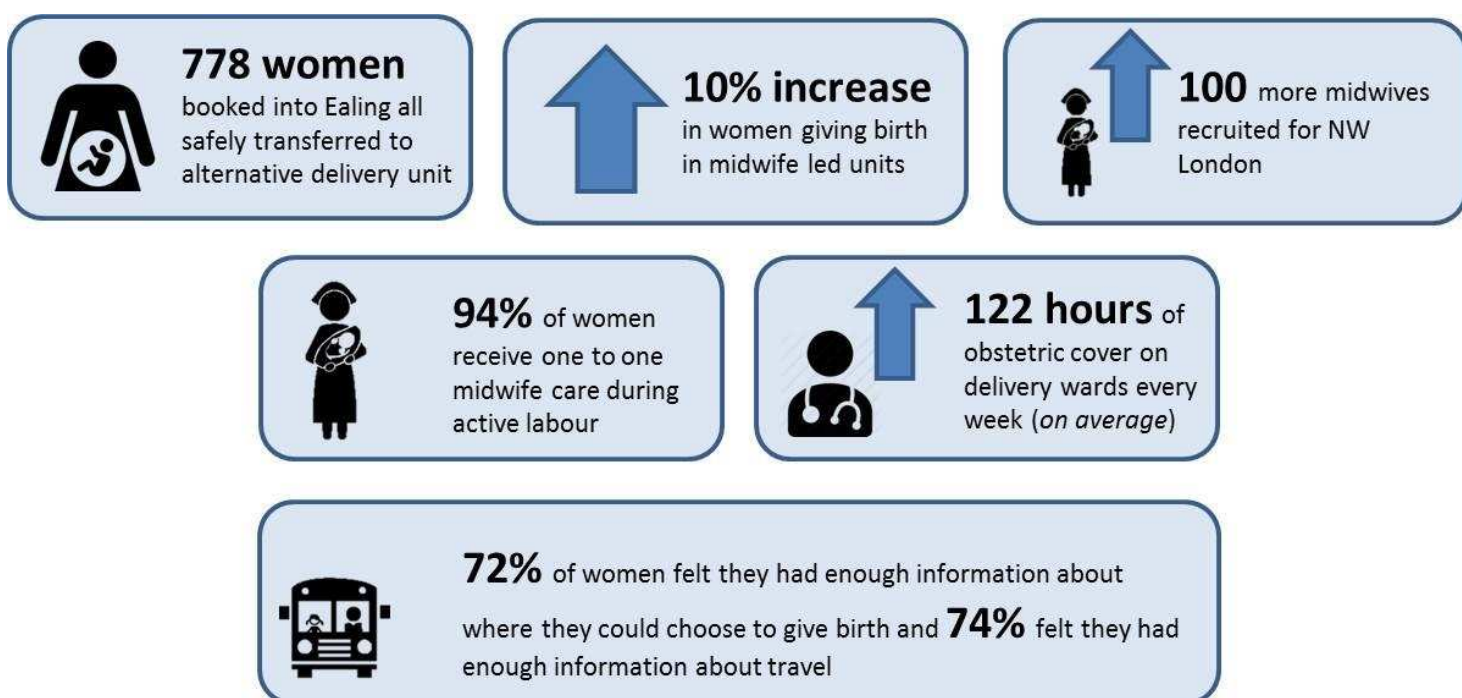
To improve the quality of care for mothers and babies across North West London, maternity services in the region underwent significant change in July 2015, including the closure of Ealing Hospital’s maternity unit and development of community services. These clinically-led changes were essential to: respond to the increasing number of women with complex health needs during pregnancy; provide consistent high-quality maternity care by concentrating staff, expertise and resources in fewer centres and; increase the number of midwives and the hours of senior consultant cover.

This maternity review has found that the changes have been made safely and patients are now seeing improvements to their care.

All women booked to give birth at Ealing Hospital prior to the changes had their care transferred safely to nearby hospitals. Across NW London, we have improved the midwife to birth ratio to meet national standards, and all six maternity units have increased hours of senior consultant cover. Despite national shortages of staff, 100 new midwives have been recruited to NW London as a result of these changes. In Ealing there is now improved continuity of antenatal and postnatal care closer to people’s homes and we are also piloting a new perinatal mental health service for the area.

This report considers how the change has been managed and evaluates progress made on the expected the benefits. The report sets out key recommendations where further work is needed and where lessons of best practice should be shared with the wider NHS.

Maternity care in NW London will continue to be developed and monitored closely and a further review will be made in 2017.



# Chapter summary

## Chapter 1: Context

The maternity changes – or transition - were made as part of the clinically led Shaping a Healthier Future (SaHF) programme to improve healthcare for the two million people across NW London.

There were three primary reasons why maternity services needed to be changed:

- there are an increasing number of women with complex healthcare needs during pregnancy in NW London
- maternity units in NW London need to provide consistent high-quality, safe care, in line with the London Quality Standards. This could only be achieved by having fewer units to better concentrate staff, expertise and resources
- the need to increase the number of midwives so that one to one (1:1) midwife care in labour can be achieved for 100% of women and to assist maternity units in moving towards 168 hours of consultant presence on delivery wards each week.

There are 19 clinical aims outlined for the transition of which 14 clinical aims have already been met. Progress has been made with the remaining five and work continues to deliver them in full. This is explored further throughout this report.

### *The 2016 national maternity review*

In February 2016 the national maternity review, overseen by Baroness Cumberledge published its report “*Better Births, Improving outcomes of maternity services in England*” which sets out the five year forward plan for maternity services across the country.

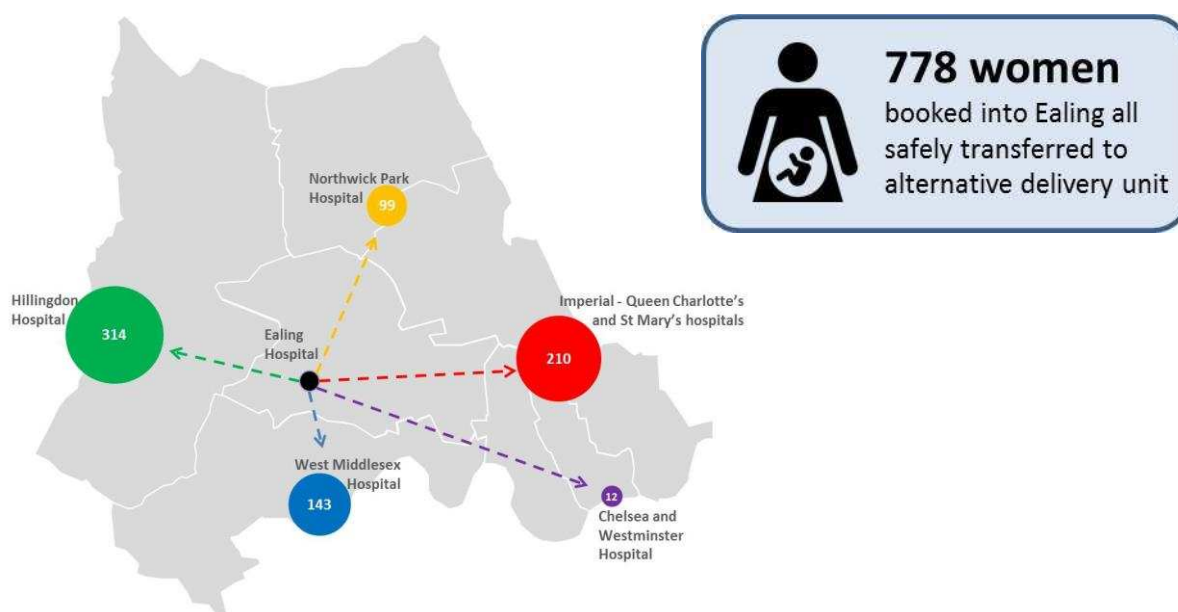
The changes in NW London are aligned with this national vision meaning NW London is already delivering the majority of the standards of care outlined in the review.



## Chapter 2: Transfer of women

In total, 778 women who were booked to deliver their babies at Ealing Hospital after the planned closure date of its maternity unit needed to be re-booked to a new delivery unit. Of those, just 15 did not get their first alternative choice.

All the women were transferred safely with no clinical incidents or concerns raised and by the end of January 2016 all had given birth.



## Chapter 3: Maternity model of care

### 3.1 Early pregnancy care

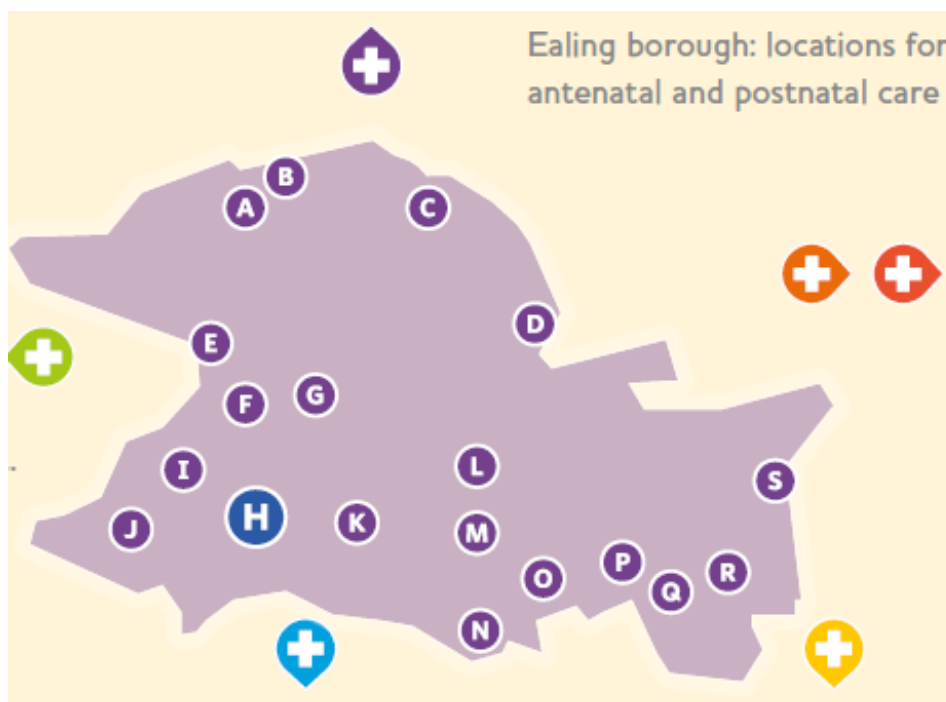
Nationally, the aim is for all pregnant women to be booked into their chosen birth unit by the 12th week of pregnancy. Improvements in NW London mean we are meeting this and are now aiming to have women booked in before their 11<sup>th</sup> week of pregnancy.

As part of the changes, a Maternity Booking Service (MBS) was set up to manage demand and capacity centrally. The primary purpose is to assist women who are not able to get their first choice of maternity unit. Since October, all women have received their first choice.

### 3.2 Antenatal care

Women in Ealing now have more consistent community midwifery as midwives from West Middlesex, Northwick Park, St Mary's, Queen Charlotte's and Hillingdon hospitals are now providing antenatal clinics in 18 locations across Ealing, primarily through children's centres and health centres. This means women in Ealing are able to see midwives from the same team throughout antenatal, birth and postnatal care.

St Mary's, Queen Charlotte's, West Middlesex, Northwick Park, and Hillingdon Hospitals also run antenatal clinics out of Ealing Hospital. Women can also request some antenatal and postnatal care in their own homes.



Since the changes have been made, all Ealing women have been able to be seen in the clinic location of their choice as long as their clinical needs can be met in the clinic.

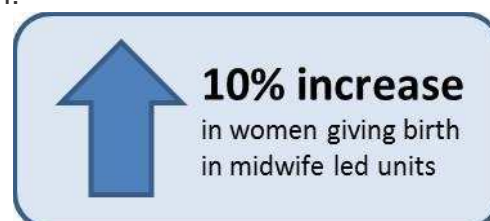
However, many of the clinics in the community in Ealing are not being well used, including a low uptake of scanning appointments which are still available at Ealing Hospital for some women. A maternity diabetes clinic remains at Ealing Hospital but also has seen low uptake.

A significant amount of extra capacity was built into the system to ensure women could get an appointment where they requested. However, it is unclear whether women are choosing to go elsewhere as a preference or whether they are not being made aware that local clinics are available.

### 3.3 Care in labour and at birth

Women who deliver on a midwife-led unit have a lower risk of unnecessary intervention. There is now a midwife-led unit alongside every obstetric unit in NW London, including two new midwife-led units developed as part of these changes, giving women more choice in where they give birth.

There has been a 10% increase in women giving birth in midwife-led units since the changes were made, with 15% of all deliveries in NW London now taking place in a midwife-led unit.



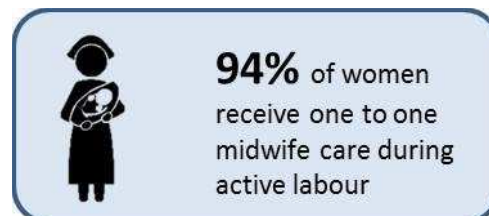
A key focus of the changes was to improve midwifery staffing across NW London to meet the London Quality Standards' minimum staffing ratio of one midwife to thirty births (1:30). Prior to the changes, only Northwick Park was meeting that standard.



All 88 midwives working at Ealing Hospital were transferred to other maternity units within NW London, and over 100 more midwives were recruited to the area as a result of the changes.

This has meant that, as well as Northwick Park, Chelsea and Westminster, Queen Charlotte's and St Mary's hospitals have all now managed to achieve the 1:30 standard. West Middlesex has improved but the ratio at Hillingdon Hospital has remained unchanged.

In line with the London Quality Standards, NW London is working to make sure that women receive one-to-one care from a midwife while they are in active labour. All hospitals have improved with the exception of St Mary's and Queen Charlottes where performance has decreased. Current figures show that 94% of women receive one-to-one care, which is the same as the average prior to the changes.



The London Quality Standard for consultant cover is for 168 hours of consultant presence on delivery wards every week (i.e. consultant presence 24 hours a day 7 days a week). Prior to the change, Ealing Hospital was achieving 60 hours of



consultant cover – lower than all neighbouring hospitals. NW London set out to achieve 123 hours in 2015/16 and is on track to achieve that target with five out of six hospitals now providing more obstetric consultant-led care than they did before the changes.

To ensure the benefits of the changes are being realised, trusts are reporting against a set of quality metrics each month which are being monitored by the NW London Clinical Board.

### 3.4 Postnatal care

As part of the changes, trusts worked together to review their catchment boundaries for maternity care to help improve continuity of care. Before the changes, 42% of women had their postnatal care provided by a different hospital trust to their antenatal care. This has now reduced to 21%, meaning more women are seeing improvements in the continuity of their care as a result of the changes.

One major development in clinical care is the implementation of 'transitional care units'. These units provide the additional support that some babies require, whilst allowing mother and baby to remain together on the postnatal ward.



There has also been an improvement in breastfeeding initiation rates in every unit except for Northwick Park and West Middlesex hospitals. Queen Charlotte's and St Mary's have introduced a community breastfeeding support service and Hillingdon has a new feeding coordinator for infants.

As part of the changes, it was agreed to develop mental health care relating to pregnancy and birth. Recruitment for staff is now complete and the perinatal mental health service is now being piloted.

## Chapter 4: Demand on maternity services

Planning for the changes include 3000 expected deliveries moving from Ealing Hospital. This is 500 more deliveries than Ealing Hospital saw on average, building in capacity for potential population increases. As expected, the majority of women from around Ealing Hospital have chosen to book at West Middlesex or Hillingdon hospitals.

There has been no change in the overall volume of deliveries since the transition and forecasts show that no maternity unit will exceed the number of births they expected from Ealing. However, other factors – including a growth in births from Brent – means Northwick Park Hospital is projected to exceed its maximum annual capacity if no action is taken.

## Chapter 5: Interdependent services

### *5.1 Neonatal services*

The unit closed safely on 29 June 2015 with no babies in the unit at the time of closure that required transfer.

As a result of these changes, 15 neonatal cots were put in place at the other hospitals in NW London, which includes the cots reassigned from Ealing Hospital.

All twelve neonatal nurses working at Ealing Hospital were able to transfer to their first choice of hospital and are settling in well.

While the average numbers of transfers within NW London have not changed, there has been an increase in transfers to other networks due to lack of intensive care capacity for babies needing surgical care. However, Ealing Hospital did not previously this level of care, therefore this increase in demand is unrelated to the closure at Ealing.

### *5.2 Emergency gynaecology service at Ealing Hospital*

Ealing Hospital continues to provide planned inpatient and outpatient gynaecology services on-site. It also now provides new emergency gynaecology services to support the emergency department at Ealing Hospital. These included an enhanced gynaecology emergency clinic at Ealing Hospital during the week, incorporating an

early pregnancy assessment unit, and an emergency gynaecology clinic at the weekend.

All the early pregnancy assessment units across NW London have seen average numbers of attendance increase, including at Ealing Hospital, following the transition.

## Chapter 6: Women's experience

A survey was undertaken with women whose care was moved from Ealing Hospital. 778 postal surveys (with freepost return envelope) were sent out and face-to-face surveys took place in two children's centres in NW London. In total there were 103 responses (13%), which is higher than expected for this type of survey.

### 6.1 Information and materials



**63%** received this in the post

**76%** said they had received information about hospital choices and travel

**55%** received this from their midwife

**72%** felt they had enough information about where they could choose to give birth and **74%** felt they had enough information about travel



**10%** said they would have liked more travel information on parking and travel by car

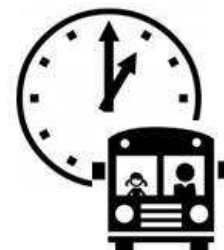


## 6.2 Travel to access care

Only **45%** said their midwife asked about their travel plans when they had their care moved



A quarter felt less able to get to appointments on time after they were moved. Some women did highlight an increase in travel time – especially where public transport was involved



**68%** said the change did not make it harder for them to attend their antenatal appointments



## 6.3 Overall experience of care

**59%** felt supported through the transition but **26%** did not



Once under the care of their new unit **79%** were happy with the care their received

## 6.4 Experience of women living in Southall

Thirty three women from Southall completed the experience survey which is a third of all respondents.

- under the care of their new units most women (75%) were happy with the care that they received
- 75% agreed they had received enough information about other hospitals where they could choose to give birth
- 78% indicated they received enough information about travel
- However a larger percentage of Southall women indicated that it had become harder for them to attend their antenatal/postnatal appointments on time, 36% compared to 19% of the overall survey respondents. This could be driven by the fact that only 28% of the Southall women indicated that they received antenatal or postnatal care locally from a children's centre or health centre.

## Chapter 7: Staff experience

### 7.1 Approach to staff transfers

The priorities for staff focussed on retaining skills and knowledge within NW London as well as increasing the overall number of midwives in the area. There were no redundancies, or resignations, as a result of transition and training bursaries were provided to staff transferring to another unit.

However a change in date of transition – and a period of uncertainty around that date – did have a negative impact on staff morale.

Whilst vacancy rates in midwifery continue to be a national issue, significant improvements have been made in NW London as a result of the transition. In total, an equivalent of 100 additional full time midwives were recruited.



### 7.2 Clinical leadership

Strong relationships were forged between clinical leaders as the heads of midwifery from all trusts came together on a regular basis to implement the changes. This combined expertise has been instrumental in driving up clinical quality. Community midwifery leads continue to meet weekly to review and refine care provision as appropriate.

### 7.3 Midwifery staff

Focus groups were undertaken in January 2016 with 29 midwives at four out of the five trusts to obtain feedback on the transition and learn for the future.

Most midwives spoken to from Ealing did not find the transition straight forward and raised issues around the uncertainty of the closure date and the speed of the transition. There was a divide between these midwives over the effectiveness of communications to them, with some receiving information from many sources and others saying they hadn't received any personal communications. Equally there were varying issues around travel, with some finding their commute shorter whilst others experienced longer journeys. The majority of midwives had now settled into their new jobs well.

A number of midwives commented that they felt their workload had increased post-transition and raised issues associated with this. The majority of the midwives at the focus groups felt that the level of care they were individually providing had remained the same. As has been highlighted in other areas of this report, quality indicators have indicated that the cumulative effect of all the changes have meant that levels of care have improved.

### 7.4 Midwifery trainees

Midwifery trainees commented on the positive aspects of moving from Ealing Hospital and felt they were able to make informed choices about which units to transfer to.

### *7.5 Obstetrics and gynaecology postgraduate medical trainees*

Six obstetrics and gynaecology postgraduate medical trainees based at Ealing were matched to an alternative hospital in line with their normal cycle of rotations and no trainees failed to meet their annual competencies as a direct result of the transition. A survey to all obstetrics and gynaecology trainees in NW London found a general feeling that workload had increased but there was a split view on whether this increase in workload has positively or negatively impacted their training.

### *7.6 General Practitioners (GPs)*

A survey to GPs also went out across four boroughs with 21 practices responding.

All GPs felt that women usually need some form of support in making an informed choice and 57% felt the information they had received from their CCG (75% in Ealing) had been useful in helping to communicate the changes.

**Best practice learning and recommendations can be found in chapter 8 of this report.**

# Chapter 1: Context

## 1.1 Background

Shaping a Healthier Future (SaHF) is a clinically led programme to improve care for the two million people across North West (NW) London. In February 2013, following on from extensive public consultation in summer 2012, the Joint Committee of Primary Care Trusts agreed the proposals set out under SaHF. This included the reconfiguration of maternity services across the area to improve the quality of maternity care. In October 2013, based on advice from the Independent Reconfiguration Panel (IRP), the Secretary of State endorsed the SaHF decision to transition inpatient maternity, neonatal, and interdependent gynaecology services from Ealing Hospital to six other hospitals in NW London. On 20th May 2015, Ealing CCG Governing Body agreed the timing of the transition of services. The transition of these services was implemented on 1st July 2015. This introduced new arrangements for community maternity across NW London, provided new facilities for community clinics in Ealing and inpatient obstetric units at hospitals across NW London and closed the inpatient maternity and neonatal unit at Ealing Hospital.

There were three primary reasons why maternity services needed to be changed:

1. there are an increasing number of women with complex healthcare needs during pregnancy in NW London,
2. maternity units in NW London need to provide consistent high-quality, safe care, in line with the London Quality Standards. This could only be achieved by having fewer units to better concentrate staff, expertise and resources,
3. the need to increase the number of midwives so that one to one (1:1) midwife care in labour can be achieved for 100% of women and to assist maternity units in moving towards 168 hours (24/7) of consultant presence on delivery wards each week.

In June 2015, the Ealing Maternity Transition Safety Committee recommended that an interim review was undertaken six months after the transition to:

- Conduct an initial assessment of the planned benefits and their realisation,
- highlight the good practice that has developed as a result of the transition, including evaluating the clinical benefits, estate developments, and further benefits,
- Identify any areas that require further development in order to realise additional benefits.

## 1.2 Benefits case

The model of care for maternity services in NW London set out a clear objective and expected outcomes that the transition of services should achieve.

The objective was to introduce a consistent model of care for maternity and new-born services in NW London to:

- Improve equity of access to the same levels of care.
- Provide care closer to home.
- Offer a choice in location of antenatal care, birth setting and postnatal care.
- Improve continuity of care for women throughout their antenatal and postnatal pathway.

The following table outlines the objectives for the development of maternity care services in NW London and provides an overview of progress towards achieving these in the first six months following transition. These are explored in more detail through this report. This snapshot clearly demonstrates the rapid progress that has been made in improving care to women in NW London.

Objectives of the transition	compliance	progress	Report section
To improve equity of access to maternity care.		96% of women referred for antenatal care now have a booking appointment before their 12 <sup>th</sup> week of pregnancy. 3% improvement post transition	3.1.1
Offer a choice in location of antenatal care, birth setting and postnatal care.		Across NW London choice has been increased for antenatal care, birth and postnatal care increasing the range of clinic settings and introducing midwife-led birth units	3.2.1 and 3.3.1
Improve continuity of care for women throughout their antenatal and postnatal pathway.		Through agreeing consistent pathways and more accurately matching trust catchment areas to women's choice of delivery unit 79% of women now have the same provider for their whole maternity experience an increase of 21% since the transition (from 58%)	3.4.1
Choice of community setting with more care close to home (Children's Centres, Health Centres, GP Surgeries, Community Hubs).		Care is provided in 18 children's centres and health centres in Ealing, at Ealing hospital, and directly in women's homes	3.2.1

Objectives of the transition	compliance	progress	Report section
A defined model of shared care between GPs, midwives and obstetricians as appropriate.		This element did not form specific part of the transition but has been highlighted as an areas that requires further work	3.2.2
Triage, treat and transfer protocols to avoid unnecessary admissions.		These have been agreed across the network.	3.4.4
Access to 24-hour maternity triage and emergency gynaecology services for women should problems occur.		Access to early pregnancy assessment unit services has increased with significant more capacity in Ealing. Usage of these facilities has increased significantly	5.2
1:1 midwifery care in active labour.		The percentage of women receiving 1:1 midwifery has remained constant at 94%, the aim is to achieve 100%	3.3.3
Improve midwife to birth ratios across NW London so all units achieve the minimum target of one midwife to thirty births (1:30).		The ratio has improved across from 1:31 to 1: as an average across NW London, however, two units remain outside this ratio. The unit with the worst ratio has improved from 1:35 to 1:32.	3.3.2
Increase consultant obstetric presence on the delivery ward (moving towards the target of 168 hours presence).		Since transition the average number of consultant hours on each obstetric ward has increased from 101 hours to 122 hours. Plans need to be agreed to achieve 168 hours	3.3.4
Choice of birth setting – home, midwifery led or obstetric led.		Women are able to choose to have their baby at home, in a midwife led unit or an obstetric unit. The number of midwife led units has increased and the number of births in these units has increased 10% since the transition.	3.3.1
Choice of setting - care either in home or close to home in community settings postnatal		Postnatal care is offered in women's homes and in community settings	3.4.1
A model of Transitional Care for babies and an agreed Tariff		All units are now offering transitional care however, work needs to be undertaken to agree a common specification	3.4.3



Objectives of the transition	compliance	progress	Report section
		for this and an associated tariff	
Clear handover protocols and communication with identified healthcare professional for the transition to parenthood.		These are in place across the network	3.4.2
Enhanced children's safeguarding through development of provider: borough protocols.		The safeguarding processes and paperwork have been standardised across NW London	3.4.2
Ensure sufficient cot capacity in NW London		Cots in the receiving hospitals were increased by 15. There has been no increase in transfers as a result of the maternity transition. However, there are an increasing number of babies in NW London requiring surgical cots and current capacity does not meet this demand. Chelsea and Westminster hospital are reviewing the capacity they can provide with a view to increasing provision	5.1.1
Clinical outcomes within national metrics		A comprehensive quality dashboard has been developed that enables oversight of key clinical outcome measures	3.3.5
Sufficient maternity delivery capacity in NW London		There is sufficient capacity across NW London and since October 2015 all women have been able to have their babies in their first choice of unit	4

**Good practice learning for future transitions 1:** It is important to agree a strong set of clinical quality aims with all stakeholders against which performance can be measured in addition to the more simple transitional process measures.

### 1.3 The 2016 national maternity review

In February 2016 the national maternity review, overseen by Baroness Cumberledge published its report "*Better Births, Improving outcomes of maternity services in England*". This sets out the five year forward plan for maternity services.

The report lays out a five- year vision for maternity:

*“Our vision for maternity services across England is for them to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances.*

*And for all staff to be supported to deliver care which is women centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries.”*

The report pulls out a series of recommendations for the development of maternity services over the next five years to ensure the realisation of this vision.

It is reassuring, that although the transition in NW London predates the national review, the objectives set for the development of maternity services in NW London through the transition (as outlined in 1.2) align with the national vision and recommendations. As such NW London is already delivering the majority of the standards of care outlined in the review.

For example, there is a large focus on women receiving continuity of care in pregnancy. It suggests that women should be cared for by small teams of midwives who are able to provide this continuity of care. It also recommends that women should be provided with comprehensive information to support them to make their personalised choice in where to have their baby, either in a labour ward, birth centre or at home and that the service should wrap around them to support their choice.

The model of midwifery care implemented in NW London has small teams of community midwives providing continuity of care to women. The information booklet provides unbiased, comprehensive information to women to help inform their choice of maternity care and the estates investments undertaken through the transition ensure that women in all providers now have choice of giving birth in a labour ward, birth centre or at home.

Importantly the review recommends that professionals, providers and commissioners should come together on a larger geographical area through Clinical Networks, coterminous for both maternity and neonatal services, to share information, best practice and learning, to provide support and to advise about the commissioning of specialist services which support local maternity systems. The strong network of heads of midwifery, consultant obstetricians, commissioners and others is a positive outcome arising from the NW London transition; this is discussed later within this report.

The development of a quality dashboard to track, benchmark and improve quality is a further recommendation that has been developed by NW London through this transition.

There are, of course, recommendations from the national review that are not yet delivered within NW London such as a specific obstetrician being allocated to each small community team, and each women having electronic maternity records. It is therefore important that the NW London maternity network review the full recommendations of this report and develop an action plan to achieve all the recommendations over the next five years.

The report calls for volunteer localities to be identified as early adopters and it recommended that NW London volunteers for this.

**Recommendation 1:** NW London maternity network to assess current progress against the new national review recommendations and develop an action plan to deliver to them.

## 1.4 Governance

The review has been undertaken by an independent researcher and overseen by:

- Dr Mohini Parmar, Chair of Ealing CCG
- Dr Mark Spencer, Medical Director of Shaping a Healthier Future and Medical Director of NHS England London Region
- Pippa Nightingale, Director of Midwifery/Clinical Director of Women's services at Chelsea and Westminster and West Middlesex Hospitals
- Carmel Cahill, Lay Member, Ealing CCG Governing Body
- Juliet Brown, Programme Director, Shaping a Healthier Future

The report has been independently reviewed by Donna Ockenden, Expert Midwife and Independent Healthcare Advisor.

## Chapter 2: Transfer of women

The evidence provided to this review demonstrates that the transfer of inpatient maternity services from Ealing Hospital was a streamlined process, which was well planned and clinically led. Prior to the transition, all of the 969 women who were booked to give birth at Ealing Hospital were telephoned by a midwife about the planned changes. If a midwife was unable to contact a woman by telephone, they were visited at home. Following agreed protocols, 778 of the women who were contacted had a new delivery unit agreed and their care was transferred to the respective trust. This transfer process was undertaken as quickly as possible to reduce the uncertainty for women. The time from contacting the first women to all women having appointments with their new trust was eight weeks. Fifteen women were not able to be offered their first alternative choice of unit and their care was rearranged by the Maternity Booking Service, with reports that they were satisfied with the unit to which they were transferred. Clinical notes were transferred to the receiving units and a clinical review by a midwife, lead consultant and/or safeguarding lead as appropriate was undertaken for each woman to ensure that the right clinical and social pathways were implemented.

Of the remaining 191 women, 190 were contacted, but their care did not require to be transferred as either they delivered at Ealing Hospital in June, had moved out of the area or were no longer pregnant. Only one woman could not be contacted despite following a number of detailed procedures, including contacting her GP and attempting to visit her at home. The team have since been informed that she has moved out of area and registered with a GP out of London.

The maternity unit closed safely on 1st July 2015 and the clinical and operational teams who led and managed the transfer should be praised for the safe implementation of the transfer, which was on time, as planned, with no clinical incidents or concerns raised by local population or GPs. As of end January 2016, every woman who had their care transferred from Ealing Hospital has given birth.

**Good practice learning for future transitions 2:** Direct verbal contact with women, rather than relying on written communication, resulted in a smooth transfer and no unexpected births at Ealing following the transition.

**Good practice learning for future transitions 3:** The transfer process was clinically led and all women were clinically assessed prior to transfer ensuring appropriate care was put in place.

**Good practice learning for future transitions 4:** Vulnerable women were a clinical priority and received high priority in the acceptance criteria. This has been continued through the Maternity Booking Service so that vulnerable women are always able to access their first unit of choice.

# Chapter 3: Maternity model of care

## 3.1 Early pregnancy care

The benefits case set out the following objectives for early pregnancy promoting improved access to care:

- To improve equity of access to maternity care including early access to maternity services by eleven weeks and six days of pregnancy.

### 3.1.1 Early access to booking appointments

Women are supported in making their choice for maternity care from the six maternity providers in NW London by GPs, other care providers and the Maternity Booking Service. There are, on average, 3,000 pregnancy booking appointments in NW London each month. During a booking appointment, a full medical and social needs assessment is conducted by a healthcare professional, who will also provide advice and support on lifestyle, breastfeeding, diagnostics and other pregnancy related matters. Specialised services such as translation, interpreting and advocacy services can also be offered at this time, if required.

Booking before the twelfth completed week of pregnancy is a national target, and the minimum standard is 90%. Post transition 96% of women are seen within this timeframe, compared to 93% before the transition. This 3% increase in compliance means 90 additional women per month are accessing maternity care on time.

This progress has been driven by a significant improvement in arranging timely booking appointments at St Mary's Hospital, where 98% was achieved in November 2015, from a baseline of 88%. This is as a result of the improvement in the community midwifery model and increased provision of community clinics.

NW London is exceeding the national standard and the improved performance is evidence that the clinical standard of improving early access to maternity services has been achieved. This will continued to be monitored monthly to ensure compliance continues to improve and the trusts are now reviewing options to ensure women are seen by the 10th week and 6th day of pregnancy.

**Table 1: Percentage of women referred before the 11th completed week of pregnancy that have a booking appointment before the 12th completed week of pregnancy**

Maternity Unit	Pre-transition		Post-transition				Average Jul-15 - Nov-15	
	Average		Jul-15	Aug-15	Sep-15	Oct-15		Nov-15
	Jul-14 - Jun-15	Jul-15						
Chelsea & Westminster	93%	93%	94%	94%	94%	91%	<b>93%</b>	
Hillingdon	96%	96%	98%	95%	96%	96%	<b>96%</b>	
Imperial (Queen Charlotte's)	94%	95%	98%	95%	96%	96%	<b>96%</b>	
Imperial (St Mary's)	88%	96%	96%	94%	96%	98%	<b>96%</b>	
Northwick Park	97%	96%	98%	94%	96%	98%	<b>96%</b>	
West Middlesex	94%	98%	97%	96%	95%	95%	<b>96%</b>	
<b>North West London Average</b>	<b>93%</b>	<b>96%</b>	<b>97%</b>	<b>95%</b>	<b>96%</b>	<b>96%</b>	<b>96%</b>	

Source: Maternity Quality Dashboard

### 3.1.2 The Maternity Booking Service

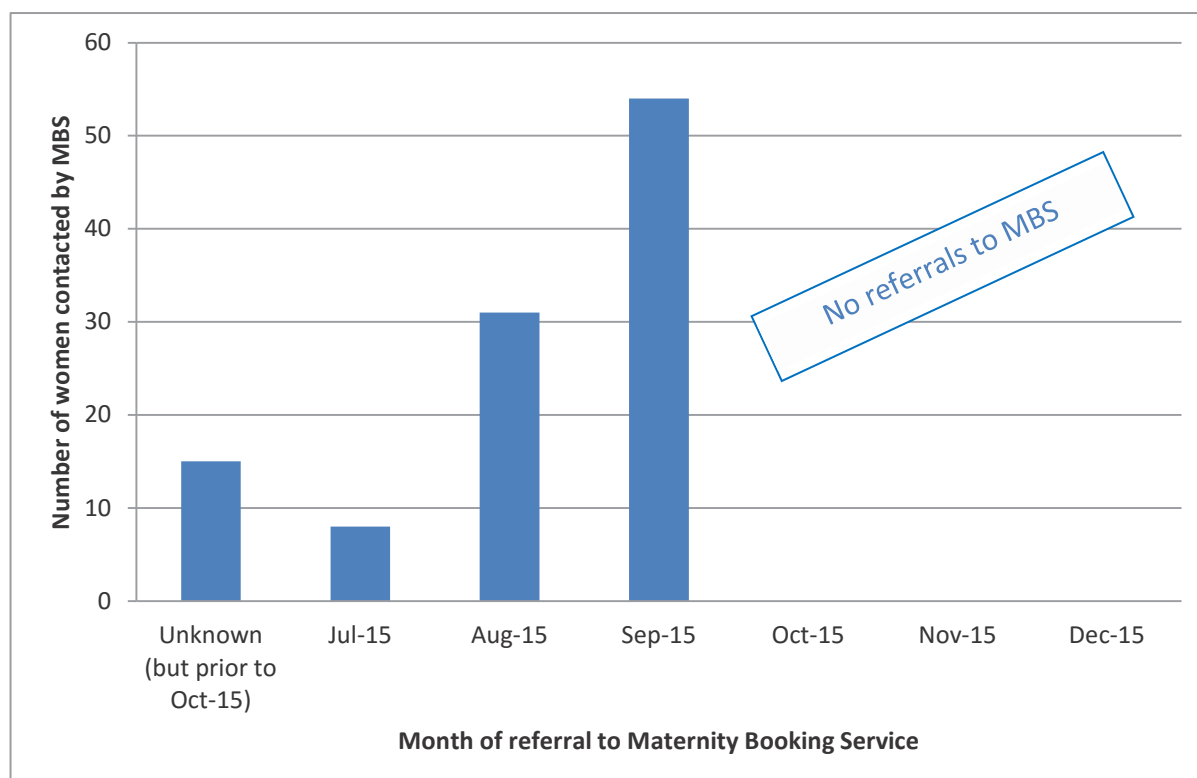
The Maternity Booking Service (MBS) was commissioned in November 2014. It aims to ensure women are offered a choice of maternity provider in NW London while managing demand and capacity centrally to support women's choices, improve their experience and prevent delays in booking appointments for antenatal care in line with the national maternity booking standard. Its primary purpose is to assist women who are not able to book into their first choice of maternity unit choose an alternative unit within NW London. It is coordinated using a bespoke Excel database, developed and managed by the MBS team. All referrals to MBS are clinically screened and vulnerable cases, such as women with safeguarding issues, are placed in their first preferred choice of unit.

The planning assumptions were made on a worst case scenario of 5% of women not receiving their first choice. However, to date only 1% of women have not received their first choice.

The 1% of women who did not receive their first choice (108 women, 58 who live in NW London) occurred in the first three months following transition and were unable to book into Hillingdon Hospital (THH). The project team were quick to respond to this and supported Hillingdon Hospital to refine their acceptance and booking processes. Since October all women have been accepted into their first choice trust and there have been no referrals to MBS, as demonstrated in Figure 1 below. This shows that the modelling of demand and capacity in preparation for the transition was sound and the changes are now embedding in the system. It should be recognised that there will be times when women will not receive their first choice of maternity unit. For this reason, the MBS will continue to operate to assist those women choose an alternative unit within NW London.

All women who were not placed in their first choice in the first three months were clinically screened. If safeguarding or vulnerable needs were present, they were accepted at Hillingdon Hospital. All other women were placed in their second choice trust within 72 hours.

**Figure 1: Number of women living in NW London referred to the Maternity Booking Service by month of booking**



Source: Maternity Booking Service

Following redirection from Hillingdon Hospital, the most popular second choice maternity units for women from NW London are Queen Charlotte’s and Chelsea Hospital (Queen Charlotte’s Hospital) and West Middlesex University Hospital (West Middlesex Hospital). It is worth noting that the MBS has not had any problems communicating with women who have been referred to them and used appropriate translation services in four cases.

Not all women from NW London choose to have their baby at birth units in NW London. Should their chosen hospital, outside NW London, be fully booked they will be referred to the MBS to arrange an alternative NW London hospital. GPs have asked that further work is undertaken with neighbouring hospitals to establish this referral route more robustly.

There was no central booking system prior to transition, so it is not possible to provide comparative pre-transition data. Anecdotally, we know that a number of women did not receive their first choice of unit. In the absence of a Maternity Booking Service, women then either had to follow up themselves or a GP surgery would do it for them. The development of the MBS can therefore clearly be seen to have reduced waiting times and reduced uncertainty for many women.

**Good practice learning for future transitions 5:** A central booking system improves system resilience, minimises disruption for women who are unable to book into their first choice unit and improves access to care for women.

**Recommendation 2:** SaHF and the NW London clinic network should share the MBS model with the wider London network to consider if this approach should be taken across London. This would also assist women from NW London who choose to book outside of the sector.

## 3.2 Antenatal care

The benefits case for antenatal care promotes choice in care delivery through:

- choice of community setting with more care close to home (children's centres, health centres, GP surgeries, community hubs)
- a defined model of shared care between GPs, midwives and obstetricians as appropriate,
- triage, treat, and transfer protocols to avoid unnecessary admissions.

### 3.2.1 Choice of care setting

The clinical aim when planning the transition was that the children's centres in use in Ealing would continue and Ealing Hospital would be used as an additional community maternity clinic setting. It was also agreed that a consistent community midwifery model of care would exist across the sector.

This has been achieved and women in Ealing now have choice about where they would like to receive their maternity care. There are eighteen different locations across the borough (children's centres and health centres). In addition West Middlesex Hospital, Northwick Park, St Mary's, Queen Charlotte's and Hillingdon Hospitals provide services from Ealing Hospital or women can attend clinics at the hospital where they have chosen to give birth. Midwives also provide postnatal and some antenatal care to women in their own homes.

All six maternity providers extended their community areas to encompass the Ealing community area, to ensure that high quality midwifery care could be provided in Ealing, so as to not to inconvenience the local women. New community clinics were also planned and delivered in children's centres by Imperial College Healthcare Trust in areas of Brent and Chelsea and Westminster in Chiswick.

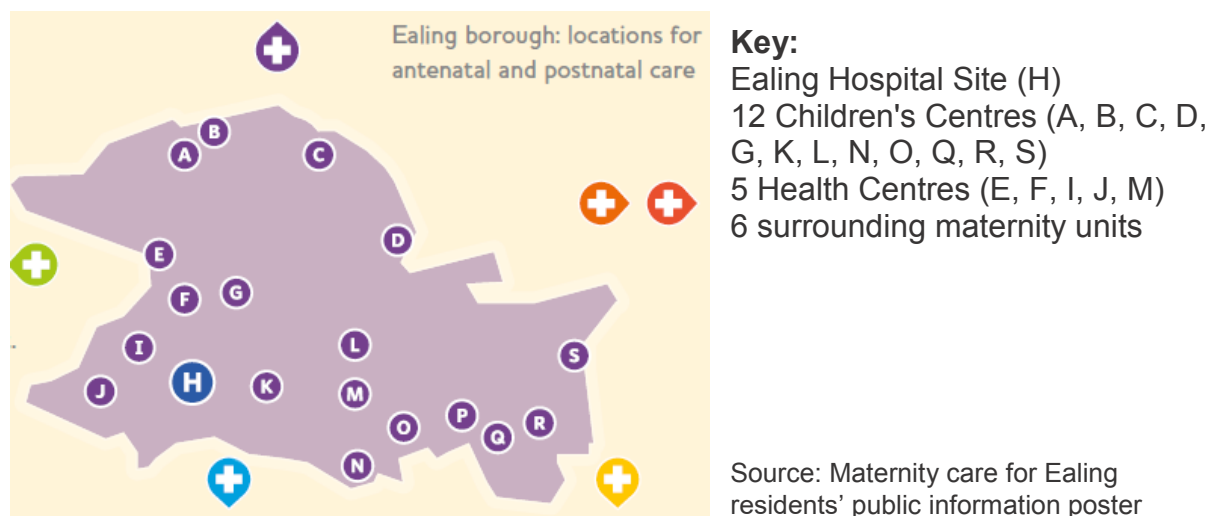
The majority of women are therefore now able to receive local maternity care, to agreed protocols, by midwifery teams from their chosen hospital, who provide their antenatal and postnatal care in a community setting where clinically appropriate.

The new midwifery clinics in children's centres and health centres commenced 13 June 2015 and the Community Maternity Clinics at Ealing Hospital opened 6 July 2015. Northwick Park Hospital and Hillingdon Hospital also offer consultant-led antenatal clinics, specialist diabetic services and ultrasound scanning from the Ealing Hospital site.

Full details of the public information poster on the location for community care provision in Ealing Borough can be found in Appendix 1.



**Figure 2: Planned Ealing borough locations for antenatal and postnatal care**



The clinical team made the decision to continue to provide community care in children's centres, which are aligned with the wider multidisciplinary teams such as health visitors and social workers and all agree this is a good model. In the vast majority of areas this model is working well, however, the transition has highlighted some issues relating to the different commissioning arrangements for children centres (they are commissioned by local authorities). Children's centres are funded in relation to local women attending the centre and the geographic boundaries do not map exactly to the maternity services. This has only caused difficulty in some areas of Chiswick where the funding arrangements have meant that some women have not been able to access their maternity care in a children's centre as they do not live within the appropriate catchment area. To manage this, midwives have been visiting these women at home to prevent them having to travel into the hospital. It is also acknowledged that children's centre funding in general is under review and this may have implications in the future.

The clinical project group continue to support the view that providing care in children centres is the best clinical alignment for women and health professionals. Providers need to work in partnership with commissioners and Local Authorities to understand the planned provision and role of children centres in the future and align service availability for women.

### 3.2.2 Shared care arrangements for antenatal care

As in the rest of the country, there are differing models within NW London with regard to antenatal care and the involvement of GPs and hospital maternity teams. This is commonly referred to as shared care. These arrangements were discussed in the planning phase of this transition and a decision was made not to progress changes to these arrangements at the same time as transition. As such the differing commissioning arrangements for shared antenatal care between GPs and the maternity providers continue and have not been resolved through the transition. The change in commissioning arrangements for Ealing patients has further highlighted the need to resolve this and it has been agreed that this will be progressed through 2016/17 contract negotiations.

**Recommendation 3:** Providers need to work in partnership with commissioners and local authorities to understand the planned provision and role of children centres in the future. Negotiations should be held with Chiswick children’s centres to agree access for local women.

**Recommendation 4:** Commissioners and providers need to work together to agree commissioning arrangements for shared antenatal care. In future transitions, contracting issues that affect transition should be managed within the transition framework.

### 3.2.3 Demand for outpatient maternity services

Providing sufficient outpatient capacity to support women’s choice and ensure future resilience were key planning concepts of the transition. Significant additional capacity was therefore built into the outpatient clinic capacity in Ealing Hospital, the children’s centres and health centres.

Since transition, all women have been able to be seen in the clinic location of their choice as long as their clinical needs can be met in the clinic.

At Ealing Hospital, 43 maternity clinics were initially planned. However due to the flexibility planned into the system, only 40% of the planned 43 clinics are running as there is not sufficient demand for the clinics. Furthermore, several of the clinics are underutilised, with many women choosing to have their care delivered at children's centres, health centres or the location of their maternity unit instead.

**Table 2: Clinics offered by each trust at the Ealing Hospital site**

Hospital Trust	Services Offered	Number of clinics planned	Number of clinics not started	Number of clinics in place
Chelsea & Westminster	Not applicable	0	0	0
Hillingdon	Antenatal care only	4	2	2
Imperial	Bookings and antenatal care	18	10	8
London North West	Bookings and antenatal care	9	4	5
West Middlesex	Antenatal care only	12	10	2
<b>Total</b>	<b>Bookings and antenatal care</b>	<b>43</b>	<b>26</b>	<b>17</b>

Source: Community Midwifery Leads

The clinics run by Hillingdon Hospital and Imperial Healthcare Trust are well attended with more than 75% of appointments booked. In the two clinics run by West Middlesex Hospital however, one has less than 25% of appointments utilised and the other has 75% utilised. London North West Healthcare Trust is also running clinics which are under capacity, with two out of their five clinics only having 25-50% of appointments taken up. They are working to address this, including improved marketing of the site. Hillingdon Hospital's scanning clinic is running as planned at Ealing Hospital, however only 51 - 75% of available appointments are booked. London North West Healthcare Trust were planning to run eight scanning clinics, but only three have been required to meet demand.

The trusts running clinics from the Ealing Hospital site report that the clinics are running well and they have overcome some early challenges regarding IT integration.

In the planning phases of the transition there was a strong view from the public that a diabetic service remained at Ealing. Both Hillingdon Hospital and London North West Healthcare Trust provide maternity diabetic clinics at Ealing Hospital. In similarity to the general maternity clinics there was significant over capacity planned and the services are not fully utilised. Further work is being undertaken by Hillingdon Hospital and London North West Healthcare Trust to review their diabetic pathways.

Trusts are also providing community clinics from the children's centres and health centres in Ealing as planned (the only exception being that Imperial Healthcare Trust moved services from Mattock Lane Health Centre to Masbro Children's Centre, as Mattock Lane were not able to provide a room for the clinic.) As seen at Ealing Hospital, demand from women for these community clinics is lower than planned, resulting in only 60% of the 65 clinics taking place. Another reason for lower utilisation at these clinics is that they also offer postnatal care, which is also offered directly in women's homes, a preferable arrangement for many women.

Women who had their care transferred from Ealing Hospital during the transition provided feedback on the information they received about the range of options available to them, including access to maternity appointments. Further details are provided in Section 6: Women's Experience.

**Recommendation 5:** Review the utilisation of clinics as Ealing Hospital and refine the clinic capacity and demand.

**Recommendation 6:** Providers should work with women in the area to highlight that they can access high quality antenatal care by the same team who will deliver their baby, without the need to travel to the centre where they have chosen to give birth.

**Recommendation 7:** Within the next six months the maternity diabetic pathway needs to be reviewed across the sector to ensure provision of specialist services to meet clinical need.

### 3.3 Care in labour and at birth

The benefits case set out the following objectives for labour and birth, promoting choice and appropriate skilled staffing levels:

- choice of birth setting – home, midwifery -led or obstetric- led.
- 1:1 midwifery care in active labour.
- increase in midwife to birth ratios across NW London so all units achieve the minimum target of one midwife to thirty births (1:30).
- increase consultant obstetric presence on the delivery ward (end point target for 168hrs presence, transition target average 123 hours per week).

#### 3.3.1 Midwife-led units

Since the start of the planning for this transition there are now two additional midwife- led units in the sector and there is now a midwife-led unit alongside every obstetric-led unit in NW London, giving women more choice in delivery setting. There are now 31 midwife-led unit rooms in NW London. The following table shows the number of births in the midwife-led units each month for the NW London maternity units. This shows a 10% increase from 349 births per month in a midwife-led unit pre transition to 371 per month post transition. The 31 midwife-led unit delivery rooms in NW London account for 32% of the 97 delivery rooms available, with 15% of all deliveries happening in a midwife-led unit. Although the birth occupancy may appear low at 32%, the length of stay for a woman in a midwife-led unit includes her inpatient postnatal stay therefore the overall occupancy is considerably higher. Further work should be undertaken to increase the percentage of women who deliver on a midwife-led unit as women who deliver in these units have a lower risk of unnecessary interventions and increased satisfaction.

**Table 3: Number of monthly midwife-led unit deliveries by maternity unit**

Maternity Unit	Pre-transition			Post-transition			Average Jul-15 - Nov-15
	Average						
	Jul1-14 - Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	
Chelsea & Westminster	57	53	59	60	76	67	63
Hillingdon	5	43	*7	40	47	37	42
Imperial (Queen Charlotte's)	66	70	80	70	56	86	72
Imperial (St Mary's)	60	57	49	57	57	65	57
Northwick Park	49	71	42	40	55	47	51
West Middlesex	76	98	82	83	97	69	86
Ealing Hospital	37	-	-	-	-	-	-
<b>NWL Monthly Total</b>	<b>349</b>	<b>392</b>	<b>319</b>	<b>350</b>	<b>388</b>	<b>371</b>	<b>371</b>

\*Data quality issue due to coding problem. Not included in post-transition average calculation.

Source: Maternity Quality Dashboard

Not surprisingly, the biggest increase in midwife-led unit deliveries has been at Hillingdon Hospital where this service was newly introduced at the time of transition. However, the number of midwife-led unit deliveries at St Mary's Hospital has dropped by an average of three per month post-transition. This is despite an overall increase in the number of deliveries at this unit. This may be due to the recent

refurbishment of the midwife-led unit at Queen Charlotte’s Hospital, so women booked with Imperial may be choosing to go to that unit instead.

**Recommendation 8:** In line with national and London-wide guidance, labour and birth in alongside midwifery- led units should be actively promoted for low risk mothers as they are associated with a lower risk of unnecessary interventions and increased satisfaction.

### 3.3.2 Midwife to birth ratio

The London Quality Standards set out a midwifery staffing ratio of a minimum of one midwife to thirty births (1:30) across all birth settings. Prior to the transition, the only receiving hospital achieving this standard was Northwick Park Hospital with a ratio of 1:24, which was an elevated ratio reflecting improvement work that was underway in 2015 following recommendations by the Care Quality Committee Care Quality Commission.

A focus of the transition was therefore to improve midwifery staffing at all receiving trusts, with the aim of improving the midwife to birth ratio at each site. There were 88 midwives working at Ealing Hospital at the time of the transition who were transferred to the other maternity units in the sector, resulting in an initial reduction in the vacancy rates at the receiving trusts. Furthermore, there was a concerted drive to recruit additional midwives to NW London in preparation for the transition, which dramatically increased the number of midwives working in the sector from 840 whole time equivalents (WTEs) in February 2015 to 939 WTEs in December 2015.

The following table compares the midwife to birth ratio, pre and post transition, for each maternity unit.

**Table 4: Midwife to birth ratio (Standard 1:30)**

Maternity Unit	Pre-transition	Post-transition
Chelsea & Westminster	1:33	1:30
Hillingdon	1:31	1:31
Imperial (Queen Charlotte's)	1:33	1:30
Imperial (St Mary's)	1:33	1:30
Northwick Park	1:24	1:27
West Middlesex	1:35	1:32
<b>North West London Average</b>	<b>1:31</b>	<b>1:30</b>

Source: Maternity Quality Dashboard

Following the transition, Chelsea and Westminster Hospital, Queen Charlotte’s Hospital and St Mary’s Hospital have all improved midwifery cover to achieve the 1:30 standard. West Middlesex Hospital has improved since the transition to a ratio of 1:32, but further work is required at the unit to achieve the standard. Hillingdon Hospital’s ratio has not yet changed, but it is forecast to improve following recruitment of a number of additional midwives in December and January. Northwick Park Hospital has completed the improvement work requiring the unit to have an

elevated ratio, so this has been reduced to 1:27, which is still exceeds the London Quality Standards.

**Recommendation 9:** West Middlesex Hospital and Hillingdon Hospital should continue to actively recruit midwives to achieve the 1:30 target set out in the London Quality Standards and agree a plan to achieve this ratio with their respective commissioners.

### 3.3.3 One to one care for all women in active labour

In line with the London Quality Standards, NW London aims to guarantee that women receive one to one care from a midwife in active labour, regardless of their chosen place of birth. By the end of November, this was achieved for 94% of women across the sector, but NW London is aiming for 100% therefore further development is required in this area.

This aggregated percentage disguises variation in performance across the sector. At 98%, Northwick Park Hospital has been consistently achieving the highest 1:1 midwifery cover in labour, which reflects their excellent midwife to birth ratio of 1:27. All other trusts are above the pre-transition average and at 96% or above, with the exception of Imperial Healthcare. At both St Mary's Hospital and Queen Charlotte's Hospital the post-transition average has deteriorated from a spot audit done pre-transition, from 91% to 89% and 88% respectively. This data needs to be treated with caution and is likely to be linked to data quality rather than a change in practice. Imperial have now moved to electronic collection of this data and the trust is experiencing data quality issues. The trust is currently revalidating this data.

**Table 5: Percentage of women receiving 1:1 midwifery care in labour**

Maternity Unit	Pre-transition			Post-transition			
	Average			Average			
	Jul-14 - Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Jul-15 - Nov-15
Chelsea & Westminster	95%	95%	96%	99%	98%	-	97%
Hillingdon	96%	97%	96%	95%	96%	96%	96%
Imperial (Queen Charlotte's)	*91%	81%	84%	87%	92%	94%	88%
Imperial (St Mary's)	*91%	-	84%	91%	92%	88%	89%
Northwick Park	97%	-	98%	-	98%	97%	98%
West Middlesex	94%	98%	97%	96%	95%	95%	96%
<b>North West London Average</b>	<b>94%</b>	<b>93%</b>	<b>93%</b>	<b>94%</b>	<b>95%</b>	<b>94%</b>	<b>94%</b>

\*Pre-transition data from one spot audit during the year

Source: Maternity Quality Dashboard

It should be noted that this data is notoriously difficult to collect and work should be undertaken to ensure that all trusts are using the same data collection methodology.

**Recommendation 10:** Undertake immediate review of data collection processes with respect to 1:1 midwifery care in labour to ensure consistency of methodology across trusts. Imperial Healthcare Trust need to revalidate their 1:1 care in labour data. Compliance with this should be monitored through their Care Quality Group.

### 3.3.4 Obstetrics & gynaecology consultant presence on labour ward

The London Quality Standards state that obstetric units should provide 168 hours of consultant presence on delivery wards every week (i.e. 24 hours a day, 7 days a week). Through Shaping a Healthier Future, NW London providers and commissioners committed to delivering the London Quality Standards for maternity although achievement of the full standard was not anticipated immediately upon transition. The benefits case set out an ambition to achieve 123 hours of consultant presence in 2015/16, following transition and NW London is on track to achieve this target. The consolidation in the number of maternity units in July 2015 has enabled significant improvement in this metric across the sector from 101 hours pre-transition, to an average of 122 hours in November 2015. Five of the six trusts in NW London provide more consultant-led care than they previously did. St Mary's Hospital is the only exception and continues to provide 98 hours per week. Commissioners will work with Imperial Healthcare Trust through contract negotiations, to ensure that this level of cover is improved.

It is worth noting that prior to the transition, Ealing Hospital had a much lower level of consultant presence (60 hours a week) compared to any of its neighbouring trusts. The five obstetrics and gynaecology consultants, who were working at Ealing Hospital at the time of the transition, continue to work within London North West Healthcare Trust, contributing to the improved hours of cover at Northwick Park Hospital.

To provide a complete perspective for clinical cover, it is also important to consider the midwife to birth ratio. The following table analyses the consultant cover at each unit in NW London alongside the current midwife to birth ratio.

**Table 6: Hours of consultant presence on the delivery ward per week**

Maternity Unit	Pre-transition Consultant presence Jul14 - Jun15	Nov-15 Consultant presence	Nov-15 Midwife: birth ratio
Chelsea & Westminster	110	115	1:30
Hillingdon	96	108	1:31
Imperial (Queen Charlotte's)	98	116	1:30
Imperial (St Mary's)	98	98	1:30
Northwick Park	98	132	1:27
West Middlesex	146	164	1:32
Ealing Hospital	60	-	-
North West London Average	101	122	1:30

Source: Trust Data Returns on Consultant Labour Ward Presence

**Recommendation 11:** Each trust should work with commissioners to finalise plans to further improve clinical cover on labour wards in 2016/17, taking in to account any new guidance issued in this area. St Mary's Hospital needs to increase the consultant presence on labour ward as soon as possible - this needs to be monitored by their Clinical Quality Group.

### 3.3.5 Quality outcomes

The benefits case set out the following objectives to ensure understanding of quality outcomes:

- to measure clinical outcomes within national metrics

In order to monitor the quality of maternity services in NW London and ensure the intended benefits of the service changes are realised, a set of quality metrics were agreed by the SaHF Clinical Board.

For governance purposes, data is collected from trusts on a monthly basis to produce a report, which is submitted for review and action to the SaHF Clinical Board and the Ealing Quality Committee. The report is also submitted for information to the SaHF Programme Executive, the Implementation Programme Board, Ealing Governing Body and the NW London CCG Quality Committees.

This is a comprehensive set of metrics that enables comparison of performance pre and post transition at individual trust and NW London levels. These are in the context of London Quality Standards and national performance criteria.

The programme intends to continue monitoring these indicators beyond the transition period, through incorporating them into trust quality schedules and therefore into agreed business as usual quality reports.

The full dashboard for December 2015 is given in Appendix 2. Information from the dashboard has been used through this report to evidence the impact of the transition e.g. midwife to birth ratio, 1:1 midwifery care in active labour, breastfeeding initiation rates.

To date the programme has used the dashboards to ensure that standard quality measures such as caesarean section rates, puerperal sepsis have not changed significantly. With only 6 months of post transition data it is too early to identify clear statistical trends. However, it is important that this data continues to be monitored regularly using statistical process control techniques so that any changes in quality of care can be identified promptly.

The programme intends to continue monitoring these indicators beyond the transition period, through incorporating them into trust quality schedules and therefore into agreed business as usual quality reports.

**Good practice learning for future transitions 6:** It is important to establish a clinical outcomes dashboard prior to the transition and use this to monitor quality performance and guide on-going discussions.

**Recommendation 12:** An in-depth analysis of the quality data should be conducted when one year of data is available, to compare to pre-transition data and benchmark against other maternity units in London for measures such as caesarean section rates, assisted deliveries and complications, babies born before arrival, haemorrhage, normal birth, and booking by before 13 weeks.



### 3.3.6 Maternity unit estate development

In preparation for the transition of maternity services, there was a significant amount of investment in estates across NW London to improve delivery and experience of maternity care.

An extension of the estates at West Middlesex Hospital has resulted in much better facilities for women. A new midwife-led unit has been built, labour ward capacity has been extended and there is new antenatal clinic space. To further improve women's experience, inpatient en-suite facilities have also been provided.

Imperial Healthcare Trust focused on renovation and making changes to the utilisation of clinical areas. Relocation of the Day Assessment Unit and Maternity Triage at Queen Charlotte's Hospital created another ward in which to expand the number of postnatal beds. A new Day Assessment Unit has also been developed at St Mary's Hospital.

At Hillingdon Hospital, part of the delivery ward has been adapted to create a new midwife-led unit, as previously mentioned, and more bespoke work is planned to develop this further in the future. Gynaecology was transferred to another location at the hospital to free up capacity in maternity so that a larger maternity triage area could be developed.

All trusts offer 24 hour access to maternity triage facilities, as they did before the transition, so women can seek clinical advice at any time should they experience any problems.

## 3.4 Postnatal care

The benefits case set out the following objectives for postnatal care promoting continuity of care:

- choice of setting - care either in home or close to home in the community settings.
- a model of transitional care for babies,
- clear handover protocols and communication with identified healthcare professional for the transition to parenthood,
- enhanced children's safeguarding through development of provider: borough protocols,
- improved continuity of care for women throughout their antenatal and postnatal pathway.

### 3.4.1 Redefinition of trust community boundaries

Planning for the transition enabled trusts to come together to redefine their community boundaries, which had previously developed organically. This divided NW London into six areas, one for each of the five trusts and one shared area. These areas were mapped to the units where women choose to deliver. The main aim of undertaking this review of boundaries was to increase the number of women who had continuity of care with the same midwifery team providing their antenatal

and postnatal care. In the five areas associated with a particular trust, there has been much improved clarity about care provision improving women's care and improving efficiency for staff. Pre transition only 58% of women had all their care provided by the same midwifery team. This redefinition of community areas has meant that post transition 79% of women now have properly integrated antenatal and postnatal care, provided by the same team of midwives.

**Figure 3: Trust community boundaries in and around Ealing borough**



Source: Maternity Model of Care

Women are informed that if they live within the boundary for their chosen trust, midwives come into Ealing to provide clinics so they can have their full pathway of midwifery care delivered at a location close to home. The boundaries do not prevent a women choosing a different trust and having her care in Ealing, but she may not get that at the children's centre nearest to her home.

The one shared area is between Imperial Healthcare Trust and London North West Healthcare Trust (the hatched area in Figure 6). Whilst this has worked well for the majority of women, challenges have arisen and, although small in number, there have been reports of women contacting units to alert them they have not yet received postnatal care. This area needs to be reviewed and clearly defined areas to be assigned to each trust.

The community midwifery leads continue to meet weekly to review provision of community care and collaboratively decide to refine as required.

### 3.4.2 Safeguarding

The safeguarding processes and paperwork have been standardised across NW London in partnership with the safeguarding teams to ensure a robust process.

Agreed, standardised community hand over processes and documentation between different community providers and to health visitors following discharge have been implemented across NW London.

**Good practice learning for future transitions 7:** The agreement of a consistent model of care across the network with agreed community catchment areas is instrumental in improving continuity and quality of care for women.

**Recommendation 13:** Continue to review and adjust the community areas to ensure they are aligned with women's choice of provider so that continuity of antenatal and postnatal care can be provided.

**Recommendation 14:** Review the booking data in the shared area to redefine the trust boundaries so there are no shared areas.

**Recommendation 15:** Continue to monitor compliance with providing continuity of through antenatal and postnatal care.

### 3.4.3 Care of new-born babies – transitional care

Transitional care units are units where babies who need a little more nursing care and monitoring can stay with their mother rather than being cared for separately in a special care baby unit. This means the mother can be the main carer for her baby. As part of the maternity transition, a model of transitional care has been developed across NW London and is being implemented in all NW London maternity units. This is a major development in clinical care providing considerable benefits to mothers and their babies. There are agreed criteria for transitional care that includes, for example, care for babies requiring intravenous antibiotics, blood sugar measurement, phototherapy or nasogastric tube feeding. The heads of midwifery continue to work together as a network to standardise the clinical model of transitional care and they are working with commissioners to establish an agreed tariff.

### 3.4.4 Triage, treat and transfer protocols care

Agreed treat and transfer pathways for care were agreed through the transition planning process through the maternity and neonatal networks so that women and babies have streamlined access to specialist services within the sector. The aim is to minimise women and babies having to be transferred out of NW London for tertiary care.

### 3.4.5 Breastfeeding

The breastfeeding initiation rate has improved post-transition in every unit except Northwick Park Hospital and West Middlesex Hospital, where it has remained the same, as demonstrated in the following table.

**Table 7: Breastfeeding initiation rates at each maternity unit**

Maternity Unit	Pre-transition			Post-transition			
	Average			Average			
	Jun-14 - May-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Jul-15 - Nov-15
Chelsea & Westminster	89%	97%	90%	88%	89%	88%	90%
Hillingdon	84%	86%	86%	87%	87%	87%	86%
Imperial (Queen Charlotte's)	83%	93%	90%	91%	93%	95%	92%
Imperial (St Mary's)	87%	96%	95%	90%	98%	96%	95%
Northwick Park	85%	83%	86%	85%	85%	86%	85%
West Middlesex	90%	93%	91%	88%	90%	90%	90%

Source: Maternity Quality Dashboard

The most marked improvement has been at Queen Charlotte's Hospital and St Mary's Hospital, where they have recently introduced a community breastfeeding support service. Hillingdon Hospital has also recently created a new infant feeding coordinator role, which it is anticipated will help them to further improve in this area.

### 3.4.6 Perinatal mental health

In planning for the transition it was agreed to develop a new model of care for perinatal mental health in NW London. A community perinatal mental health service to ensure comprehensive and coordinated care is being piloted in Ealing, Hounslow and Hammersmith and Fulham. The team includes a consultant psychiatrist, a psychologist, two mental health nurses and an administrative assistant. The service is aligned to existing midwifery and health visiting services. This represents a major investment in this important area and one from which key learning should be extrapolated and spread.

**Recommendation 16:** Confirm and fully commission an agreed model of transitional care across NW London with an agreed tariff. The impact of this on neonatal admissions and length of stay should be actively monitored.

**Recommendation 17:** Review the impact of the perinatal mental health pilot and spread learning through NW London.

# Chapter 4: Demand on maternity services

The benefits case set out the following objectives in relation to capacity to promote choice:

- sufficient maternity delivery capacity in NW London

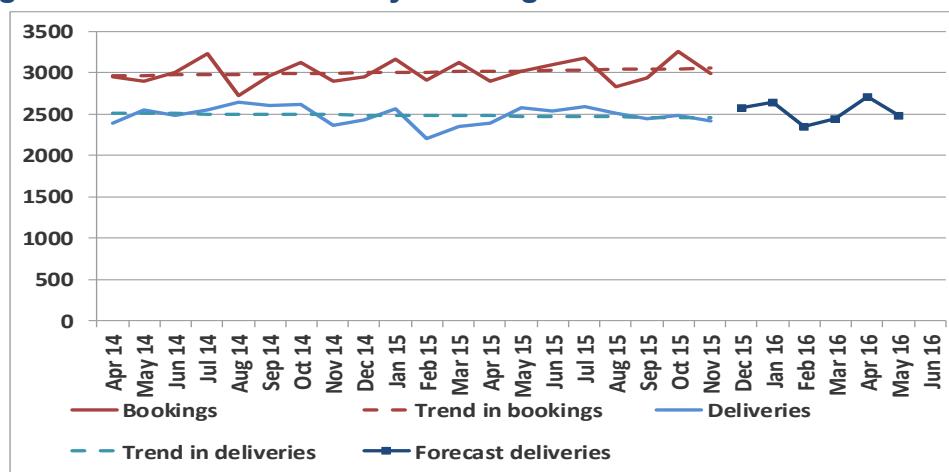
During planning for the transition, NW London clinicians developed a bed model and an Ealing allocation model, to test trust capacity plans. The bed model showed that compared to 2011/12, when units experienced a peak in birth activity yet managed their own maternity services, NW London planned to have more beds to handle the fewer deliveries forecast in 2015/16. The Ealing allocation model looked at six different ways (allocations) of understanding where the women currently choosing Ealing Hospital may choose to go based on historic activity, proximity to sites, GP preferences and women’s preferences. NW London clinicians (SaHF Clinical Board) agreed a weighting of these based on confidence in the different allocations to use as the best available predictor of where women would choose to go.

Based on these models, the maternity units across NW London planned shared capacity for an additional 3,000 deliveries from Ealing Hospital per annum, 500 more than the 2,500 that previously delivered at the unit. This ensured that the model of care is sustainable and allows for potential future population increases.

## 4.1 Bookings and deliveries activity

There are approximately 36,000 bookings and 30,000 deliveries in North West London each year. Monthly monitoring of these levels since April 2014 has shown no change in trends since the transition of maternity services in July 2015, with an average of 3,000 bookings and 2,500 deliveries per month.

**Figure 4: Number of monthly bookings and deliveries in NW London**



Source: Maternity Quality Dashboard

Fewer deliveries were originally forecast in 2015/16, but the actual number is set to rise by 1% compared to 2014/15 as demonstrated in the following table.

**Table 8: Total number of deliveries in NW London since 2011/12**

Financial Year	Total Number of Deliveries
2011/12	31,600
2012/13	30,700
2013/14	29,600
2014/15	29,800
2015/16 (forecast)	30,100

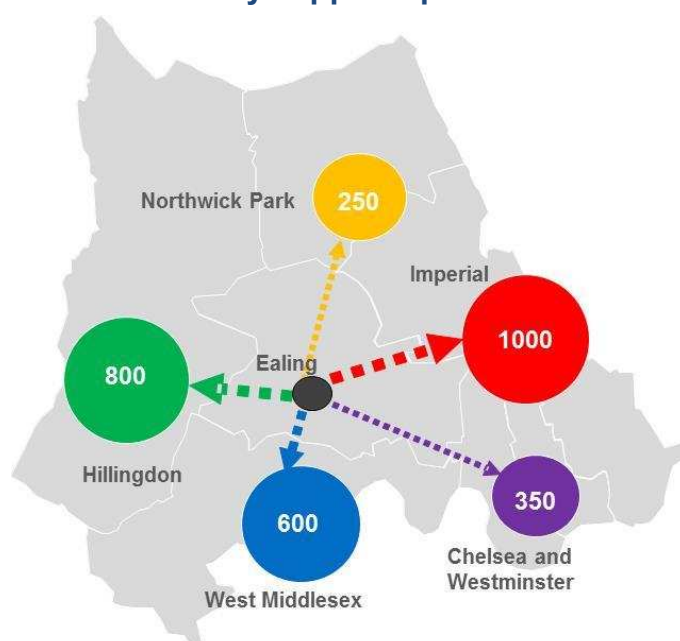
Source: SUS data

Just under half of the forecast increase in 2015/16 is due to a net increase from out of sector flows, with more women from outside the sector choosing to deliver in NW London than those who choose to leave. The remaining increase is due to a rise in the birth rate, mainly in Hounslow (6% increase) and Brent (4% increase), although notably, the birth rate in Ealing is forecast to fall by 284 (5%) in 2015/16. The rise in number of deliveries is within the contingency that was built into the new model to accept 500 additional births per annum across the sector.

## 4.2 Actual versus planned activity for each maternity unit

Based on the modelling and the trust assurance plans, the annual additional maternity activity from Ealing Hospital that each receiving trust can manage following the transition was agreed and is detailed in the figure below.

**Figure 5: Summary of agreed annual additional maternity activity receiving trusts can safely support upon closure of Ealing Hospital maternity unit**



Source: Maternity Model of Care

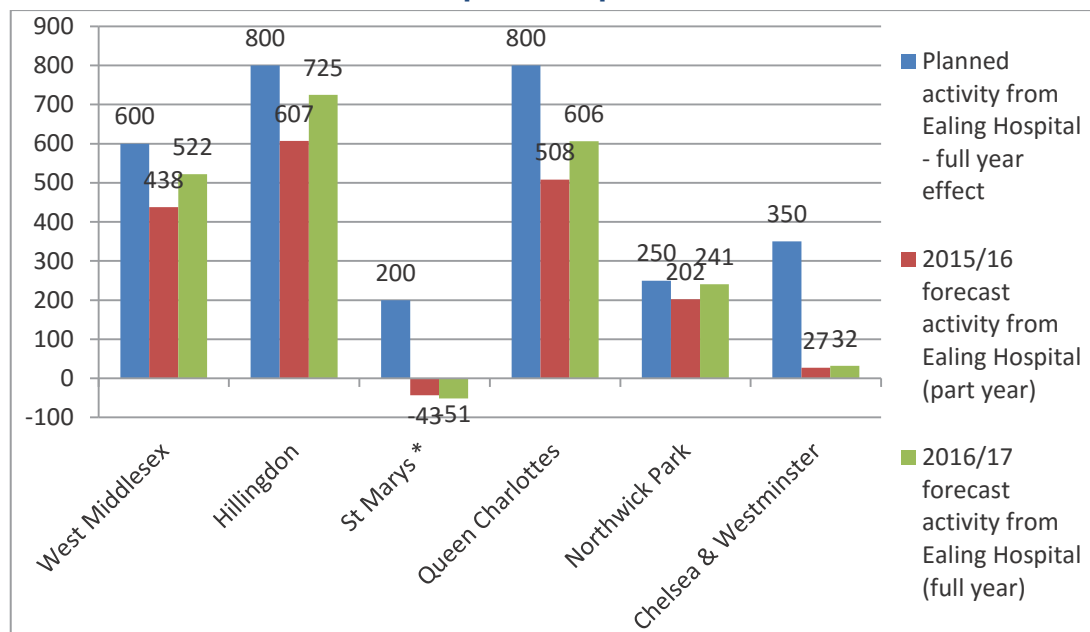
To assess the robustness of the activity modelling, the actual change in deliveries in NW London maternity units has been estimated using trust data provided to monitor the maternity transition.

- The pattern of Ealing deliveries between 2013/14 and 2014/15 was compared to establish a baseline data set. There were no major changes in the provider shares of deliveries by women from Ealing in the lead up to the transition, therefore the latest full year of actual delivery data from 2014/15 was used as a baseline for analysis,
- delivery activity data for the five months following transition (July - November 2015) was compared to the same months in 2013 and 2014 to determine if the activity level has changed from the baseline.
- using a factor that takes account of historic seasonal patterns in delivery, the change at each unit for July to November 2015 was used to forecast the annual activity expected at each unit following the transition,
- service (SUS) data was used to identify activity relating to:
  - women registered with Ealing CCG GP practices
  - women registered with other NW London GP practices
  - activity flows from outside of the NW London sector
- the forecast annual change is compared with planned changes and capacity.

In 2015/16, 86.3% of women who would have previously delivered at Ealing Hospital, but have now delivered at another maternity unit, were registered with a GP in Ealing CCG. Change in delivery activity from Ealing CCG at the other maternity units in 2015/16 was therefore extrapolated to represent the total change in activity attributable to the closure of inpatient services at Ealing Hospital. This assumed that the remaining 13.7% of activity from other NW London CCGs or outside of the sector followed the same distribution pattern as the Ealing CCG activity.

The following graph shows where the activity from Ealing Hospital has moved to following the transition. Ealing Hospital still had 470 deliveries in 2015/16; therefore 2016/17 is the first year to forecast a full year's distribution of activity. These activity flows are an estimate based on current activity levels and it should be recognised that anticipated flows may continue to change until the model of care is more embedded.

**Figure 6: Forecast activity from Ealing Hospital in 2015/16 and 2016/17 compared to planned**



\*When Ealing Hospital maternity unit was in operation, Ealing women still chose to give birth at other units. This graph indicates that fewer women are choosing to go to St Marys after the transition than did previously.

Source: SUS data

This graph shows that no maternity unit is forecast to exceed the planned additional activity expected from Ealing Hospital. This is most likely due to the fact that a contingency of 500 additional births was factored into the modelling. The activity most aligned to the modelling is Northwick Park Hospital, which is expected to receive 96% of its 250 planned additional births in 2016/17. Hillingdon Hospital and West Middlesex Hospital are also expected to receive close to planned activity with 91% and 87% respectively. Imperial however, was projected to receive a lot more activity than has been demonstrated because Queen Charlotte's Hospital is only receiving 76% of planned activity and fewer women who live in Ealing are choosing to give birth at St Mary's Hospital since the transition than were using the unit before Ealing Hospital closed. Chelsea and Westminster Hospital has also had a very marginal increase in the number of women who would have previously delivered at Ealing Hospital, equating to an additional two to three deliveries a month or 9% of planned additional activity. This change for Chelsea and Westminster Hospital was expected as women were anticipated to be redirected from areas of Hammersmith & Fulham to Chelsea and Westminster Hospital, to release capacity at Queen Charlotte's Hospital, rather than redirecting women from Ealing.

While the closure of inpatient maternity services at Ealing was the biggest change in the system, there have also been other factors which have affected the distribution of activity across the system. The following table shows the forecast activity change from 2014/15 to 2015/16 and 2016/17 from all sources when compared to the planned additional activity from Ealing Hospital.



**Table 9: Forecast activity change from all sources compared to planned additional activity from Ealing Hospital**

Maternity Unit	Baseline activity 2014/15	Planned additional activity	Maximum annual capacity	Forecasted activity 2015/16	Forecasted change 2015/16	Forecasted activity 2016/17	Forecasted change 2016/17
Ealing	2521	0	0	470	-2051	0	-2521
Chelsea & Westminster	5150	350	6000	5250	100	5270	120
Hillingdon	4143	800	5000	4762	619	4882	739
Imperial (Queen Charlotte's)	4977	800	6000	5525	548	5631	654
Imperial (St Mary's)	3610	200	4000	3693	83	3709	99
Northwick Park	4827	250	5300	5251	424	5333	506
West Middlesex	4524	600	5500	5181	657	5308	784
<b>NWL unit total</b>	<b>29752</b>	<b>500</b>	<b>31800</b>	<b>30132</b>	<b>380</b>	<b>30133</b>	<b>381</b>

Source: SUS data

**Table 10: Understanding the composition of the change from actual 2014/15 activity to forecast 2015/16 activity**

Maternity Unit	Baseline activity 2014/15	Forecasted activity 2015/16	Change in activity	Change in activity by CCG		
				Ealing CCG	Other NW London CCGs	Out of sector CCGs
Ealing	2521	470	-2051	-1771	-173	-107
Chelsea & Westminster	5150	5250	100	23	59	18
Hillingdon	4143	4762	619	524	-136	231
Imperial (Queen Charlotte's)	4977	5525	548	438	69	41
Imperial (St Mary's)	3610	3693	83	-37	104	15
Northwick Park	4827	5251	424	174	231	18
West Middlesex	4524	5181	657	378	251	28
Other providers	-	-	73	-13	86	-
<b>Total</b>	<b>29752</b>	<b>30132</b>	<b>380</b>	<b>-271</b>	<b>405</b>	<b>244</b>

Source: SUS data

This data shows that all units in NW London are forecast to have an increase in the number of deliveries in 2015/16 and 2016/17. This is in part due to the forecasted increase in the number of deliveries in NW London to 30,100. While no units are expected to receive more activity than was planned from Ealing Hospital, Northwick Park Hospital and West Middlesex Hospital are expected to receive a significant amount of additional activity from elsewhere in the system.

In addition to receiving 96% of their planned activity from Ealing Hospital (202 deliveries), Northwick Park Hospital has actually seen a bigger rise in the number of deliveries from Brent. Deliveries from this borough have increased by 4%. This means that the unit has exceeded the maximum increase of 250 additional births requested by commissioners in response to the Care Quality Commission report in 2014 (where maternity care at Northwick Park Hospital received a "Requires Improvement" rating). Without intervention this will lead to a forecast annual delivery rate of 5,330, which is above the maximum annual capacity for the unit. This needs to be considered within the context that Northwick Park is delivering a safe service for these mothers and babies, the unit has the best midwife to birth ratio in the sector and monitoring through the maternity dashboard indicates that the unit is currently

meeting the quality metrics for maternity. A review of the capacity at Northwick Park Hospital needs to be undertaken in partnership with the CCG, provider and SaHF to understand the provider's plans for growth. There is capacity in neighbouring trusts and community areas could be further adjusted to support more women from Brent choosing to have their babies at St Mary's Hospital, if this is the approach agreed upon.

The majority of additional activity at West Middlesex Hospital is from Ealing Hospital but it has also seen a significant rise in the number of deliveries from Hounslow, which has also demonstrated a growth in birth rate (6%). Unlike NPH, West Middlesex Hospital is expected to remain within its maximum annual capacity of 5,500 with a forecast annual delivery rate of 5,310 in 2016/17.

Hillingdon Hospital's biggest rise in activity is from Ealing, but it is also forecast to receive an additional 276 deliveries in 2016/17 from out of sector. This is balanced by a large fall in the number of women choosing the unit from other NW London CCGs, so the unit is forecast to have activity of 4,882 in 2016/17, which is within the unit's capacity of 5,000 deliveries. The rise in out of sector activity may reflect an increased number of women choosing Hillingdon Hospital over neighbouring out of sector units that had been rated as 'inadequate' by the Care Quality Commission at Watford General Hospital and Wexham Park Hospital. A recent Care Quality Commission review of Wexham Park in October 2015 however, rated the service as 'good', which, if this is a factor in women's choice, may impact activity numbers in future months.

Queen Charlotte's Hospital also took the majority of its activity increase from Ealing Hospital, but much less than expected and it has seen had little change in activity from elsewhere. Alongside Chelsea and Westminster Hospital and St Mary's Hospital, which have only had a small increase in activity, these units have significant additional available capacity.

**Good practice learning for future transitions 8:** A cautious activity model building extra capacity into the system, facilitated women's choice following the transition and built in resilience. Once the system stabilises this additional capacity can be reviewed.

**Recommendation 18:** An urgent review of capacity and catchment areas at Northwick Park Hospital is required to address the forecasted rise in activity beyond the expectations of commissioners and the unit's capacity.

**Recommendation 19:** Continue to monitor activity at the other maternity units, particularly as the changes to the trust catchment areas embed, to ensure there are no issues with capacity.

### 4.3 Comparison of delivery activity within trust catchment areas

A further analysis was conducted to determine whether the new trust catchment areas in Ealing are matched to the main providers for deliveries in each postcode area of Ealing borough.

**Figure 7: The ten postcode areas in Ealing Borough**



Source: Shaping a Healthier Future Ealing Postcode Map

**Table 11: Top providers for deliveries in 2015/16 compared to trust catchment areas for each postcode area**

Ealing Postcode	Postcode Trust Catchment areas	Top 3 providers for delivery in 2015/16					
		Provider	%	Provider	%	Provider	%
NW10	ICTH, NWP	ICTH	66%	NWP	24%	Out of sector	7%
UB1	THH, WMUH, ICTH, NWP	THH	52%	NWP	19%	ICTH	18%
UB2	WMUH, ICTH, NWP	WMUH	39%	THH	30%	NWP	17%
UB5	THH, NWP, ICTH	ICTH	36%	NWP	32%	THH	26%
UB6	THH, NWP, ICTH	ICTH	49%	NWP	31%	THH	11%
W3	ICTH	ICTH	91%	CWHFT	5%	Out of sector	2%
W4	ICTH, CWHFT	ICTH	63%	CWHFT	23%	WMUH	11%
W5	ICTH, WMUH	ICTH	77%	WMUH	13%	CWHFT	7%
W7	WMUH, ICTH	ICTH	59%	WMUH	19%	NWP	19%
W13	ICTH, WMUH	ICTH	66%	WMUH	17%	CWHFT	7%

Source: SUS data

On the whole, the delivery activity forecast in 2015/16 equates to the trust catchment areas for each postcode in Ealing. However, Hillingdon Hospital provides 30% of deliveries for the UB2 postcode but UB2 is not in the trust’s catchment area. Whilst these women are still able to access their care from Hillingdon Hospital it would be helpful to review catchment areas for this area to align to women’s choice. This action is captured under recommendation 13.

# Chapter 5: Interdependent services

## 5.1 Neonatal service transition

The benefits case set out the following objectives for neonatal care, promoting choice and access:

- Ensure sufficient cot capacity in NW London
- Develop a model for transitional care for babies

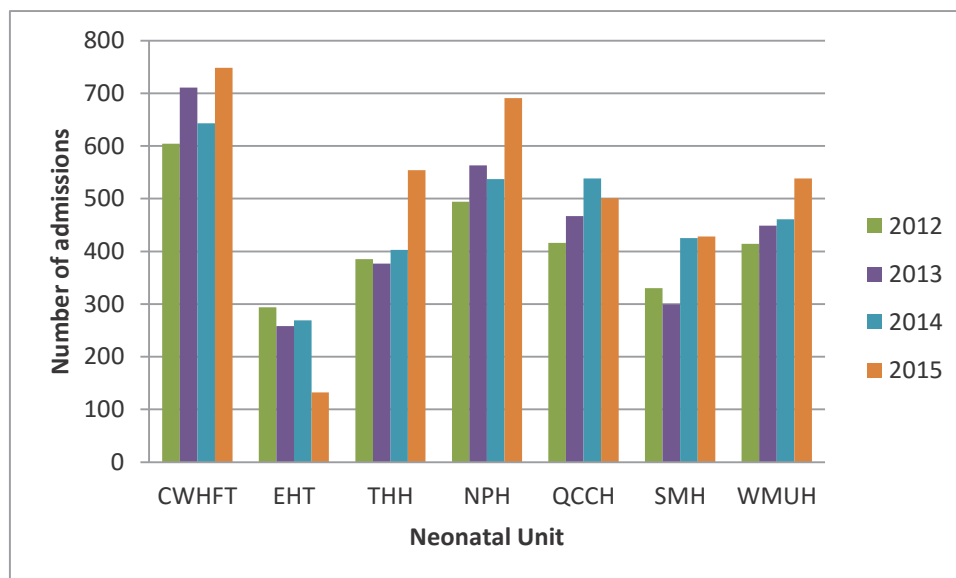
The neonatal unit at Ealing Hospital closed two days before the maternity unit, on 29 June 2015. There were no babies in the unit at the time that required transfer and the unit closed safely. The key objective of the new neonatal model of care was to ensure all babies needing on-going neonatal care have rapid access to the appropriate level of care as close to home as possible. Key elements include:

- a specialist neonatal transport service (this was an existing service)
- established care pathways that allow mothers and babies to rapidly access a unit offering the appropriate level of neonatal care
- adequate assessment of need and provision of appropriate capacity
- development and standardisation of transitional care (see 3.4.3)

### 5.1.1 Neonatal demand and capacity

With the exception of Ealing Hospital, the number of neonatal unit admissions across the sector has been gradually increasing each year since 2012. The following graph shows the annual change in the numbers by trust.

**Figure 8: Total number of annual admissions to the neonatal units in NW London**



Source: Acute Trust Badgernet Database

The majority of babies admitted to the neonatal units in NW London are from the area and this percentage has remained constant over the last two years (92-94%), therefore a rise in the number of babies from outside NW London does not account for the increase. While there has been an increase in the extremely preterm babies admitted to neonatal units in NW London, the majority of the increase in admissions is due to the increase in the numbers of babies admitted at term. This follows a national trend in increasing term admissions reported by NHS England.

Further analysis of the local data was performed to compare the monthly admission numbers for each unit post-transition with the baseline monthly average (July 2014 - June 2015 data). This shows the total number of admissions across the sector following the transition has consistently been higher than the baseline, although this is variable.

**Table 12: Number of neonatal unit admissions by trust following the Ealing transition**

Neonatal Unit	Baseline	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Average post-transition
Chelsea & Westminster	58	69	66	61	59	59	63
Hillingdon	33	46	62	65	56	65	59
Imperial (Queen Charlotte's)	44	44	42	35	36	48	41
Imperial (St Mary's)	36	31	55	29	28	44	37
Northwick Park	49	66	56	47	63	56	58
West Middlesex	40	40	54	53	53	39	48
Ealing	23	0	0	0	0	0	0
<b>NWL Total</b>	<b>225</b>	<b>227</b>	<b>269</b>	<b>229</b>	<b>236</b>	<b>252</b>	<b>243</b>

Source: Acute Trust Badgernet Database

Activity in the Special Care Baby Units has increased in NW London and this is particularly evident in three units – Hillingdon Hospital, West Middlesex Hospital and Northwick Park Hospital. The increase in activity at Hillingdon Hospital and West Middlesex Hospital can be accounted for by the increase in deliveries following the closure of inpatient services at Ealing Hospital. However, the increase at Northwick Park Hospital does not completely equate to the rise in activity. Northwick Park Hospital is currently reviewing all admissions to establish the cause for this increase. These three units do not yet have an embedded transitional care service which could be adding to the increase in neonatal admissions. The model of transitional care is being standardised in NW London and a tariff is being agreed, the services are at different stages of implementation and using different clinical models currently, standardisation of this needs to occur. Overall the network data does not suggest that the length of stay has increased at any of the neonatal units.

Additional physical capacity of fifteen neonatal cots was put in place in the receiving trusts for the transition, which includes the cots reassigned from Ealing Hospital. All of these were SCBU cots; there was no increase in intensive care or high dependency cots. This is in line with the type of neonatal activity at Ealing Hospital. The Neonatal Network share demand management approaches between trusts, which has been further supported by the merger of Chelsea and Westminster Hospital and West Middlesex Hospital at the end of 2015. There is good communication between the neonatal units in the Network to refer babies both for intensive care and also to transfer babies back to local hospitals for continuing care. The following table compares the average number of monthly neonatal transfers pre-transition with post-transition, both within NW London and outside the Network.

**Table 13: Comparison of the average numbers of neonatal transfers pre-transition with post-transition**

Type of transfer	Location of transfer	Pre-transition monthly average (Jan - Jun 2015)	Post-transition monthly average (Jul - Dec 2015)
In Utero Transfer	Transfer within NWL	0.8	0.7
	Transfer to another Network	1.0	1.2
Postnatal Transfer	Transfer within NWL	17.3	17.5
	Transfer to another Network	1.3	4.0

Source: NHS England

While the average numbers of transfers within NW London have not changed following the transition, there has been an increase in transfers within the network due to lack of intensive care capacity. Transfers to other networks are also normally due to lack of intensive care capacity and the number of babies transferred postnatally to another network has increased since the transition. This has been due to a lack of specialist cots for babies with surgical problems. Chelsea and Westminster Hospital is the provider of surgical cots and they are currently reviewing and auditing this increase in demand with a plan to increase their intensive care cot capacity for babies requiring surgical management.

Ealing Hospital did not previously provide intensive care capacity or surgical cots in its neonatal unit; therefore this increase in demand is unrelated to the transfer.

### 5.1.2 Neonatal workforce

All twelve of the neonatal nurses working at Ealing Hospital were able to transfer to their first choice of hospital and were fully supported with the changes. The clinical lead nurse for the transition had one-to-one meetings with all of them, both formal and informal, and all receiving units were reported to be very welcoming. All of the neonatal nurses who transitioned are still in post. Feedback to the clinical lead has been that they are all settling in really well in their new positions.

**Recommendation 20:** A neonatal nurse focus group should be organised to obtain feedback from this staff group about their experience of the transition.

## 5.2 Emergency gynaecology service at Ealing Hospital

The benefits case set out the following objectives for gynaecology services in relation to maternity care:

- access to 24-hour maternity triage and emergency gynaecology services for women should problems occur:

Gynaecology services were interdependent with the maternity service at the Ealing Hospital site before the maternity transition due to shared medical staffing and activity from pregnancy related conditions. Following the transition, Ealing Hospital continues to provide elective inpatient and outpatient gynaecology services on-site as before. It also provides a new model of emergency gynaecology services to support the emergency department at Ealing Hospital and ensure continuity of care for women in the local area. The key aspects of the new emergency gynaecology model of care are:

- enhanced gynaecology emergency clinic in the core hours during the week, which includes an Early Pregnancy Assessment Unit,
- introduction of a gynaecology emergency clinic at the weekend,
- improved middle grade medical cover at Ealing hospital for emergency gynaecology patients,
- consultant cover for gynaecology emergencies: in hours, onsite and out of hours from Northwick Park Hospital.

The new model aims to deliver a better service to the local population, support the emergency department and avoid putting pressure on nearby trusts by preventing them from having additional emergency attendances and admissions. The following table shows the number of attendances at early pregnancy assessment Units across NW London.

**Table 14: Early Pregnancy Assessment Unit activity at sites across NW London**

EPAU	Baseline						Post-
	average	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	transition average
Chelsea & Westminster	521	581	502	558	578	574	559
Hillingdon	307	338	281	306	284	-	302
Imperial (Queen Charlotte's)	453	464	406	489	509	461	466
Imperial (St Mary's)	439	513	473	535	527	488	507
Northwick Park	685	795	689	795	931	776	797
West Middlesex	443	492	439	488	487	475	476
Ealing Hospital	189	197	187	223	239	242	218
<b>NWL Monthly Total</b>	<b>3037</b>	<b>3380</b>	<b>2977</b>	<b>3394</b>	<b>3555</b>	<b>3016</b>	<b>3325</b>

Source: Trust EPAU data

The average number of attendances at early pregnancy assessment Units appears to have increased at every unit, including Ealing Hospital, following the transition, except Hillingdon Hospital. There has been a significant increase at Northwick Park Hospital (>100 cases per month), which is more than would be anticipated relative to their increase in delivery activity when compared to the other trusts, especially as there has also been an increase at the other London North West Healthcare Trust site at Ealing Hospital. There has been a significant increase at St Mary's Hospital, which their gynaecology consultants believe is due to the direct access to early pregnancy assessment unit from A&E at this site. At Imperial's other site at Queen Charlotte's Hospital, the women is referred on to early pregnancy assessment unit from the Urgent Care Centre or their GP.



# Chapter 6: Women's experience

As part of this review a postal survey was conducted to evaluate the experience of mothers and mothers-to-be whose care was moved from Ealing Hospital as a result of the transition. Membership Engagement Services (MES) was commissioned to design, issue and report on findings. The survey was co-designed with lay partners and the SaHF Travel Advisory Group to solicit feedback about information and materials, travel to access care and overall experiences of care throughout the transition. Details of the complete survey can be found in Appendix 4.

778 postal surveys, covering letters and Freepost reply envelopes were prepared by MES and despatched directly from London North West Healthcare NHS Trust. Postal surveys were supplemented by visiting two children's centres in North West London where additional surveys were conducted face-to-face. There were 103 responses collected (13% response rate), which is higher than would be anticipated for a survey of this type. The spread of responses for each maternity unit was representative of the number of women who were transferred to the units.

## 6.1 Information and materials

Overall, 76% of participants indicated they were given information about other hospitals and travel, with the highest level of response seen among those whose care was moved to Queen Charlotte's Hospital (90%). Of those who had been given information, the highest proportion cited receiving the 'Giving birth' booklet (64%) followed by a letter (50%) and bus map (47%). Around a quarter (24%) of participants noted receiving the 'giving birth' easy read booklet, and this figure was highest among participants for West Middlesex Hospital (33%).

**Figure 9: Information and materials**

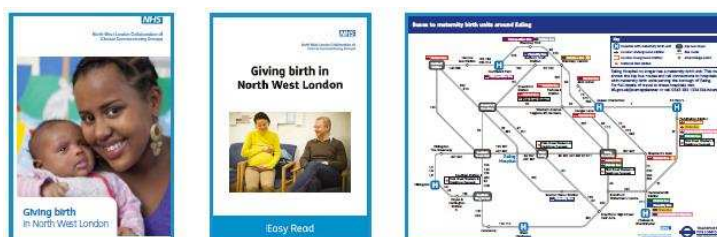


Image 1 – Giving Birth Booklet, Image 2 – Easy Read Booklet, Image 3 – Bus Map

The majority of women (63%) received this information by post, or their midwife (44%), and significantly fewer noted receiving this at a GP practice (5%) or children's centre (4%). Those who moved to Queen Charlotte's Hospital were least likely to receive information from a midwife, with just over a quarter having done so.

Nearly three quarters of participants felt that they had enough information about other hospitals where they could choose to give birth (72%) and travel (74%) compared to 13% who disagreed. Participants were able to indicate what additional information would have been useful. Around a third of participants (35) provided a

free-text response for this question, and one in six of these took the opportunity to reiterate they felt they had enough information. Around one in four indicated they had enough information, but this may have been things they already knew, heard via word-of-mouth or researched themselves. Nearly a third of these 35 respondents cited a desire for more travel information such as parking and travel by car and maps including how to get around the hospitals themselves. A similar proportion of responses would have liked more information about hospitals they could access including quality and range of services.

## 6.2 Travel to access care

Overall, less than half of participants (45%) said their midwife asked them about their travel plans to the hospital where they were moved, a slightly higher proportion than those who were not asked about their plans (41%). However, more women at Queen Charlotte's Hospital (48%) and West Middlesex Hospital (48%) were not asked.

The largest proportion of participants received their antenatal and postnatal care at a hospital (77%). Around a third received care at a children's centre or health centre (37%) or at home (34%). When asked if the transition had made it harder for them to attend their appointments on time, the majority of participants disagreed with this statement or indicated it made no difference: 68% for antenatal and postnatal appointments and 69% for hospital-based appointments. This compared to the quarter of participants who felt less able to get to these appointments on time following the transition.

Participants had the opportunity to describe any other travel difficulties they had experienced after their maternity care was moved to another hospital. Just 17 participants provided a free text response to this question. A key theme among comments received was the longer journey time to access maternity care.

## 6.3 Overall experience of care

Overall, a majority (59%) of participants felt supported during the transition, however 26% indicated that they did not feel supported, highlighting the complexity of the transition. Once under the care of their new units most women (79%) were happy with the care that they received. Most respondents gave reasons for this with half citing staff as a key reason for their satisfaction; key themes included friendly, respect, care and support.

## 6.4 Experience of women living in Southall

Ensuring a positive experience for the women of Southall has been a key area of focus within the transition especially in relation to communications and travel. 33 women from Southall completed the experience survey, 1/3 of all respondents, enabling insight to be gained as to whether these women had a positive experience.

Under the care of their new units most women (75%) were happy with the care that they received and this is comparable to all women who underwent the transition. In relation to information, 75% agreed they had received enough information about other hospitals where they could choose to give birth and 78% indicated they received enough information about travel.

When asked if the transition had made it harder for them to get to their hospital appointments, the responses were similar to the experience of women in general. However a larger percentage of women indicated that it had become harder for them to attend their antenatal/postnatal appointments on time, 36% compared to 19% of the overall survey respondents. This could be driven by the fact that only 28% of the Southall women indicated that they received antenatal or postnatal care from a children's centre or health centre. It is recommended that midwives and the CGG work with GPs and women in this area to assure them that high quality antenatal and postnatal care can be received locally and that it will be delivered by the same team of midwives who deliver their baby in hospital.

**Good practice learning for future transitions 9:** A comprehensive set of information material, developed with lay partners, brought together information on maternity care across NW London for the first time, facilitated women's choices and was well received.

**Recommendation 21:** Ensure further communications are provided to women in relation to their choice of antenatal and postnatal care, especially within the borough of Ealing.

# Chapter 7: Staff experience

## 7.1 Approach to staff transition

When transitioning staff and building the workforce at each of the receiving units there were two significant priorities:

1. to retain the skills and knowledge within the sector
2. to increase the number of midwives in NW London (to improve midwifery to birth ratios and ensure 1:1 care for women in active labour)

To do this, a 'no redundancies' approach was developed. All staff were offered opportunities for redeployment in NW London and moved across to receiving units via the TUPE<sup>1</sup> process. There were no resignations as a result of the transition. In the vast majority of cases, staff were able to transfer to their trust of choice. Any transition is challenging and the timing of the maternity transition was particularly so. Predictably, a change to the date in transition and short period of time to transfer had a negative impact on staff morale. To help support staff at this time of uncertainty, retention bonuses were paid to staff. In addition, Health Education England North West London provided significant training bursaries for each of the transferring members of staff. The retention of staff over the transition period as well as the recruitment of new midwives is a testament to the calibre of midwives themselves, management by the trusts in NW London and validity of the workforce transition approach.

At the time of the transition there were 88 midwives working at Ealing Hospital who were transferred to the other maternity units in the sector, resulting in an initial reduction in the vacancy rates at the receiving trusts. A collaborative approach was taken by the trusts to ensure there was no 'poaching' of staff which could have risked destabilisation of the workforce in the sector. Furthermore, there was a concerted drive to recruit additional midwives to NW London in preparation for the transition, which resulted in an increase of almost 100 whole time equivalent midwives from 840 in February 2015 to 939 in December 2015.

There have been eight midwives from Ealing who have left their posts since the transition. Two were due to retirement, two to work closer to home, one due to ill health and one to take up an opportunity to work as an independent midwife.

Vacancy rates in nursing, midwifery and general medical staff continue to be a national problem for the NHS. However, the coordinated focus on recruitment and

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<sup>1</sup> When TUPE applies, the employees of the outgoing employer automatically become employees of the incoming employer at the point of transfer. They carry with them their continuous service from the outgoing employer, and should continue to enjoy the same terms and conditions of employment with the incoming employer.

Following a transfer, employers often find they have employees with different terms and conditions working alongside each other and wish to change/harmonise terms and conditions. However, TUPE protects against change/harmonisation for an indefinite period if the sole or principal reason for the change is the transfer

retention through this transition not only maintained staff from Ealing Hospital, but made significant improvements in reducing vacancy rates in NW London as a sector.

**Good practice learning for future transitions 10:** Additional staff retention and development packages helped retain staff through an unsettling time.

**Good practice learning for future transitions 11:** A coordinated, sector-wide approach to recruitment with agreed principles of not encouraging staff to move between units had significant impact on vacancy levels.

## 7.2 Clinical leadership

A strong network of dedicated clinical leaders emerged from the transition to drive quality and consistency of care for women. Clinical leadership and the strengthening of relationships across NW London has been a real benefit of the service transition. In the past the heads of midwifery did come together occasionally for workshops and professional development, but the transition required them to meet regularly to make decisions, gain consensus and agree implementation of changes across the sector. The strong relationships that were forged during this time have continued and now extend into other forums, including the London Strategic Network. This has enabled them to inform commissioning standards together, so they are the same across the sector, and there is now a good relationship and a direct clinical link with the lead nurse clinical commissioners. This collaboration and knowledge sharing is driving up the quality and consistency of care for women.

The community midwifery leads continue to meet weekly to review provision of community care and refine as required. An additional benefit has been the opportunity to work on other projects to improve care delivery, for example, working towards electronic discharge arrangements.

**Good practice learning for future transitions 12:** This was a clinically-led transition with good engagement from all providers and commissioners, supported by a strong programme management approach. This was key to the success of the transition and the benefits of the strong clinical network continue to be realised beyond transition.

## 7.3 Midwifery staff

Focus groups were conducted in January 2016 to obtain feedback on midwives' experience of the transition and inform future service changes. Membership Engagement Services, a communications and research agency that specialises in public and member engagement in the healthcare sector, was commissioned to design, run and report on findings from the focus groups. The key objective was to obtain midwives' views on the transition and its impact on maternity care in the area. It is worth noting that this was a small-scale study and therefore care must be taken in interpretation of the findings as those who participated may not necessarily be representative of their maternity unit or of maternity staff as a whole.

Focus groups were held at five of the six receiving hospitals in North West London. Hillingdon Hospital was the only maternity unit which was not able to hold a focus group as they were unable to release staff. Overall, there were 29 participants, which included midwives transferred from Ealing, receiving staff, community-based midwives and trainees. All were recruited to take part by heads of midwifery at each unit.

### 7.3.1 Midwifery experience of the transition

Most participants did not find the transition straightforward, with the main issues mentioned being the uncertainty over the closure of Ealing hospital and the perceived shortness of the timetable to closure once the decision was announced. The majority of midwives from Ealing felt the speed of the transition with short notice of the closure date caused additional rush and stress.

Participants' views on the communications they had received varied widely. Some were aware of many channels, while others mentioned only one or two. Others said they had never received personal communication about the changes, although also acknowledged that they may not have been receptive at that stage so communications may have gone un-noticed. To some extent, their view of the efficacy of the communications was tainted by the uncertainty over the closure: in the absence of concrete information some 'tuned out'. Overall, there was a divide among these midwives on whether the communication was as effective as it could have been, given the uncertainties of the situation in the run-up to the closure.

Among the participating midwives, the extent to which the transition affected travel arrangements varied. Some lived close to the hospital they joined and so their journey was much shorter than to Ealing, while others had gone from being a short walk to Ealing hospital to two hours' travel a day. It is not possible from this exercise to say what the overall effect on all midwives' travel arrangements has been. Other issues mentioned were paying for car park permits and the lack of pool cars, while the practical issues of claiming for travel costs were sometimes complicated by the lack of knowledge among human resources.

**Recommendation 22:** The uncertainty about the decision to implement the maternity and neonatal transition had a negative impact on staff experience and engagement in the changes. Decisions for future changes need to be made further in advance of implementation, to prepare staff.

**Recommendation 23:** Trusts need to ensure an effective route in communicating with their staff. This needs to be coordinated by an accountable individual to prevent mixed messages, rumours, and disengagement.

### 7.3.2 Midwifery experience of the new maternity units

At the time of the research, six months following the transition, the majority of those who had moved from Ealing had settled-in well, having been welcomed and well-supported by the receiving staff. The receiving unit staff were delighted to gain new and sometimes very experienced staff. Feeling integrated and fully up-to-speed could, however, take new joiners some months. Not all of those interviewed were as

content however, with mentions of a 'them and us' mentality at St Mary's Hospital and West Middlesex Hospital and at least one joining staff member at the latter hospital feeling isolated and requesting more support. It is important that comments such as these are captured and acted on but they represent a small part of a successful workforce transition.

A mixed picture also emerged from the participants concerning the buddy system and orientation days i.e. some were aware and experienced them but sometimes the workload simply meant that allocating a buddy or allowing staff on orientation days just to observe, was not possible. Sometimes orientation days could be so far ahead of the individual's move across that they felt they had forgotten much of what they had learned by the time they began work at their new hospital.

In addition, the day-to-day changes in the systems they would be working with were not always well-addressed. Many participants struggled with the differences in the computer systems at their new hospitals and some mentioned that training on these systems was not available at the right time.

**Good practice learning 13:** Senior grades need more support to settle into new positions, especially if there is a significant change in their role. Senior midwives changed from being largely administrative at Ealing, to more clinical roles at the receiving trusts, which some found challenging.

### 7.3.3 Midwifery experience of workload and quality of care

Both joiners and receivers at some hospitals commented on the increase in workload, with this issue being particularly prevalent among community-based staff. While the receiving hospitals had obviously gained more staff, the staff were given the choice of which clinical area they wanted to go to and this left some community areas relatively short staffed.

The receiving hospitals were felt to have found absorbing the extra staff quite easy, not least because of prior staff shortages. There was less agreement on how well the extra patients had been absorbed, with staff at three out of five of the hospitals expressing varying levels of concern and more generally a sense that midwives have to cope with a greater workload post-transition. At almost all the hospitals some issues were raised about whether the facilities were sufficient and there were concerns about a lack of IT facilities in the community sites.

The majority of participating midwives did not feel that care had improved as a result of the changes. Going from seven hospitals to six did not address the perceived difficulty in recruiting and retaining midwives. There was a sense at some hospitals that there was still not the correct balance between extra staff and additional patients. There was a view that care was less personal; clinics at hospitals and in the community were under pressure and patients experienced long waits, however the midwives felt they were coping at present. Only at one hospital (Queen Charlotte's Hospital) was there any mention of benefits arising from the transition which was additional staffing, improved community boundaries and improved estates.

These expressed views do not correlate with the quality indicators or the low utilisation rate of community clinics as detailed in other sections of this report.

**Recommendation 24:** Additional engagement with workforce members following transition on the effect of the change should take place to address staff concerns and further communicate outcomes and experiences of the transition.

**Recommendation 25:** In future services changes, more could be done to prepare staff for the changes, particularly in regard to the increase in activity for staff moving to busier units.

## 7.4 Midwifery trainees

In April 2015, Health Education England, North West London (HEE NWL) hosted a student forum, which included representation from midwifery students from the University of West London (UWL). They were keen to feedback about the very positive aspects of moving from Ealing Hospital, despite this being potentially stressful and difficult for them. They welcomed the organised visits to the three other units linked to UWL to help them make an informed choice about their preferences and the maternity units that ultimately received them had been welcoming and supportive, thus making a potentially disruptive event very successful.

This clearly reflected the work of the University, the receiving placement providers and the individual mentors for the students. Informal feedback from the Ealing students was that the Lead Midwife for Education at UWL was particularly pivotal to the seamless transition. She communicated in one-on-one conversations, team meetings, email messages and at conferences to ensure that everyone was well informed about changes as they occurred, minimising apprehension and fear that the moment of uncertainty might have created. She negotiated with the trusts to ensure that the vast majority of students had their first choice hospital allocated. Finally, to contribute to the development of student experience, she encouraged the students to view this challenge as an opportunity to develop flexibility and expand their skills in working in different units, thus expanding skills and learning experience.

Midwifery trainees also participated in the midwifery focus groups run by Membership Engagement Services. There were four trainees who participated in these overall and, when asked specifically how the transition had affected them, their response was more positive than the midwives. They all agreed that post-transition, they were able to experience more births, which all saw as a benefit. Working in a different unit also gave those who had moved from Ealing more confidence in their abilities.

## 7.5 Obstetrics and gynaecology postgraduate medical trainees

Obstetrics and gynaecology postgraduate medical trainees usually rotate to a new trust each year in October as part of their training programme, which enables them to experience different training opportunities. Each of the six trainees working at



Ealing Hospital at the time of the transition was matched to the trust they would rotate to in October, according to their specific training needs. These training placements were spread across NW London.

No obstetrics and gynaecology trainees have resigned following the transition and no new ones have yet been recruited because the recruitment cycle is annual. At present, Health Education England believes there are more obstetrics and gynaecology trainees than the projected number of consultant posts that will be available in the future, and therefore a national review of obstetrics and gynaecology workforce is underway with the recommendations due to be published in the summer 2016.

Health Education England, North West London plans to review trainee placements again in July 2016, one year after the transition. This will include a review of information on trainee preferences for placements and feedback from the General Medical Council National Trainee Survey, which forms part of the quality data, and would be a useful indicator for a future review. A trainee's perspective on how they will be supported and valued strongly influences their choice of placement. No trainees failed to meet their annual competencies as a direct result of the transition of services from Ealing.

Health Education England, North West London via Imperial Lead Provider sent out an online survey to the 149 obstetrics and gynaecology trainees and training leads in NW London to seek views and feedback on the impact of this transition. The survey was undertaken in November 2015 and focused on the impact of the closure of the maternity unit at Ealing on activity and quality of training and asked individuals to comment on the following areas:

- Has your workload been affected by the closure of the maternity unit at Ealing Hospital? If so, please comment;
- Has the activity in obstetrics increased after the closure of Ealing maternity unit? Please comment;
- Has the activity in gynaecology increased after the closure of Ealing maternity unit? Please comment
- Has the quality of training changed due to the closure of the maternity unit at Ealing Hospital? Please comment
- Do you have any further comments about your training post?

Initial findings from the 33 responses received (22%), from trainees of varying grades ranging from ST1 to ST7, would indicate there is a general feeling that the O&G workload across the NW London has increased for trainees as a result of the changes to Ealing maternity. The general increase in workload corresponds with a similar increase to obstetric activity across NW London sites. Feedback on gynaecology activity reported that activity had increased at most sites, with the exception of Northwick Park Hospital and Chelsea and Westminster Hospital where it was felt to be no different. There was a split view regarding the impact of changes on the quality of training; some trainees cited the increased workload as a barrier to accessing appropriate training opportunities whereas other felt the increase volume offered more opportunities. This view was consistent across NW London.

**Recommendation 26:** Health Education England North West London to review trainee placements as planned one year following the transition and factoring in information on trainee preferences for placements as one indicator of training quality.

## 7.6 General Practitioners

GPs are the gateway to referral into maternity services in the majority of cases. To obtain feedback on the transition from GPs, a survey was developed with Ealing GPs to ask for their opinion on the quality of the information they received and impact this has had on referrals of women to the six maternity units in NW London. The full survey is detailed in Appendix 3. The survey was offered to all CCGs for distribution and Ealing, Brent, Hammersmith & Fulham and Hillingdon CCGs, the four areas most affected by the transition, circulated it to member practices in January 2016.

There were 21 survey responses received in total, 12 of which were from Ealing practices, equating to a 15% response rate from their 78 member practices. All GPs who responded believe that women consulting them for referral to maternity services usually need some form of support to make an informed choice about their options. Interestingly, advice from the GP was thought to be more of a key factor in women's choice in Ealing CCG when compared to the other CCGs, potentially reflecting women's greater reliance on this following the major changes in the borough. The other key factors GPs thought influenced women's choice are the unit's reputation for quality of care, recommendations from friends or family, the unit's proximity to home and previous experience of the unit. Proximity of the maternity unit to the GP practice was not thought to be an influencing factor.

With regard to communication about the changes, 57% of GPs (75% in Ealing) felt the information received from their CCG was effective or very effective in helping them to communicate changes, while 29% thought it was neither effective nor ineffective and 14% thought it was ineffective. Patient information leaflets were less helpful to the GPs in communicating changes; less than a third reported these were effective. The most useful elements of the information received were the summary of travel details on the referral letter and the poster detailing the different centres available in Ealing for community care.

In Ealing, some of the GPs reported that some women still thought inpatient maternity care was available at Ealing after the transition, in line with the feedback from London North West Healthcare Trust. The feedback from those who responded from Brent, Hillingdon and Hammersmith and Fulham CCGs has been that the transition has not affected their referral pathways, although there have been some challenges when maternity units were full and did not accept any more referrals. One of the Hillingdon GPs did not appear to be aware of the Maternity Booking Service to support them with referral to other units.

Finally, with regard to community provision, there is almost an even split in opinion across all GPs with 38% rating it good, 33% rating it neither good nor poor and 29% rating it poor. The majority of Ealing GP respondents are also unsure if the redistribution of community boundaries in Ealing has improved continuity of care for women. This reflects the confusion surrounding the shared Ealing catchment area

between LNW and Imperial Healthcare Trust. A previous recommendation in this report has been made to define this catchment area more clearly and thereby improve continuity of care for women living in this area.

# Chapter 8: Summary of good practice and recommendations

This review of the first six months following the transition of maternity and neonatal services has highlighted many areas of good practice. Factors key to the success of the transition have been highlighted through the report and are summarised below as key learning for future transitions. In addition, there are several areas identified for further focus to ensure the intended benefits are fully realised. These recommendations should be monitored to ensure they are completed in order to further improve the maternity model of care in NW London.

## 8.1 Summary of good practice learning to inform future transitions

1. It is important to agree a strong set of clinical quality aims with all stakeholders against which performance can be measured in addition to the more simple transitional process measures.
2. Direct verbal contact with women, rather than relying on written communication, resulted in a smooth transfer and no unexpected births at Ealing following the transition.
3. The transfer process was clinically led and all women were clinically assessed prior to transfer ensuring appropriate care was put in place.
4. Vulnerable women were a clinical priority and received high priority in the acceptance criteria. This has been continued through the Maternity Booking Service so that vulnerable women are always able to access their first unit of choice.
5. A central booking system improves system resilience, minimises disruption for women who are unable to book into their first choice unit and improves access to care for women.
6. It is important to establish a clinical outcomes dashboard prior to the transition and use this to monitor quality performance and guide on-going discussions.
7. The agreement of a consistent model of care across the network with agreed community catchment areas is instrumental in improving continuity and quality of care for women.
8. A cautious activity model, building extra capacity into the system, facilitated women's choice following the transition and built in resilience. Once the system stabilises this additional capacity can be reviewed.

9. A comprehensive set of information material, developed with lay partners, brought together information on maternity care across NW London for the first time, facilitated women's choices and was well received.
10. Additional staff retention and development packages helped retain staff through an unsettling time.
11. A coordinated, sector-wide approach to recruitment with agreed principles of not encouraging staff to move between units had significant impact on vacancy levels.
12. This was a clinically-led transition with good engagement from all providers and commissioners, supported by a strong programme management approach. This was key to the success of the transition and the benefits of the strong clinical network continue to be realised beyond transition.
13. Senior grades need more support to settle into new positions, especially if there is a significant change in their role. Senior midwives changed from being largely administrative at Ealing, to more clinical roles at the receiving trusts, which some found challenging.

## 8.2 Summary of recommendations

1. NW London maternity network to assess current progress against the new national review recommendations and develop an action plan to deliver to them.
2. SaHF and the NW London clinic network should share the MBS model with the wider London network to consider if this approach should be taken across London. This would also assist women from NW London who choose to book outside of the sector.
3. Providers need to work in partnership with commissioners and local authorities to understand the planned provision and role of children centres in the future. Negotiations should be held with Chiswick children's centres to agree access for local women.
4. Commissioners and providers need to work together to agree commissioning arrangements for shared antenatal care. In future transitions, contracting issues that affect transition should be managed within the transition framework.
5. Review the utilisation of clinics as Ealing Hospital and refine the clinic capacity and demand.
6. Providers should work with women in the area to highlight that they can access high quality antenatal care by the same team who will deliver their

baby, without the need to travel to the centre where they have chosen to give birth.

7. Within the next six months the maternal diabetic pathway needs to be reviewed across the sector to ensure provision of specialist services to meet clinical need.
8. In line with national and London-wide guidance, labour and birth in alongside midwifery led units should be actively promoted for low risk mothers as they are associated with a lower risk of unnecessary interventions and increased satisfaction.
9. West Middlesex Hospital and Hillingdon Hospital should continue to actively recruit midwives to achieve the 1:30 target set out in the London Quality Standards and agree a plan to achieve this ratio with their respective commissioners.
10. Undertake immediate review of data collection processes with respect to 1:1 midwifery care in labour to ensure consistency of methodology across trusts. Imperial Healthcare Trust need to revalidate their 1:1 care in labour data. Compliance with this should be monitored through their Care Quality Group.
11. Each trust should work with commissioners to finalise plans to further improve clinical cover on labour wards in 2016/17, taking in to account any new guidance issued in this area. St Mary's Hospital needs to increase the consultant presence on the labour ward as soon as possible - this needs to be monitored by their Care Quality Group.
12. An in- depth analysis of the quality data should be conducted when one year of data is available, to compare to pre-transition data and benchmark against other maternity units in London for measures such as caesarean section rates, assisted deliveries and complications, babies born before arrival, haemorrhage, normal birth, booking by thirteen weeks.
13. Continue to review and adjust the community areas to ensure they are aligned with women's choice so that continuity of antenatal and postnatal care can be provided.
14. Review the booking data in the shared area to redefine the trust boundaries so there are no shared areas.
15. Continue to monitor compliance with providing continuity of through antenatal and postnatal care.
16. Confirm and fully commission an agreed model of transitional care across NW London with an agreed tariff. The impact of this on neonatal admissions and length of stay should be actively monitored.

17. Review the impact of the perinatal mental health pilot and spread learning through NW London.
18. An urgent review of capacity and catchment areas at Northwick Park Hospital is required to address the forecasted rise in activity beyond the expectations of commissioners and the unit's capacity.
19. Continue to monitor activity at the other maternity units, particularly as the changes to the trust catchment areas embed, to ensure there are no issues with capacity.
20. A neonatal nurse focus group should be organised to obtain feedback from this staff group about their experience of the transition.
21. Ensure further communications are provided to women in relation to their choice of antenatal and postnatal care, especially within the borough of Ealing.
22. The uncertainty about the decision to implement the maternity and neonatal transition had a negative impact on staff experience and engagement in the changes. Decisions for future changes need to be made further in advance of implementation, to prepare staff.
23. Trusts need to ensure an effective route in communicating with their staff. This needs to be coordinated by an accountable individual to prevent mixed messages, rumours, and disengagement.
24. Additional engagement with workforce members following transition on the effect of the change should take place to address staff concerns and further communicate outcomes and experiences of the transition.
25. In future services changes, more could be done to prepare staff for the changes, particularly in regard to the increase in activity for staff moving to busier units.
26. Health Education England NW London to review trainee placements as planned one year following the transition and factoring in information on trainee preferences for placements as one indicator of training quality.

## Conclusion

NW London has managed a complex service change safely and with clear benefits to patients, mothers and their babies. New community services have been developed, facilities at the receiving hospitals invested in, a significant number of new midwifery staff appointed and the maternity and neonatal units closed safely and to the planned date. Furthermore the majority of women who had their care transferred felt supported and well communicated with. Whilst it has been a major change for staff who worked at Ealing hospital, they are beginning to feel more settled in their units and through the strong head of midwifery network that has been formed; they will continue to be actively supported.

The benefits case for the new model of care set out clear objectives and expected outcomes that the transition of services should achieve. This review has considered the progress towards the achievement of these benefits; in so doing much good practice has been highlighted as well as several recommendations for the further development of the service.

After a large service change, such as this, the system will take time to normalise. It is therefore recommended that the key quality indicators continue to be actively monitored and that a further in-depth review is undertaken in 2017, this will also provide an opportunity to assess progress against the National Maternity Review.



## Appendix 1: Maternity care for Ealing residents' information poster

### MATERNITY CARE FOR EALING RESIDENTS

You can no longer give birth at Ealing Hospital. This poster shows where women living in Ealing can choose to have their antenatal and postnatal care, depending on which hospital they have chosen to give birth in.

The improvements to community care mean that, for many pregnant women, more care can be provided in convenient locations across Ealing and in neighbouring boroughs.

Women in Ealing can also choose to access community antenatal and postnatal care in the boroughs of their chosen unit.

Women who have underlying health conditions and need additional support may not be able to have all their appointments in the community as they may require additional hospital-based support.

Ealing borough locations for antenatal and postnatal care

Key: CC Children's Centre, HC Health Centre

	CHICKEN AND WOODHOUSE HOSPITAL	HILLINGDON HOSPITAL	NORTHWICK PARK HOSPITAL	QUEEN CHARLOTTE'S AND CHASE HOSPITAL	ST MARY'S HOSPITAL	WEST MIDDLESEX UNIVERSITY HOSPITAL
<b>CHOOSING A UNIT TO GIVE BIRTH IN</b>	<ul style="list-style-type: none"> <li>Chickens and Woodhouse Hospital</li> </ul> <p>Women can have care in the Ealing borough and will be provided by midwives from other hospitals.</p>	<ul style="list-style-type: none"> <li>Hillingdon Hospital</li> <li>Ealing Hospital*</li> <li>Hip Manor cc</li> <li>Grand Linton Village cc</li> <li>Jubilee Gardens cc</li> <li>Southall Broadway cc</li> </ul>	<ul style="list-style-type: none"> <li>Northwick Park Hospital</li> <li>Ealing Hospital*</li> <li>Peta Hill cc</li> <li>Rowenden cc</li> <li>Parkside cc</li> <li>Wintmill cc</li> </ul>	<ul style="list-style-type: none"> <li>Queen Charlotte and Chase Hospital</li> <li>St Mary's Hospital</li> <li>Ealing Hospital*</li> <li>Wintmill cc</li> <li>Harwell cc</li> <li>Hathway cc</li> <li>Melbush Lane cc</li> <li>Grange cc</li> <li>Maple cc</li> <li>John Henry cc</li> </ul>	<ul style="list-style-type: none"> <li>St Mary's Hospital</li> <li>Queen Charlotte and Chase Hospital</li> <li>Ealing Hospital*</li> <li>Wintmill cc</li> <li>Harwell cc</li> <li>Hathway cc</li> <li>Melbush Lane cc</li> <li>Grange cc</li> <li>Maple cc</li> <li>John Henry cc</li> </ul>	<ul style="list-style-type: none"> <li>West Middlesex University Hospital</li> <li>Ealing Hospital*</li> <li>Southall Broadway cc</li> <li>Featherstone Road HC</li> <li>Log Cabin cc</li> </ul>
<b>ANTENATAL CARE</b>	Chickens and Woodhouse Hospital	Hillingdon Hospital	Northwick Park Hospital Ealing Hospital*	Queen Charlotte and Chase Hospital	St Mary's Hospital	West Middlesex University Hospital
<b>SCANS</b>	Chickens and Woodhouse Hospital	Hillingdon Hospital	Northwick Park Hospital Ealing Hospital*	Queen Charlotte and Chase Hospital	St Mary's Hospital	West Middlesex University Hospital
<b>BIRTH</b>	Chickens and Woodhouse Hospital Home	Hillingdon Hospital Home	Northwick Park Hospital Home	Queen Charlotte and Chase Hospital Home	St Mary's Hospital Home	West Middlesex University Hospital Home
<b>POSTNATAL CARE</b>	<ul style="list-style-type: none"> <li>Home</li> <li>Chickens and Woodhouse Hospital</li> </ul> <p>Women can have care in the Ealing borough and will be provided by midwives from other hospitals.</p>	<ul style="list-style-type: none"> <li>Home</li> <li>Hillingdon Hospital</li> <li>Hip Manor cc</li> <li>Grand Linton Village cc</li> <li>Jubilee Gardens cc</li> <li>Southall Broadway cc</li> </ul>	<ul style="list-style-type: none"> <li>Home</li> <li>Ealing Hospital*</li> <li>Northwick Park Hospital</li> <li>Peta Hill cc</li> <li>Rowenden cc</li> <li>Parkside cc</li> <li>Wintmill cc</li> </ul>	<ul style="list-style-type: none"> <li>Home</li> <li>St Mary's Hospital</li> <li>Wintmill cc</li> <li>Harwell cc</li> <li>Hathway cc</li> <li>Melbush Lane cc</li> <li>Grange cc</li> <li>South Acton cc</li> <li>Maple cc</li> </ul>	<ul style="list-style-type: none"> <li>Home</li> <li>St Mary's Hospital</li> <li>Wintmill cc</li> <li>Harwell cc</li> <li>Hathway cc</li> <li>Melbush Lane cc</li> <li>Grange cc</li> <li>South Acton cc</li> <li>Maple cc</li> </ul>	<ul style="list-style-type: none"> <li>Home</li> <li>Ealing Hospital*</li> <li>Southall Broadway cc</li> <li>Featherstone Road cc</li> <li>Log Cabin cc</li> </ul>

**!** This poster is about community services in Ealing. There is also antenatal and postnatal care available in other boroughs in North West London. Please ask your midwife for the most up-to-date information. All sites are subject to change.

**H** \* with antenatal department (referred to from 1st July 2023 as HW1 Community Maternity Clinic)

## Appendix 2: Quality and system monitoring dashboard

Metrics - Maternity (Monthly)	
Demand	Deliveries (Births)
	Deliveries (Births) by women from Ealing postcodes
	Births in MLU
	Births at Home
	Births at Labour Ward
	Bookings
	Bookings by women from Ealing postcodes
Capacity	NICU cot days
	Midwifery vacancy rate
	Maternity support vacancy rate
	Neonatal nurses vacancy rate
	Consultant vacancy rate
	Middle Grade (training & non-training) OG vacancy rate
	Consultant (Anaesthetic) vacancy rate
Sonographer vacancy rate	
Quality	Maternity Serious Untoward Incidents
	Midwifery to birth ratio
	1:1 midwifery labour care
	12+6 weeks booking rate (exc. late referrals; i.e. after 10+6 weeks)
	Consultant cover on labour wards (hours)
	Elective C-Sections
	Emergency C-Sections
	Average Friends and Family Test score
	Number of complaints
	Number Born Before Arrival
	Unbooked deliveries
	Attrition Rate (Bookings to Deliveries)
	Breastfeeding initiation rate
	% of women with Post Partum Haemorrhage (> 1,500mls)
% of instrumental deliveries	
% of Puerperal Sepsis	
Resilience	Number of Temporary Closures
	Women getting first choice unit
	Number of first choice bookings turned away

Metrics - Maternity (Weekly)	
Demand & Quality	Deliveries (Births)
	Deliveries (Births) by women from Ealing postcodes
	Bookings
	Bookings by women from Ealing postcodes
	Women getting first choice unit
Number of first choice bookings turned away	

Metrics - Neo Natal (Monthly)	
Demand & Quality	In Utero Transfer within NWL
	In Utero Transfer to another Network
	Post natal Transfer within NWL (Medical & Surgical)
	Post natal Transfer to another Network (Medical & Surgical)

## Appendix 3: GP survey

1. Practice Name
2. Practice Code
3. CCG
  - Brent
  - Central London
  - Ealing
  - Hammersmith & Fulham
  - Harrow
  - Hillingdon
  - Hounslow
  - West London
4. How effective was the information from the CCGs in updating you on the transition of maternity and neonatal inpatient services from Ealing Hospital and what this meant for you and your patients?
  - Very ineffective
  - Ineffective
  - Neither effective nor ineffective
  - Effective
  - Very effective
5. Free text box for further information if applicable (4000 characters)
6. How effective were the patient information materials (e.g. booklets and posters) in helping you communicate the changes to the women affected and the associated travel arrangements?
  - Very ineffective
  - Ineffective
  - Neither effective nor ineffective
  - Effective
  - Very effective
  - I have not seen this information
7. Free text box for further information if applicable (4000 characters)
8. How much support do you think women need from their GP in choosing a maternity unit?
  - No support
  - Minimum support
  - Moderate support

- Maximum support
9. What factor(s) do you think are most important in helping women make a choice about which maternity unit they would like to be referred to? (Multiple options may be selected)
- Proximity of the maternity unit to home
  - Proximity of the maternity unit to the GP practice
  - Availability of community services close to home
  - Previous experience of the maternity unit
  - Recommendations from friends or family
  - Maternity unit's reputation for quality of care
  - Advice from GP
  - Other
10. If other, please specify
11. Have you had any problems referring to any of the maternity units following the transition?
- Yes
  - No
12. If yes, which maternity unit(s) have you had problems referring to? (Multiple options may be selected)
- Not applicable
  - Chelsea and Westminster Hospital
  - Hillingdon Hospital
  - Northwick Park Hospital
  - Queen Charlotte's and Chelsea Hospital
  - St Mary's Hospital
  - West Middlesex University Hospital
13. If yes, why was this a problem? (Multiple options may be selected)
- Not applicable
  - Administrative or clerical reason
  - Maternity unit capacity issue – patient lives within catchment area
  - Maternity unit capacity issue – patient lives outside of the catchment area
  - Other
14. If other, please specify
15. How would you rate access for your patients to community maternity clinics since the transition of maternity services?
- Very poor
  - Poor

- Neither poor nor good
  - Good
  - Very good
16. Question for Ealing GPs only - Do you think continuity of care has improved since all the Maternity Units now provide antenatal and postnatal community care in Ealing?
- Yes
  - No
  - Not sure
17. Is there any other information about maternity care in NW London that would be helpful for you, your practice and your patients? (Free text box for further information if applicable)

## Appendix 4: Women's experience survey

### Feedback on Your Maternity Care

The survey should take no more than 15 minutes of your time and will remain open until 15th January 2016. The purpose of this survey is to get feedback on your experience of your maternity care being moved from Ealing Hospital to another maternity unit in North West London. All responses are in total confidence and comply with Market Research Society Code of Conduct. You will not be able to be identified through your answers.

#### Questions:

1. Which hospital was your maternity care moved to? [Please tick only one]

- Chelsea and Westminster Hospital
- Hillingdon Hospital
- Northwick Park Hospital
- Queen Charlotte's and Chelsea Hospital
- St Mary's Hospital
- West Middlesex University Hospital
- Don't know/Not Sure

2. Were you given any information about other hospitals and travel?

- Yes
- No [skip to question 5]
- Don't know/Not Sure [skip to question 5]

3. If yes at question 2, what materials or information did you receive? [Please tick as many as apply]

- Letter
- Giving birth booklet [see *Image 1*]
- Giving birth Easy Read booklet
- [see *Image 2*]
- Bus map [see *Image 3*]
- Other (please state)
- Don't know/Not sure

4. If yes at question 2, how did you receive this information? [Please tick as many as apply]

- Midwife

- GP
- Children's Centre
- Post
- Other (please state)
- Don't know/Not sure

5. Please state to what extent you agree or disagree with the following statement: 'Overall, I feel I had enough information about other hospitals where I could give birth.' [Please tick only one]

- Disagree strongly
- Disagree
- Neither agree nor disagree
- Agree
- Agree strongly
- Don't know/Not sure

6. Please state to what extent you agree or disagree with the following statement: 'Overall, I feel I had enough travel information.' [Please tick only one]

- Disagree strongly
- Disagree
- Neither agree nor disagree
- Agree
- Agree strongly
- Don't know/Not Sure

7. If you did not feel as though you had enough information on either hospitals or travel, please tell us what additional information would have been useful?

[FREE TEXT BOX FOR RESPONSE]

8. Did your midwife ask you about your travel plans to the hospital where you were moved?

- Yes
- No
- Don't know/Not sure

9. Where did you receive your antenatal (before birth) and postnatal (after birth) care? [Please tick as many as apply]

- Hospital

- Children's/Health center
- Home
- Don't know/Not sure

10. Please state the extent to which you agree or disagree with the following statement: 'Overall, I have felt less able to get to my antenatal (before birth) and postnatal (after birth) appointments on time after I moved hospitals' [Please tick only one]

- Disagree strongly
- Disagree
- Neither agree nor disagree
- Agree
- Agree strongly
- Don't know/Not sure

11. Please state the extent to which you agree or disagree with the following statement: 'Overall, I have felt less able to get to my hospital-based appointments, including scans, on time after I moved hospitals' [Please tick only one]

- Disagree strongly
- Disagree
- Neither agree nor disagree
- Agree
- Agree strongly
- Don't know/Not sure

12. Did you have any other travel difficulties after the hospital providing your maternity care changed?

- Yes
- No [Skip to question 14]
- Don't know/Not sure [Skip to question 14]

13. If yes, why?

[FREE TEXT BOX FOR RESPONSE]

14. Please state the extent to which you agree with the following statement: 'Overall, I felt supported when my maternity care was moved from Ealing Hospital' [Please tick only one]

- Disagree strongly
- Disagree



- Neither agree nor disagree
- Agree
- Agree strongly
- Don't know/Not sure

15. Why do you say that?

[FREE TEXT BOX FOR RESPONSE]

16. Please state the extent to which you agree with the following statement:

- 'Overall, I was happy with the maternity care I received after I moved hospitals'  
[Please tick only one]
- Disagree strongly
- Disagree
- Neither agree nor disagree
- Agree
- Agree strongly
- Don't know/Not sure

17. Which parts of your care were you most happy about?

[FREE TEXT BOX FOR RESPONSE]

18. Are there any parts of your care that could have been improved?

[FREE TEXT BOX FOR RESPONSE]

**Your Details:**

If you would like to receive a £10 high street voucher as thanks for taking part in the survey, you can give your contact details so we can post this out to you. You have our guarantee that these details will in no way be used to identify your responses and you do not need to give you details if you don't want to.

Name:

Postal address:

## Contact us:

*Email:* [Healthiernwl@nw.london.nhs.uk](mailto:Healthiernwl@nw.london.nhs.uk)

*Online:* [www.healthiernorthwestlondon.nhs.uk](http://www.healthiernorthwestlondon.nhs.uk)

*Twitter:* @HealthierNWL

*Freepost:* FREEPOST, Healthier North West London

*Freephone:* 0800 1777 990

## Appendix B

### Population growth assessment for North West London CCGs

April 2016

#### Approach:

For the five years to 2020/21 the planning assumptions are based on the higher of the ONS and GLA figures for this period so our projections either match or surpass the latter.

For the five years from 2021/22 to 2025/26 the specific housing developments for each borough have been identified from the current London Plan published by the Mayor of London and the London Assembly, specifically the projected housing in Opportunity Areas and Housing Zones.

The population numbers associated with the housing developments has been calculated by taking an average number of people per new house and the proportion of those people who are expected to move in from outside the borough. These estimates are sourced from the guidance notes published by the London Healthy Urban Development Unit to support their population modelling tool. Finally in order to provide a conservative estimate for the population growth that will take place within the five year period, 100% of the increase from each development has been used in order to anticipate the maximum impact in the period to 2026.

This was compared with the annual level projected in the GLA 2014 round number projections and the population growth increased to that level if it was greater.

**Source:** <http://data.london.gov.uk/dataset/2014-round-population-projections/resource/92742b3a-d35f-48d4-8cac-1a795553ccfa>

#### Results:

The population growth figures for each borough are set out on the following page.

#### Old Oak Common

We have made provision for Old Oak Common in our projections for Brent, Ealing and Hammersmith & Fulham, based on a third share each of the 9,000 properties expected to be built by 2025/26, out of a total of 24,000 expected on this development.

#### Projections post-2025/26

Our current thinking is that growth will continue to track the current trend of c 1-1.5% but we will continue to update our planning projections regularly. We will continue to discuss these projections regularly with London's councils to make sure all relevant factors, such as housing projects and major infrastructure developments, are included. We will also factor in the potential impact of the latest breakthroughs in medicine and technology, which may change how and where clinicians provide services and treatment to their patients in the years ahead.

#### NW London-wide figure

Across NWL, we are modelling average annual growth for SaHF of 1.2%, against the GLA number of 0.8% growth.

### Ealing

(000's)	Opening population	Higher of ONS & GLA	Demographic growth			Closing population		GLA projection	
			Old Oak Common	Southall (Opportunity area)	Southall (Housing zone)	#000	% growth	#000	% growth
2015/16	n/a					354.6			
2016/17	354.6	3.5				358.2	1.0%	352.8	
2017/18	358.2	3.6				361.7	1.0%	355.9	0.9%
2018/19	361.7	3.6				365.4	1.0%	359.0	0.9%
2019/20	365.4	3.3				368.6	0.9%	362.1	0.9%
2020/21	368.6	3.3				372.0	0.9%	365.2	0.9%
2021/22	372.0		1.2	2.5	1.8	377.4	1.5%	368.4	0.9%
2022/23	377.4		1.2	2.5	1.8	382.9	1.5%	371.6	0.9%
2023/24	382.9		1.2	2.5	1.8	388.4	1.4%	374.9	0.9%
2024/25	388.4		1.2	2.5	1.8	393.9	1.4%	378.1	0.9%
2025/26	393.9		1.2	2.5	1.8	399.4	1.4%	381.3	0.9%
						Average	1.2%	0.9%	

### Underlying Demographic growth assumptions:

2016/17 to 2020/21 - ONS growth (source: Population Projections Unit, ONS 2014)

2021/22 to 2025/26 - Additional growth to achieve 1% overall increase including the specified housing developments

### Housing Developments

Opportunity Area	Houses	Av		Contribution to population growth	
		Occupancy	People	Incomers	
Southall	6,000	2.9	17,487	71%	12,349
Old Oak Common	3,000	2.9	8,700	71%	6,144
<b>Housing Zones</b>					
Southall	4,345	2.9	12,664	71%	8,943

### Sources:

**Opportunity area:** <https://www.london.gov.uk/what-we-do/planning/implementing-london-plan/opportunity-areas/opportunity-areas/southall>

**Housing zone:** [https://www.london.gov.uk/sites/default/files/housing\\_zones\\_brochure\\_march\\_2016\\_5.pdf](https://www.london.gov.uk/sites/default/files/housing_zones_brochure_march_2016_5.pdf)

**Average Occupancy/Incomers:** London Healthy Urban Development Unit Guidance

## Brent

Underlying Demographic growth assumptions:

(000's)	Opening population	Demographic growth								Closing population		GLA projection	
		Higher of ONS & GLA	Old Oak Common	Colindale/Burnt Oak	Kensal Canalside	Park Royal	Wembley (Opportunity area)	Alperton	Wembley (H Zone)	#000	% growth	#000	% growth
		2015/16	n/a									325.4	
2016/17	325.4	3.4								328.8	1.0%	328.8	
2017/18	328.8	3.4								332.2	1.0%	332.2	1.1%
2018/19	332.2	3.5								335.7	1.1%	335.7	1.0%
2019/20	335.7	3.3								339.0	1.0%	339.0	1.0%
2020/21	339.0	3.3								342.3	1.0%	342.3	1.0%
2021/22	342.3		1.2	1.0	1.4	0.6	4.7	1.3	1.0	353.7	3.3%	345.4	0.9%
2022/23	353.7		1.2	1.0	1.4	0.6	4.7	1.3	1.0	365.0	3.2%	348.5	0.9%
2023/24	365.0		1.2	1.0	1.4	0.6	4.7	1.3	1.0	376.4	3.1%	351.5	0.8%
2024/25	376.4		1.2	1.0	1.4	0.6	4.7	1.3	1.0	387.7	3.0%	354.3	0.8%
2025/26	387.7		1.2	1.0	1.4	0.6	4.7	1.3	1.0	399.1	2.9%	357.0	0.8%
										Average	2.1%	0.9%	

2016/17 to 2020/21 - GLA 2014 round number projections <http://data.london.gov.uk/dataset/2014-round-population-projections/resource/92742b3a-d35f-48d4-8cac-1a795553ccfa>

2021/22 to 2025/26 - 100% of the population growth due to the specified housing developments

Opportunity Area	Houses	Av Occupancy	People	Incomers	Population growth age profile				
					Contribution to population growth	0-14	15-59	60-74	75+
Old Oak Common	3,000	2.9	8,744	71%	6,175	4,405	11,920	1,589	619
Colindale/Burnt Oak	2,500	2.9	7,286	71%	5,146	1,224	3,311	441	172
Kensal Canalside	3,500	2.9	10,201	71%	7,204	1,713	4,636	618	241
Park Royal	1,500	2.9	4,372	71%	3,087	734	1,987	265	103
Wembley	11,500	2.9	33,517	71%	23,670	5,629	15,231	2,031	791
<b>Housing Zones</b>									
Alperton	3,213	2.9	9,364	71%	6,613	1,573	4,256	567	221
Wembley	2,380	2.9	6,937	71%	4,899	1,165	3,152	420	164

### Sources:

**Opportunity area:** <https://www.london.gov.uk/what-we-do/planning/implementing-london-plan/opportunity-areas/opportunity-areas>

**Housing zone:** [https://www.london.gov.uk/sites/default/files/housing\\_zones\\_brochure\\_march\\_2016\\_5.pdf](https://www.london.gov.uk/sites/default/files/housing_zones_brochure_march_2016_5.pdf)

**Average Occupancy/Incomers:** London Healthy Urban Development Unit Guidance

## Harrow

(000's)	Opening population	Demographic growth			Closing population		GLA projection	
		Higher of ONS & GLA	Harrow & W'stone	Heart of Harrow	#000	% growth	#000	% growth
2015/16	n/a				253.8			
2016/17	253.8	3.1			256.9	1.2%	251.4	
2017/18	256.9	3.1			260.0	1.2%	252.9	0.6%
2018/19	260.0	3.2			263.2	1.2%	254.5	0.6%
2019/20	263.2	2.9			266.1	1.1%	256.1	0.6%
2020/21	266.1	3.0			269.1	1.1%	257.6	0.6%
2021/22	269.1		1.2	2.2	272.4	1.2%	259.2	0.6%
2022/23	272.4		1.2	2.2	275.8	1.2%	260.8	0.6%
2023/24	275.8		1.2	2.2	279.1	1.2%	262.4	0.6%
2024/25	279.1		1.2	2.2	282.4	1.2%	264.0	0.6%
2025/26	282.4		1.2	2.2	285.8	1.2%	265.6	0.6%
Average						1.2%	0.6%	

2016/17 to 2020/21 - ONS growth (source: Population Projections Unit, ONS 2014)

2021/22 to 2025/26 - 100% of the population growth due to the specified housing developments

Opportunity Area	Houses	Av		Incomers	Contribution to population growth
		Occupancy	People		
Harrow & Wealdstone	2,800	2.9	8,161	71%	5,763
<b>Housing Zones</b>					
Heart of Harrow	5,294	2.9	15,429	71%	10,896

### Sources:

**Opportunity area:** <https://www.london.gov.uk/what-we-do/planning/implementing-london-plan/opportunity-areas/opportunity-areas>

**Housing zone:** [https://www.london.gov.uk/sites/default/files/housing\\_zones\\_brochure\\_march\\_2016\\_5.pdf](https://www.london.gov.uk/sites/default/files/housing_zones_brochure_march_2016_5.pdf)

**Average Occupancy/Incomers:** London Healthy Urban Development Unit Guidance

## Hillingdon

(000's)	Opening population	Demographic growth		Closing population		GLA projection	
		Higher of ONS & GLA	Heathrow	#000	% growth	#000	% growth
2015/16	n/a			300.4			
2016/17	300.4	4.8		305.2	1.6%	298.0	
2017/18	305.2	4.3		309.5	1.4%	299.6	0.5%
2018/19	309.5	4.3		313.8	1.4%	301.1	0.5%
2019/20	313.8	4.4		318.2	1.4%	302.6	0.5%
2020/21	318.2	4.1		322.4	1.3%	304.2	0.5%
2021/22	322.4		1.9	324.2	0.6%	305.6	0.5%
2022/23	324.2		1.9	326.1	0.6%	307.0	0.5%
2023/24	326.1		1.9	327.9	0.6%	308.4	0.5%
2024/25	327.9		1.9	329.8	0.6%	309.8	0.5%
2025/26	329.8		1.9	331.6	0.6%	311.3	0.5%
				Average	1.0%		0.5%

2016/17 to 2020/21 - ONS growth (source: Population Projections Unit, ONS 2014)

2021/22 to 2025/26 - 50% of the population growth due to the specified housing developments  
(Heathrow is split 50:50 with Hounslow)

Opportunity Area	Av				Contribution to pop growth
	Houses	Occupancy	People	Incomers	
Heathrow	4,500	2.9	13,115	71%	9,262

### Sources:

**Opportunity area:** <https://www.london.gov.uk/what-we-do/planning/implementing-london-plan/opportunity-areas/opportunity-areas>

**Housing zone:** [https://www.london.gov.uk/sites/default/files/housing\\_zones\\_brochure\\_march\\_2016\\_5.pdf](https://www.london.gov.uk/sites/default/files/housing_zones_brochure_march_2016_5.pdf)

**Average Occupancy/Incomers:** London Healthy Urban Development Unit Guidance

## Westminster

(000's)	Opening population	Demographic growth		Uplift to match GLA	Closing population		GLA projection	
		Higher of ONS & GLA	Paddington		#000	% growth	#000	% growth
2015/16	n/a				234.9			
2016/17	234.9	3.3			238.2	1.4%	237.2	
2017/18	238.2	2.9			241.1	1.2%	239.4	0.9%
2018/19	241.1	2.8			243.8	1.1%	241.6	0.9%
2019/20	243.8	2.3			246.1	0.9%	243.8	0.9%
2020/21	246.1	2.2			248.3	0.9%	246.0	0.9%
2021/22	248.3		0.4		248.7	0.2%	247.7	0.7%
2022/23	248.7		0.4	0.3	249.4	0.3%	249.4	0.7%
2023/24	249.4		0.4	1.3	251.1	0.7%	251.1	0.7%
2024/25	251.1		0.4	1.3	252.8	0.7%	252.8	0.7%
2025/26	252.8		0.4	1.1	254.4	0.6%	254.4	0.7%
						Average	0.8%	0.8%

2016/17 to 2020/21 - ONS growth (source: Population Projections Unit, ONS 2014)

2021/22 to 2025/26 - 100% of the population growth due to the specified housing developments

<http://data.london.gov.uk/dataset/2014-round-population-projections/resource/92742b3a-d35f-48d4-8cac-1a795553ccfa>

Opportunity Area	Houses	Av			Contribution to population growth
		Occupancy	People	Incomers	
Paddington	1,000	2.9	2,915	71%	2,058

### Sources:

**Opportunity area:** <https://www.london.gov.uk/what-we-do/planning/implementing-london-plan/opportunity-areas/opportunity-areas>

**Housing zone:** [https://www.london.gov.uk/sites/default/files/housing\\_zones\\_brochure\\_march\\_2016\\_5.pdf](https://www.london.gov.uk/sites/default/files/housing_zones_brochure_march_2016_5.pdf)

**Average Occupancy/Incomers:** London Healthy Urban Development Unit Guidance



**Kensington & Chelsea**

(000's)	Opening population	Demographic growth		Closing population		GLA projection	
		Higher of ONS & GLA	Earl's Court	#000	% growth	#000	% growth
2015/16	n/a			158.4			
2016/17	158.4	0.7		159.0	0.4%	156.6	
2017/18	159.0	0.7		159.7	0.4%	157.3	0.4%
2018/19	159.7	0.7		160.4	0.4%	157.9	0.4%
2019/20	160.4	0.5		161.0	0.3%	158.5	0.4%
2020/21	161.0	1.3		162.3	0.8%	159.0	0.3%
2021/22	162.3		3.1	165.4	1.9%	160.4	0.8%
2022/23	165.4		3.1	168.5	1.9%	161.8	0.9%
2023/24	168.5		3.1	171.6	1.8%	163.2	0.9%
2024/25	171.6		3.1	174.6	1.8%	164.6	0.8%
2025/26	174.6		3.1	177.7	1.8%	165.9	0.8%
				Average	1.2%		0.6%

2016/17 to 2020/21 - ONS growth (source: Population Projections Unit, ONS 2014)

2021/22 to 2025/26 - 100% of the population growth due to the specified housing developments

Opportunity Area	Houses	Av Occupancy	People	Incomers	Contribution to population growth
Earls Court	7,500	2.9	21,859	71%	15,437

**Sources:**

**Opportunity area:** <https://www.london.gov.uk/what-we-do/planning/implementing-london-plan/opportunity-areas/opportunity-areas>

**Housing zone:** [https://www.london.gov.uk/sites/default/files/housing\\_zones\\_brochure\\_march\\_2016\\_5.pdf](https://www.london.gov.uk/sites/default/files/housing_zones_brochure_march_2016_5.pdf)

**Average Occupancy/Incomers:** London Healthy Urban Development Unit Guidance

## Hammersmith & Fulham

(000's)	Opening population	Demographic growth			Closing population		GLA projection	
		Higher of ONS & GLA	Old Oak Common	White City	#000	% growth	#000	% growth
2015/16	n/a				181.8			
2016/17	181.8	2.2			184.0	1.2%	183.3	
2017/18	184.0	2.0			186.0	1.1%	185.4	1.2%
2018/19	186.0	2.0			188.0	1.1%	187.5	1.1%
2019/20	188.0	1.9			189.9	1.0%	189.5	1.1%
2020/21	189.9	1.4			191.3	0.7%	191.4	1.0%
2021/22	191.3		1.2	2.5	195.0	1.9%	192.8	0.7%
2022/23	195.0		1.2	2.5	198.7	1.9%	194.6	0.9%
2023/24	198.7		1.2	2.5	202.4	1.9%	196.1	0.8%
2024/25	202.4		1.2	2.5	206.1	1.8%	197.6	0.8%
2025/26	206.1		1.2	2.5	209.8	1.8%	199.0	0.7%
					Average	1.4%	0.9%	

2016/17 to 2020/21 - ONS growth (source: Population Projections Unit, ONS 2014)

2021/22 to 2025/26 - 100% of the population growth due to the specified housing developments

Opportunity Area	Houses	Av		Incomers	Contribution to population growth
		Occupancy	People		
White City	6,000	2.9	17,487	71%	12,349
Old Oak Common	3,000	2.9	8,700	71%	6,144

### Sources:

**Opportunity area:** <https://www.london.gov.uk/what-we-do/planning/implementing-london-plan/opportunity-areas/opportunity-areas>

**Housing zone:** [https://www.london.gov.uk/sites/default/files/housing\\_zones\\_brochure\\_march\\_2016\\_5.pdf](https://www.london.gov.uk/sites/default/files/housing_zones_brochure_march_2016_5.pdf)

**Average Occupancy/Incomers:** London Healthy Urban Development Unit Guidance

## Hounslow

(000's)	Opening population	Demographic growth			Closing population		GLA projection	
		Higher of ONS & GLA	Hounslow Town centre	Heathrow	#000	% growth	#000	% growth
2015/16	n/a				276.4			
2016/17	276.4	4.1			280.5	1.5%	274.0	
2017/18	280.5	4.2			284.7	1.5%	276.1	0.8%
2018/19	284.7	4.0			288.7	1.4%	278.3	0.8%
2019/20	288.7	3.8			292.4	1.3%	280.4	0.8%
2020/21	292.4	3.8			296.2	1.3%	282.6	0.8%
2021/22	296.2		1.4	1.9	297.7	0.5%	284.7	0.8%
2022/23	297.7		1.4	1.9	299.1	0.5%	286.9	0.8%
2023/24	299.1		1.4	1.9	300.5	0.5%	289.1	0.8%
2024/25	300.5		1.4	1.9	302.0	0.5%	291.2	0.7%
2025/26	302.0		1.4	1.9	303.4	0.5%	293.4	0.7%
					Average	0.9%		0.8%

2016/17 to 2020/21 - ONS growth (source: Population Projections Unit, ONS 2014)

2021/22 to 2025/26 - 100% of the population growth due to the specified housing developments

Opportunity Area	Houses	Av Occupancy	People	Incomers	Contribution to population growth
Heathrow (Heathrow split 50:50 with Hillingdon)	4,500	2.9	13,115	71%	9,262
<b>Housing Zones</b>					
Hounslow Town Centre	3,478	2.9	10,137	71%	7,158

### Sources:

**Opportunity area:** <https://www.london.gov.uk/what-we-do/planning/implementing-london-plan/opportunity-areas/opportunity-areas>

**Housing zone:** [https://www.london.gov.uk/sites/default/files/housing\\_zones\\_brochure\\_march\\_2016\\_5.pdf](https://www.london.gov.uk/sites/default/files/housing_zones_brochure_march_2016_5.pdf)

**Average Occupancy/Incomers:** London Healthy Urban Development Unit Guidance

## Appendix C

### Improvements in local services and priorities for the year ahead

#### Brent CCG

- Launch of the Whole Systems Programme enabling primary care to provide more proactive care for people with long term conditions
- Piloted the first community sickle cell service. Brent Sickle Cell Society provides advice and support helping avoid unnecessary hospital admissions
- All GP practices are offering more week day and weekend appointments to meet demand. This has created hundreds of additional appointments out of normal hours
- Launch of the new community cardiology service in May 2015
- Stroke patients are spending less time in hospital after Brent CCG commissioned an Early Supported Discharge Service ensuring better follow-up care and rehabilitation are available in the community
- Provision of specialist substance abuse nurse in A&E who can refer patients onto voluntary services for support and minimise unnecessary re-admission
- Urgent care mental health single point of access launched for patients and professionals experiencing mental health crisis and requiring urgent assessment within 4 hours, to give parity with physical health and emergencies
- Education and training of local nursing home staff in care homes to minimise risk of falls among their elderly residents, conduct proper assessments and avoid unnecessary hospital admissions
- North West London's Clinical Commissioning Groups secured £3.8m to help raise the standard of children and young people's mental health services across north-west London. The initiative will improve access to care and support making it easier for people to get help. It includes training and support for parents and provision of a specialist community eating disorder service
- GPs now have greater access to patients' health and social care records helping them make more informed decisions about patient care via specially designed software
- Patients with arthritis and heart conditions are now monitored in primary care rather than hospital clinics
- Provision of community-based dementia nurses helping increase capacity for diagnosis and early intervention
- Increased capacity for IAPT and commissioned the Big White Wall - an online provider of psychological therapies
- Extension of Looked After Children Service and CAMHS to minimise waiting times and prevent patients' condition deteriorating
- Launched a service to provide better education and responsive primary care to residents of nursing homes
- Successfully improved diagnosis rates for dementia so that over 80% of the local population with dementia have been diagnosed and offered support. A Dementia Steering Group is also coordinating a multi-agency response to dementia
- During November 2015, the CCG hosted a delegation of approximately 20 healthcare professionals from the National Healthcare Group of Polyclinics in Singapore to learn about the UK health system and the role of the CCG in commissioning services
- The CCG is reaching out to a wider group of GPs such as sessional and salaried GPs

#### Priorities year ahead

Some of Brent CCG's priorities in the year ahead are:

- Greater investment in IT to share information across primary and secondary care. This will be delivered through the existing EMIS system. It will allow clinicians to track patients' interaction with health and social care services and offer appropriate interventions. Improvements will include greater use of electronic referrals and ordering of diagnostic tests, online discharge summaries and faster delivery of GP communications including A&E, urgent care and outpatient letters.
- GPs will continue to play an increasingly proactive role in identifying cancer patients in line with NHS England's *Five Year Cancer Commissioning Strategy for London*. This includes access to a broader range of tests, greater management of anti-cancer treatment, improving 'follow up' pathways and psychological support for patients, where appropriate. Benefits include improving early detection of cancer and potential access to a wider range of treatments.
- A renewed focus on Brent's end-of-life care strategy which has seen limited progress in the past year as a result of system changes affecting end of life care. The current pathway will be reviewed to ensure it meets the current needs of the population, especially those in their last year of life. This will include a 'single point of access' service linking the London Ambulance Service, NHS 111, district nursing teams, a patient's GP, the GP out-of-hours service and care agencies. Benefits include patients receiving the right care, at the right time in the right place, an integrated care pathway and signposting to appropriate services.
- Brent CCG and Brent Council are committed to the on-going development of the Brent Better Care Fund, which improves quality of care while reducing patients' reliance on hospitals and institutional care. Its work is shaped by the Brent Joint Strategic Needs Assessment and is focused on integrated care and reducing health inequalities. These changes include avoiding unnecessary hospital admissions, more effective hospital discharges, reduce inappropriate admissions due to mental health and create multi-disciplinary health teams integrating health and social care professionals. Benefits include reductions in residential care admissions, delayed transfers of care, hospital admissions/readmissions.
- For Whole Systems Integrated Care the development of multi-disciplinary teams of health and social care professionals who will initially provide seamless care for over 65s living with one or more long-term health conditions. The teams will work closely with GP practices addressing the increase in long-term conditions and number of emergency admissions for over 65s. Benefits include better interventions and support for patients along with more confidence to self-manage their condition.
- The CCG is committed to strengthening its community-based services, supporting people with mental health issues in the community and reducing unnecessary hospital admissions. This includes renewed focus on a 'recovery' model including greater support from carers, clinicians and peers, quicker access to services and helping people develop personal improvement plans. Psychiatric support will continue to be available in A&E and the CCG will look at setting up a 'street triage' service to support the Police assisting someone with mental health issues. Benefits include more opportunity to access services that help improve mental ill health, quick referral to specialist services and greater support in the community.
- Brent CCG has an on-going commitment to improve the quality of care for people with learning disabilities (LDs) and improve access to primary care. Improvements include supporting people with LDs to improve their health and wellbeing, upgrading in-patient facilities and care pathways and implementing a joint strategy with the council for people with LDs. Benefits include more annual health checks and good health actions plans, the

opportunity to access personal health and personal social care budgets and development of a joint health and social care strategy.

- A review of challenges facing Brent carers ensuring they receive adequate support from health and social care. Improvements will include formal assessment of care and signposting to appropriate support, earlier identification of carers and better support including respite breaks. Benefits include greater recognition and support for carers, helping them stay physically and mentally healthy, providing an option to take up personal health budgets and encouraging carers to seek advice and support, where appropriate.

## **Central London CCG**

### **Local Services Strategy**

Seven day access to a GP is one of the 19 services delivered by GP surgeries as part of the Local Services Strategy. The other 18 services include blood pressure monitoring, anticoagulation services for those on blood-thinning medication, complex wound management, ECGs, and some mental health services. All GP practices in CCG area will be working together to deliver these services to all patients in a convenient community setting.

### **Improvements to mental health urgent care - Single Point of Access (SPA)**

A 24/7 urgent and crisis mental health Single Point of Access (SPA) support service was successfully launched in November 2015. The service is provided by Central and North West London NHS Foundation Trust (CNWL) and has been available to Westminster residents since November. Staffed by mental health professionals with psychiatrists in support, the service gives advice and reassurance over the phone, books appointments for follow-up care and when urgent care is needed, dispatches a rapid response home treatment team to be at the caller's home within four hours. The model was developed with service users, commissioners, providers and partners including the Metropolitan Police.

### **Other improvements**

- In January 2016, £3.8 million has been awarded to CCGs across North West London, including Central London CCG, to find improvements to children's and young people's mental health services.
- Working together with other CCGs, patients, and local community groups, Ealing CCG has developed a quality standard and patient's charter for hospital patient transport to ensure that quality is consistent regardless of where the patient happens to live, or where they need to travel to.
- Central London CCG and its partners at the council worked hard to improve dementia diagnosis rates, successfully increasing them from 59.15 per cent in April last year to 71.68 per cent in March this year. Our work so far has included: providing greater support for GPs in identifying and referring patients to memory assessment services; commissioning more frontline services such as dementia-specialist nurses; and ensuring sufficient post-diagnosis support is in place to encourage patients to get help faster in the earlier stages of the condition.
- In 2015 Central London CCG launched a campaign to promote its talking therapies IAPT (Increasing Access to Psychological Therapies) service for residents who are experiencing serious but non-urgent mental health problems such as anxiety, stress, sleep problems, and depression. Talking therapies are delivered at a number of locations across Westminster, including some GP practices, health centres and community venues. Therapies available include: computer-based CBT (cognitive behavioural therapy); mindfulness courses; stress management courses; and postnatal support groups.

### **Priorities year ahead**

Some of Central London CCG's priorities in the year ahead are:

- Central London CCG together with West London and Hammersmith and Fulham CCGs will introduce a new neuro-rehabilitation service in Spring 2016 providing an expanded model of bed and community based care which will
  - provide positive patient experience by substantially reducing unwarranted delay to their next phase of care
  - reduce additional cost incurred due to the unwarranted increase in the length of stay in hospital

- measurable improvement in patient outcomes due to improved functional gain as a result of timely interventions and reductions avoidable complications
- quantifiable reduction in long-term (continuing care) costs due to a measurable reduction in the person's weekly on-going care costs
- support transitions in care back to localities following rehabilitation.

The aim of this service is to reduce bed-based care and support patients in their own homes and communities, while helping them return to independence as quickly as it is safe to do so.

- We will be increasing investment to increase the size and scope of the Primary Care Plus mental health service. This service will enable more people to receive mental health services in a primary care setting, and will be complemented by new services being provided by GPs.
- We will be working with Central and North West NHS Trust to improve access to urgent mental health services. This is likely to include implementing a single point of access and reconfiguring teams to deliver a service which is able to respond to the needs of patients in crisis. We will also be working with the local authority to ensure that there is a Child and Adolescent Mental Health Service (CAMHS) professional available 24 hours a day to respond to young patients in crisis.
- In 2015/16 we will be replacing our existing musculoskeletal services, and increasing the scope to include pain management and rheumatology. We will also be re-commissioning our community gynaecology to include urogynaecology. We will be commissioning new ophthalmology and urology services in 2015/16. These services will provide 20,000 appointments in the community instead of in a hospital.
- The CCG will be working on a number of initiatives related to improving our homeless population's experience of healthcare. This will include continuing investment in hepatitis C clinics, improving care planning, and increasing GP and nursing input into existing services.
- Central London CCGs long-term plan is to develop three hubs or health and wellbeing centres: in Lisson Grove in the north of the borough, at South Westminster Centre for Health. We are also actively looking for a location for a hub in the centre of the borough. These hubs will provide a range of integrated services, closer to people's homes.



## Ealing CCG

### Home Ward service

Home ward offers support to people who live in the borough of Ealing or who have Ealing GPs. Anyone over 18 is eligible to use the service, though the majority of patients are older adults with frailty and multiple long term conditions. The service comprises four components:

- A **single point of access** – coordinating the caseload with ability to provide referrers with immediate clinical advice and signposting to other resources
- A **rapid response team** – this is a Consultant-led multidisciplinary team with doctors, nursing and therapy staff who can assess patients and offer acute care to patients in their own homes. All patients are reviewed in a daily ward round of this ‘virtual ward’, seven days a week
- An intermediate care ward in a Community Hospital, **Magnolia Ward** – this offers brief admissions to a consultant-led, fully nursed environment in a lower intensity setting than an acute hospital. Upon discharge patients may step down into Rapid Response or Short term rehabilitation
- **Short term rehabilitation and reablement team** – this team offers up to six weeks of occupational and physical therapy alongside reablement social care to help people recover their baseline function after an episode of ill health.

The service itself is provided by a host of organisations who are working together to provide a truly integrated service including West London Mental Health NHS Trust (WLMHT), Central and North West London NHS FT (CNWL), Chelsea and Westminster Hospital NHS FT (C&W), London Central and West Unscheduled Care Collaborative (LCW), and the London Borough of Ealing.

### Other improvement

- A new consultant-led, community cardiology service running seven days a week cardiology service was launched in February 2016.
- In January 2016, £3.8 million has been awarded to CCGs across North West London, including Ealing CCG, to find improvements to children’s and young people’s mental health services.
- Working together with other CCGs, patients, and local community groups, Ealing CCG has developed a quality standard and patients charter for hospital patient transport to ensure that quality is consistent regardless of where the patient happens to live, or where they need to travel to.
- In 2015 Ealing CCG launched an innovative scheme to transport vulnerable residents from their homes to GP appointments. The service is provided in partnership with local charity Ealing Community Transport (ECT).

### Priorities year ahead

Some of Ealing CCG’s priorities in the year ahead are:

- Ealing CCG will be extending the Ealing Community Transport (ECT) scheme so more GP practices and more vulnerable patients can benefit with transport from home to GP appointments, improving access, reducing the number of GP home visits, and reducing the number of DNA (Did Not Attend) at surgeries.
- Ealing CCG will push ahead with our work integrating health and social care to ensure the patient journey is seamless. We will be expecting our providers and other partners to work with members of the Joint Care Team to make the new models of care business as usual. The local voluntary sector will recruit and manage seven care navigators aligned to the wider Model of

Care and Joint Care Teams. Meanwhile, community services, acute consultants, West London Mental Health Trust (WLMHT), and social workers to continue with their meetings. Community services and WLMHT to fully align to Networks of GPs and form Joint Care Teams in partnership with care coordinators, social workers and primary care teams.

- To implement the primary care strategy, Ealing CCG will need to prioritise our workforce and education plans, with a special focus on nurses and Health Care Assistants (HCAs). The CCG will look to identify new roles for primary care and the training for the extended primary care teams. Community services and other providers will work with local GPs to deliver excellent quality core training and education around our key treatment areas such as diabetes, wound care and dementia.
- Ealing CCG will continue to prioritise the rollout of our local services strategy. In 2016-17 we will review local services performance and conduct a detailed review in partnership with our colleagues in the CWHHE Collaborative. This will include reviewing and amending the service specifications and developing new services that align to the local services such as dementia or paediatric phlebotomy. There will be particular attention paid to mental health services brought into a community setting with providers working closely with the surgeries in order to manage to complex common mental health concerns and shifting settings of care as laid out in the service specification.

## **Hammersmith & Fulham CCG**

### **Achievements 2015/16**

#### **Community Independence Service (CIS)**

The successful Community Independence Service (CIS), which involves a team of a GP, a social worker, a hospital consultant, a community matron, nurses and therapists, a health and social care coordinator, and a personal case manager supporting the patient with care in their own home, has been extended to cover residents of Westminster and Kensington and Chelsea as well as residents of Hammersmith and Fulham. (This area is sometimes known collectively as the 'Triborough'.) Imperial College Healthcare NHS Trust has been appointed to coordinate the service. So far over 400 patients have received vital support thanks to the scheme.

#### **Local Services Strategy**

The seven day GP service (above) is one of the 19 services delivered as part of the Local Services Strategy. The other 18 services include blood pressure monitoring, anticoagulation services for those on blood thinning medication, complex wound management, ECGs, and some mental health services. All 31 GP practices in the borough of Hammersmith and Fulham will be working together to deliver these services to a common standard so that they are available to all patients, in a convenient, community setting.

#### **Improvements to mental health urgent care - Single Point of Access (SPA)**

A 24/7 urgent and crisis mental health Single Point of Access (SPA) support service was successfully launched in November 2015 and will be available in Hammersmith and Fulham from April 2016. The service is provided by West London Mental Health NHS Trust. Staffed by mental health professionals with psychiatrists in support, the service gives advice and reassurance over the phone, books appointments for follow-up care and, when urgent care is needed, dispatch a rapid response home treatment team to be at the caller's home within four hours. The model was developed with service users, commissioners, providers and partners including the Metropolitan Police.

#### **Integrated patient transport service**

Working together with other CCGs, patients, and local community groups, Hammersmith & Fulham CCG has established a set of clear, enforceable standards for patient transport to ensure that quality is consistent regardless of where the patient happens to live, or where they need to travel to. The standards are known as the Quality Standards and Patient Charter, and were developed by a patient-led group called the Patient Transport Steering Group, and were also influenced by a survey of 700 patients. The Charter will be a mandatory requirement of all transport procurement going forward. A similar review of transport services to Mental Health hospitals and to community sites is also planned for the coming year.

#### **Primary care joint co-commissioning arrangements with NHS England**

In April 2015, Hammersmith and Fulham CCG entered into primary care joint co-commissioning arrangements with NHS England allowing the CCG to have more influence on the commissioning of GPs for Hammersmith and Fulham, enabling the CCG to better meet local population needs. Joint co-commissioning will support the CCG goals of designing integrated and joined up care with strong patient involvement.

#### **£3.8m boost to young people's mental health services**

In January 2016, £3.8million has been awarded to CCGs across North West London, including Hammersmith and Fulham CCG, to deliver their children and young people's mental health plan. The plan aims to improve the quality of and access to mental health services for young people.

### **Cardio-respiratory service launched**

In April 2015, local GPs and hospital doctors proposed a new community service which provides integrated cardiology and respiratory care i.e. to assess and treat people with heart and/or lung conditions in the community. This is in line with the Out of Hospital Strategy which seeks to improve primary care and community care, thereby avoiding and/or shortening hospital stays where it is safe to do so.

### **Parsons Green Health and Care Centre**

The Parsons Green Health and Care Centre is home to a range of health services, including a walk-in centre and various community services. Hammersmith and Fulham Clinical Commissioning Group and Central London Community Healthcare (CLCH), which owns the site, are working together to deliver a joint project which will improve the site and offer new services such as an on-site GP practice and an expanded mix of health, social care, and voluntary sector services. The project is currently in the design phase. Local residents will have many opportunities to get involved in the project through the ongoing engagement work that will be undertaken by both the CCG and by CLCH.

### **Plans for the new musculoskeletal (MSK) service have begun**

Plans have begun for the new musculoskeletal (MSK) service will provide specialist multi-disciplinary MSK care for the registered population of Hammersmith and Fulham CCG. Work has already begun to seek patient involvement in the designing and commissioning process, with a public event held in July 2015. The service specialties that are to be included within the Service scope are: MSK physiotherapy services; outpatient orthopaedic services; outpatient rheumatology services; and chronic MSK pain management services. The service is due to launch in May 2016.

### **Seven day GP access for Hammersmith and Fulham patients**

From September 2015, patients in Hammersmith and Fulham have had access to GP services seven days a week. The seven day GP service commissioned by the CCG allows patients to see a GP at the weekend and in the evenings on weekdays. Practices offering the service are: Brook Green Medical Centre, Cassidy Medical Centre, and Parkview Practice (Dr Canisius and Dr Hasan). Patients do not have to be registered with the practice providing seven day access, and using the service will not affect their registration with their own GP.

### **The Primary Medical Services (PMS) Review**

Hammersmith and Fulham CCG and NHS England are making good progress locally with the national review of GP's PMS contracts. Some GP practices under the PMS contract receive extra funding per patient that is not available to their colleagues who receive funding under the GMS contracting arrangements.

### **Safeguarding and the implementation of the Care Act 2014**

In April the Care Act 2014 came into force. Hammersmith & Fulham CCG has been working to make sure all accountability and assurance framework is fully up to date and correct. All adult safeguarding leads will continue to play a part in the revision of existing procedures. In addition to the standard assurance framework, the CCG undertakes regular clinical visits to ensure adults are properly safeguarded in especially vulnerable locations such as care homes.

### **Priorities 2015/16**

#### **Neuro-rehabilitation community support**

Hammersmith & Fulham CCG together with Central London and West London CCGs will introduce a new neuro-rehabilitation service in spring 2016 providing an expanded model of bed and community

based care which will:

- provide positive patient experience by substantially reducing unwarranted delay to their next phase of care
- reduce additional cost incurred due to the unwarranted increase in the length of stay in hospital
- measurable improvement in patient outcomes due to improved functional gain as a result of timely interventions and reductions avoidable complications
- quantifiable reduction in long-term (continuing care) costs due to a measurable reduction in the person's weekly on-going care costs
- support transitions in care back to localities following rehabilitation.

The aim of this service is to reduce bed-based care and support patients in their own homes and communities, while helping them return to independence as quickly as it is safe to do so.

#### **Future in mind' – improving CAMHS**

Hammersmith and Fulham CCG will implement the Future in Mind programme to improve Children and Adolescent Mental Health (CAMHS). A plan was submitted in October 2015 and we are now looking forward to commissioning new services which will include an eating disorder service for young people.

#### **Milson Road Health Centre**

The Milson Road Health Centre has been identified by Hammersmith and Fulham CCG as requiring modernisation and development, and such we are considering a number of options for the site. A project group has been established to analyse the best way forward and we will work with local residents and stakeholders to explore possible options.

#### **Modernising children services**

Subject to evaluation, the CCG will be expanding Connecting Care for Children beyond Parkview and North End practices by the close of 2016. We will also continue with our work in implementing the Children and Care Act which involves planning and support for children with disabilities. We will make sure that services like child development teams are available within the most convenient and appropriate setting. We will also be re-commissioning and re-procuring Speech and Language Therapy services for children.

#### **Tissue viability service**

Central London Community Healthcare (CLCH) has been commissioned by the CCG to provide a new tissue viability service which will fill a gap for Hammersmith and Fulham residents. We set out our plans to achieve this last year, and we are proud to be in a position to deliver them.

#### **Cardiovascular service**

The CCG will launch a new cardiovascular service in the borough in 2016. We will also be looking at the benefits of a cardiac community specialist nurse as a way of preventing or reducing avoidable admissions to hospital.

#### **Wheelchair redesign**

In March 2015, the wheelchair service redesign piece of work began. Local people across Hammersmith and Fulham, along with Brent, Barnet, Kensington and Chelsea, Westminster, Ealing, and Hounslow, were all invited to an event to kick off discussion about redesigning services and get the input of patients and carers. The service redesign is now underway and the CCG expects to commission a new wheelchair service in summer 2016.

**Joined-up 111 service across North West London**

Working in partnership with the other seven CCGs in the North West London Collaboration of CCGs, Hammersmith and Fulham CCG has begun a piece of engagement work to involve the public in the process of commissioning a new, joined-up 111 'front-end' service to operate across all eight boroughs. Engagement events with the public and GPs have been held in November 2015 and February 2016 and further engagement is planned.

**Review of asthma care**

There will be opportunities over the next year to strengthen asthma care in Hammersmith and Fulham and we intend to review the current service alongside an analysis of Long Term Conditions (LTCs) in general.

**Community Urology Service**

Two practices are piloting a community urology service [supported by Imperial]. In 2016-17, the CCG will evaluate the pilot and determine whether to extend the piloted service, or commission a new one.

**Extension of Out of Hospital Strategy**

When the six month review of the Out of Hospital Strategy is complete, will finalise our plans for delivery of the full 19 out of hospital services in the borough.

## Harrow CCG

### Achievements

- A Community Cardiology service was launched in October 2015, as a pilot, and is already working to its full capacity
- The provision of cardiology out-patient clinics in the community and BNP/ECG testing, which allows GPs to rule out heart failure by using a simple blood test, has been expanded.
- A single point of access to services for patients in the last year of life, providing a range of support services for patients and carers including a 24/7 helpline and a rapid response service, was launched as a pilot in June
- This has succeeded in avoiding hospital admissions for 90% of the patients the service has supported. Acknowledging the great work achieved, the joint team at Harrow CCG and St Luke's Hospice have been nominated as 'Palliative Care Team of the Year' at The British Medical Journal Awards 2016.
- There was an expansion of the Ophthalmology outpatient services in the community in conjunction with Moorfields Eye Hospital, enabling accessible services - locally closer to home.
- Harrow CCG has rolled out the Map of Medicine pathway tool across a range of specialties to improve the quality of referrals to secondary care as well as to optimise the skills of primary care.
- A review of rehabilitation service needs resulted in better use of community beds and more effective management of the discharge processes led to a reduction in delays in Discharging People from Hospital
- As part of our drive to introduce whole systems integrated care, virtual wards were established across Harrow to provide multi-disciplinary support to vulnerable patients in the community rather than in secondary care.
- The Single Point of Access (SPA) went live for Harrow in November 2015 and became fully 24/7 in January 2016, allowing faster pathways for urgent assessment in Secondary Mental Health Services.
- The Winterbourne Concordat was fully implemented, reducing the number of Harrow service users in long term care. By the end of March it is expected that all cases in transforming care will have been discharged.
- North West London's Clinical Commissioning Groups secured £3.8m to help raise the standard of *children and young people's mental health services* across North West London
- Harrow CCG, collaborated with Harrow local authority to plan a joint Children & Young People's Emotional Health and Wellbeing Service
- The CCG commissioned a new Children Looked After health assessment service with Harrow Council.
- In 2015, the CCG's Governing Body decided to integrate its community services to enhance the experience of patients in the community through the more effective co-ordination of services. A range of potential providers participated in a tender process that resulted in the contract being awarded to Central London Community Healthcare, an established community healthcare provider that delivers services in London and Hertfordshire. The new service will commence in summer 2016.

### Priorities

Harrow CCG has 12 commissioning intentions for 2016/17 detailing how and where it will invest in healthcare. They have been drawn up with stakeholders and reflect the needs of the local community.

### **Integrated Care**

The Whole Systems Integrated Care system continues to evolve offering patients' greater care and support in the community with the support of GP-led multi-disciplinary teams. Its initial focus is on over 65s living with one or more long-term conditions. Improvements will include a named GP and case manager for every patient at high risk of hospital admission, helping multi-disciplinary teams settle into their new role and ensuring patients have a say in their care plan.

### **Unscheduled care**

Develop a more sustainable model of unscheduled care which includes A&E, urgent care and the NHS 111 service. This includes educating the public about the best service to use, improving patient experience of A&E, establishment of patient champions, investment in community beds and continued investment in existing rapid response and walk-in services.

### **Planned care**

Harrow CCG is looking at the redesign and relocation of various care pathways in the community. This includes redevelopment of musculoskeletal pathways including trauma and orthopaedics, rheumatology, physiotherapy and pain management services. Cardiology, gynaecology and ophthalmology will also move including a 'same day' cardiology service with quick access to consultations and diagnostics. The CCG will also review the provision of dermatology, neurology, paediatrics, ENT and minor surgery services with a view to moving them into the community.

### **Mental health**

The number of people affected by mental illness is rising. Harrow CCG is commissioning 'recovery focused' mental health care which supports people to get better in the community. This will include on-going support for carers and voluntary and community groups, a renewed focus on early intervention, new care pathways, a redesign of community mental health services and jointly procuring IAPT services with Brent and Hillingdon.

### **Children and young people**

The number of births in Harrow has increased by 39% in the past decade reflecting the growing needs of children and young people. The CCG commissions the majority of services for children and plans to offer more services in home and school settings, a single point of access for advice and support, improve the transition between paediatric and adult services and improve care pathways.

### **Children and Adolescent Mental Health Service**

Mental illness is increasingly common among younger people and Harrow CCG will offer quick effective access to advice and treatment. This will include early intervention, measuring how effective treatment is, developing new care pathways, improving access to IAPT treatment and single point of access for advice and treatment.

### **Medicines management**

Medicine wastage costs the NHS more than £350m a year and Harrow CGG will support GPs to be more effective prescribers. This will include cost effective and appropriate prescriptions, supporting GP practices with advice from clinical pharmacists and medicines management teams and shared hospital and discharge summaries.

### **End of Life Care**

Palliative and end of life care are increasingly important as the elderly population grows and becomes more vulnerable to ill health. Proposed improvements include identifying people nearing the end of their lives, provision of 24/7 advice and support for people in their last year of life, greater involvement of family members and carers and ensuring the care pathway includes bereavement support.

### **Community Services**

One of the keys to improving health outcomes is moving care closer to home in the shape of community-based services. This includes community nursing, cardiology, diabetes and podiatry



services. Improvements include an agreed care plan and named case manager for all patients receiving community based support, increased investment in community nursing offering 92,700 contacts per year, and GP-led multi-disciplinary teams.

#### **Primary care**

Harrow CCG is increasingly co-commissioning primary care services with NHS England. It will use this newfound influence to help reshape primary care making it more receptive to patients' needs. This will include offering seven day a week services, a wider range of services at surgeries, an integrated diabetes strategy and better data-sharing across primary care.

#### **Continuing Health Care and Complex Care**

Harrow CCG will increase availability of personal health care budgets for people who are not in hospital but have been assessed as needing support. This will be available to people with long term conditions or a child or young person with special educational needs. It will also improve the referral process for budgets and focus on how effective they are through use of the CQC and various audits.

#### **Information technology**

The development of IT and health informatics systems hold the key to GPs getting a bigger and more informative picture about individual and collective health needs. Harrow CCG's immediate task is to ensure different clinical information about a patient is collated in the primary care record so it offers the definitive source of an individual's medical history. There will also be IT solutions allowing multidisciplinary teams to function as integrated teams, greater use of apps to improve patient understanding of alternative pathways and patients being given access to their own medical records to monitor and report on their own care.

## Hillingdon CCG

### Achievements

The CCG has achieved the following milestones during 2015/16:

- *A reduction in hospital admissions* with more than 1,500 patients helped home through ambulatory pathways and a further 200 via intermediate care services
- This, together with better psychiatric support and the creation of a mental health assessment lounge, has contributed to faster discharge times from A&E which means getting people home safely and quickly
- *A single point of access* for people wanting advice, support and referrals into mental health services. This 'one stop' approach has proved popular elsewhere in the UK
- The CCG met all its QIPP commitments for 2015/16 and has identified 80% of its targets for 2016/17 allowing the organisation to remain within budget
- *Memory Assessment Services* have reduced waiting times for first time dementia referrals to six weeks. Diagnosis now exceeds the national target of 67% and additional support is now available to dementia sufferers and their carers.
- Recruitment of 59 'dementia champions' and front-line staff are in various stages of completing *Level One, Two and Three dementia awareness training*
- Wider availability of psychological therapies for treatment of anxiety, depression and stress
- *An emergency help line for wheelchair users* who are stranded or in need of urgent support. This initiative was shortlisted for a national award.
- Provision of more pressure relieving mattresses to reduce incidence of pressure sores.
- Introduction of a community-based dermatology service for a variety of skin complaints
- The Community Learning Disability service will be expanded in line with national best practice. This will include introduction of new management arrangements to improve service efficiency
- *First aid courses* are now available to parents with young children in a joint initiative between the CCG and Red Cross  
It is hoped the training will help reduce unnecessary A&E admissions for minor ailments, such as nappy rash and minor burns and scolds. Initial feedback has been positive.
- The empowered patient programme now offers clinical and non-clinical workshops for patients and carers. The two-hour workshops focus on self-management and include cardiology, type 2 diabetes, COPD and First Aid for parents with young children)
- Progress with the implementation of the older people model of care and Accountable Care Partnership development (which involves our main providers coming together to deliver services in a more integrated fashion)
- Significant progress with mental health services– achievement of national targets and commissioning of a new non-elective (urgent) care pathway.

### Priorities

The CCG's commissioning intentions for 2016/17 have been agreed in partnership with local stakeholders. They focus on the areas of greatest need detailing how, where and when services will be commissioned.

### Integrated Care

The on-going development and implementation of the Better Care Fund and Whole System Integrated Care Programme to improve health outcomes and experience of care for frail older

people. This includes expanding the model of care for older people with one or more long-term condition as well as developing a stronger working relationship and shared accountability between the CCG and its various providers. Benefits include coordinated care for patients, increased focus on prevention, giving patients a bigger say about their own care and joint commissioning of health and social care.

### **Services for Older People**

The assessment of needs and subsequent provision of care for the elderly will be integrated between health, social care and third sector providers. Older people and their family or carers will also have a bigger say in their care. This includes co-ordinated planning and provision of care, better involvement of patients and carers in planning their care, moving from reactive to proactive care and measuring the revised service's effectiveness. This provision is underpinned by increasingly joined up IT services so patients need only tell their story once.

### **Unplanned care**

The pressures on unplanned care, such as A&E and urgent care are well documented and the CCG continues to look at ways to direct patients to the most appropriate service and avoid unnecessary hospital attendances or admissions. This will include redesigning emergency and urgent care services, implementation of seven-day-a-week working and an evaluation of the effectiveness of ambulatory emergency care. Benefits will include greater ability for unplanned care to cope with spikes in activity, increased support for people discharged at weekends and support to meet various care standards including the four hour A&E treatment target.

### **Planned care**

Greater provision of community based services closer to people's homes. This has already included the provision of community based dermatology, ENT, gynaecology, ophthalmology and urology services. It will also look at community based musculoskeletal services. Benefits include improving primary care's ability to manage patients outside of hospital, improving how patients are referred and treated, better health outcomes and reducing cost of secondary care treatment.

### **Long term conditions**

The CCG is committed to reducing health inequalities in life expectancy which is already being addressed in three 'waves' of activity that include cancer, cardiology and respiratory conditions. The next year will see better prevention, self-management and integration of services including stroke, inflammatory bowel disease and rheumatology. The CCG will also be looking at the development of a number of related initiatives, including the empowered patient programme, health promotions, screening and diagnostic services. Benefits will include integration of health services, reducing unplanned care needs, greater self-management, better health outcomes and reducing costs.

### **Mental health**

A mental health strategy is already being implemented across Hillingdon. Plans for the coming year include further improvement of dementia services, ensuring the Improved Access to Psychological Therapies (IAPT) service continues to meet local need, developing a mental health urgent care pathway, improving employment opportunities for people with mental health problems and on-going support for children and young people.

### **Children and young people**

The CCG is improving services for children and young people through a variety of measures. Its goals during the coming year include reducing the number of unplanned attendances and

admissions, greater support for vulnerable groups, improve early intervention and reconfiguring acute services to best meet the needs of young people.

### **Medicines management**

The medicines management team will continue to work with GP practices to improve medicine usage and get the best out of the medication they prescribe. Planned measures include supporting GPs to prescribe efficiently and cost effectively, greater joint working between health professionals, pharmacy advice to transformation groups and GP networks and reviewing medicine use in care homes.

### **End of Life care**

Development of a new strategy to underpin further development of effective end of life care including identifying patients earlier, providing appropriate support and advice to both themselves and their family/carers, providing integrated care and service integration across various sectors.

### **Community services**

Community services are crucial in supporting the out-of-hospital agenda along with the delivery of additional strategies, including long term conditions, and planned and unplanned care. Its focus is ensuring service integration with GP networks, offering value-for-money and ensuring services work as the 'third arm' of the health economy. Its goals include improving the quality and effectiveness of community services, greater service integration, and redesigning service specifications.

### **Primary care**

Primary care is undergoing substantial change to meet the demands of 21<sup>st</sup> century healthcare. In order to meet these demands, the CCG is adopting new models of care, integrating services with its partners and investing in its workforce. Its focus during the next 12 months will include supporting the on-going development of GP networks, improving links between primary care and public health around prevention and improving intelligence gathering. The CCG is also working closely with Brent and Harrow CCGs to ensure the availability of a skilled, adaptable and motivated primary care workforce.

### **Continuing Health Care and Complex Care**

The CCG has overseen continuing healthcare budgets (CHC) since its inception and in 2014 combined management of the service with that of Brent and Harrow CCGs. The service provides ongoing care outside of hospital to patients who meet national criteria. Patients needs are assessed by a multi-disciplinary team. Its goals for the coming year include expansion of personal health budgets outside CHC to include those with a long term conditions or a child with special educational needs, three and twelve month eligibility reviews and regular reviews to access the quality and evaluation of an individual's care package.

## **Hounslow CCG**

Some of Hounslow CCGs achievements during 2015/16 include:

### **Community recovery service**

As part of our work to empower patients by bringing care closer to home, Hounslow CCG launched a Community Recovery Service in 2015-16. The service is intended to support patients to become independent again as quickly as possible following acute illnesses or injuries, or dramatic changes in life circumstances.

Health and social care professionals from four different teams share resources to create one single talent pool, which includes physiotherapists, occupational therapists, social workers, support workers and rehabilitation assistants, and at least one specialist Parkinson's nurse and one Multiple Sclerosis nurse.

This model co-ordinates care in an efficient way, with the patient in control of their own self-management and with all information shared in a timely and secure way.

### **Care Navigator service**

GPs can refer patients to the care navigator service which helps to direct people to all the health and social care support they may need. The service helps to prevent pressure on hospital and emergency services by directing people to alternatives services and catching issues early before they need acute care. Piloted in 2014/15, the service was expanded in 2015/16 with the addition of telephone and face-to-face appointments, increasing the number of people supported to 5,000 per year.

### **Social workers in emergency departments**

In 2015/16 we supplied additional social workers in hospital emergency departments to ensure that people who are detained in hospital for a mental health assessment are seen within 48 hours, significantly reducing delays in transfers of care.

### **Social workers in GP surgeries**

Building on work from 2014/15 we extended the presence of social workers in general practice to all five localities in 2015/16 and made the service available seven days a week through our weekend GP services.

### **Out of Hospital services**

Hounslow CCG has commissioned an out of hospital services (OOHS) portfolio, with standardised specifications and prices, to replace the previous Local Enhanced Services (LES). For Hounslow CCG, the total investment of £5.5m represents an increase of £3.1m on the 2014/15 LES budget (including additional funding for extended hours). Out of hospital services have been commissioned at a GP locality level, with GPs working together in a 'federation' as a provider of choice for primary care services. The federation will be providing a range of services with standardised specifications and prices. This will ensure that, for the first time, all patients across Hounslow are able to access the same range of services.

### **Community diabetes intermediate care**

We commissioned a new Community Diabetes Intermediate Care Service with three distinct elements of service delivery that went live in May 2015. The service includes care for intermediate patients with diabetes, foot protection, and patient education. The service is providing patients in Hounslow with a robust, safe and reliable community-based diabetes care that meets their needs and improves their health outcomes.

### **Care Plans**

Using IT systems that are integrated across services as a platform for care plans for over 75s and people with long-term conditions has increased their effectiveness. In 2015/16 we offered these care plans to 7,000 local patients, supporting people more effectively and treating problems earlier to avoid hospital.

### **Transforming mental health and wellbeing services**

In 2015/16 we developed a strategic plan to transform mental health and wellbeing services across North West London. The plan involves partnership working across health and social care and other partners.

### **Primary care joint co-commissioning arrangements with NHS England**

In April 2015, Hounslow CCG entered into primary care joint co-commissioning arrangements with NHS England allowing the CCG to have more influence on the commissioning of GPs for Hounslow, enabling the CCG to better meet local population needs. Joint co-commissioning will support the CCG goals of designing integrated and joined up care with strong patient involvement.

### **Out of Hospital Strategy**

Seven day access to a GP is one of the 19 services delivered by and in GP surgeries as part of the Out of Hospital Strategy. The other 18 services include blood pressure monitoring, anticoagulation services for those on blood-thinning medication, complex wound management, ECGs, and some mental health services. All 54 GP practices in the borough will be working together to deliver these services to a common standard so that they are available to all patients, in a convenient, community setting.

### **Improvements to mental health urgent care - Single Point of Access (SPA)**

A 24/7 urgent and crisis mental health Single Point of Access (SPA) support service was successfully launched in November 2015. The service is provided by West London Mental Health Trust. Staffed by mental health professionals with psychiatrists in support, the service gives advice and reassurance over the phone, books appointments for follow-up care and, when urgent care is needed, dispatch a rapid response home treatment team to be at the caller's home within four hours. The model was developed with service users, commissioners, providers and partners including the Metropolitan Police.

### **Integrated patient transport service**

Working together with other CCGs, patients, and local community groups, Hounslow CCG has established a set of clear, enforceable standards for patient transport to ensure that quality is consistent regardless of where the patient happens to live, or where they need to travel to. The standards are known as the Quality Standards and Patient Charter, and were developed by a patient-led group called the Patient Transport Steering Group, and were also influenced by a survey of 700 patients. The Charter will be a mandatory requirement of all transport procurement going forward. A similar review of transport services to Mental Health hospitals and to community sites is also planned for the coming year.

### **Primary care joint co-commissioning**

Primary care is currently commissioned by NHS England, with very limited local influence. A number of options for co-commissioning were developed by NHS England and across North West London all eight CCGs opted to explore the potential of the joint commissioning option. Co-commissioning brings CCGs into the commissioning process for GP services and provides the potential for its alignment to local plans. Only with expanded influence through co-commissioning can the CCG be

sure that primary care can act as a driver for our ambitious plans for transforming the local health and care economy.

Specifically, co-commissioning provides the opportunity for the North West London CCGs to commission new primary care services that meet specific local needs; to develop additional incentives for GPs to work to local health priorities; and to exert increased influence over quality improvement and primary care premises.

By aligning this with the rest of our on-going transformation work, we believe that we can secure the following patient benefits:

- services that are joined up, coordinated, and easily navigated, with more services available closer to people's homes;
- high quality out-of-hospital care;
- improved health outcomes, equity of access, reduced inequalities, and better patient experiences; and
- enhanced local patient and public involvement in developing services, with a greater focus on prevention, staying healthy, and patient empowerment.

In March 2015 member practices voted in support of the CCG entering into joint primary care co-commissioning arrangements with NHS England.

A joint co-commissioning committee has been established with NHS England, which has decision-making power over primary care in our area. It includes a range of clinical, executive, and lay members and it will be advised by our local Healthwatch committee and Health and Wellbeing Board. London-wide LMC was consulted throughout the design of the co-commissioning structure and will also advise the joint committee on its work.

### **£3.8m boost to young people's mental health services**

In January 2016, £3.8 million was awarded to CCGs across North West London, including Hounslow CCG, to deliver their mental health plan for children and young people. The CCG's plan for the cash aims to improve the quality of and access to mental health services for young people.

### **Quality Deep Dive**

The shared Quality Team of the CWHHE Collaborative of CCGs prepared and executed a 'deep dive' into quality as part of the NHS England assurance process. The exercise identified successes and areas to focus on over the next year.

### **NHS Health devolution in London**

London's CCGs and London Councils have agreed to work closely together to go further and faster in integration and collaboration using devolution as a tool to achieve this. NHS England and Public Health England as well as central government all agree to support this agenda by being active partners in the pilots and demonstrating a shared commitment to health and care devolution in London. The parties to the 'London Health and Care Collaboration Agreement' are:

- all 32 London Clinical Commissioning Groups (CCGs);
- all 33 local authority members of London Councils;
- the Mayor;
- NHS England; and
- Public Health England.

The London Health Devolution Agreement has been signed by these parties in addition to central

government.

#### **Dementia diagnosis rate success**

Hounslow CCG is working hard with its partners at the council to improve dementia diagnosis rates. Our work so far has included providing greater support for GPs in identifying and referring patients to memory assessment services, commissioning more frontline services, such as dementia-specialist nurses and ensuring there is sufficient post-diagnosis support in place so as to encourage patients to get help faster in the earlier stages of the condition.

#### **IAPT Hounslow continues to improve mental health services access**

Hounslow continues to promote and invest in local talking therapies services through the IAPT (Increasing Access to Psychological Therapies) service for residents who are experiencing serious but non-urgent mental health problems such as anxiety, stress, sleep problems, and depression. Talking therapies are delivered at a number of locations across Hounslow, including some GP practices, health centres and community venues. Therapies available include: computer-based CBT (cognitive behavioural therapy); mindfulness courses; stress management courses; and postnatal support groups.

#### **Safeguarding and the implementation of the Care Act 2014**

In April the Care Act 2014 came into force. Hounslow CCG has been working to make sure all accountability and assurance framework is fully up to date and correct. All adult safeguarding leads will continue to play a part in the revision of existing procedures. In addition to the standard assurance framework, the CCG undertakes regular clinical visits to ensure adults are properly safeguarded in especially vulnerable locations such as care homes.

#### **Setting Up a children's paediatric assessment unit (PAU) at West Middlesex Hospital**

The Paediatric Assessment Unit (PAU) at West Middlesex Hospital has been operational since 21st September 2015. The PAU is a six-bedded unit that provides rapid assessment of children and young people who require a length of stay in hospital of less than 24 hours, and aims to assess, treat and discharge home as early as clinically safe. In most cases, children are referred to the PAU from their local GP, the Urgent Care Centre (UCC) or A&E department at WMUH. Since opening, the PAU has seen over 2,300 children and young people. The PAU has enabled WMUH to more effectively manage the additional non-elective activity generated as a result of the Ealing transition. The PAU means that children can be moved out of the UCC and A&E more quickly and inpatient stays of less than 24 hours are reduced. Paediatric consultants are based in the PAU 8:30am-10:30pm, seven days a week and during this time they are able to provide specialist advice to GPs via the PAU telephone hotline.

#### **Priorities year a head**

Hounslow CCG will introduce or continue to develop a number of service areas including:

#### **Review long-term conditions service specifications**

Hounslow CCG will set up a commissioner group to review Long-Term Conditions (LTCs) service specifications and ensure robust performance management of self-management programmes before April 2017. We expect to see a clear improvement in outcomes for patient as a direct result.

#### **Patient transport improvements**

Hounslow CCG plans to commission a new integrated non-emergency patient transport service, and coordinate fully with hospital discharge procedures. Our aim is for patients to have access to this new service from spring 2017. We will work in association with North West Surrey CCG on procuring



this important new resource for patients.

### **The Primary Medical Services (PMS) Review**

Hounslow CCG and NHS England are making good progress locally with the national review of GP's PMS contracts. Some GP practices under the PMS contract receive extra funding per patient that is not available to their colleagues who receive funding under the GMS contracting arrangements. The purpose of the PMS review is to ensure that this extra PMS funding is aligned to services which best meets the needs of all of the local population, and that where it isn't, it is reinvested to the benefit of all GP practices and all patients across the CCG area.

### **Outcome-based GP contracts**

Building on the out of hospital contracts, Hounslow CCG will be commissioning a set of enhanced primary care services above the core level which represent the role of primary care within whole systems and develops the new model of care. Additional services will be made available to patients in a primary care setting, and patients will see stronger continuity of care, with a refreshed emphasis on prevention.

### **Pathology service**

The CCG will commission a new pathology service as part of a wider programme to expand pathology care across North West London. We envisage the new service to be up and running by the end of 2016.

### **Community ophthalmology service**

Hounslow CCG has made plans to commission a new community service following an evaluation of current performance. The procurement process is due to begin soon with a view to the service being ready to go live by March 2017. By bringing services into the community patients will be able to access care in a convenient setting, which will usually be closer to home.

### **Chronic obstructive pulmonary disease (COPD) review**

There will be a full scale evaluation of the chronic obstructive pulmonary disease (COPD) services after which Hounslow CCG will decide whether to extend the current contract with BOC Clinical Services which provides Home Oxygen Therapy Assessment and Review, Pulmonary Rehabilitation services, and help with self-management.

### **Ears, nose and throat service**

Before the end of 2016, Hounslow CCG will have commissioned a new ears, nose, and throat service for people living in or registered in the borough, and it will be up and running. It will be a community service, so that patients can access safe, quality care as close to home as possible.

### **Help for people in extra care accommodation**

Hounslow CCG is going to look at gaps in the provision of health (including mental health) residents living in extra care accommodation, and, as required, identify potential areas for additional services to be delivered at these sites and build into the specifications. This will include the development of supported housing for complex mental health needs, and more rehabilitation and recovery services being made available for patients through supported housing. People should be able to access the facility from April 17.

### **Care navigators**

The evaluation that we carried out on 2014-15 revealed that we need stronger integration across health and social care, and that there needs to be an effective care navigator service working across health, social care, and the third sector at a local level in Hounslow. We have a high number of

residents with complex needs and complex lifestyles in Hounslow, so the CCG is proud to say we will be commissioning a new care navigator service in line with the recommendations of last year's evaluation.

#### **Better Care Fund**

Hounslow CCG will continue to implement the policies outlined in the documents around the 2016-17 Better Care Fund (BCF) projects and will continue to commission the 2015-16 projects in accordance with national guidance.

#### **Urgent mental health care**

As part of our long-term plan to achieve parity for mental health in the NHS, Hounslow CCG will be procuring new urgent care services specifically for mental illness. We will make sure there is a fully staffed and mobilised service. We will also be reviewing the existing urgent care facilities for people experiencing a mental health problem and evaluating the effectiveness of the care pathways with a particular target of achieving faster response times. In addition to all this, Hounslow CCG intends to re-commission the fully-funded CAMHS out-of-hours service.

#### **Primary care mental health**

Hounslow CCG is reviewing its performance to determine the demand and capacity of Primary Care Plus, including the workforce and contracting implications, to support the development of a new specification for 2017. This may develop as part of our plans to integrate health and social care more closely.

#### **Accountable Care Partnerships (ACP)**

With the other CWHHE CCGs, as well as the providers, local authorities, and other partners we work with, Hounslow CCG will establish an ACP with a fully integrated organisation structure, common systems, and responsibility for shared outcomes and pooled and capitated budgets for the population covered. This work will take place as part of the GP outcomes-based contract project.

#### **Cancer guidelines**

Cancer is a tremendously important condition to our residents and patients. By April 2017 Hounslow CCG will have implemented the National Cancer Guidelines in full.

#### **Urgent mental health services – SPA Single Point of Access**

We will be working with West London Mental Health NHS Trust to improve access to urgent mental health services. This includes implementing a single point of access and reconfiguring teams to deliver a service which is able to respond to the needs of patients in crisis. We will also be working with the local authority to ensure that there is a Child and Adolescent Mental Health Service (CAMHS) professional available 24 hours a day to respond to young patients in crisis.

#### **Developing health and wellbeing hubs**

Hounslow CCGs long-term plan is to ensure reliable access to health and wellbeing hubs. These hubs will provide a range of integrated services, closer to people's homes.

## **West London CCG**

Some of West London CCG achievements in 2015/16 include:

### **Community Independence Service (CIS)**

The service involves a team of a GP, a social worker, a hospital consultant, a community matron, nurses and therapists, a health and social care coordinator, and a personal case manager to support the patients by providing care in their own home. The service has been extended to cover residents of Westminster and Kensington & Chelsea, as well as residents of Hammersmith and Fulham where it was initially set up. Imperial College Healthcare NHS Trust was appointed to coordinate the service as a lead health provider in 2015/16 and in the year ahead commissioners are proceeding with a new full procurement.

### **Local Services Strategy**

Seven day access to a GP is one of the 19 services delivered by and in GP surgeries as part of move to provide more services away from hospital settings and closure to people's homes. Other services include:

- Blood pressure monitoring;
- Anticoagulation services for those on blood-thinning medication;
- Complex wound management;
- ECGs,
- Some mental health services.

All GP practices in their respective CCGs will be working together to deliver these services to a common standard so that they are available to all patients, in a convenient, community setting.

### **Improvements to mental health urgent care - Single Point of Access (SPA)**

A 24/7 urgent and crisis mental health Single Point of Access (SPA) support service was launched successfully in November 2015. The service is provided by Central and North West London NHS Foundation Trust (CNWL) and has been available to Westminster residents since November. Staffed by mental health professionals with psychiatrists in support, the service gives advice and reassurance over the phone, books appointments for follow-up care and when urgent care is needed, dispatches a rapid response home treatment team to be at the caller's home within four hours. The model was developed with service users, commissioners, providers and partners including the Metropolitan Police.

### **Integrated patient transport service**

Working together with other CCGs, patients, and local community groups, West London CCG has established a set of clear, enforceable standards for patient transport to ensure that quality is consistent regardless of where the patient happens to live, or where they need to travel to. The standards are known as the Quality Standards and Patient Charter, and were developed by a patient-led group called the Patient Transport Steering Group, and were also influenced by a survey of 700 patients. The Charter will be a mandatory requirement of all transport procurement going forward. A similar review of transport services to Mental Health hospitals and to community sites is planned for the coming year.

### **Primary care joint co-commissioning arrangements with NHS England**

In April 2015, West London CCG entered into primary care joint co-commissioning arrangements with NHS England allowing the CCG to have more influence on the commissioning of GPs for Kensington & Chelsea and Queen's Park & Paddington, enabling the CCG to better meet local population needs. Joint co-commissioning will support the CCG goals of designing integrated and joined-up care with strong patient involvement.

### **£3.8m boost to young people's mental health services**

In January 2016, £3.8 million has been awarded to CCGs across North West London, including West London CCG, to deliver their children's and young people's mental health plan. The CCG plans to use these funds to improve the quality of and access to mental health services for young people.

### **Improvements to services at St Mary's**

Vocare Ltd, an experienced nationwide provider of urgent care services nationwide was appointed to run the urgent care centre at St Mary's Hospital in Paddington. The St Mary's Hospital Urgent Care Centre (SMHUCC) will continue to operate a highly accessible service, 24/7 throughout the year.

### **Quality Deep Dive**

The shared Quality Team of the CWHHE Collaborative of CCGs prepared and executed a 'deep dive' into quality as part of the NHS England assurance process. The exercise identified successes and areas to focus on over the next year.

### **Seven day GP access**

Residents now have access to GP services seven days a week. The seven day GP service commissioned by the CCG allows patients to see a GP at the weekend and in the evenings on weekdays. Patients do not have to be registered with the practice providing seven day access, and referral to a GP during these hours will not affect their registration with their own GP.

### **Integrated care service for over 65s**

The Whole Systems Integrated Care service is commissioning a variety of new services at integrated care centres. St Charles Integrated Care Centre opened in autumn 2015 and another integrated care centre in Chelsea will be operational from spring 2016 at the Violet Melchett Centre once essential building work there has been completed. The team behind Whole Systems has worked with local patients and provider partners including GPs, hospitals, community services, adult social care and voluntary organisations such as Age UK, to develop the service. The St Charles Integrated Care Centre will house social care staff, a pharmacist, a community dementia nurse, basic foot care services, an Open Age centre, cardiology and respiratory services, and a consultant geriatrician all on site. It will launch in June 2016.

### **The Primary Medical Services (PMS) Review**

West London CCG and NHS England are making good progress locally with the national review of GP's PMS contracts. Some GP practices under the PMS contract receive extra funding per patient that is not available to their colleagues who receive funding under the GMS contracting arrangements. The purpose of the PMS review is to ensure that this extra PMS funding is aligned to services which best meets the needs of all of the local population, and that where it isn't, it is reinvested to the benefit of all GP practices and all patients across the CCG area.

### **Investing in NHS estates**

The CCG has invested in NHS premises locally to make sure that there is a sufficient capacity to provide services in the community and out of hospital settings where it is safe to do so. The St Charles Centre health hub is one example of this and Violet Melchett, due to open later in 2016, is another.

### **Priorities year ahead**

### **Neuro-rehabilitation community support**

West London CCG together with Central London and Hammersmith and Fulham CCGs will introduce a new neuro-rehabilitation service in spring 2016 providing an expanded model of bed and community based care which will:

- provide positive patient experience by substantially reducing unwarranted delay to their next phase of care
- reduce additional cost incurred due to the unwarranted increase in the length of stay in hospital
- measurable improvement in patient outcomes due to improved functional gain as a result of timely interventions and reductions avoidable complications
- quantifiable reduction in long-term (continuing care) costs due to a measurable reduction in the person's weekly on-going care costs
- support transitions in care back to localities following rehabilitation.

The aim of this service is to reduce bed-based care and support patients in their own homes and communities, while helping them return to independence as quickly as it is safe to do so.

### **Community Independence Service (CIS)**

West London CCG will be introducing the Community Independence Service (CIS) to deliver a coordinated rapid and responsive out of hospital care for people with acute needs, provided by health and social care teams working together in a co-ordinated way across Westminster and Kensington & Chelsea. This will be an expansion of the service already operating in Hammersmith and Fulham with great success. The Tri-borough CCGs have commissioned a single provider to manage the new financial investment of £1.7 million over 2015-16 to ensure appropriate staffing levels for the expected increase in referrals and delivery to the new specification across all boroughs. This programme is a new way of working with local authority colleagues where solutions for patients are identified and implemented across organisational boundaries seamlessly, with the patient and their family at the heart of decision making.

### **Urgent care baseline review**

West London CCG will conduct a baseline review of all urgent care services with a plan to develop an integrated urgent care business case.

### **Out of hospital services portfolio**

Our member practices are already working together in the West London GP Federations to ensure equity of access for patients. In 2015/16 our GP practices continued working together in this way to start to deliver 19 services over and above the core contract, such as complex wound care, phlebotomy and management of complex common mental health problems, ensuring access to all services across the whole population by April 2016.

### **Seven day GP access**

From May 2016, residents in the West London CCG area will have access to a GP seven days a week, including in the evenings from Monday-Friday. The service will be primarily for pre-booked appointments but there will be an allocation of time for urgent primary care needs to be met as well. Patients who need a GP in the evening or at the weekend will be referred to a GP at the St Charles Integrated Care Centre or at the Violet Melchett Centre.

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## North West London Joint Health Overview and Scrutiny Committee (NWL JHOSC) Arrangements for Next Municipal Year

### Recommendations

The committee members are asked to note the contents of this report and agree to:

1. Instruct support officers to put in place arrangements for the NWL JHOSC annual meeting, and as soon as practicable:
2. Seek local agreement on whether their borough will continue to participate on the NWL JHOSC
3. If continuing to participate provide details to officers of the elected members who will represent their borough on the NWL JHOSC
4. Note that the position of Chair and Vice-chair will need to be agreed at the annual meeting

### 1. Introduction

- 1.1 According to its terms of reference the Committee is required to hold an annual review of its work in May of each year, or as soon as practical thereafter, where it will consider and decide whether there is a need for the NWL JHOSC to continue or whether it has fulfilled its remit.
- 1.2 At this annual meeting it is intended that the Committee will also, in consultation with the North West London Collaboration of Clinical Commissioning Groups, agree a work programme for the forthcoming municipal year.
- 1.3 This reports provides guidance to the Committee on what steps each individual borough will need to undertake in advance of the annual meeting.

### 2. Current Status

- 2.1 The North West London Joint Health Overview and Scrutiny Committee (NWL JHOSC) was formed by the London Boroughs of North West London at the request of NHS North West London as part of the statutory consultation process for *Shaping a Healthier Future (SaHF)*. The NWL JHOSC held its first meeting in July 2012 and completed its review of the hospital reconfiguration consultation in November 2012 with the submission of its final report to the NHS. This submission completed the NWL JHOSCs statutory role in the reconfiguration process<sup>1</sup>.
- 2.2 In November 2013, following the final decision on the structure of the reconfiguration setting out which hospitals would be developed as major and local hospitals, the North West London Collaboration of Clinical Commissioning Groups submitted a report to the NWL JHOSC requesting that

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<sup>1</sup> Local authorities are required to appoint joint scrutiny committees where a relevant NHS body or health service provider consults more than one local authority's health scrutiny function about substantial reconfiguration proposals. When the joint scrutiny committee completes its review they can submit recommendations to the NHS body with the health service required to respond to these recommendations.

the Committee continued to provide a forum where issues relating to *SaHF*, which cross borough boundaries, could be scrutinized and discussed.

- 2.3** At the 6<sup>th</sup> August 2014 meeting the NWL JHOSC operated under provisional arrangements with Cllr Mel Collins (LB Hounslow) acting as interim Chair. When the Committee reconvened in the autumn it reconfirmed its terms of reference and set out a work programme to reflect the business planning and implementation timeframe of the *SaHF* programme.
- 2.4** Revised Terms of Reference were agreed at the 16<sup>th</sup> October 2014 meeting and the Committee has met three times since then, the last meeting held on 14<sup>th</sup> October 2015.
- 2.5** To ensure that proper governance arrangements are in place for the Committee alongside a structured work programme the annual meeting is required to:
- Confirm the NWL JHOSC wishes to continue
  - Elect a Chair and Vice-chair
  - Agree a work programme for the year
  - Review the terms of reference of the Committee, and
  - Agree how member boroughs will provide ongoing officer support
- 2.6** This is to provide a clear understanding for all stakeholders of the role and remit of the Committee and the areas of the *SaHF* programme that it wishes to focus on, and to provide member boroughs with an indication of the timelines and resources required to ensure the Committee can effectively fulfil its remit.
- 2.7** In order to facilitate this process each borough is requested as part of their own health scrutiny planning arrangements to consider the points above at paragraph 2.5 and to request their officers to liaise with officers from the London Borough of Hounslow so that arrangements for the annual meeting can be put in place.
- 2.8** For reference the current terms of reference and committee membership is set out at Appendix A below.



## APPENDIX A

### North West London Joint Health Overview and Scrutiny Committee Terms of Reference

#### 1. Membership

Membership of the NWL JHOSC will be two members from each participating council. In terms of voting rights each borough will have one vote. Individual boroughs may nominate co-optees to be their second representative as a non-voting member (only elected members may vote on behalf of a borough).

As of 16<sup>th</sup> May 2016 the membership of the JHOSC consists of the following boroughs and elected members:

London Borough of:	First Member	Second Member
Brent	Cllr Matt Kelcher	Cllr Mary Daly
Ealing	Cllr Theresa Byrne	Cllr Peter Mason
Hammersmith & Fulham	Cllr Rory Vaughan	Cllr Sharon Holder
Harrow	Cllr Rekha Shah	Cllr Vina Mithani
Hounslow	Cllr Melvin Collins	Cllr Myra Savin
Kensington & Chelsea	Cllr Charles Williams	Cllr Wil Pascall
Richmond	Cllr John Coombs	Cllr Liz Jaeger
Westminster City Council	Cllr Antonia Cox	Cllr Barbara Arzymanow

#### 2. Quorum

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

#### 3. Chair and Vice Chair

The NWL JHOSC will elect its own chair and vice chair.

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.

#### 4. Duration

The planned implementation timeframe for *The Shaping a Healthier Future Programme* runs up to 2018. It is proposed that the NWL JHOSC operates alongside the implementation programme up to 2018 with its duration expanded should the SaHF programme run beyond this date.

It is important that the NWL JHOSC operates on the basis of being able to contribute to the effective scrutiny of cross-borough issues relating to SaHF and provides a forum for cross borough engagement and consultation between its member local authorities, and health service commissioners and providers. As such, it is proposed that 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 NWL JHOSC to continue or whether it has fulfilled its remit and should terminate earlier than 2018. This would not preclude individual local authorities from giving notice at the NWL JHOSC annual meeting of their intention to withdraw from the Committee. Should there be any proposals for a JHOSC beyond this date, this would

be considered by each participating authority in line with its own constitution and policies.

#### **5. Remit of the NWL JHOSC**

In recognition of the decision of the NWL JHOSC at the November 2012 meeting the Committee's remit will be based on performing 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 with cross borough implications.
2. 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.
3. 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 NWL JHOSC is to consider issues with cross-borough implications 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.

At each annual meeting the NWL JHOSC will develop, in consultation with the North West London Collaboration of Clinical Commissioning Groups, a work programme for the forthcoming municipal year based upon their agreed remit.

Individual local authority members of the NWL 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 NWL JHOSC will not preclude any scrutiny or right of response by individual boroughs.

In particular, and for the sake of clarity, the NWL JHOSC is a discretionary joint committee and therefore is not appointed for and nor does it have delegated to it the functions or powers of the local authorities, either individually or jointly, under Section 23(9) of the local authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

This means that in accordance with the Regulations and subsequent non-statutory guidance the power of referral to the Secretary of State is not delegated to the NWL JHOSC but retained by individual boroughs.