



North West London
Primary Care Trusts

NWL COLLABORATIVE PROGRAMME

NWL COLLABORATIVE COMMISSIONING INTENTIONS 2009-2014

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SECTION 1

FOREWARD

This Collaborative Commissioning Intentions Plan describes a five year strategy for commissioning at a supra-PCT level. It draws on the Commissioning Strategies developed for each of the eight PCTs in NWL (NWL) and the Healthcare for London (HFL) programme, focusing specifically on those areas where there is significantly greater value in commissioning collectively than individually.

The Plan is the product of joint working between the eight PCTs and their respective partner organisations; the public and clinicians. The work is overseen by the Collaborative Commissioning Group (CCG) which is the Executive arm of the Joint Committee of the NWL PCTs (JCPCT). Details of how the plan will be delivered are described in Section 5 and the governance arrangements for the JCPCT and its sub-committees are outlined in the NWL Collaborative Governance Arrangements (Appendix 1).

The plan sets out the JCPCT's vision for healthcare in NWL over the next 5 years within the context of the current health status of the population served; the level and quality of healthcare provision in NWL and the challenges identified through the local needs assessment work and the work of the Clinical Reference Group and associated Clinical Networks. From this a set of strategic objectives have been derived that outline the programme of work for the next 5 years. Specific initiatives to deliver these objectives in the short and longer term are then described in more detail with an assessment of any risks and how success will be measured and monitored.

The CCI was developed through a series of planning workshops with key partners to agree the approach content and feedback mechanisms and to determine the overarching Vision, Values, Strategic Objectives and Prioritisation Criteria.

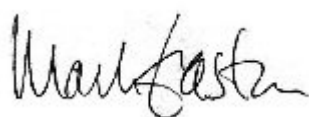
Participants in the development of this plan are listed below.

NWL PCTs

Brent	Hillingdon
Ealing	Hounslow
Hammersmith & Fulham	Kensington & Chelsea
Harrow	Westminster

NWL Clinical Reference Group; NWL Clinical Networks; NWL Specialist Commissioning Group; Local Boroughs – through the CSPs; Patients and the Public – PCT engagement events and routine feedback mechanisms.

This collaborative plan is a key component of the developing strategy for health improvement across London and should be read in conjunction with PCT Commissioning Strategy plans and the Healthcare for London plans. Although describing a 5 year time period, the initiatives will be refreshed annually.



Mark Easton
Chair, NWL Collaborative Commissioning Group
March 2009

EXECUTIVE SUMMARY

This Collaborative Commissioning Intentions (CCI) Plan describes a five year strategy for commissioning at a supra-PCT level for the eight PCTs in NWL (NWL). The plan sets out over five chapters the vision for health and healthcare for the population of NWL; the environment in which we operate; our strategic plan; and how we intend to deliver the proposed changes.

VISION AND VALUES

Vision

Over the next 5 years the PCTs in NWL will work together, where this adds value, to transform the health and well being of existing and new and changing populations.

The aim is to improve health, reduce inequalities and transform the quality and delivery of health services for the population of NWL, building on work within individual PCTs and the Healthcare for London programme (Better Health, Better Healthcare).

This will be achieved through the development of strong and sustainable partnerships with patients and the public; providers of healthcare; and health and social care within the world class commissioning framework.

VALUES

Working together for patients. We put patients first in everything we do. We put the needs of patients and communities before organisational boundaries.

Improving lives. We strive to improve health and well-being and people's experiences of the NHS.

Everyone counts. We use our resources for the benefit of the whole community, and make sure nobody is excluded or left behind.

Commitment to quality of care. We ensure continuous service development led by clinicians in partnership with patients, founded on the best international research and practice.

Partnerships in care. We will strengthen partnerships between commissioners, patients/public, healthcare providers, local authorities and the third sector so that the public receive equitable and appropriate care.

Strategic investment of resources. We will develop joint investment/disinvestment strategies that ensure the best use of taxpayers' money.

CONTEXT

This section of the plan sets the scene for the development of the collaborative commissioning strategy. It describes the demographics and health status of the population of NWL; how healthcare is currently provided, in terms of the way care is provided, the structures through which care is delivered and the level of investment; and the local and national context within which we operate. Insights from patients, public, clinicians and partners have then been sought to shape and focus the plan going forward.

The health system in NWL is highly complex – ranging from small GP practices providing primary care locally to major teaching hospitals conducting cutting edge specialist research and treating patients from across the country including the first Academic Health Sciences Centre in the UK based at Imperial Healthcare Trust.

Demographics and Health Status of the Population

- The NWL sector covers eight PCTs with a resident **population** estimated at 1.85 million people (ONS data).
- The population is predicted to grow by 3.9% over the next 10 years. Growth in PCT populations appears to be concentrated more in the inner boroughs.
- The overall growth disguises variation in growth rates by age band. For those PCTs with the highest predicted growth, the greatest growth appears to be in the 0-15 age band and the 45-64 age bands.
- There is considerable variation in **ethnic composition** of the PCT populations.
- The greatest change in ethnic profile over the next 10 years will be in the white population with an overall decrease of 4%. By contrast, both the Asian and Chinese & Other populations are predicted to rise by around 2% each.
- The population of NWL is not particularly **deprived** when viewed in the round. However, the PCT rankings vary from 53 (NHS Brent) which is the most deprived in the sector to 205 (NHS Harrow) which is the least deprived in the sector. Even at PCT level, the rankings disguise significant pockets of deprivation.
- NWL sector average life expectancy is above the England and London average for both males and females.
- There are wide differences in health outcomes for various diseases. However, these differences in health outcomes can be attributed to differentials that exist in socio-economic groups, ethnicity, pockets of deprivation in wards across PCTs and also differences in lifestyle and behaviour.
- There are no significant variations in prevalence rates between 2006/7 & 2007/8 across the NWL sector for most diseases. However, for a number of diseases there are noticeable variations in prevalence rates at PCT level.

Four diseases have a large impact on the health and well being of the population of NWL.

Coronary Heart Disease (CHD)

- CHD is one of the main causes of death for all NWL PCT's, with higher premature mortality in higher deprived or ethnic populations. Borough level rates mask large inequalities. However, all PCT's improved the CHD mortality rate from 2003-2006.
- The prevalence of CHD is not predicted to change significantly in NWL over the next 12 years.

- Future treatment priorities will include ensuring access to cardiac rehabilitation, developing community based heart failure services and end of life care and ensuring the management of angina patients is optimised.

Stroke

- Stroke is the commonest cause of severe disability in adults.
- Increased incidence of stroke is strongly associated with ageing
- High numbers of strokes are predicted in specific wards in the outer NWL PCTs (Ealing, Brent, Harrow and Hillingdon) which will need to be taken into account in determining the geographical configuration of stroke services.

Cancer

- Cancer treatments and services have improved dramatically over last seven years. NWL has the fourth lowest mortality rate for cancer in England (2008).
- The incidence rates per 100,000 of population are greater for breast cancer and prostate cancer, and lowest for colorectal and lung cancer.
- For most tumour sites, the earlier a cancer can be diagnosed, the better the clinical outcomes.
- Screening programmes and awareness-raising are vital in combating the disease.

Diabetes

- Diabetes is becoming a more common condition world-wide. It can affect people of all ages in every population.
- Significant inequalities exist in the risk of developing diabetes, in access to health services and the quality of those services, and in health outcomes, particularly with regard to people with Type 2 diabetes.
- The prevalence rate in NWL is slightly higher than the England average with little change in prevalence predicted to 2010.
- However, the NWL average disguises significant differences in prevalence rates between the PCTs. Harrow, Ealing, Brent and Hounslow all have prevalence rates above 5% which probably relates to their high ethnic populations.

How healthcare is currently provided

Provider landscape

NWL PCTs commission healthcare from a wide range of providers. The health system in NWL is highly complex – ranging from small GP practices providing primary care locally to the UK's first Academic Health Science Centre, which brings together the delivery of healthcare services, teaching and research in a single organisation, in partnership with the wider West London healthcare community. There are 7 Acute Trusts, 2 Mental Health Trusts and **8 PCT provider services, which have formed 4 groupings: Inner NWL Alliance; Hounslow with Richmond & Twickenham; Ealing & Harrow; and two borough based APOs; Brent and Hillingdon.**

Hospital Trusts

All of the acute non-FT Trusts have been rated as amber or red in relation to the quality and safety of their services for 2008-9. Three Trusts failed to meet the A&E, 4 hour target and five Trusts declared not met/insufficient assurance on at least 1 national core standard in 2007-8.

The PCTs purchased the following activity from acute providers in 2007-8

Type of activity	Quantity
<i>Acute Trusts</i>	
Spells	519126
Outpatients	2054725
A&E	790291
<i>Mental Health Trusts</i>	
Occupied bed days	612506
Day cases	68504
Outpatients	92627

NHS London is currently undertaken a stock take of acute provider ability to achieve FT status in the light of HfL projects and changes to commissioning. This is likely to signal a strategic review of provider services within NWL. This has already been anticipated and an initiative is included within section 4 of the CCI.

Community Providers

NHS London has requested all PCTs to demonstrate how they will achieve full Autonomous Provider Organisation (APO) status for their provider arms by April 2009, and to complete the externalisation process by April 2010. Plans in NWL are outlined below:

Inner London Alliance

The Alliance for NHS Community Services in inner NWL brings together the provider services arms of the PCTs in Westminster, Hammersmith & Fulham and Kensington & Chelsea. The Central West London Community Service was formed in July 2008. The current Alliance falls short of full integration as statutory accountability for the performance of each of the provider services arms remains with the respective host PCT. However, it provides a framework within which to test future models to achieve full integration. A single over-arching management team has been established and a Joint Provider Committee (JPC) has been created as a formal sub-committee of each PCT Board.

Whilst the institutional end point for many community services within the Alliance is not completely clear, the three PCTs are currently exploring a range of organisational options for the future management and delivery of their community services. These include options within and external to the NHS, including joint ventures. **The JPC proposed the formation of a Community Foundation Trust (CFT) to the PCT Boards for consideration in January 2009. The proposal to form a CFT was accepted.**

Outer NWL Federation

PCTs in outer NWL (Brent, Harrow, Hillingdon, Hounslow and Ealing) have established a range of vehicles to take their community services forward. Hounslow has linked with Richmond & Twickenham, Ealing has linked with Harrow, and two borough based APOs have been formed in Brent and Hillingdon. As with the inner grouping the aim is to create fit-for-purpose organisations that can compete in a market environment

The strengths and weaknesses of Provider services are described throughout the CCI. These are summarised at a high level below.

Strengths: Three teaching hospitals, one of these is the UK's first AHSC
Broad range of local provision
Progress being made in terms of reducing waiting times for treatment

Weaknesses: Performance against HCC reports (Urgent Care & Maternity) and National Sentinel Stroke Audit is mixed with some providers achieving best performing and others least well performing.
Two NWL Acute Trusts (NWLH & WMUH) reported material financial variance at Month 4. NWLH is forecasting to achieve a breakeven plan and WMUH is forecasting a £1m variance from plan.
Provider arm capacity and understanding of services being provided.
Fragmentation of services

Market development plans

Market development plans are still in their infancy and have mainly been initiatives within individual PCTs. The externalisation of PCT Provider services is the first step in shaping the market for community care, although it is not anticipated that there will be major changes in service provision before 2010-11. The development of independent sector provision of acute care has not resulted in the expected level of change anticipated by the DOH and within NWL and there is sufficient capacity within the acute trusts to deliver 18 weeks resulting in under-utilisation of the DH agreed ISTC provision. The main drivers for change on the supply-side will be the Healthcare for London programme, particularly in relation to Stroke, Urgent Care, the Local Hospitals project and Polyclinics, and the development of a NWL Children, Young People and Maternity Services network. Both the Healthcare for London programme and the Paediatric work is likely to lead to changes in the provider landscape within NWL.

Healthcare provision

The focus of the NWL collaborative programme over the last 18 months has been on reviewing clinical scale, capacity and quality.

In prioritising their collaborative work programme for 2007-9, the CCG paid close attention to a number of recent reviews (Sentinel audit, Health Care Commission reviews) which demonstrated a high level of variability between services in the sector and a variation from national averages.

As for other sectors in London, a number of clinical service reconfigurations had been implemented in NWL over the last 5 years to address issues of patient safety as well as clinical quality to achieve better health outcomes (e.g. concentration of vascular surgery within a network arrangement; reconfiguration of NICU providers into a network; implementation of the recommendations in the Coronary Heart Disease NSF through the Cardiac network; merger of the St Mary's and Hammersmith Trust renal units to create a single lead centre for the sector etc.). These changes were supported by PCTs working with their providers to deliver improved clinical pathways with consideration of the access, capacity and workforce implications.

During 2005-7, the focus on commissioning of health services had been on the delivery of national access targets and on ensuring value for money. Over the last 12-18 months, the focus has changed, as a result of the work of the CRG, endorsed by the CCG, on improving the quality of services provided to the people of NWL. For example, improving access to primary care, maternity and neonatal care and

reshaping unscheduled care services is known to improve both the quality and health outcomes from an intervention. A collaborative approach to commissioning paediatric surgery and acute stroke services both derive from evidence used successfully elsewhere to show that current service configurations do not yield the best outcomes.

The development of national standards of care has provided a means of measuring the quality of care provision (see data on stroke care as an example of this) and this approach is being adopted in SLAs to ensure that all providers are working to deliver the same level of quality. The development of true outcome measures (as opposed to structure or process measures used as a proxy for outcome) is in its infancy. However, some excellent work on 'Monitoring Clinical Outcome, Patient Experience and Equality and Diversity Metrics for SLA 2008-2009' is underway as part of the SLA with Imperial Healthcare. This work has been tested during 2008-9 and will be rolled across the sector in 2009-10.

The CRG also agreed an ambitious programme of work during 2008-9 on understanding variability across patient pathways with the intention of developing pathway indicators to support targeted interventions, leading over time to **improvements** in care within NWL. The initial phase of this work was completed in October 2008.

It is this variation in performance and a commitment to achieving levels of health and health care comparable with the world's best which are the drivers for the NWL strategy over the next 5 years.

Investment in healthcare

Total investment in healthcare in the sector will be around £3.3 billion in 2009-10 rising to £3.6 billion in 2012-13, a growth of 12% overall. The brought forward surplus at the end of 2008-9 is expected to be around £44 million. Over the 4 years period, this surplus is predicted to reduce by around 50%. Some of the surplus will be reinvested in direct healthcare and some in reducing underlying deficits. However, the current uncertainties around the medium to long term financing of the NHS suggests that the level of surplus will change over the CCI planning period.

There is considerable variability in the level of increase in investment across the 8 PCTs. Further sector-wide work is required to link the CSP analysis to programme budgeting to understand the importance of the variability in terms of collaborative service planning and commissioning.

The local and national context within which we operate

Three reports and the World Class Commissioning initiative set the national and local (London) context for strategic commissioning across NWL. These are:

- "High Quality Care For All. NHS Next Stage Review Final Report" (June 2008);
- Better Health, Better Healthcare (2008);
- **NHS Operating Framework 2009-10**

"High Quality Care For All" builds on the reforms of the last 10 years and promises to have an even more profound affect on NHS services and people's experience of them. If the challenge 10 years ago was capacity, the challenge today is to drive improvements in the quality of care. The NHS will be more personalised, responsive

to individuals, focused on prevention, better equipped to keep people healthy and capable of giving real control and real choices over care and people's lives.

The vision and key steps in the document mirror and complement the vision and values adopted by the NWL collaborative programme in 2007-9 and refined for the 2009-14 CCI plan. The information provided in the previous section and within section 4 - Initiatives demonstrates that PCTs across NWL are already making progress in delivering the Next Stage Review aspirations for the next 10 years.

“Better Health, Better Healthcare” is a programme of reform run by the NHS and local communities in London. It will improve health services throughout the capital over the next 10 years. It will make a real change and deliver what we know patients want – responsive, safe, accessible and high-quality healthcare.

NWL PCTs have been working both individually and collectively over the last 12 months to deliver the principles set out in the Healthcare for London programme and significant progress has been made in improving partnership working and reducing differences in healthcare. Our vision and values build on these principles, whilst the strategic objectives and initiatives outlined in section 4 demonstrate where we believe collaborative working will ensure delivery of the five priority areas for action outlined above and the specific programmes of work within the Healthcare for London programme.

The NHS Operating Framework 2009-10 **has as its focus 'Implementing High Quality Care for All'**. Included within this an approach to planning and managing priorities both nationally and locally – the *“vital signs”*. These describe three levels of priorities which PCTs (working with providers) need to explicitly plan to deliver. Tiers 1 and 2 cover existing and new national priorities, whilst tier 3 allows for local discretion in the monitoring of care.

There is significant variability in performance across the eight PCTs in NWL. Performance across the board has improved from Q1; however there is still considerable work to be done. The CCG discussed performance in October 2008 and committed to work collectively to address poor and variable performance collectively through a process of 'do once and share'. This work will be developed to support the delivery of the CCI in 2009-10.

The PCTs in NWL **were** assessed against the **World Class Commissioning Competencies** during Dec-January 2008-9 and their individual CSPs and the NWL CCI formed a key component of the evidence base for the assessments. A high level self-assessment carried out in April 2008 suggested each of the PCTs had some way to go to achieve the baseline position overall, although there was considerable variation against the individual competencies. The NWL Collaborative Programme work to date, and planned approach for the next 5 years, provides a strong platform for delivery against competencies 2, 3, 4, 5, 8 and 10. In addition, the PCTs have agreed a structure for delivering WCC (outlined in Section 5) which will, ensure continuous improvement in practice.

Engagement in the CCI planning process

All PCTs have involved their local clinicians, patients and public in the planning phase of their Commissioning Strategy Plans (CSPs) through a series of public events. The findings from these events have been used to inform their priority setting,

vision and values. In addition to the engagement of patients, public and local clinicians by the PCTs, the NWL Programme Team has also involved a number of stakeholders including local NHS Trusts, local clinicians (through PEC Chairs) and funded clinical networks to ensure that the CCI receives significant input around priority setting, vision and values from these local partners. Previous engagement activity carried out by PCTs has also helped to inform individual PCTs' CSPs and in turn, the CCI.

The key themes which PCTs have consistently found to be high-priority areas for local residents are strikingly similar and support the findings from both the HfL and nationwide consultations. Some of the key issues highlighted in PCTs' findings include:

- Healthy living and prevention, particularly the need for better information being available widely in the community for people to manage their own health and wellbeing.
- Access to primary care services, particularly GP services and Out Of Hours (OOH) care.
- Access to mental health services, in some cases particularly for BME communities.
- Integrated service provision, with a strong emphasis on the need for a stronger link between health and social care, with this extending to housing and education services.
- Improving the quality and safety of services.
- Greater emphasis on involving patients and the public.

A number of Trusts have ongoing engagement initiatives which are highly relevant to the collaborative work in NWL and more work is required to draw on the insights gained from these engagement activities. Trusts have demonstrated a high level of commitment to the continual improvement of how they engage with their patients to feed directly into the strategic planning and review of services.

At a sector-level, work will continue to develop leadership in Communications and Engagement through a specific engagement initiative (see Delivery section) as well as ensuring that there is significant and relevant public engagement within each of CCI priorities.

STRATEGY

Having laid out the context for the CCI in section 3, section 4 outlines the NWL Collaborative plan to deliver the Vision over the next 5 years.

Strategic Objectives

The CCG has developed a focused set of objectives drawing on individual PCT objectives which were then refined through discussions with PCT Chairs, Chief Executives and PEC Chairs. The final objectives listed below specifically focus on those areas where collaboration is required either at a sector or pan London level.

The PCTs will work in collaboration, where this adds significant value, to:

Improve the health of the current and future population of NWL

Individual PCTs, in association with their local Boroughs, will be responsible for improving the health of the population. However, the CCG, in line with *Better Health, Better Healthcare*, will continue to monitor indicators of health across the whole population of NWL and will actively champion prevention and early detection strategies known to lead to significant improvements in health.

Reduce inequalities

Individual PCTs will focus on reducing inequalities in health (see above). This objective focuses on reducing inequalities in access to healthcare.

- Reduce inequalities in access to care and in access to certain treatments (eg. cancer drugs).
- Improve the life expectancy of patients with cancer, to below the England average, through the commissioning of patient pathways that are compliant with NICE Improving Outcomes Guidance and through delivery of the Cancer Reform Strategy 2008 goals regarding cancer waiting times and better treatment.
- Ensure that all collaborative initiatives (described later) identify and reduce inequalities in access to healthcare.

Transform the quality and delivery of health services

The PCTs will use the benefits of collaboration across a health system to proactively manage the local healthcare market and drive system reform. They will use the leverage gained from commissioning healthcare collectively to:

- Reduce variability in the quality of healthcare provision by continuous and systematic review of healthcare provision against national and international clinical best practice standards.
 - By 2013 patients accessing healthcare in NWL will receive care commissioned against sector-wide patient pathways (within networks where appropriate).
- Improve the overall quality of healthcare for key groups of patients in line with national standards.
 - By 2014 improve health and social care services for children, young people and maternity services to the levels expected within the NSF for children, young people and maternity services (2004), Every Child Matters and “Better Health, Better Healthcare”.
 - Lead the local reconfiguration of services for patients with vascular disease in line with “Better Health, Better Healthcare”.

Stroke patients will have greater access to early detection services and will receive acute and rehabilitation care in line with the best in the world. Patients with cardiac disease will continue to have access to high quality care and cutting edge developments in acute care.

- Lead the local reconfiguration of Trauma care in line with “Better Health, Better Healthcare”.
- By 2011, ensure that the population has access to a range of appropriate (stand alone and networked), high quality and timely unscheduled care services.

Become World Class Commissioners

The PCTs will collaborate at a variety of levels across the NWL health system to achieve the transformation of health and healthcare for its population. Commissioning will be strengthened by:

- Building sustained commissioning capacity and capability within, and across, PCTs in line with the aims of ‘World Class Commissioning’.
- Developing health and healthcare information which supports determination of future trends, economic analysis and drives investment/disinvestment strategies.
- Development of strong partnerships between commissioner and patients/public, healthcare providers, local authorities and the third sector in the design and delivery of care.

Initiatives

The JCPCT plans to achieve its strategic objectives and overall vision through the execution of a targeted set of initiatives. The initiatives outlined below have been developed from a list of possible initiatives identified within PCT CSPs or through the HFL work programme which were then refined using agreed prioritisation criteria into two lists.

List One describes areas of work where there is scope for collaboration on all or part of the programme and planning over, at least, a 5 year period is required.

Vascular Health – CHD, Stroke, Diabetes¹, Hypertension
 Children, Young People and Maternity Services – delivery of the NSF
 End of Life Care
 Long term conditions
 Unscheduled care
 Major Trauma
 Mental Health
 Cancer – Delivery of the Cancer Reform Strategy
 Provider Landscape

¹ Although diabetes has been identified as a major contributor to ill health and mortality across NWL, the focus in 2009-10 will be on improving risk and developing local services through CSPs

List Two describes those initiatives, drawn from the above list, which the JCPCT intends to focus on in year one of its Strategic Collaborative Commissioning Plan. These initiatives are outlined in detail below.

Cancer: IOG Implementation
 Cancer Waiting times

Maternity
Improving Surgical Services for Children and Young People in Hospital
Stroke
Major Trauma
Unscheduled Care
Improving Clinical Practice
Strengthening the Provider Landscape

Each initiative is described in more detail in the body of the CCI.

Overall impact, by Strategic Objective

This section provides a summary of the CCI initiatives and assesses their collective impact on the delivery of the vision and objectives described in the plan.

The initiatives were selected from a range of initiatives identified by the PCTs in NWL because they meet agreed prioritisation criteria, including delivering a key component of one or more Strategic Objectives, and because collaboration will deliver the overarching vision more effectively.

Individually, the work streams have, and will be, the catalyst to achieving significant improvements in the commissioning and delivery of healthcare for the population of NWL and will contribute to the vision set out in Better Health, Better Healthcare over the next 5 years.

DELIVERY

Past delivery performance

The NWL sector has had a reputation for poor strategic planning and lack of ability to deliver change. However, over the last 18 months the position has changed as the PCTs have strengthened their approach to collaborative commissioning through the funding of a dedicated NWL Collaborative Programme Team and, more recently, through funding of **dedicated programme team to support the Strengthening Commissioning agenda in NWL.**

The main body of work during 2007-8 focused on establishing the infrastructure to support the delivery of change; developing PIDs for key initiatives and identifying the body of evidence and baseline position to support the need for change. Stroke, Unscheduled care and Neonatal and Paediatric surgery initiatives will all move to the tender/designation phase over the next 6 months with implementation of change, subject to consultation, by March 2010 where necessary.

Organisational Arrangements

The NWL sector has agreed a delivery structure which builds on the strength of existing Borough and local relationships whilst creating the capacity, authority and governance arrangements to commission strategically for services that are best dealt

with at a sub-sector, sector or pan-London level. The aim is to minimise duplication of transactional and analytical processes and maximise access to scarce or expensive capabilities and commissioning skills. The following section describes the evolving commissioning arrangements in NWL.

NWL Collaborative Commissioning

The NWL Strategy Board was established in 2007 to oversee the work of the CCG and steer the strategic agenda across the NWL sector. In August 2008, the eight PCTs in NWL agreed to form a Joint Committee of the PCTs to:

- oversee the identification and delivery of collaborative commissioning intentions (CCI) in NWL
- to lead the implementation in NWL of Healthcare for London (HfL)
- to lead any formal consultations relating to the CCI or HfL required across the sector to deliver service change

NWL Commissioning Partnership

The North West London Acute Partnership is being formed to strengthen commissioning for all PCTs in the sector. The prime focus of the partnership is to improve acute sector performance and delivery. It will do this in three ways:

- determining a viable provider landscape configuration in the sector
- agreeing acute sector contracts
- performance monitoring and management of acute sector contracts

Driven by the needs of its constituent PCTs, the Partnership will deliver both individual and collective commissioning intentions for Brent, Ealing, Harrow, Hounslow, Hillingdon, Hammersmith and Fulham, Kensington and Chelsea and Westminster PCTs and their PBC Clusters.

Clinical Networks

The funded networks relevant to the NWL collaborative work are:

- Cancer
- Cardiac/Stroke
- Critical Care
- PIC
- NIC

The networks are responsible for advising the CCG on the delivery of clinically effective services within their remit. The Cardiac & Stroke and Cancer networks are facilitating specific initiatives in the CCI. Details of how the Critical Care network plans to support the delivery of the CCI and World Class commissioning is detailed in Appendix 14.

Delivery Initiatives

Two collaborative initiatives have been identified to support the delivery of the CCI. These cover IM&T and Public Engagement. The detail of these initiatives is outlined within the body of the CCI.

Risk management

A high level risk assessment has been undertaken for the CCI. The risks outlined represent the high level, critical risk factors across the initiatives in the CCI. These risks will be monitored closely by the JCPCT.

In-year monitoring

Responsibility for monitoring the delivery of the CCI rests with the Joint Committee of the PCTs (JCPCT) supported by the CCG and its sub-groups. Governance arrangements are outlined in Appendix 1. Appendix 4 of the Governance framework outlines how initiatives are developed from ideas into detailed plans and the process by which changes are implemented and monitored.

The JCPCT has responsibility for approving the Project Initiation documentation (PID) for each initiative. Each PID is supported by a detailed project timetable and an agreed set of metrics against which progress is monitored. The JCPCT receives monthly updates on all initiatives. A standard reporting proforma is used (Appendix 15). In addition, each initiative has a Senior Responsible Officer (SRO) who is accountable for its delivery. Each initiative is reviewed at least annually, or more regularly as circumstances change.

SECTION 2

VISION & VALUES

This section describes the CCG vision for transforming the health and healthcare for the 1.8M people in NWL and our commitment to the public and staff about how we will deliver this vision over the next 5 years.

VISION

Over the next 5 years the PCTs in NWL will work together, where this adds value, to transform the health and well being of existing and new and changing populations.

The aim is to improve health, reduce inequalities and transform the quality and delivery of health services for the population of NWL, building on work within individual PCTs and the Healthcare for London programme (Better Health, Better Healthcare).

This will be achieved through the development of strong and sustainable partnerships with patients and the public; providers of healthcare; and health and social care within the world class commissioning framework.

VALUES

Working together for patients. We put patients first in everything we do. We put the needs of patients and communities before organisational boundaries.

Improving lives. We strive to improve health and well-being and people's experiences of the NHS.

Everyone counts. We use our resources for the benefit of the whole community, and make sure nobody is excluded or left behind.

Commitment to quality of care. We ensure continuous service development led by clinicians in partnership with patients, founded on the best international research and practice.

Partnerships in care. We will strengthen partnerships between commissioners, patients/public, healthcare providers, local authorities and the third sector so that the public receive equitable and appropriate care.

Strategic investment of resources. We will develop joint investment/disinvestment strategies that ensure the best use of taxpayers' money.

SECTION 3

CONTEXT



INTRODUCTION

The health system in NWL is highly complex: from small GP practices providing **high quality** primary care to their local population; to major teaching hospitals conducting cutting edge specialist research and treating patients from across the country including the first Academic Health Sciences Centre in the UK based at Imperial Healthcare Trust. There are 7 acute trusts (delivering services from 11 sites), 8 PCTs, and 2 mental health trusts serving a population of around 1.8 million people with a wide range of health and social care needs.

Each of the eight PCTs has a 1:1 relationship with its local Borough and is responsible for creating sustainable communities in partnership with the Borough. There is considerable variation in the level of integration between health and local government and developments in this will remain flexible depending on local circumstance. At sector level we will look for opportunities to build on collaborative work already undertaken between PCTs and local Boroughs in areas such as the joint commissioning of Independent Mental Capacity Advocacy services and the development of the Supporting People framework.

This section sets the context for the five year strategy. It is divided into sections covering population demography, the local and national health context, primary care and provider landscapes and performance, insights from the public and current investment in healthcare.

POPULATION DEMOGRAPHICS AND HEALTH NEEDS

This section provides a consolidated picture of the sector drawn from PCT strategic plans and Joint Strategic Needs Assessments.

BACKGROUND

The CCI reinforces the need for all PCTs in the NWL sector to work with local partners in order to maximise health gain, add years to life, and reduce inequalities.

The ultimate aim is to improve health gain for patients in the sector by focussing on reducing death rates and prevalence of major diseases such as coronary heart diseases, cancer and stroke. Against the backdrop of maximising health gain for our population, is the need to reduce inequality gaps and deprivation by working collaboratively with our local partners.

The box below summaries some of the key contextual issues for the CCI for the period between 2009-14.

Demographics

- The NWL sector covers eight PCTs with a resident **population** estimated at 1.85 million people (ONS 2007 data).
- The population is predicted to grow by 3.9% over the next 10 years. Growth in PCT populations appears to be concentrated more in the inner boroughs.
- The overall growth disguises variation in growth rates by age band. For those PCTs with the highest predicted growth, the greatest growth appears to be in the 0-15 age band and the 45-64 age bands.
- There is considerable variation in **ethnic composition** of the PCT populations.
- The greatest change in ethnic profile over the next 10 years will be in the white population with an overall decrease of 4%. By contrast, both the Asian and Chinese & Other populations are predicted to rise by around 2% each.
- The population of NWL is not particularly **deprived** when viewed in the round. However, the PCT rankings vary from 53 (NHS Brent) which is the most deprived in the sector to 205 (Harrow PCT) which is the least deprived in the sector. Even at PCT level, the rankings disguise significant pockets of deprivation.

Maximising Health Outcomes

- NWL sector average life expectancy is above the England and London average for both males and females.
- There are wide differences in health outcomes for various diseases. However, these differences in health outcomes can be attributed to differentials that exist in socio-economic groups, ethnicity, pockets of deprivation in wards across PCTs and also differences in lifestyle and behaviour.
- There are no significant variations in prevalence rates between 2006/7 & 2007/8 across the NWL sector for most diseases. However, for a number of diseases there are noticeable variations in prevalence rates at PCT level.

CHD

- CHD is one of the main causes of death for all NWL PCT's, with higher premature mortality in higher deprived or ethnic populations. Borough level rates mask large inequalities. However, all PCT's improved the CHD mortality rate from 2003-2006.
- The prevalence of CHD is not predicted to change significantly in NWL over the next 12 years.
- Future treatment priorities will include ensuring access to cardiac rehabilitation, developing community based heart failure services and end of life care and ensuring the management of angina patients is optimised.

Stroke

- Stroke is the commonest cause of severe disability in adults.
- Increased incidence of stroke is strongly associated with ageing.
- High numbers of strokes are predicted in specific wards in the outer NWL PCTs (Ealing, Brent, Harrow and Hillingdon) which will need to be taken into account in determining the geographical configuration of stroke services.

Cancer

- Cancer treatments and services have improved dramatically over last seven years. NWL has the fourth lowest mortality rate for cancer in England (2008).
- The incidence rates per 100,000 of population are greater for breast cancer and prostate cancer, and lowest for colorectal and lung cancer.
- For most tumour sites, the earlier a cancer can be diagnosed, the better the clinical outcomes.
- Screening programmes and awareness-raising are vital in combating the disease.

Diabetes

- Diabetes is becoming a more common condition world-wide. It can affect people of all ages in every population.
- Significant inequalities exist in the risk of developing diabetes, in access to health services and the quality of those services, and in health outcomes, particularly with regard to people with type 2 diabetes.
- The prevalence rate in NWL is slightly higher than the England average with little change in prevalence predicted to 2010.
- However, the NWL average disguises significant differences in prevalence rates between the PCTs. Harrow, Ealing, Brent and Hounslow all have prevalence rates above 5% which probably relates to their high ethnic populations.

POPULATION PROFILE

This section provides a more in-depth look at the demography of NWL including population size, predicted growth and segmentation by age, gender, socio-economic status and ethnicity.

Population Estimates

The NWL sector covers eight PCTs with a resident population estimated at 1.85 million people (ONS data).

The ONS resident based population data is presented in Table 1. The ONS estimates originate from Census 2001 figures and have been adjusted mid year to give the current estimates for residents in each PCT.

For validation purposes, ONS population figures used in this report reconcile, and are consistent with, those used in the world class commissioning 'data packs'. In addition, Greater London Authority (GLA) projections are provided for use in forecasting and as a planning aid into the future. GP registered population figures are included for completeness (Table 2). The congruence between ONS, GLA, & GP registered population estimates has improved substantially over the years, although for GP registered populations there are still some minor issues around list inflation.

ONS Population estimates

The ONS population estimates presented in (Table 1) below are based on the sub-national projections for England revised every two years.

Table 1: ONS resident based population

	All Persons (100K)	All Males (100k)	All Females (100k)
Brent	270	135.2	134.8
Ealing	305.3	154.6	150.7
Harrow	214.6	106	108.7
Hillingdon	250.7	122.6	128.1
Hounslow	220.6	111.6	109
Hammersmith and Fulham	172.5	85.5	87
Kensington and Chelsea	178.6	87.6	91
Westminster	234.1	117.2	116.9
North West London	1846.4	920.3	926.2

Data source: ONS Mid 2007 rounded estimates to nearest thousand

GP registered population²

This is based on aggregated patient numbers registered with a general practitioner (GP) within a PCT. The GP list dataset in table 2 is for the end of April 2007 (reconciled with the ONS 2006 mid-year estimates). However, it should be noted that current GP total list size figures reported by PCTs in their Commissioning strategy plans are based on capitation figures to the end of April 2008 which are subject to validation. These suggest an overall GP population of around 2 million which is in line with projected population growth estimates below.

Table 2: GP registered population

Name	All Persons	Males	Females
Brent Teaching PCT	281,002	141,135	139,867
Ealing PCT	319,881	163,075	156,807
Hammersmith and Fulham PCT	169,360	83,792	85,568
Harrow PCT	198,301	97,333	100,968
Hillingdon PCT	240,061	116,536	123,525
Hounslow PCT	220,327	110,224	110,103
Kensington and Chelsea PCT	188,945	91,768	97,177
Westminster PCT	232,123	117,471	114,652
NWL	1,850,001	921,334	928,667

Data source: GP list extracted from ADS 2007

Predicted population growth

The population is predicted to grow by 3.9% over the next 10 years for NWL residents, with Hammersmith & Fulham PCT showing the biggest increase (7.3%) compared to other PCTs. Growth in PCT populations appears to be concentrated more in the inner boroughs. The percentage growth between 2009 & 2018 by PCT is shown in Table 3.

Table 3: Percentage (%) growth between 2008 & 2018

PCT	2008	2018	2008-18	% Increase
Brent Teaching PCT	277,546	286,779	9,233	3.3%
Ealing PCT	314,214	329,780	15,566	5.0%
Hammersmith and Fulham PCT	177,133	189,995	12,861	7.3%
Harrow PCT	215,370	215,852	482	0.2%
Hillingdon PCT	243,733	244,253	520	0.2%
Hounslow PCT	226,266	240,390	14,124	6.2%
Kensington and Chelsea PCT	166,613	174,332	7,719	4.6%
Westminster PCT	215,287	226,787	11,500	5.3%
NWL	1,838,171	1,910,186	72,016	3.9%

Data source: GLA Data Management and Analysis Group
(demography@london.gov.uk)

² GP list extracted from ADS2006 and reconciled to ONS mid 2005 estimates for LA – excluding special populations.

Ethnicity profile

The ethnic breakdown of each PCT is shown in table 4 below. The major ethnic categories are calculated as a proportion of the total ONS mid 2006 population estimates for each PCT, expressed as a percentage.

Table 4: Ethnicity profiles

	Brent	Ealing	Hammersmith & Fulham	Harrow	Hillingdon	Hounslow	Kensington & Chelsea	Westminster	NWL London
Whites	46.0%	58.9%	78.1%	56.0%	75.2%	62.7%	77.2%	71.2%	65.7%
Black	18.4%	8.7%	9.8%	7.0%	4.9%	4.9%	6.4%	6.6%	8.3%
Asian	27.7%	23.3%	5.3%	30.7%	14.7%	25.9%	6.4%	10.5%	18.1%
Mixed Race	4.0%	3.9%	3.7%	3.1%	2.7%	3.2%	4.0%	4.3%	3.6%
Chinese or other Ethnic groups	3.8%	5.2%	3.1%	3.2%	2.5%	3.2%	6.3%	7.3%	4.3%

Data source: ONS Mid 2006 estimates

There is considerable variation in ethnic composition of PCT populations. Hammersmith & Fulham has the highest white population at 78.1% and Brent TPCT with the lowest proportion at 46.0%. Similarly, for the black population Brent TPCT has the highest proportion at 18.4% and Hillingdon and Hounslow with the lowest at 4.9%. In contrast, Harrow has the highest Asian population at 30.7% and Hammersmith and Fulham has the lowest at 5.3%.

Greater London Authority (GLA) forecasts predict that there will be differential growth in ethnic groups to 2018. This is shown in table 5 below.

Table 5: Percentage (%) change in main Ethnic categories between 2008-18

Borough	Black total	Chinese & Other	Asian total	White
Brent	-0.2%	0.8%	2.1%	-2.6%
Ealing	-0.4%	3.9%	0.2%	-3.8%
Hammersmith and Fulham	-0.1%	1.1%	0.7%	-1.7%
Harrow	0.7%	1.2%	5.7%	-7.6%
Hillingdon	2.0%	0.7%	4.0%	-6.7%
Hounslow	0.3%	1.8%	4.5%	-6.6%
Kensington and Chelsea	-0.6%	1.3%	0.0%	-0.7%
Westminster	-0.8%	1.8%	0.6%	-1.6%
NWL	0.1%	1.7%	2.1%	-4.0%

Data source: GLA Data Management and Analysis Group

The greatest change in ethnic profile over the next 10 years will be in the white population with an overall decrease of 4%. By contrast, both the Asian and Chinese & Other populations are predicted to rise by around 2% each.

The health impact of these predicted changes in ethnic profile of the population are described in more detail in the section on health status. However, a rise in the Asian

and Chinese/Other population is likely to result in increased prevalence and incidence of vascular disease (heart/stroke/hypertension) and diabetes.

Age Profile

The age profile of NWL population is shown in Fig 1. & tables 6a-b.

Fig. 1: Percentage (%) resident population by specific age group

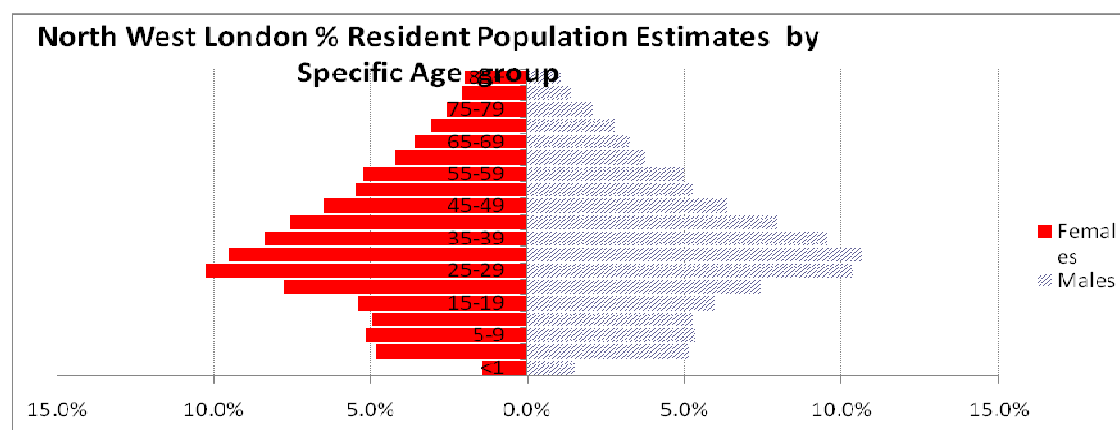


Table 6a: Age profile of the population

	Brent	Ealing	Hammersmith & Fulham	Harrow	Hillingdon	Hounslow	Kensington & Chelsea	Westminster	NWL London Average
0-15yr olds	18.7%	18.8%	16.1%	19.5%	20.5%	19.5%	15.4%	12.9%	17.7%
16-44yr olds	49.3%	49.1%	55.7%	42.9%	43.8%	48.5%	50.4%	57.1%	49.6%
45-64 yr olds	20.3%	20.8%	17.9%	23.5%	22.3%	21.0%	22.0%	19.1%	20.9%
Over 65's	11.7%	11.3%	10.3%	14.2%	13.5%	10.9%	12.2%	10.9%	11.9%

Data source: ONS Mid 2006 estimates

The population age profile is relatively young with 88% of the population being under 65 years.

Predicted Changes to Age Profile of NWL population for period between 2008 - 2018

The predicted changes by age groups are presented below in table 6b. The actual numbers of the total population by 2018 have been drawn from the current Greater London Authority (GLA) estimates. The variability in PCT growth rates disguises considerable variability in growth rates by age group. For those PCTs with the highest predicted growth, the greatest growth appears to be in the 0-15 age band and the 45-64 age bands.

Table 6b: % change by age groupings between 2008-18

	Brent	Ealing	Hammersmith & Fulham	Harrow	Hillingdon	Hounslow	Kensington & Chelsea	Westminster	NWL London
0-15	3.7%	6.7%	12.2%	2.0%	0.0%	8.4%	7.6%	11.2%	5.9%
16-44	-6.8%	-3.3%	2.2%	-5.6%	-5.9%	-1.2%	2.1%	1.4%	-2.4%
45-64	21.0%	17.9%	21.9%	7.0%	8.9%	18.0%	8.8%	14.5%	14.8%
65	13.2%	12.1%	2.7%	5.7%	5.6%	12.3%	3.4%	-0.3%	7.5%
All Ages	3.5%	5.0%	7.3%	0.2%	0.1%	6.2%	4.6%	5.3%	3.9%

Data source: GLA Data Management and Analysis Group

The growth in the 0-15 age band and the 45-64 age bands need to be considered in relation to prioritising work on Children's and Maternity Services and flags the need to tackle health and lifestyle factors in the 45-64 age band to avoid complications in older age.

Deprivation

The Index of Multiple Deprivation (IMD) scores are used to compare areas of England according to a range of social health and economic factors such as housing, health, education, crime, income and employment. A score or rank is calculated which gives a measure of deprivation for a specific location, known as a Super Output Area. PCT level, index of multiple deprivation (IMD) scores were aggregated from lower super output areas (LSOA) level scores.

The current IMD in use is for 2007. It provides a relative ranking of areas across England according to their level of deprivation. The NWL position is shown in table 7. The rank of average scores gives an indication of where the PCT is placed in comparison to its counterparts. As shown, Brent TPCT with a rank score of 53 is the most deprived in NWL sector, and Harrow with a rank score 205 is the least deprived in the sector. PCT are ranked out of a total of 354 organisations.

Table 7: Index of Multiple Deprivation scores for NWL PCTs

PCT	Overall IMD Average 2007 score	Rank of Avg score
Hillingdon	18.56	157
Hammersmith and Fulham	28.08	59
Hounslow	23.20	105
Brent Teaching	29.22	53
Harrow	15.59	205
Kensington and Chelsea	23.51	101
Westminster	26.30	72
Ealing	25.10	84

Data source: London Health Observatory, IMD 2007

This information is illustrated graphically in the form of deprivation maps. Fig 2a shows the index of multiple deprivation scores for 2004; and Fig 2b the change in relative rank between 2004 and 2007 respectively.

Fig 2a: Index of Multiple deprivation map 2004

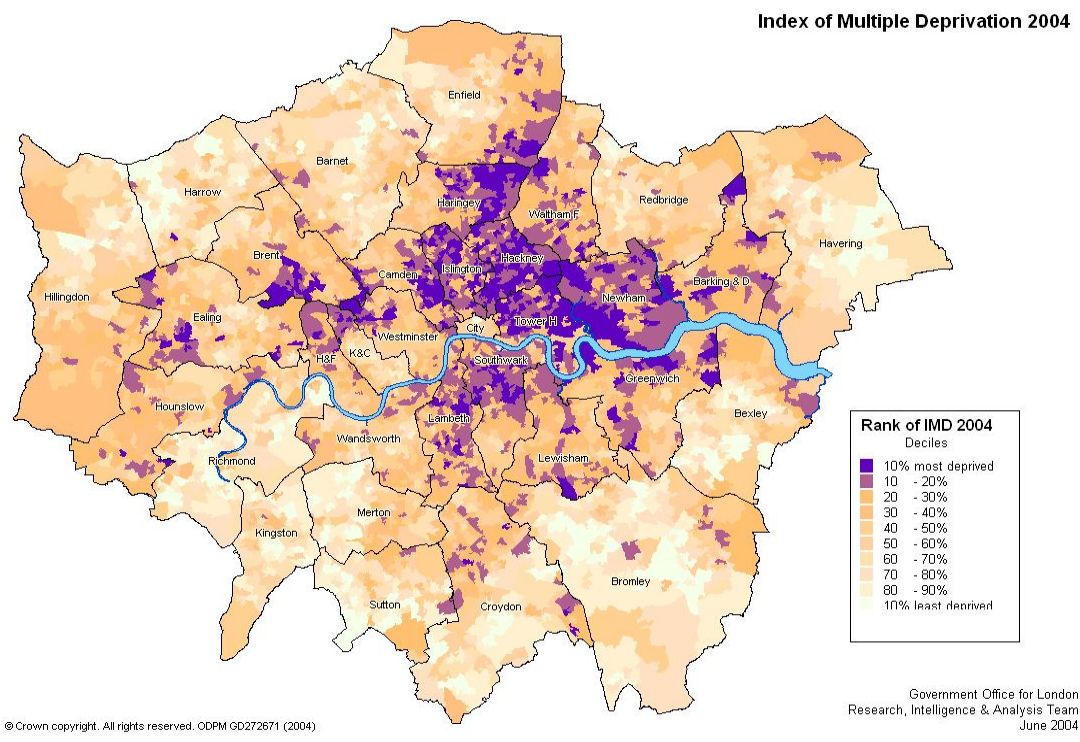
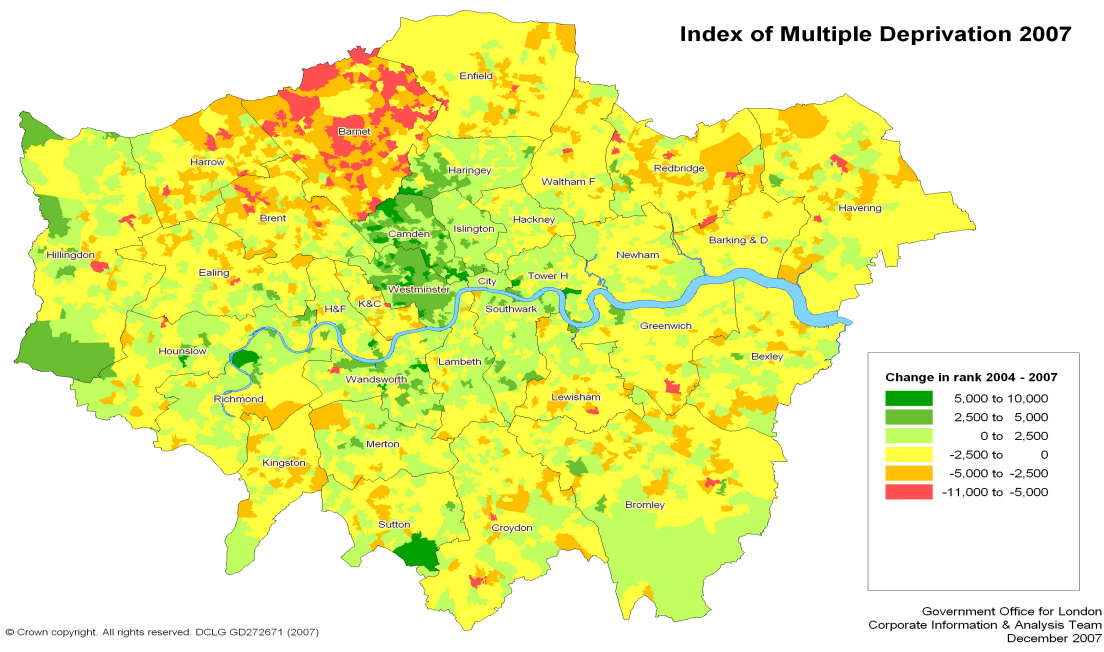


Fig. 2b: Change in Rank 2004-2007



In addition, a comparison of the average index of multiple deprivation scores between 2004 and 2007 is presented in table 8 below. Westminster has improved from the 2004 position and the position in Hammersmith & Fulham and Hounslow has remained fairly static. In contrast, the other PCTs have recorded an increase in relative deprivation.

Table 8: Difference in average IMD scores 2004-2007

PCT Name	IMD Average Score	Income	Employment	Health	Education	Housing	Crime	Environment
Hillingdon PCT	-0.88	-0.03	-0.01	-0.05	0.70	5.70	-0.09	-0.18
Hammersmith and Fulham PCT	-0.25	-0.02	0.00	-0.20	2.04	5.03	0.09	-6.14
Hounslow PCT	0.05	-0.04	-0.01	-0.07	2.22	5.01	0.11	-0.61
Brent Teaching PCT	-3.26	-0.04	-0.01	-0.17	0.31	-3.61	-0.18	-2.74
Harrow PCT	-2.09	-0.04	-0.01	-0.09	0.48	-2.53	0.06	-2.01
Kensington and Chelsea PCT	-2.01	0.00	0.00	0.05	0.91	-14.43	0.25	-1.10
Westminster PCT	5.41	0.00	0.01	0.31	3.64	7.63	0.35	-0.42
Ealing PCT	-1.68	-0.03	0.00	-0.05	-1.35	-2.66	0.04	-3.53

Data source: World Class Commissioning data packs: 2008

Generally, the NWL sector is not particularly deprived and the impact on collaborative initiatives will be limited. However, pockets of significant deprivation exist within PCTs as outlined in individual CSPs, and the expectation is that the effect of deprivation in the planning and delivery of healthcare to these populations will be dealt with at a borough level. Where appropriate, deprivation is taken into account within collaborative initiatives.

HEALTH STATUS

This part of the CCI is split into two sections. The first provides a general analysis of health status across the NWL sector. Section two looks at diseases where health status is an issue across all eight PCTs.

SECTION 1

Life Expectancy

Life expectancy is a measure of the average length of time a person is expected to live. It is calculated separately for gender and location. Life expectancy for males and females varies across the PCTs in NWL, and against the England average as shown in table 9.

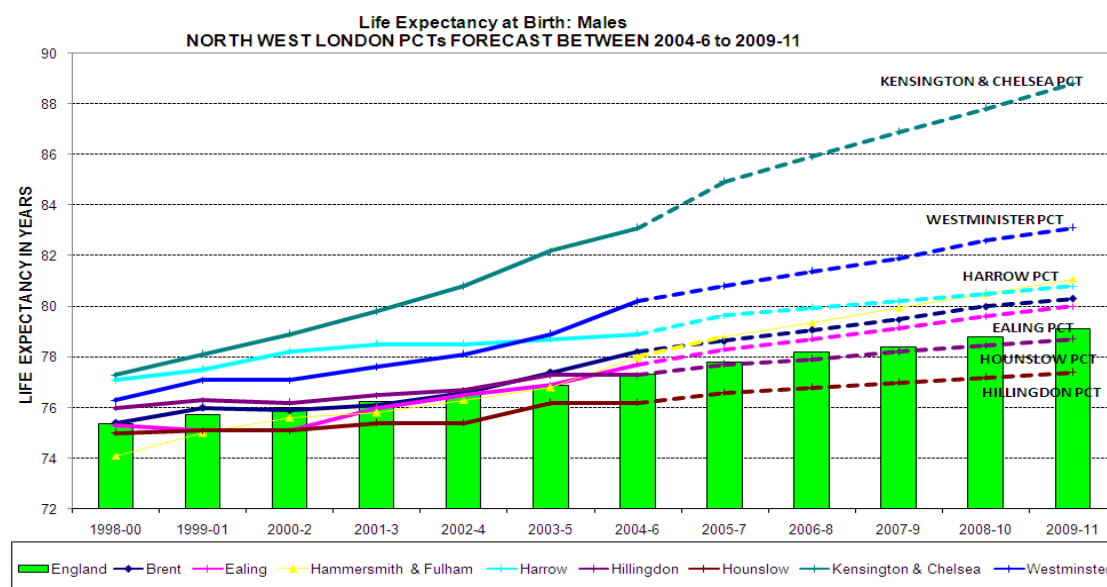
Table 9: Life expectancy in years by PCT

	Brent	Ealing	Hammersmith & Fulham	Harrow	Hillingdon	Hounslow	Kensington & Chelsea	Westminster	London	England
Life expectancy: Males	78.2	77.7	78	78.9	77.9	76.2	83.1	80.2	77.4	77.3
Life Expectancy: Females	83.4	82.1	83.5	83.1	82.2	80.6	87.2	84	82	81.6

Data source: National Clinical Health Outcomes Database: 2004-6

NWL sector average life expectancy is above the England and London average for both males and females.

Fig. 3: Life expectancy at birth for males – current achievement and forecast up to 2011 by PCT

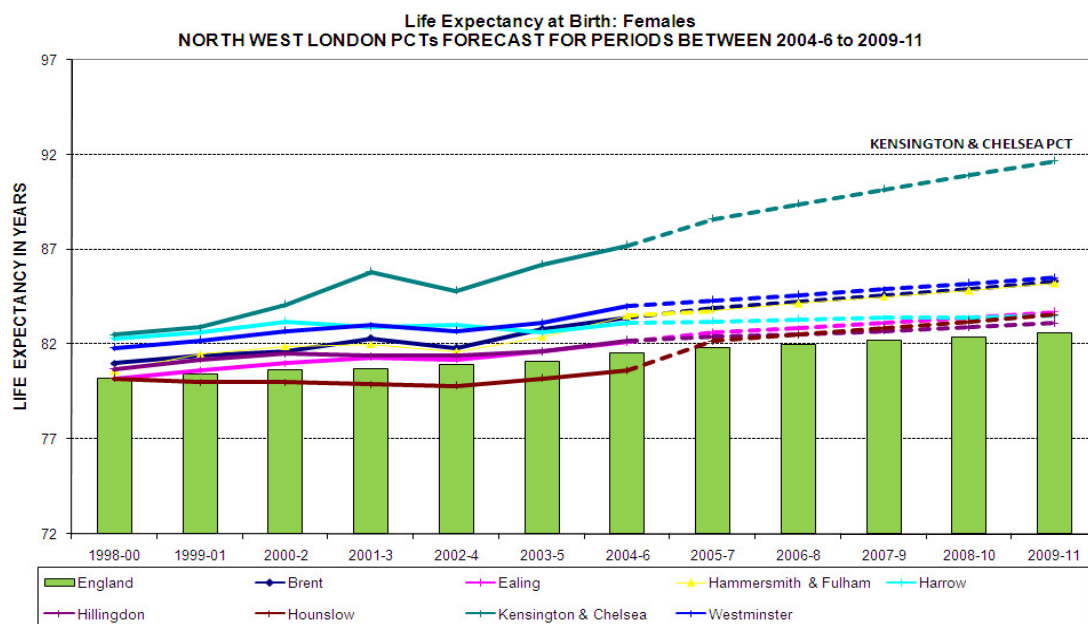


Meeting the life expectancy targets for males is particularly challenging for some PCTs (Hillingdon and Hounslow). All other PCTs are predicted to exceed the England average by 2011. Of particular note is the increasing divergence in life expectancy of males across the sector with men in Kensington and Chelsea predicted to live 12 years longer than those in Hillingdon by 2011, an increase of 5 years compared to 2004. A number of factors relating to the health, disease burden

and deprivation of the population are known to influence life expectancy, although it is not clear why the survival rates in K&C and Westminster are increasing exponentially. One theory is that the marked improvement in male life expectancy in K&C (and probably in Westminster and H&F) may be attributed to better survival rates for men with HIV/AIDS.

In contrast, the outlook for females as shown in Fig. 4 is much more optimistic, and provided all PCTs in NWL maintain their current position, they will achieve the England average by 2010. The spread in life expectancy is much narrower for women between PCTs, although women in Kensington & Chelsea are predicted to live 11 years longer than their counterparts in Hounslow by 2011. Again the reasons for this are not clear.

Fig. 4: Life expectancy at birth for females – current achievement and forecast up to 2011 by PCT



The life expectancy gap for all primary care trusts in the sector between male and female is shown in table 10 below. Life expectancy gap is a measure of the difference in years between males and females. The life expectancy gap between male and females varies across PCTs in the sector and has remained fairly static over the four years to 2006. Brent and Hammersmith & Fulham have a life expectancy gap above the England average.

Table 10: Life Expectancy Gap Analysis between male and females

	Brent	Ealing	Hammersmith & Fulham	Harrow	Hillingdon	Hounslow	Kensington & Chelsea	Westminster	England
2004-6	5.2	4.4	5.5	4.2	4.9	4.4	4.1	3.8	4.23
2003-5	5.4	4.7	5.6	3.9	4.3	4	4	4.2	4.2
2002-4	5.2	4.7	5.3	4.5	4.7	4.4	4	4.6	4.38

Data source: London health observatory

Inequalities

The term 'health inequalities' is used to describe unfair and avoidable differences in health status between different population groups. These differences are driven by inequalities in society, and can occur, for example, between those of different socioeconomic status, gender, ethnic group or place of residence.

In the NWL sector as a whole, there are wide differences in health outcomes for various diseases (see Section 2). These differences in health outcomes can be attributed to differentials that exist in socio-economic groups, pockets of deprivation in wards across PCTs (see Figure 2), and also differences in lifestyle and behaviour. The aim is to reduce the inequalities gap through targeted health and social care interventions delivered largely at a borough and sub-borough level.

Lifestyle and Behaviour

Evidence from available surveys suggests that life style and behaviour play a significant role in prevalence and incidence of wide range of diseases. As a consequence there exists an association between life styles and behaviour and disease burden.

Table 11a shows average estimates (expressed as a percentage (%)) for the prevalence of healthy lifestyle indicators in relation to smoking, obesity, healthy eating and binge-drinking for people aged 16 and over aggregated at super output areas³ for each PCT.

Table 11a: Prevalence of key lifestyle factors

	2003-5 period											
	Life Style - smoking			Life Style - obesity			Life Style - Healthy Eating			Life Style - Binge Drinking		
	Average Estimate	Lower CI	Upper CI	Average Estimate	Lower CI	Upper CI	Average Estimates	Lower CI	Upper CI	Average Estimates	Lower CI	Upper CI
Brent	18.6	15.7	21.9	21.6	19.6	23.8	30.1	27.5	32.8	12	10.2	14.2
Ealing	18.6	16.5	20.9	20.0	18.0	22.2	30.8	28.7	33.0	12.5	10.7	14.5
Hammersmith & Fulham	24.2	20.8	27.9	15.4	13.7	17.3	35.7	32.7	38.8	16.4	13.8	16.4
Harrow	14.5	11.9	17.5	19.1	17.5	20.9	34.5	31.6	37.4	9.7	8.2	11.7
Hillingdon	22.4	19.5	25.5	20.9	19.0	22.9	29.3	26.7	32.1	10.7	9.3	12.3
Hounslow	22.0	19.4	24.9	19.4	19.4	23.6	26.7	24.6	28.8	12	10.4	14
Kensington & Chelsea	18.8	14.4	24.2	13.1	11.4	15.0	45.8	41.2	50.4	14.7	12.6	17.2
Westminster	22.8	18.7	27.6	14.7	13.0	16.6	35.1	31.5	39.0	15.7	13.5	15.7
North West London Average	20.2	17.582	22.88	18.0	15.38	20.88	33.5	28.59	38.40	13.0	10.96	14.96
London Average	23.3	21.6	25.1	18.4	16.8	20.1	29.7	27.5	31.9	12.7	11.4	14

Source: Information Centre: Health Surveys for England 2003 to 2005

Data source: Modelled estimates on Health surveys for 2003/05

A comparison of the different lifestyles presented in table 11b indicates wide variation in prevalence rates across the four lifestyle factors and between PCTs. However, it is difficult to draw specific conclusions from this data due to the wide confidence intervals generated by gathering data at super-output levels.

On the whole NWL does better than the London average in all areas of lifestyle with the exception of healthy eating.

Table 11b: Relationship between outcomes and life styles

³ Super output areas are created by the Office for National Statistics (ONS) for collecting, aggregating and reporting statistics.

Compare relationship between outcomes and lifestyles (Smoking, Obesity, Health Eating & Binge Drinking)

	Prevalence rates CHD	CHD Mortality Rates	Diabetes Mortality	Prostate cancer mortality	Lung cancer mortality
Smoking	0.39	0.37	0.30	0.23	0.48
Obesity	-0.22	-0.24	-0.16	-0.58	0.17
Healthy Eating	0.12	-0.06	0.03	0.25	-0.75
Binge Drinking	0.21	-0.16	-0.12	-0.09	-0.18

Source; Derived data from World class commissioning data packs – Aug 2008

The table above is a crude comparison of the strength of relationship between different outcomes (prevalence & mortality) and the different life styles that are contributory factors to disease incidence and prevalence. The strength of relationships was compared using a correlation matrix in which a pair of datasets (outcomes versus lifestyles) were used to obtain a set of values which gave an indication of the strength of the relationship between the two variables. Smoking had the strongest relationship with any of the outcomes in comparison to other life styles represented in the table above. As expected, the strongest relationship was with Lung cancer mortality.

Prevalence and Incidence

Incidence data for this report is presented for the main killer diseases such as stroke (see incidence map on stroke for London) and cancer (see table 19).

The epidemiology of disease prevalence is well documented in public health reports for PCTs in the sector. However, most PCTs share a common view that the major killers (coronary heart diseases, stroke and hypertension, cancer, and diabetes) should be the main focus of attention both at PCT and sector level. This is reflected in the collaborative initiatives in section 4.

In this, and Section 2, there are two sets of tables on prevalence rates: one shows the estimated forecast for the next ten years; and the other shows the current unadjusted prevalence rates derived from the quality and outcomes framework (QOF). The differences are:

Tables (12b-d, & 18a-c & 22) show estimated prevalence growth projections for a ten year period for CHD, stroke and diabetes. In contrast, Table 12a shows the unadjusted (percentage numbers of patients on disease registers as a proportion of total list size) levels of prevalence as recorded in the QOF – disease registers for GP practices in each PCT.

Table 12a: Unadjusted prevalence rates from QOF for periods 2006/7 & 2007/8

Unadjusted prevalence rates in QOF for periods 2006/7 & 2007/8										
		Brent	Ealing	Hammersmith & Fulham	Harrow	Hillingdon	Hounslow	Kensington & Chelsea	Westminster	NWL London
Asthma prevalence at PCT level	2006/7	4.5%	4.9%	4.6%	5.5%	5.3%	4.5%	3.3%	3.3%	4.48%
	2007/8	4.0%	5.0%	4.3%	5.5%	5.1%	4.4%	3.4%	3.4%	4.39%
Cancer prevalence at PCT level	2006/7	0.6%	0.7%	0.7%	0.8%	0.8%	0.7%	0.7%	0.7%	0.69%
	2007/8	0.7%	0.8%	0.7%	1.0%	0.9%	0.8%	0.9%	0.8%	0.83%
CHD prevalence at PCT level	2006/7	2.1%	2.6%	1.9%	3.0%	2.7%	2.4%	1.9%	1.9%	2.31%
	2007/8	2.1%	2.7%	1.8%	2.9%	2.6%	2.4%	1.9%	1.9%	2.29%
COPD prevalence at PCT level	2006/7	0.6%	0.7%	1.0%	0.7%	1.1%	0.7%	0.8%	0.7%	0.8%
	2007/8	0.7%	0.8%	1.0%	0.8%	1.1%	0.8%	0.8%	0.7%	0.8%
Diabetes prevalence at PCT level	2006/7	4.6%	4.3%	2.8%	4.9%	3.9%	3.9%	2.3%	2.6%	3.65%
	2007/8	4.8%	4.6%	2.9%	5.1%	4.0%	4.1%	2.6%	2.7%	3.85%
Hypertension prevalence at PCT level	2006/7	10.7%	11.2%	8.7%	12.7%	11.9%	10.9%	8.1%	7.6%	10.22%
	2007/8	10.7%	11.2%	8.7%	12.7%	11.9%	10.9%	8.1%	7.6%	10.23%
Stroke and TIA prevalence at PCT level	2006/7	0.9%	0.9%	0.9%	1.2%	1.2%	0.9%	0.9%	0.9%	0.98%
	2007/8	0.9%	1.0%	0.9%	1.3%	1.2%	0.9%	0.9%	0.9%	1.0%
Mental health prevalence at PCT level	2006/7	0.9%	0.9%	1.0%	0.8%	0.6%	0.7%	1.2%	1.0%	0.89%
	2007/8	1.0%	1.0%	1.0%	0.9%	0.7%	0.7%	1.2%	1.0%	0.94%
Dementia prevalence at PCT level	2006/7	0.2%	0.3%	0.2%	0.3%	0.2%	0.3%	0.2%	0.2%	0.24%
	2007/8	0.2%	0.3%	0.2%	0.3%	0.3%	0.3%	0.3%	0.2%	0.26%

There are no significant variations in prevalence rates between the two time periods (2006/7 & 2007/8) across the NWL sector for most diseases. However for each of the diseases there are noticeable variations in prevalence rates at PCT level. Harrow PCT has the highest recorded rate of Asthma, Cancer, CHD, Diabetes, Hypertension and Stroke which suggests high levels of disease detection in primary care linked to the ethnicity and age of the population. The much lower rates in Westminster and Kensington & Chelsea PCT may be due to a lower burden of disease in these more affluent populations.

However, generally, the prevalence of diseases recorded in general practice registers is far lower than predicted estimates and completing disease registers will be an important step, not only in reducing mortality from diseases, but also in reducing local health inequalities.

SECTION 2

This section looks at specific diseases where health status has been identified as an issue across all eight PCTs.

CORONARY HEART DISEASE

CHD is one of the main causes of death for all NWL PCT's, with higher premature mortality in higher deprived or ethnic populations. Borough level rates mask large inequalities. NWL cardiac and stroke network (NWLCSN) monitors, reviews and reports annually QOF (Table12a) performance on cardiovascular indicators to PCTs. This still indicates that whilst patients on cardiac registers are well treated, the prevalence of CHD appears to be lower than national estimates suggest. The NWLCSN facilitates dissemination of good practice on stopping smoking, healthy eating and physical activity to support cardiovascular risk reduction. The Network priorities in primary care are to facilitate the implementation of vascular risk assessment; validation of primary care registers; development of cost effective community cardiology pathways; consistent accreditation processes for practitioners with specialist interest (PwSI) in heart disease and developing local clinical management guidelines. In the acute sector the Network priorities are to ensure equality of access to revascularisation services and a maximum waiting time of 5 days for inter-hospital transfers.

The Network leads training on heart disease in the sector including a five day cardiology certificate course for GP's accredited by Thames Valley University; a three day practice nurses course; and half day updates for practitioners (e.g. community matrons), where a need is identified, on heart failure and end of life care.

Prevalence Rates

The estimated, predicted growth rates for prevalence of coronary heart disease for the period to 2020 have been modelled for PCTs. These are shown in table 12b, 12c, and 12d for all people, females and males respectively aged 16+. The data covers all cases of CHD, and undiagnosed cases.

Table 12b: CHD Prevalence rates

PCT	2005	2006	2007	2008	2009	2010	2015	2020
Brent	4.5%	4.6%	4.6%	4.6%	4.6%	4.7%	4.9%	5.1%
Ealing	4.6%	4.6%	4.7%	4.7%	4.8%	4.8%	5.1%	5.4%
Hammersmith and Fulham	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	3.9%	4.0%
Harrow	4.5%	4.5%	4.5%	4.5%	4.5%	4.6%	4.8%	5.0%
Hillingdon	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.8%	5.0%
Hounslow	4.7%	4.7%	4.7%	4.7%	4.7%	4.8%	5.0%	5.2%
Kensington and Chelsea	4.6%	4.6%	4.7%	4.7%	4.7%	4.7%	4.9%	5.2%
Westminster	4.0%	4.0%	4.0%	4.0%	3.9%	3.9%	3.9%	4.1%

Data source: Eastern Region Public Health Observatory

Table 12c: CHD prevalence rates in women

PCT	2005	2006	2007	2008	2009	2010	2015	2020
Brent	3.6%	3.7%	3.7%	3.7%	3.7%	3.7%	3.9%	4.0%
Ealing	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	3.9%	4.0%
Hammersmith and Fulham	3.1%	3.1%	3.1%	3.1%	3.1%	3.0%	3.1%	3.1%
Harrow	3.6%	3.6%	3.6%	3.6%	3.7%	3.7%	3.8%	4.0%
Hillingdon	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.8%	3.9%
Hounslow	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	3.9%	4.1%
Kensington and Chelsea	3.7%	3.7%	3.8%	3.8%	3.8%	3.8%	4.0%	4.2%
Westminster	3.2%	3.2%	3.2%	3.1%	3.1%	3.0%	3.0%	3.1%

Data source: Eastern Region Public Health Observatory

Table 12d: CHD Prevalence rates in men

PCT	2005	2006	2007	2008	2009	2010	2015	2020
Brent	5.4%	5.5%	5.5%	5.6%	5.6%	5.7%	6.0%	6.3%
Ealing	5.4%	5.5%	5.5%	5.6%	5.8%	5.8%	6.3%	6.7%
Hammersmith and Fulham	4.5%	4.5%	4.5%	4.5%	4.6%	4.6%	4.7%	4.9%
Harrow	5.3%	5.4%	5.4%	5.4%	5.4%	5.5%	5.8%	6.1%
Hillingdon	5.5%	5.5%	5.5%	5.6%	5.6%	5.6%	6.0%	6.3%
Hounslow	5.6%	5.5%	5.6%	5.6%	5.6%	5.7%	6.0%	6.3%
Kensington and Chelsea	5.5%	5.6%	5.6%	5.6%	5.6%	5.6%	5.9%	6.2%
Westminster	4.9%	4.9%	4.9%	4.8%	4.7%	4.7%	4.9%	5.1%

Data source: Eastern Region Public Health Observatory

The prevalence of CHD is not predicted to change significantly in NWL over the next 12 years. This disguises some difference in prevalence between the PCTs and between males and females. Overall the CHD prevalence is higher in men than in women and NHS H&F and Westminster have the lowest overall prevalence rates.

Prevention and Treatment

Prevention – management of risk factors

Raised blood pressure and high cholesterol are significant risk factors in the development of CHD. Table 13 shows the level of control of these risk factors for patients who are known to their GP. All PCTs need to improve performance against these targets and to develop systems for detecting and treating patients at risk within the general population.

Table 13: Risk factors

		Brent	Ealing	Hammersmith & Fulham	Harrow	Hillingdon	Hounslow	Kensington & Chelsea	Westminster	NWL London
The percentage of patients with coronary heart disease, in whom the last blood pressure reading (measured in the last 15 months) is 150/90 or less	2006/7	88.5%	89.6%	88.5%	89.5%	88.7%	88.9%	89.8%	87.7%	88.9%
The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the last 15 months) is 5 mmol/l or less	2006/7	79.9%	79.7%	74.1%	80.9%	81.1%	76.3%	78.1%	78.2%	78.5%

Data source: Quality and Outcomes framework 2006/7

Cigarette smoking is one of the key non-hereditary risk factors for the development of coronary heart disease. In the UK, 19% of deaths are caused by smoking. Reducing the number of smokers should reduce prevalence of cardiovascular disease as well as lowering death rates and improving life expectancy.

The framework for delivering this target is set within PCT'S local delivery plans. Within the Local Delivery Plans (LDP) for 2003-06 and 2005-08, each PCT has targets for the cumulative number of 4-week smoking quitters who attended NHS Stop Smoking Services.

The NHS Stop Smoking Services target smokers and supporting them to quit within four weeks. The monitoring of the progress made within this programme provides a proxy for the level of performance on reducing smoking prevalence in the population.

The number of smokers who had set a quit date in 2007/08 and had successfully quit at four week follow up (based on self-report) with NHS stop smoking services against the planned number of quitters is shown in the table 14 below.

Table 14:

		Cumulative smoking quitters Q4 2007/08									
		Brent	Ealing	Hammersmith & Fulham	Harrow	Hillingdon	Hounslow	Kensington & Chelsea	Westmins	NWL London	
2007/8	Cumulative Actual	2272	1597	1744	1271	1906	1852	841	2269	13752	
2007/8	Cumulative Target	2360	2800	1875	1220	1800	1770	1550	1930	15305	
	% Cumulative no of quitters	96%	57%	93%	104%	106%	105%	54%	118%	90%	

Data source: London health observatory – public health management report Aug 2008

Although performance against this target is relatively good for NWL, significant improvement is required in Brent and K&C. It should be noted, however, that this indicator only measures those smokers who have expressed a desire to quit and is not a measure of the number of smokers in a given community.

Treatment

Despite the relatively stable prevalence and incidence of heart disease, emergency treatment rates for CHD continue to increase, whereas elective rates have reached a plateau. Future priorities (aside from contributing to efficiency, for example by the inter-hospital transfer project, reviewing discharge communications, process mapping and other service improvement processes) will include ensuring access across NWL for all cardiac patients to cardiac rehabilitation, developing community based heart failure services and end of life care and ensuring the management of angina patients is optimised.

Mortality Rates

Considerable variation exists in CHD mortality rates (Table 15) across PCTs in NWL. Most PCT's in NWL - with the exception of Hounslow (105.57 per 100,000 persons), are below the England rate of 101.81 per 100,000 persons. All PCT's improved the CHD mortality rate from 2003-2006.

Table 15: Mortality rates for Coronary heart Diseases Direct Standardised rate (DSR) per 100,000

(Rate per 100,000 population)	Brent	Ealing	Hammer smith & Fulham	Harrow	Hillingdon	Hounslow	Kensington & Chelsea	Westminster	England
2004-6	93.67	101.58	86.5	88.4	94.84	105.57	56.33	66.73	101.81
2003-5	101.75	113.69	93.54	95.9	100.93	114.74	64.77	80.11	

Data source: National Clinical Health Outcomes Database

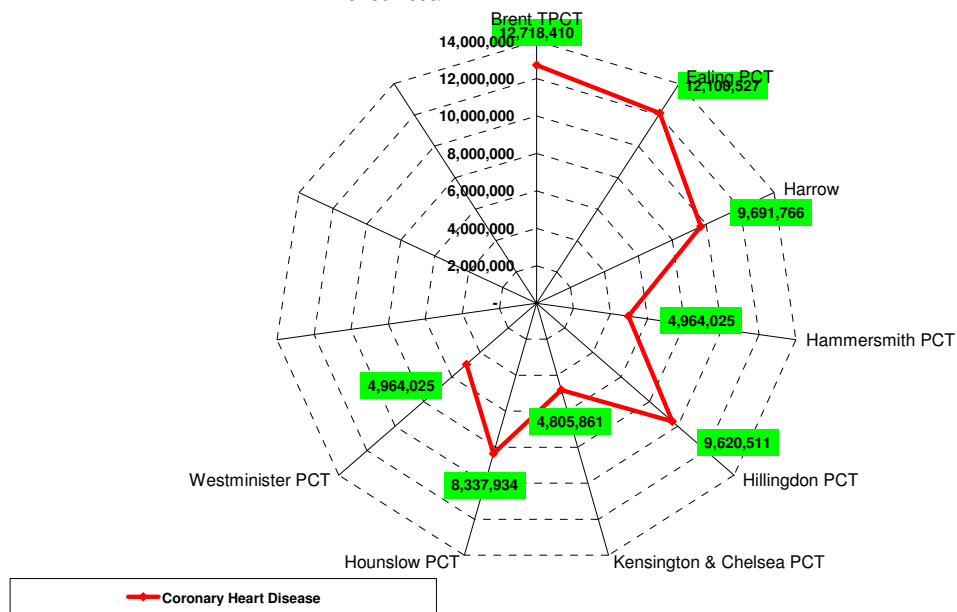
Programme budgeting

Programme budgeting is an analysis of spend by PCT, by disease category. The chart (PCT spend per 100,000) enables a comparison of spend across PCTs. The total cost per 100,000 utilised a capitation formula which takes into account adjustments for age, sex and need. A significant degree of the variation in the amount PCTs spend on different diseases can be explained by the following factors: the age and need profile of the population; the local cost of services; and any disparity between the amount of money a PCT actually receives and its target allocation under the resource allocation formula.

An analysis of spend across PCTs indicates Brent TPCT as the biggest spenders and Hammersmith & Fulham and Westminster PCTs as the lowest spenders in the sector. More recently, a Kings Fund report (Sept 2008) suggested that budget allocations do not represent actual spend on diseases. This requires further investigation by PCTs. The Kings Fund report was also unable to establish any correlation between spend and outcome.

Fig 5: Spend per 100,000 population on CHD

North West London PCT Spend per 100,000 population comparison by Disease Category
Period:2006/7



STROKE

Stroke is the commonest cause of severe disability in adults. The risk factors associated with stroke are lack of physical activity, obesity, smoking, drinking excessive alcohol, hypertension and diabetes.

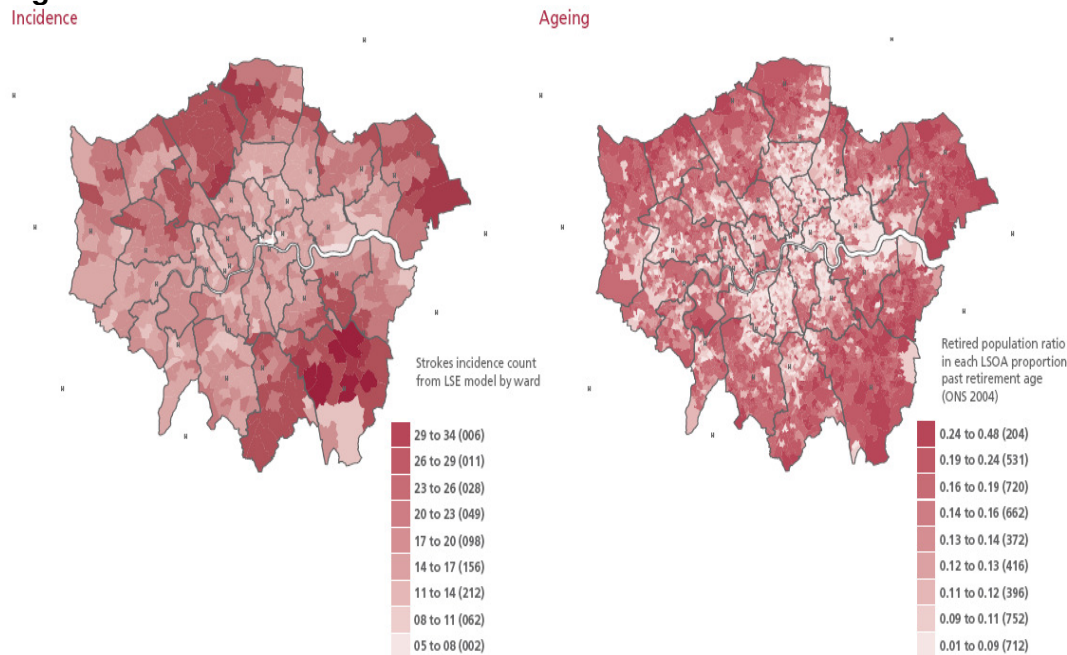
Incidence

The Healthcare for London (HfL) Stroke Project Team has modelled current and future demand for stroke services using prevalence data from the South London Stroke Register. Maps used in the London Stroke Strategy to show the expected incidence by ward and the impact of ageing, ethnicity and deprivation have been reproduced and are shown in Figures 6 and 7. The incidence map shows the predicted number of strokes in 2008, the darker shading indicates that a greater number of strokes are predicted. This shows that particularly high numbers of strokes are predicted in specific wards in the outer NWL PCTs (Ealing, Brent, Harrow and Hillingdon) which will need to be taken into account in determining the geographical configuration of stroke services.

Risk factors – impact on the incidence of stroke

Increased incidence of stroke is strongly associated with ageing and therefore the ageing map demonstrates a similar pattern (i.e. higher incidence in locations with an ageing population).

Fig 6



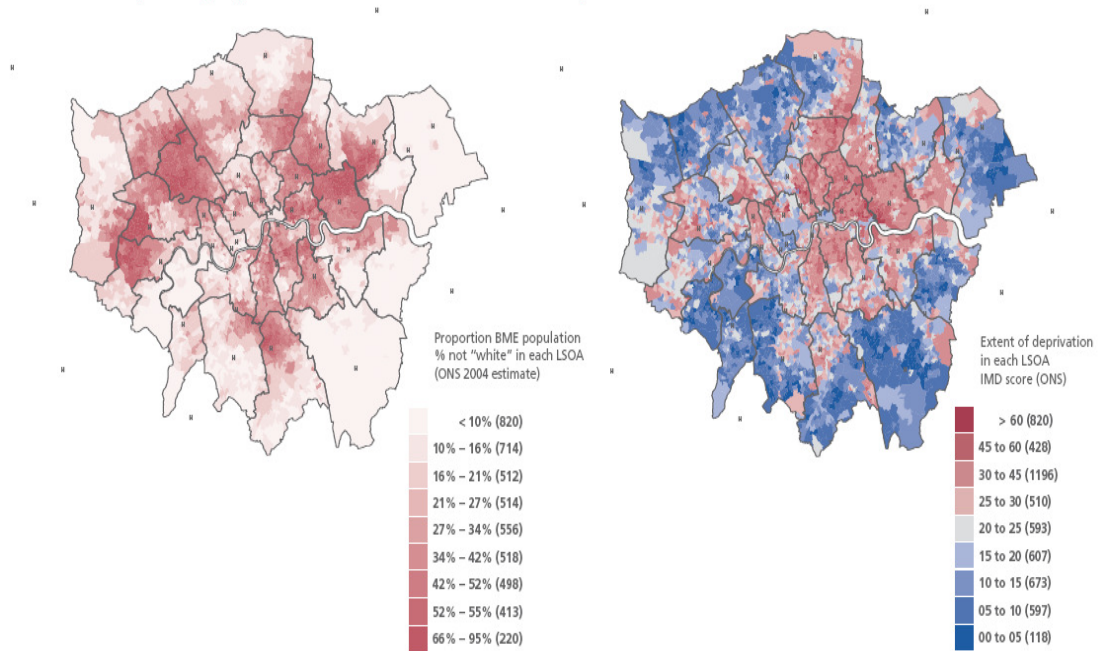
Maps reproduced with permission from preliminary stroke strategy – NHS London

Ethnicity and deprivation are not as closely associated with the incidence of stroke, as shown in Figure 7. There is a 60% greater incidence rate of stroke within the black African and black Caribbean populations at a considerably lower age. However, areas with a greater proportion of BME populations do not show a higher incidence of stroke. This is due to the fact that within London the proportion of BME people decreases steadily as age increases. The map of social deprivation scores (2004) shows that the incidence of stroke is not strongly associated with increasing deprivation.

Fig 7

Black and minority ethnic groups

Deprivation



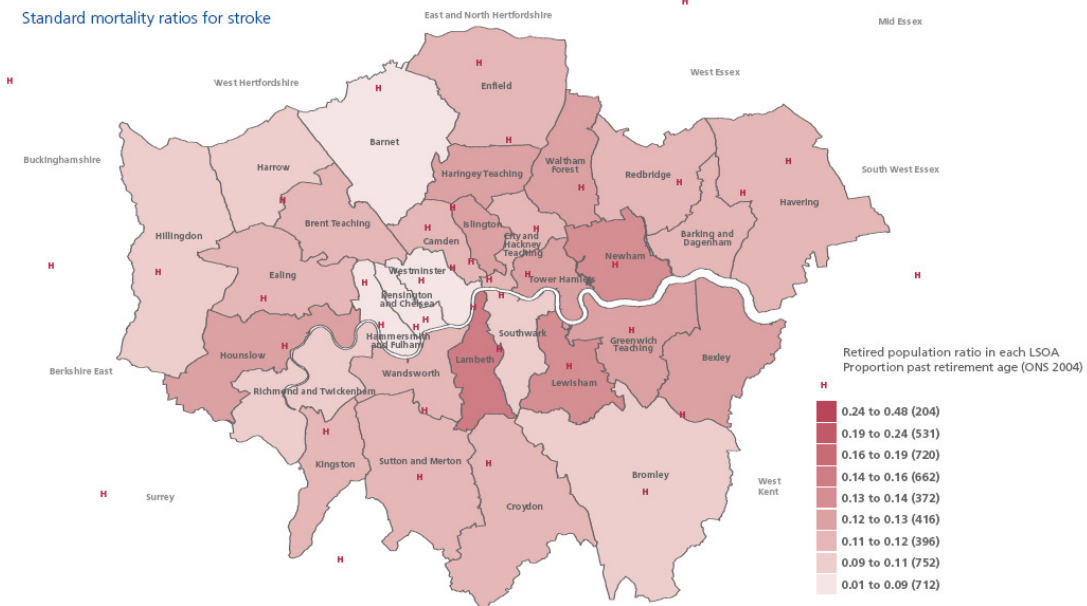
Maps reproduced with permission from preliminary stroke strategy – NHS London

Mortality

Standard mortality ratios for stroke vary considerably across London as a whole and PCTs in NWL as shown in Figure 8.

Fig 8

Standard mortality ratios for stroke



Maps reproduced with permission from preliminary stroke strategy – NHS London

The 2004 -6 mortality rate per 100,000 population is shown in table 16 for all ages and the 65-74 age group for all NWL PCTs. This shows significant variation with the lowest rates in K&C (29.3) and the highest in Brent and Hounslow (49.2) for all ages. For the 65-74 age group, the lowest rates are also in K&C (69.8) and the highest in Hounslow (159.9). For all ages, the NWL rates are below the England average. However, in the 65-74 age group, rates are above the England average in Ealing, Hillingdon, and Hounslow. These higher rates may be due to socio-economic factors or to the quality of primary and acute care provided in these boroughs (refer to QOF and sentinel audit data).

Table 16: Mortality rates for Stroke per 100,000 population (DSR)

	Brent	Ealing	Hammersmith & Fulham	Harrow	Hillingdon	Hounslow	Kensington & Chelsea	Westminster	NWL Average	London	England
All Ages	49.2	48	40.1	41.1	44.2	49.2	29.3	40.7	42.7	48.75	53.55
65-74	113.2	127.8	110.9	91.3	130.2	159.9	69.8	105.7	113.6	129.5	124.8

Data source: National Centre for Health Outcomes Development, 2008

Prevention and Treatment

Information in relation to the prevention and acute elements of the stroke pathway is shown below.

Prevention

Stroke along with other vascular diseases such as CHD, diabetes and kidney disease, share a common set of risk factors, which include obesity, smoking, hypertension, physical inactivity and high blood lipid levels. Effective management of these risk factors in people without a history of stroke or TIA (primary prevention) and in people that have had a stroke or TIA, minimising the risk of a further event (secondary prevention), would reduce the number of strokes in NWL. Table 17 lists a range of indicators used to assess management of stroke risk factors.

Table 17: Selected primary and secondary prevention indicators

Primary prevention indicators	Secondary prevention indicators
The percentage of patient with atrial fibrillation diagnosed after 1 April 2006 with ECG or specialist confirmed diagnosis (AF2)	Stroke / TIA and blood pressure check in 15 months (Stroke 5)
The percentage of patient with atrial fibrillation who are currently treated with anti-coagulation drug therapy or an anti-platelet therapy (AF3)	Stroke / TIA and blood pressure 150/90 or less (Stroke 6)
Hypertension and blood pressure check in last 9 months (BP4)	Stroke / TIA and cholesterol check in 15 months (Stroke 7)
Hypertension and blood pressure of 150/90 or less (BP5)	Stroke / TIA and cholesterol 5.0mmol/l or less (Stroke 8)
Diabetes and blood pressure check in 15 months (DM 11)	The % of new patients with a stroke who have been referred for further investigation. (Stroke 11)
Diabetes and blood pressure 145/85 or less (DM 12)	The % of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record that an anti-platelet agent (aspirin, clopidogrel, dipyridamole or a combination), or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded) (Stroke 12)
Diabetes and cholesterol check in last	The percentage of patients with any or any

15 months (DM16)	combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD or asthma who smoke whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the previous 15 months (Smoking 2)
Diabetes and cholesterol 5.0mmol/l or less (DM 17)	

Current performance against primary and secondary prevention QOF indicators is shown for NWL PCTs in Tables 18a-b. These have been reproduced from the London Stroke Prevention Strategy.

Table 18a: QOF performance

Indicator ID	75th centile for each PCT to be achieved by 2010				
	London 75%	Brent	Ealing	Hammersmith & Fulham	Harrow
Stroke 5	96.32%	96.08%	96.20%	94.59%	97.37%
Stroke 6	87.69%	87.83%	89.47%	88.24%	87.18%
Stroke 7	90.98%	90.91%	91.62%	89.92%	92.76%
Stroke 8	71.62%	73.68%	70.00%	63.33%	70.73%
Stroke 11	8.13%	8.33%	9.52%	6.86%	5.71%
Stroke 12	58.90%	53.85%	57.41%	65.77%	63.89%
AF 2	20.31%	22.58%	23.08%	18.99%	19.19%
AF 3	91.73%	91.67%	92.37%	93.67%	91.67%
BP 4	93.08%	92.63%	92.77%	90.91%	94.12%
BP 5	78.69%	77.46%	81.29%	77.54%	80.49%
DM 11	98.03%	98.01%	97.95%	97.33%	98.72%
DM 12	79.02%	77.29%	80.11%	79.75%	79.49%
DM 16	94.80%	95.22%	95.43%	93.21%	96.88%
DM 17	76.13%	77.06%	76.08%	71.14%	77.91%
Smoking 2	19.08%	15.80%	17.33%	21.64%	12.16%

Table 18b: QOF performance

Indicator ID	75th centile for each PCT to be achieved by 2010				
	London 75%	Hillingdon	Hounslow	Kensington & Chelsea	Westminster
Stroke 5	96.32%	97.44%	96.97%	97.50%	97.30%
Stroke 6	87.69%	87.39%	91.67%	90.63%	85.96%
Stroke 7	90.98%	91.67%	92.55%	93.33%	90.35%
Stroke 8	71.62%	71.93%	73.68%	73.47%	72.22%
Stroke 11	8.13%	8.11%	8.75%	10.53%	8.33%
Stroke 12	58.90%	56.25%	54.24%	63.33%	57.33%
AF 2	20.31%	20.41%	23.08%	21.43%	15.69%
AF 3	91.73%	92.86%	93.55%	91.89%	91.01%
BP 4	93.08%	94.10%	92.86%	92.97%	91.35%
BP 5	78.69%	79.95%	83.09%	79.49%	75.42%
DM 11	98.03%	98.25%	98.20%	97.93%	98.00%
DM 12	79.02%	80.17%	82.45%	79.55%	77.21%
DM 16	94.80%	94.71%	95.59%	95.24%	94.62%
DM 17	76.13%	78.61%	76.67%	76.36%	74.57%
Smoking 2	19.08%	18.87%	18.32%	20.95%	18.86%

By early 2010 PCTs will be expected to achieve 75th centile in London for the above. With the exception of one or two indicators for each PCT, most are operating at, or close to, the London average, although continuous improvement will be required as the London average should improve dramatically over the next 2 years. Particular attention needs to be given to smoking cessation and the percentage of new patients with a stroke who have been referred for a further investigation. These are being picked up under the stroke initiative.

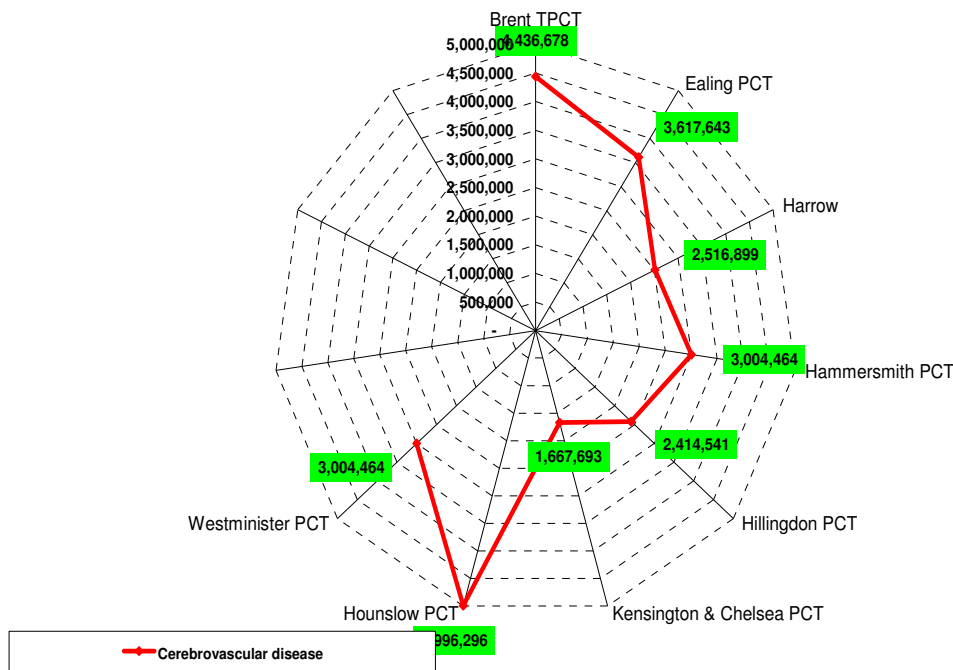
Programme budgeting

Figure 9 shows PCT spend per 100,000 population for cerebrovascular disease.

This shows that Brent TPCT and Hounslow PCT spend the most on cerebrovascular disease and Kensington & Chelsea PCT spends the least.

Fig 9

North West London PCT Spend per 100,000 population comparison by Disease Category
Period:2006/7



CANCER

Cancer treatments and services have improved dramatically over the last seven years, and a recent DH Public Health report showed NWL as having the fourth lowest mortality rate for cancer in England. The recent Cancer Reform Strategy, however, showed there was still a significant amount of work to progress and tasked PCTs, working with their Cancer Networks, with achieving the key aims.

PCT cancer-specific commissioning responsibilities include ensuring progress on:

- Using resources effectively and efficiently, especially in relation to inpatient care;

- Collecting and reporting public awareness and patient experience surveys and agreed clinical datasets;
- Increasing public awareness of factors associated with cancer and symptoms of the disease and promoting earlier presentation by patients with symptoms;
- Providing screening programmes in line with national guidance and with high levels of coverage;
- Reducing inappropriate delays in investigation and onward referral of new cancer patients by GPs;
- Achieving waiting time standards;
- Enabling all patients to receive care from a properly constituted multidisciplinary team, with complex surgery only being undertaken by centres which are compliant with NICE guidance;
- Providing information and support to promote informed choice in treatment and care;
- Delivering safe and effective radiotherapy in accordance with the recommendations of the National Radiotherapy Advisory Group;
- Ensuring the availability of safe and effective chemotherapy with new treatments being delivered in accordance with NICE guidance and having robust and fair processes in place for making decisions on drugs that have not yet been appraised by NICE;
- Providing high quality supportive and palliative care in line with NICE guidance.

Incidence

Incidence varies across PCTs as demonstrated in Table 19 below. The incidence rates per 100,000 of population are greatest for breast cancer and prostate cancer, and lowest for colorectal and lung cancer. For breast cancer, Hammersmith and Fulham have the lowest rate of 94.1 per 100,000 population and Westminster has the highest rate of 115.6 per 100,000 population. Similarly, for prostate cancer, Brent TPCT has the highest incidence rate of 106.4 per 100,000 population, while Hounslow has the lowest incidence rate at 67 per 100,000 population.

Table 19: Directly age standardised rate per 100,000 of population

		Brent	Ealing	Hammersmith & Fulham	Harrow	Hillingdon	Hounslow	Kensington & Chelsea	Westminster	NWL London Average
Breast cancer incidence	2006/7	98.6	102.0	94.1	123.4	99.9	99.2	99.3	115.6	104.0
Colorectal cancer incidence	2006/7	39.3	37.1	35.7	34.9	30.3	39.7	36.9	36.3	36.3
Lung cancer incidence	2006/7	40.0	39.0	53.0	33.0	48.0	41.0	36.0	50.0	42.5
Prostate cancer incidence	2006/7	106.4	87.4	86.2	82.4	81.4	67.0	87.2	84.0	85.2
Palliative care prevalence	2006/7	0.05%	0.05%	0.05%	0.09%	0.06%	0.06%	0.07%	0.09%	0.06%

Data source: National Clinical Health Outcomes Database

These differences do not appear to correlate with socio-economic factors.

Prevention and Treatment

Prevention

Screening programmes and awareness-raising are vital in combating the disease. It is estimated that over 50% of all cancers could be prevented by changes to lifestyle, in particular smoking, obesity, alcohol use and by reducing over exposure to sunlight.

The risk of developing a cancer can be reduced by changes to lifestyle. Smoking is the biggest single risk factor for cancer. The data on the number of smoking quitters is presented in table 14 for all PCTs in the sector.

Table 20 below represents screening coverage of eligible women invited for a screening test for cervical and breast screening for PCTs in the sector and the percentage of patients receiving definitive treatment for suspected forms of cancer within two months or urgent referral.

Table 20: Screening for cancers

	Brent	Ealing	Hammersmith & Fulham	Harrow	Hillingdon	Hounslow	Kensington & Chelsea	Westminster	NWL London Average	London Average	England
Proportion of women aged 53-64 offered screening for breast cancer	62.4%	68.4%	59.8%	71.5%	68.7%	67.3%	54.8%	53.1%	63.3%	65%	76%
Proportion of women aged 25-64 screened for cervical cancer	64.0%	65.2%	58.5%	68.1%	67.0%	65.7%	61.4%	62.4%	64.0%	65%	69.4%
Percentage of patients receiving their first definitive treatment for cancer within two months of urgent referral for suspected cancer.	98.5%	96.3%	100.0%	97.5%	98.1%	98.4%	97.0%	99.0%	98.1%	96.4%	96.1%

Data source: Information centre 2006/7

Variation exists in the breast cancer and cervical screening rates across PCTs in NWL as presented in table 20. For both cancers, the NWL sector average is below the London and England average. Performance against the cancer treatment target is above the London and England average.

Improvement in screening for cancers has been included in CSP initiatives. This will be monitored by the Cancer Network.

Treatment

Cancer treatments have improved dramatically over the years. However, for most cancers, the earlier a cancer can be diagnosed, the better the clinical outcomes.

Mortality Rates

Variation exists in the cancer mortality rates across PCTs in NWL as presented in table 21. For all cancers, most PCT's in NWL are below the London average of 114.58 and England rate of 117 per 100,000 people (National Clinical Outcomes database). Hillingdon PCT is an outlier with a mortality rate of 120.23 per 100,000 population.

However for the other types of cancers:

- Lung cancer – Hammersmith & Fulham has the highest mortality rate of 42.43 in comparison to the lowest rate at Kensington and Chelsea PCT of 25.79
- Colorectal cancer - Hammersmith & Fulham has the highest rate of 16.58 in comparison to the lowest rate at Kensington and Chelsea PCT of 11.6
- Prostate cancer – Harrow PCT has the highest rate of 30.1 in comparison to the lowest rate at Kensington and Chelsea PCT of 15.24
- Breast cancer – Hounslow PCT has the highest rate of 31.02 in comparison to the lowest rate at Kensington and Chelsea PCT of 18.34

Table 21: Mortality rates for all Cancers and Cancer types

Directly age standardised rate per 100,000 European standardised population											
		Brent	Ealing	Hammersmith & Fulham	Harrow	Hillingdon	Hounslow	Kensington & Chelsea	Westminster	England	London
All Cancer Mortality (Under 75's)	2004-6	97.06	108.89	117.27	101.7	120.23	111.89	76.71	96.62	117.06	114.58
Lung Cancer (All Ages)	2004-6	30.21	36.12	42.43	28.19	38.92	39.43	25.79	33.46	38.47	38.58
Colorectal Mortality(All Ages)	2004-6	15.31	14.8	16.58	13.75	15.77	13.38	11.6	15.7	18.18	16.89
Cervical Cancer Mortality (All Ages)	2004-6	3.05	1.65	3.19	1.83	4.34	1.47	1.24	1.85	2.49	2.42
Prostate Cancer(All Ages)	2004-6	25.62	27.17	21.95	30.1	23.07	26.73	15.24	17.22	25.68	24.9
Breast Cancer Mortality(All Ages)	2004-6	24.74	26.45	22.56	29.53	30.68	31.02	18.34	28.77	28.04	27.71

Data source: National Clinical Health Outcomes Database

For all cancer mortality, NWL PCTs have a lower death rate than the England and London averages with the exception of Hillingdon and Hammersmith and Fulham. This pattern is reflected across the majority of cancers.

It is interesting to note the significantly lower mortality rates across all cancer groups in K&C. This may also be a contributor to the significantly higher life expectancy in this borough.

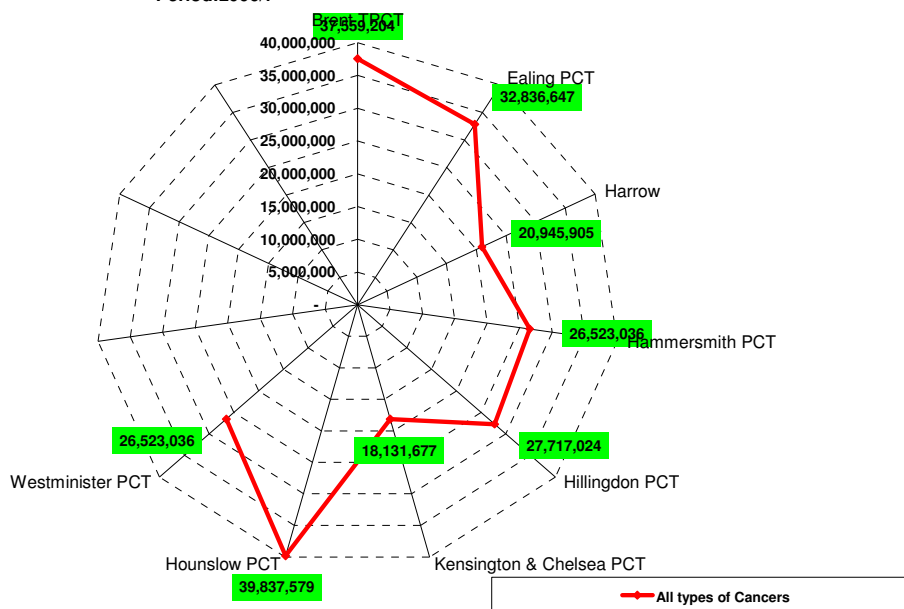
Programme budgeting

The chart (Fig.10) shows PCT spend per 100,000 population for all types of cancer.

Hounslow PCT spends the highest amount with Kensington & Chelsea PCT being the lowest spender.

Fig 10:

North West London PCT Spend per 100,000 population comparison by Disease Category
Period:2006/7



The Kings Fund report (Sept 2008) was unable to establish any correlation between spend and outcome for cancer.

DIABETES

Diabetes is becoming a more common condition world-wide. It can affect people of all ages in every population. Socially disadvantaged groups in affluent societies and people from black and minority ethnic communities (especially those of South Asian, African and African-Caribbean descent) are particularly vulnerable.

Diabetes can have a major impact on the physical, psychological and material well-being of individuals and their families, and can lead to complications such as heart disease, stroke, renal failure, amputation and blindness. There is evidence to show that:

- the onset of Type 2 diabetes can be delayed, or even prevented
- effective management of the condition increases life expectancy and reduces the risk of complications
- self-management is the cornerstone of effective diabetes care.⁴

Inequalities

Diabetes does not impact upon everyone in society equally. Significant inequalities exist in the risk of developing diabetes, in access to health services and the quality of those services, and in health outcomes, particularly with regard to people with Type 2 diabetes. Those who are overweight, physically inactive or have a family history of diabetes are at increased risk of developing diabetes. People of South Asian, African, and African-Caribbean descent have a higher than average risk of developing Type 2 diabetes, as do less affluent individuals and populations. Socially excluded people, including prisoners, refugees and asylum seekers, and people with learning difficulties or mental health problems may receive poorer quality care. More than one of these risk factors may apply to some individuals. The knowledge that people have about their diabetes also varies considerably.

Ethnicity and Age effects on inequalities

Compared with the white population, Type 2 diabetes is up to six times more common in people of South Asian descent and up to three times more common in those of African and African-Caribbean descent. It is also more common in people of Chinese descent and other non-Caucasian groups. The average age at diagnosis is also comparatively younger in these groups. The risk of death from diabetes is between three and six times higher, with these groups also being particularly susceptible to the cardiovascular and renal complications of diabetes.

At a NWL level, the differences in ethnic mix, population changes and age profiles suggest that there is significant inequality in relation to diabetes which will need to be addressed by PCTs. However, existing action on cardiac disease and planned action on stroke will have an impact on diabetes due to the overlap in relation to lifestyle management and healthcare interventions.

Prevalence & Incidence

The incidence of diabetes in the general population is influenced by a number of lifestyle factors including smoking, obesity, poor diet, and lack of physical activity. Early screening and diagnosis can help reduce the onset of the disease.

⁴ Diabetes NSF 2001

The prevalence estimates for 2005 to 2010 are calculated by combining population estimates/projections with age, sex and ethnic group specific estimated diabetes prevalence rates which are then adjusted for deprivation. This is shown in table 22.

Table 22: Growth in prevalence rates

	2005	2006	2007	2008	2009	2010
England	4.48%	4.58%	4.67%	4.77%	4.86%	4.95%
Harrow	5.7%	5.9%	6.0%	6.2%	6.3%	6.4%
Ealing	5.2%	5.4%	5.5%	5.6%	5.7%	5.8%
Brent Teaching	6.2%	6.3%	6.5%	6.7%	6.8%	7.0%
Kensington and Chelsea	4.2%	4.3%	4.3%	4.3%	4.4%	4.4%
Hounslow	5.1%	5.2%	5.3%	5.4%	5.6%	5.7%
Hillingdon	4.6%	4.7%	4.8%	4.9%	5.0%	5.1%
Westminster	4.1%	4.1%	4.2%	4.2%	4.2%	4.2%
Hammersmith and Fulham	3.9%	4.0%	4.0%	4.1%	4.1%	4.2%
North West London	4.9%	5.0%	5.1%	5.2%	5.3%	5.3%

Data source: Eastern Region Public Health Observatory

The prevalence rate in NWL is slightly higher than the England average with little change in prevalence predicted to 2010. However, the NWL average disguises significant differences in prevalence rates between the PCTs. Harrow, Ealing, Brent and Hounslow all have prevalence rates above 5% which probably relates to their high ethnic populations.

Treatment

The two key performance indicators for monitoring treatment of diabetes are HbA1C and retinopathy screening.

HbA1C

For each individual a target HbA1C should be set between 6.5% and 7.5% based on the risk of macrovascular and microvascular complications.

Table 23 shows the percentage of diabetes patients whose last recorded HbA1C (within last 15 months) was 7.5 or less (March 2008). Only 60% of patients on Practice registers who had their HbA1C measured were within the acceptable range.

Table 23

The percentage of diabetes patients whose last recorded HbA1C (within last 15 months) was 7.5 or less										
	Brent	Ealing	Hammersmith & Fulham	Harrow	Hillingdon	Hounslow	Kensington & Chelsea	Westminster	NWL London	London Average
2007/8	62.8%	59.8%	66.3%	63.0%	60.4%	61.2%	64.3%	62.1%	62.49%	63.0%

Data Source: London health observatory – public health management report Aug 2008

Diabetic retinopathy screening

Diabetic retinopathy is the most common cause of blindness in working age people in the UK. Early detection and treatment halves the risk of sight loss. The Priorities and Planning Framework 2003–2006 & Diabetes NSF Delivery strategy both include the target of 80% coverage of screening of people with diabetes by 2006 rising to

100% by the end of 2007. At the end of March 2008, as shown in table 24, 85.6% coverage was achieved across London, with a range of 76.3% (Ealing) to 100% (Harrow, Hillingdon, K & C and H&F).

Table 24:

Percentage of people screened for diabetes											
		Ealing	Hammersmith & Fulham	Harrow	Hillingdon	Hounslow	Kensington & Chelsea	Westminster	NWL London	London Average	
2007/8		94.8%	76.3%	100.0%	100.0%	100.0%	96.4%	100.0%	99.4%	95.86%	85.6%

Data Source: London health observatory – public health management report Aug 2008

Mortality Rates

Table 25: Mortality rates for Diabetes

Directly standardised rates per 100,000 standard European population for diabetes (ICD-10 E10-E14), all ages								
	Brent	Ealing	Hammersmith & Fulham	Harrow	Hillingdon	Hounslow	Kensington & Chelsea	Westminster
2004-6	7.71	7.46	6.02	5.92	7.24	9.14	3.76	3.07
2003-5	9.33	7.53	6.59	6.69	8.37	8.28	5.4	4.42

Data source: National Centre for Health Outcomes Development, 2004/06

Variation exists in the mortality rates (Table 25) across PCTs in NWL. Across all PCTs, there has been a reduction in mortality rate between 2003-5 and 2004-6.

Mortality rates are, in general, higher in those PCTs with high ethnic populations.

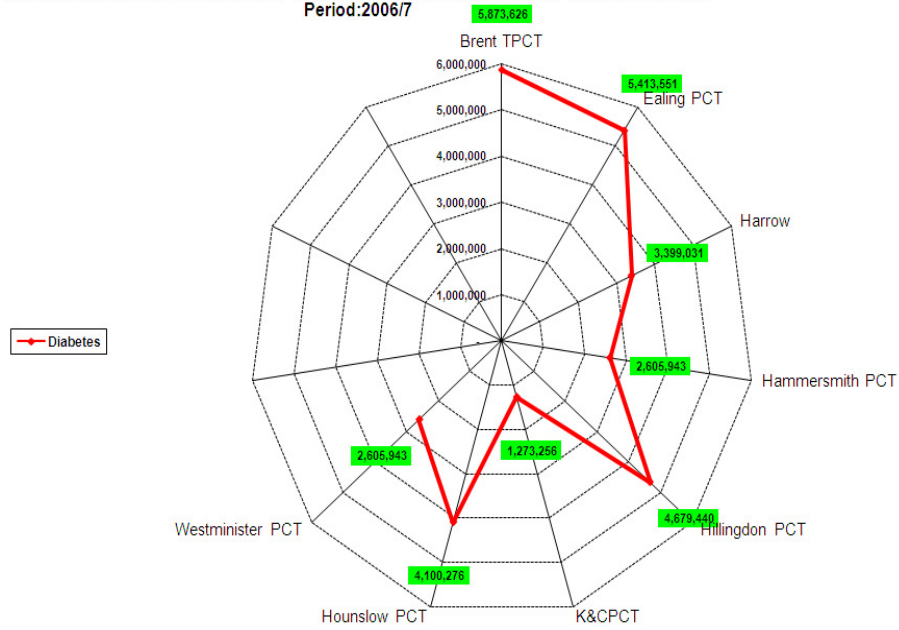
Programme budgeting

The chart (Fig.11) shows PCT spend per 100,000 for diabetes.

There is considerable variability in spend per 100,000 population. Spend is lowest in K&C, H&F and Westminster PCTs where the prevalence of disease is lowest.

Fig. 11:

North West London PCT Spend per 100,000 population comparison by Disease Category
Period:2006/7



HEALTHCARE PROVISION

The provider landscape is described later in the document. This section focuses specifically on the delivery of, and access to, health care in NWL.

In 2006-7, the PCTs in NWL, through NHS London, commissioned McKinsey to undertake an analysis of health and healthcare within the sector. Based on the analysis, the NWL Clinical Reference Group (CRG) made a series of recommendations to the CCG about priorities for action (Appendix 2). This work identified three key areas for review within NWL.

1. Clinical Scale

- A critical mass of activity is required to maximise clinical safety and outcomes
- NWL services are subscale in key clinical areas
 - Emergency Services (medicine, surgery, trauma and A&E)
 - Obstetrics
 - Paediatrics
 - Planned Care (e.g., vascular surgery)

2. Clinical Capacity

- The current number of beds per capita does not imply excess capacity
- However, NWL is significantly behind national average on several key measures
 - Admission through A&E
 - Rate of elective day cases
 - Average Length of Stay
- Improved efficiency, coupled with PCT demand management initiatives, would create excess capacity

3. Clinical Quality

- NWL trusts have respectable Healthcare Commission ratings and mortality rates
- However, service level performance is inconsistent across providers (e.g., stroke services)
- Significant changes would need to be put in place to increase clinical quality to international benchmarks

Although the areas identified for specific action are, in some cases, no longer valid, the broad headings are still relevant and have been the focus of the NWL collaborative programme over the last 18 months.

Within this section, we describe the state of play as described in 2006-7 and any changes in delivery and access to services since then.

CLINICAL SCALE

Acute Care

The CRG noted that treatment for major acute illness can be improved by the concentration of highly specialised services such as interventional cardiology and stroke care. This assertion has subsequently been confirmed by the HfL work. The section below describes work that has been undertaken, or is underway, to address issues of clinical scale within NWL.

Interventional cardiology

The sector has had good experience of re-engineering acute myocardial infarction services by providing 24/7 acute angioplasty services in a smaller number of centres with dramatic improvements in outcome measures. This was achieved through developing detailed protocols with London Ambulance Service to facilitate patient diversion to appropriate units of expertise.

Hyper-acute and Acute Stroke

The CRG identified varying clinical practice within the stroke care pathway which suggested that services were less than ideal to secure the best healthcare outcomes for patients in NWL. Significant variability in the delivery of stroke care against the National Sentinel Audit standards in 2006 (shown in Table 26) led to the inclusion of Stroke as a key initiative in the 2007-9 CCI.

Table 26: National Sentinel Audit Standards (2006)

Acute episodes Evidence 1: NWL quality indicators for Stroke are inconsistent across providers.

Summary scores (totals, brain scan & physiotherapist assessment)

	Total score across 12 indicators	Emergency brain scan within 24hours	Physiotherapy assessment within 72 hours
Chelsea and Westminster	88	84	98
Ealing	66	52	83
Hammersmith	70	54	76
Hillingdon	71	61	88
Central Middlesex	76	65	90
Northwick Park	68	36	85
St Mary's	86	80	93
West Middlesex	65	77	49
London SHA average	72	58	74

All indicators and comparison of 2004 & 2006 totals

	Number of cases in audit	Patients treated in a stroke unit	Patients treated for >50% of stay in a stroke unit	Screening for swallowing disorders <24 hours after admission	Brain scan within 24 hours	Aspirin by 48 hours after stroke	Physiotherapist assessment within 72 hours of admission	OT assessment within 7 days of admission	Patient weighted during admission	Patient's mood assessed by discharge	Patient on antithrombotic therapy by discharge	Rehabilitation goals agreed by multidisciplinary team	Home visit performed before discharge	2006 key 12 indicator score	2004 key 12 indicator score
Chelsea and Westminster	49	86	78	79	84	95	98	97	70	76	100	95	100	88	82
Ealing	62	69	58	92	52	91	83	42	100	15	100	4	91	66	67
Hammersmith	79	59	44	55	54	86	76	68	96	56	100	69	75	70	NA
Hillingdon	54	78	67	31	61	90	88	88	84	20	100	79	62	71	70
Central Middlesex	43	81	70	55	65	82	90	94	58	37	100	76	100	76	51
Northwick Park	64	50	50	82	36	91	85	91	55	20	100	63	93	68	72
St Mary's	51	82	76	86	80	97	93	78	96	86	100	100	54	86	89
West Middlesex	52	54	40	59	77	85	49	52	44	52	100	72	100	65	68
London SHA average		67	60	72	58	89	74	75	68	55	100	77	73	72	66

Source: 2006 National Sentinel Stroke Audit

A project group was established in January 2008 with a brief to:

- Review the current stroke care pathway and implement a future model of care for the appropriate management of patients presenting with a TIA or stroke in NWL that takes account of the Royal College of Physicians (RCP) guidance and the National Stroke Strategy. This should include:
 - Timely detection and effective management of patients at risk of stroke and TIA through the use of risk registers in primary care and managing risk factors such as hypertension and atrial fibrillation in line with clinical guidelines.
 - Patients presenting with a TIA or minor stroke are assessed, imaged (brain and carotid) and follow the most appropriate pathway according to the level of risk.
 - Deliver a solution where at least one Trust in NWL is able to provide specialist stroke care 24/7 (imaging and thrombolysis if it is clinically indicated), supported by full neuroscience expertise with the remainder providing treatment during the day and rehabilitation services closer to people's homes.
 - All patients with suspected acute stroke are assessed, imaged and diagnosed so that they follow the most appropriate pathway in a timely fashion.
 - All stroke patients spend the majority of their time in an acute stroke unit.
 - Identify and commission appropriate rehabilitation services to maximise functional potential following a stroke and enable the individual to have the best chance to return to as normal a life as possible.
- To improve the performance of NWL Trusts against the RCP Sentinel Audit standards.

Four project streams were established as outlined below. These groups report through a Stroke Clinical Reference group which has strong clinical and managerial representation from all of the Trusts in NWL.



Considerable work to derive a model for care and to produce sector-wide policies for hyper-acute care was undertaken over the period Jan – June 2008. During this period, the HfL Stroke project was launched and the sector approach has now dovetailed with the HfL work. Going forward, responsibility for implementing the National Stroke strategy and the outcome from the HfL stroke designation process will move to the NWL Stroke and Cardiac network, although there will continue to be close collaboration with the NWL Collaborative programme and the NWL CRG.

National Sentinel Audit 2008 (Phase 1 Organisation Audit) results have recently been published by the RCP. The results for NWL are shown in Tables 27 & 28.

Table 27: Organisational Audit data (2008)

Site name (name of Trust or hospital within a Trust)	Number of Acute Stroke Units	Number of Rehabilitation Stroke Units	Number of Combined Stroke Units	Number of SUTC key stroke unit features (max 5)	Number of ASUs at this site with all five acute criteria	Number of CSUs at this site with all five acute criteria	Specialist Community / Domiciliary Rehab Team	Team staffed by stroke or neurological specialists	Early Supported Discharge Team	Thrombolysis service either on site or a formal arrangement with another site
National results (% of sites)	50%	50%	44%	73% have all 5	42% have all 5	39% have all 5	70% have a team	70% of those with a team	31%	
Chelsea & Westminster Hospital NHS Foundation Trust	0	0	1	5	N/A	1	Yes	Yes	No	Yes
Ealing Hospital NHS Trust	1	0	0	4	0	N/A	No	N/A	No	No
Hillingdon Hospital NHS Trust	0	0	1	4	N/A	0	No	N/A	No	No
Imperial College Healthcare NHS Trust	0	2	3	5	N/A	3	Yes	Yes	No	Yes
North West London Hospitals NHS Trust (Central Middlesex Hospital including	1	0	0	4	0	N/A	Yes	Yes	Yes	Yes
North West London Hospitals NHS Trust (Northwick Park Hospital)	0	0	1	2	N/A	1	Yes	Yes	Yes	Yes
West Middlesex University Hospital NHS Trust	1	1	0	5	0	N/A	Yes	Yes	No	No

Table 28: Organisational Audit data (2008)

Site name (name of Trust or hospital within a Trust)	Average CT scan waiting time weekdays	Average CT scan waiting time weekends	Average MRI scan waiting time weekdays	Average MRI scan waiting time weekends	Neurovascular clinic	TIA service	Neurovascular clinic average waiting time	All high risk TIA patients seen and investigated within 24 hours	All low risk TIA patients seen and investigated within one week	Patient / carer views sought on service	Report produced within 12 months analysing patient / carer views	Overall position in 2008	Overall position in 2006
Chelsea & Westminster Hospital NHS Foundation Trust	0-4 hours	0-4 hours	25-48 hours	>48 hours	Yes	Yes	10	Yes	Yes	Yes	Yes	✓	✓
Ealing Hospital NHS Trust	5-24 hours	5-24 hours	25-48 hours	25-48 hours	No	Yes	N/A	No	Yes	Yes	Yes	✗	✗
Hillingdon Hospital NHS Trust	5-24 hours	5-24 hours	5-24 hours	>48 hours	Yes	Yes	12	No	No	Yes	Yes	✗	◇
Imperial College Healthcare NHS Trust	0-4 hours	0-4 hours	5-24 hours	5-24 hours	Yes	Yes	4	Yes	Yes	Yes	Yes	✓	N/A
North West London Hospitals NHS Trust (Central Middlesex Hospital including Willesden Community Hospital)	5-24 hours	5-24 hours	25-48 hours	>48 hours	N/A	No	N/A	N/A	N/A	No	No	✗	✓
North West London Hospitals NHS Trust (Northwick Park Hospital)	5-24 hours	5-24 hours	25-48 hours	>48 hours	Yes	Yes	10	No	No	Yes	Yes	◇	◇
West Middlesex University Hospital NHS Trust	5-24 hours	5-24 hours	25-48 hours	>48 hours	Yes	Yes	14	Yes	No	Yes	No	◇	◇

Key:
 ✓ best organised (upper quartile)
 ✗ least well organised (lower quartile)
 ◇ middle half

The above shows that in 2008 C&WFT and ICHT were in the upper quartile, EHT, THH and NWLH (CMH site) were in the lower quartile and NWLH (NWP) and WMUH were in the middle range of hospitals in terms of the organisation of stroke services. Disappointingly, Hillingdon and NWLH's (CMH site) performance deteriorated between 2006 and 2008 and Ealing hospital continues to be in the lower quartile for performance nationally and has not improved over the 2 year period.

The DH Asset Tool for commissioners (2004/05 HES data) has been used to estimate the scope for improving stroke care. Table 29 illustrates the impact of four acute interventions in terms of improved outcomes and bed day savings.

Table 29: Impact of four acute interventions

	Impact from Stroke Units		Thrombolysis rate 4%		Thrombolysis rate 9%		Early Supported Discharge Teams		One-stop TIA Clinics
	Beddays saved	Red'n in deaths or disabling strokes	Beddays saved	Better Outcomes	Beddays saved	Better Outcomes	Beddays saved	Better Outcomes	Strokes avoided p.a.
PCT									
Brent	2080	19	124	4	278	10	1981	15	10
Ealing	4464	42	170	6	382	14	2886	22	14
Hammersmith & Fulham	1556	15	78	3	176	6	1535	12	0
Harrow	1905	18	83	3	187	7	1184	9	10
Hillingdon	4470	42	210	8	473	17	2906	22	10
Hounslow	3328	31	194	7	436	16	3808	29	6
Kensington & Chelsea	1731	16	119	4	267	10	2332	17	0
Westminster	482	4	89	3	200	7	1748	13	3
NWL Total	20016	187	1067	38	2399	87	18380	139	53

The above shows the following in relation to each intervention:

Impact from Stroke Units

The Stroke Unit Trialists research has shown that stroke units reduce length of stay by 6 days on average and reduce the likelihood of death and dependency following a stroke. Table 29 shows a potential reduction of 187 deaths or disabling strokes across NWL if all patients were treated on a stroke unit.

Thrombolysis

Increasing thrombolysis rates to 4% or 9% would benefit 38 - 87 people in terms of a reduction in strokes leading to dependency and 1067-2399 bed-days could be saved.

Early Supported Discharge Teams (ESD)

ESD teams have been shown to reduce hospital lengths of stay by an average of 8 days for each stroke patient on their caseload, as well as improving the long-term outcomes for stroke patients.

One-Stop TIA Clinics

Research has shown that rapid access to carotid surgery following a TIA is a cost-effective intervention in avoiding strokes, so long as this happens within 2 weeks of the TIA. Expert opinion suggests that if all patients who have a TIA can access a one-stop TIA clinic within 7 days, then the total number of strokes would reduce by 2%. One-stop TIA clinics have been shown to be a cost-effective way of delivering care and if this service was in place across NWL a total of 53 strokes would have been avoided.

This information has identified that there is still considerable scope for improvement in Stroke care and has been used to inform decisions about the possible configuration of stroke services across the sector. This is being addressed through a specific initiative on Stroke across London, the local implementation of which is outlined in section 4.

Paediatric services

In its assessment of the provision of paediatric care in NWL in 2007, the NWL CRG made recommendations to co-locate paediatric and neonatal surgery with critical care services, with links to a major A&E and specialist medical services to ensure a high quality, risk minimised service. It was recommended that options development and consultation on alternative service models should take place. These recommendations resulted in complex in-patient neonatal & paediatric surgical care

being identified as one of five priority areas to be addressed by the eight NWL Primary Care Trusts.

Local providers of these services were unable to agree on how and when the above co-located model of care could be achieved. As a result, the Joint Committee of the PCTs (JCPCT) made a decision in February 2008 to establish a Paediatric Project Group to scope and specify the service required. The JCPCT also noted that no formal review of paediatric services had been undertaken in the last 10 years in NWL and as a result:

- Specialist paediatric services (surgery and medicine) are fragmented
- There is no clearly designated Lead Centre for Paediatrics
- Paediatric Intensive Care (PIC) beds are on 2 sites and the site undertaking the majority of complex surgery does not have a Paediatric Intensive Care Unit (PICU).
- PIC and Neonatal Intensive Care (NIC) services are arranged in networks but are still fragmented
- There are clear standards for the provision of PIC, NIC and Paediatric surgery. At present there is little evidence to demonstrate that these are being complied with.
- Information to demonstrate the effectiveness and quality of care is poor.

Evidence from the literature supports the development of networks of care with a lead centre providing care for those children with complex needs and supporting the continued delivery of less complex care as close to home as possible.

The Project Initiation Document (PID) produced by the Paediatric Project Group recommended that the 2014 standards for hospital care should be met in 4 phases, which are:

- Phase 1:** To resolve the current fragmentation of complex, in-patient surgery by optimising the number of centres which provide a service and aligning paediatric and neonatal critical care with that centre.
- Phase 2:** To create a paediatric surgical network, co-ordinated by the lead centre, that ensures that surgical care for children within NWL is children-centred, of the highest quality, provided as close to home as possible, meets national standards and is sustainable within the context of the Children's NSF.
- Phase 3:** To rationalise general paediatric care (medical and surgical) in line with the outputs from the Darzi review of healthcare in London.
- Phase 4:** To develop a managed Local Children's Clinical Network

The analytical component of Phase 1 was completed in September 2008. This identified the size of the issue and the distribution of care. The case-mix analysis revealed a number of issues:

- The majority of complex general paediatric surgery for the population of NWL is undertaken at Chelsea and Westminster NHS Foundation Trust. The additional complex general paediatric surgery undertaken at ICHT and RBHT is mainly undertaken by surgeons employed by C&WFT.
- Furthermore, information provided by Chelsea and Westminster hospital showed that in 2006-7, the number of surgical children transferred out was four. The paediatric surgeons carried out 27 planned general surgical operations in respiratory patients at The Royal Brompton. There were 20

admissions to PICU following surgical procedures at St Mary's on children. The proportion of children requiring PICU care, despite their surgery being defined as complex, therefore appears to be small.

- A significant amount of complex care is provided by other tertiary providers outside of NWL. Were a lead centre with appropriate facilities located within NWL there would be an opportunity to repatriate work to the sector.
- Imperial healthcare NHS Trust, although providing a PICU service, does not appear to provide a complex paediatric surgical service except where it relates to neonatal care or to those cases transferred from C&WFT.

This raised a number of questions about the process for re-commissioning care within phase 1. Were the competitive procurement route selected, this might result in a provider from outside of the NWL patch offering the best response to any Invitation to Tender (ITT). Although this would be positive in terms of meeting the criteria of the Service Specification it might:

- raise issues around access for the patient population in NWL;
- limit the viability of any provider on the NWL patch being able to successfully bid for future phases of the project; and,
- reduce the volume of cases being treated at the current tertiary centre(s) in the NWL patch, which may impact their overall neonatal and paediatric services provision.

On the basis of this assessment, it was agreed the tender process should be re-focused to identify a lead centre for neonatal and paediatric surgery and in doing so, this would deal with phases 1 & 2 of the project. The specification should require bidders to describe:

1. How they would deal with the issues of fragmentation in the short term
2. More strategically, how they would propose to support the evolution of a paediatric surgical network, ensuring that surgical care for children within NWL is children-centred, of the highest quality, provided as close to home as possible, meets national standards and is sustainable within the context of the Children's NSF.

In Oct 2008, HfL launched its Paediatric project. This work is still in its infancy, but discussions with the HfL project team have confirmed that the NWL project is in line with the direction of travel for paediatric care in London and agreement has been reached to use the NWL work as a pilot for a London-wide review of acute neonatal and surgical care. The next phase of the work is described in the section 4.

Maternity care

Improving Maternity services has become a key priority for the NWL sector in 2008/09 and beyond. NWL PCTs had already identified Maternity Services as an area for review due to issues around projected growth and capacity and, more recently, the results of the Healthcare Commission review of Maternity Services which demonstrated the poor level of care provision and perceptions of care within NWL that need to be addressed.

An initiative on Maternity care was included in the 2007-9 CCI. The key objectives for this work were:

- Improved outcomes for mothers and babies.
- To fully understand the growing demand for maternity care and implications for service delivery
- To develop capacity plans that will meet the projected demand
- To meet national standards in relation to choice, access and care pathways
- To ensure standardisation across the NWL sector for ante-natal and post-natal care with clarity of function between obstetricians, midwives and GPs
- To deliver sustainable solutions for the future

A project group was established in April 2008 to drive this initiative. This group has been working closely with the NHS London Maternity programme and more recently the HfL project lead and there has been significant input from NWL into the London-wide projects. Over time, it is anticipated that the work will be taken forward through the development of a Children, Young people and Maternity Services network.

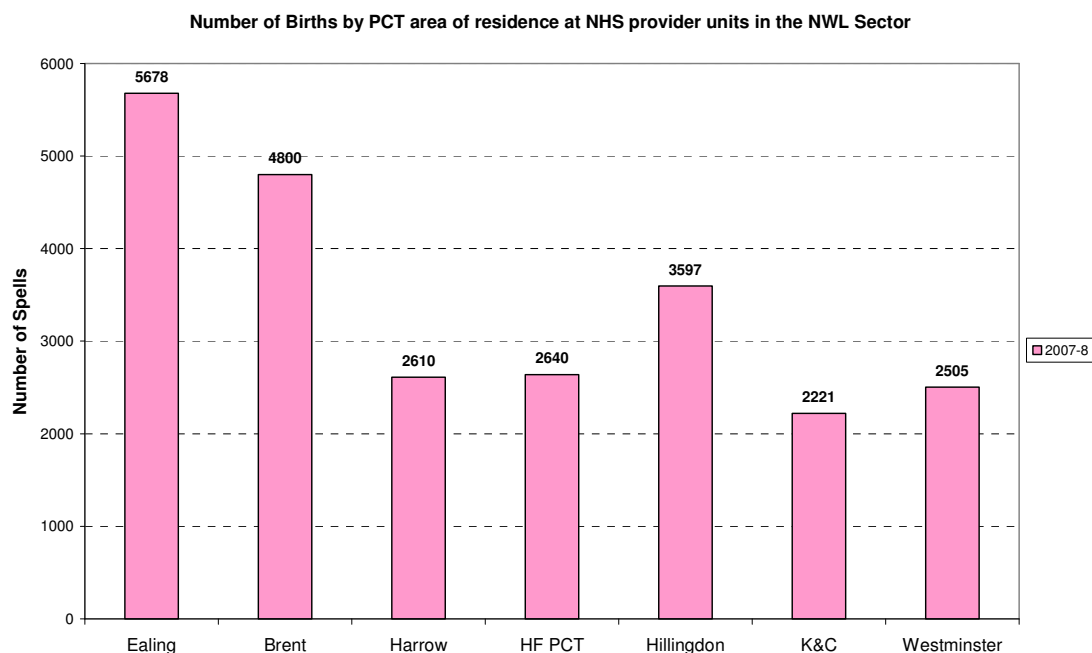
Part of the work to date has focused on understanding the growing demand for maternity care and implications for service delivery. An analysis of current service provision by PCT and NWL Providers is outlined below.

PCTs

Total Number of births by PCT area of residence in 2007/8

The number of births by area of residence for each PCT in the NWL sector for the current period is shown in fig. 12 below. The birth rate varies across PCTs ranging from 5678 in Ealing to 2221 in Kensington and Chelsea PCT.

Fig. 12



Data source: Dr Foster SUS data

Four year annual trend in number of births

Table 30 below shows the volume of births in the last four years by PCT area of residence. The average increase in birth rate over the last 4 years (between 2004/5 and 2007/8) has been 10% across the NWL sector. The highest increases is in Ealing PCT (16.6%), Hillingdon PCT (16.4%); Hounslow (12.5%) in contrast to the lowest increases in Hammersmith & Fulham (3.2%); Westminster PCT (2.1%); Kensington & Chelsea (5.2%).

However, comparison of activity between 2006/7 and 2007/8 indicates a slowing in growth rate in some PCTs.

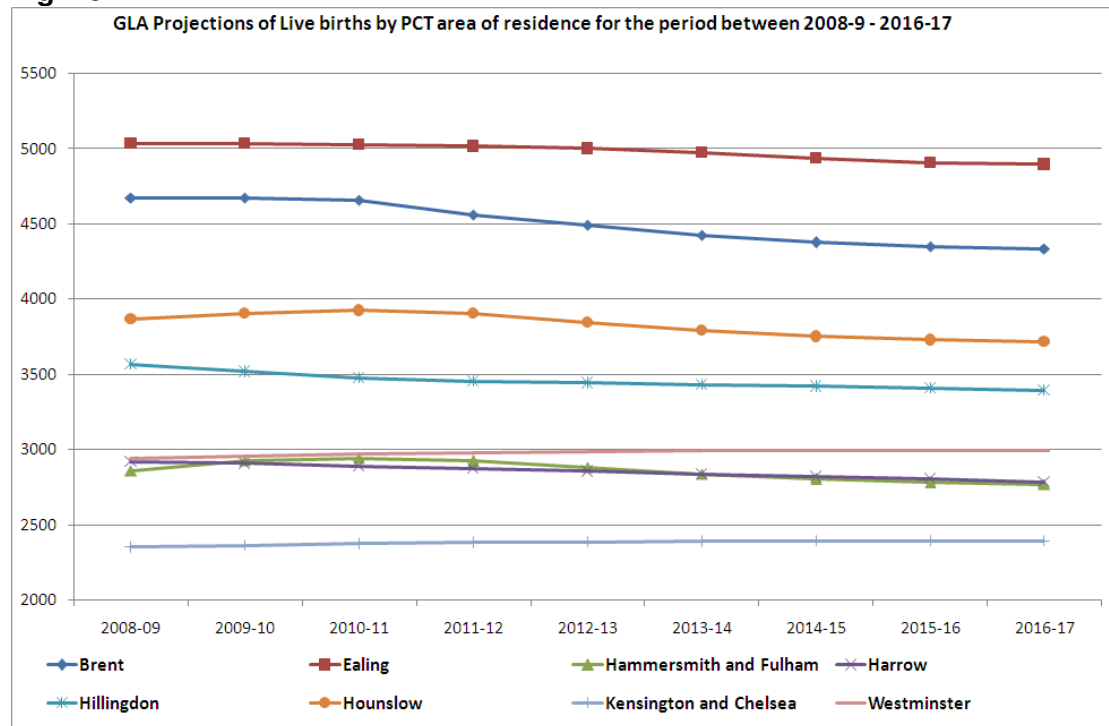
Table 30: a four year trend in numbers of births by area of residence

Total Births	Ealing	Brent	Harrow	Hounslow	HF PCT	Hillingdon	K&C	Westminster	NWL Sector
2004-5	4871	4403	2485	3634	2546	3089	2077	2453	25558
2005-6	5150	4524	2529	3559	2551	3121	2147	2597	26178
2006-7	5289	4771	2544	3770	2658	3401	2272	2547	27252
2007-8	5678	4800	2610	4090	2640	3597	2184	2505	28104
% Change from 2004/5 position	16.6%	9.0%	5.0%	12.5%	3.7%	16.4%	5.2%	2.1%	10.0%
% Change from 2006/7 position	7.4%	0.6%	2.6%	8.5%	-0.7%	5.8%	-3.9%	-1.6%	3.1%

Future projections of live births

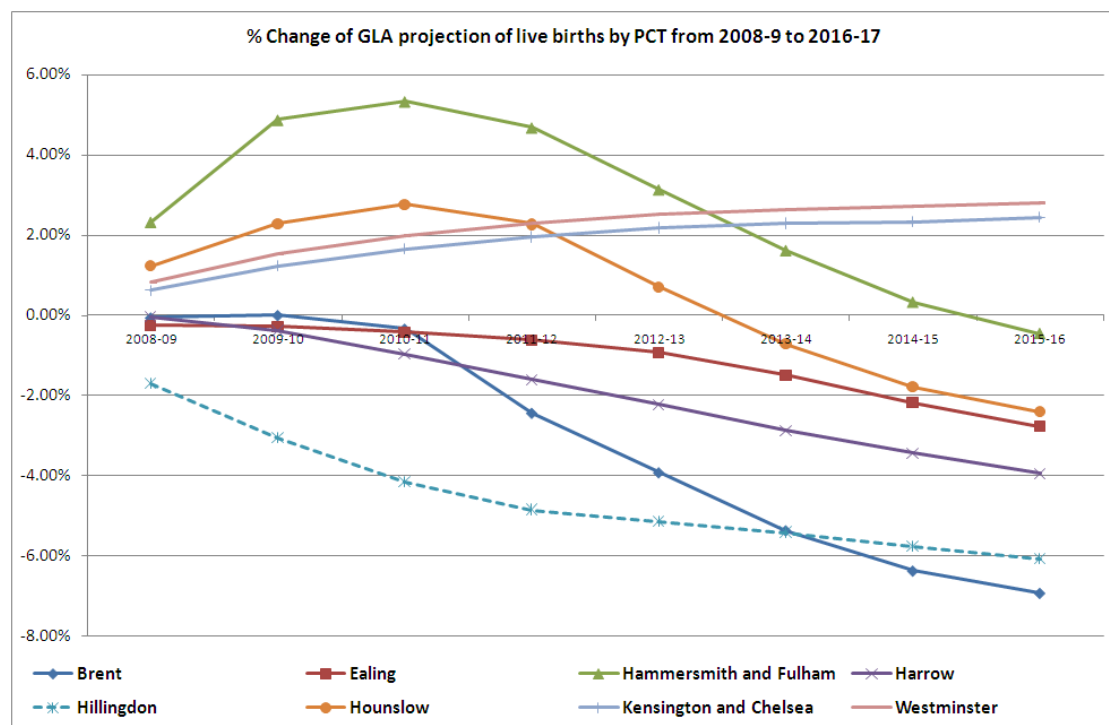
Future birth rate projections taken from the GLA birth projection estimates are shown below (Fig. 13-14) for all PCTs in the NWL sector. According to the GLA projections, Brent PCT predicts the biggest fall in numbers of births by 2017. This is further illustrated in the chart showing the percentage change between 2008-9 and 2016-2017. In contrast, Hounslow and Hammersmith & Fulham PCT show the biggest initial increase up to 2010-11, after which a gradual decline in numbers of birth is expected by 2017. These figures have been disputed as they contradict local experience and intelligence in relation to birth rate and further analysis is being undertaken to provide a more accurate local picture.

Fig. 13



Data source: GLA Estimates provided by LHO

Fig. 14



Data source: GLA Estimates provided by LHO

Total percentage of births occurring in NWL sector Trusts

92.6% of births from PCTs were delivered in maternity units within the NWL Sector for NHS Providers only (Table 31).

Table 31

North West London sector Provider									
	North West London Sector	Brent TPCT	Ealing PCT	Hammersmith and fulham pct	Harrow PCT	Hillingdon PCT	Hounslow PCT	Kensington and Chelsea PCT	Westminster
All HRGs	92.6%	89.6%	98.1%	98.2%	82.3%	93.4%	92.2%	96.6%	85.9%

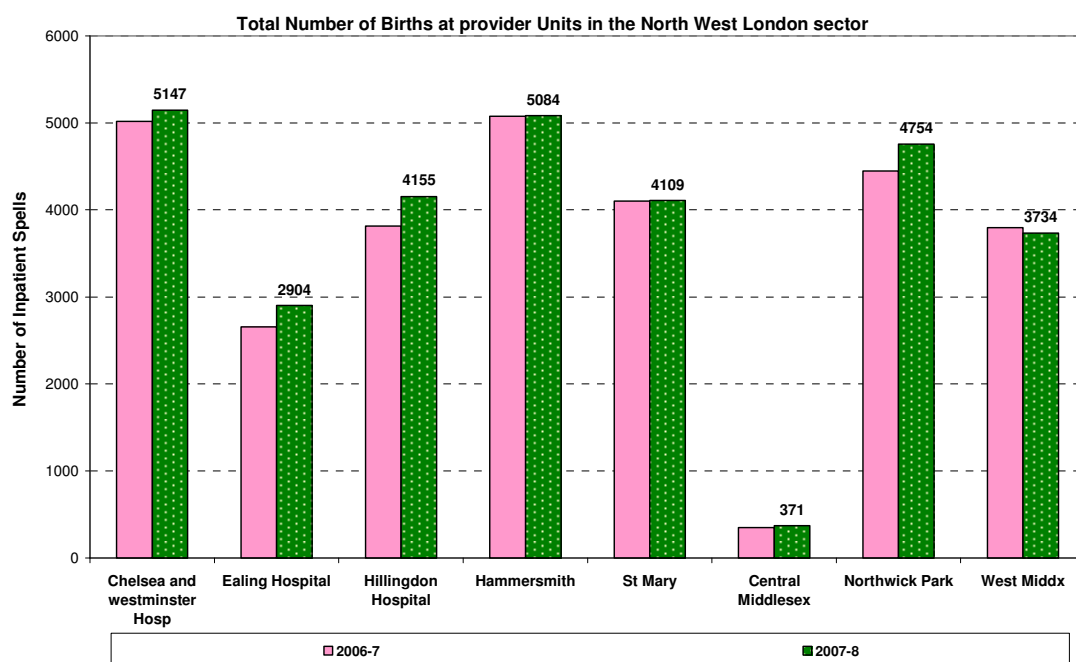
Data source: Dr Foster SUS data 2007/8

PROVIDERS

Number of births at Provider Units in NWL Sector

30,295 babies were delivered in maternity units within the sector in 2007/8 (Fig. 15 and Table 32). This represents an average increase of 3.6% (from the previous year position). This disguises considerable variability across provider units, with Ealing Hospital showing the highest increase of 9.4% in contrast to a slight decrease at West Middlesex Hospital.

Fig. 15



Data source: Dr Foster SUS Data 2007/8

Table 32: percentage growth trend in births for provider units in London

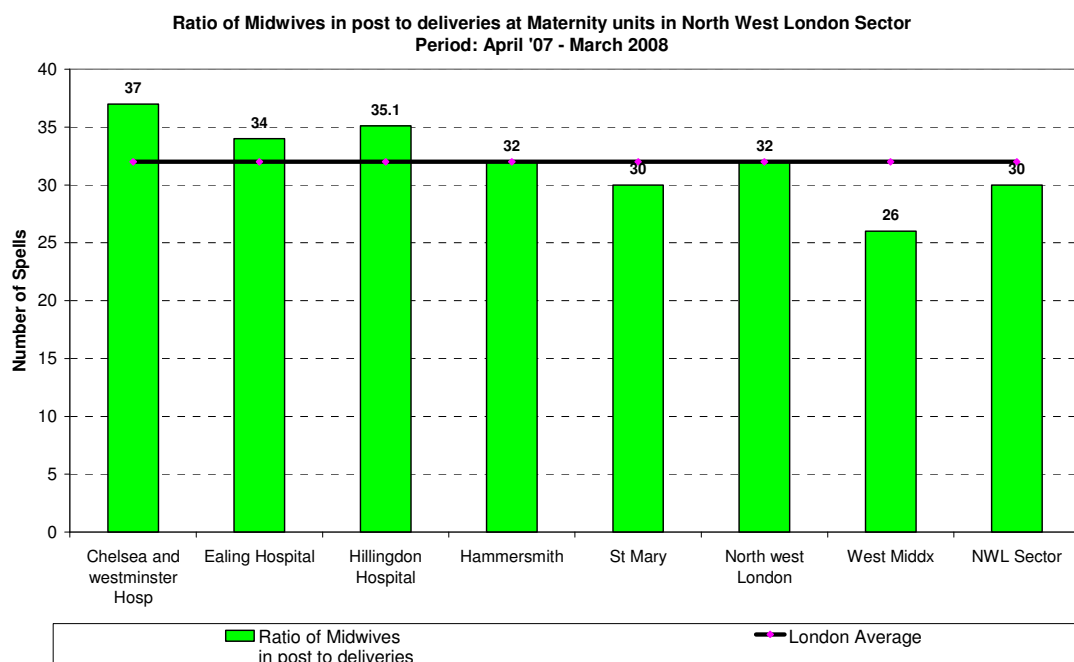
ALL HRGs	Chelwest	Ealing Hospital	Hillingdon Hospital	Imperial hospital	North west London	West Middx	NWL Sector
2005-6	4308	2905	3463	9281	4811	3295	28063
2006-7	5020	2655	3813	9179	4794	3795	29256
2007-8	5147	2904	4155	9230	5125	3734	30295
% Increase from 2006/7 position	2.5%	9.4%	9.0%	0.6%	6.9%	-1.6%	3.6%

Local providers have invested in improvements to the fabric of local units and are increasing capacity where current demand exceeds capacity.

Ratio of Midwives in post to deliveries

The ratio of midwives to numbers of deliveries per maternity unit is shown below (Fig. 16). The NWL sector average is 30 which is below the London average of 32. However, variation exists across provider units in the sector with St Mary’s Hospital and West Middlesex currently below both the London average of 32.

Fig. 16



Data source: London supervising authorities for London August 2008

Further work is underway to improve the position across the sector. Details of this initiative are included in section 4.

Trauma

The delivery of emergency trauma was identified as an issue by the CRG and subsequently identified through the Healthcare for London programme as a London-

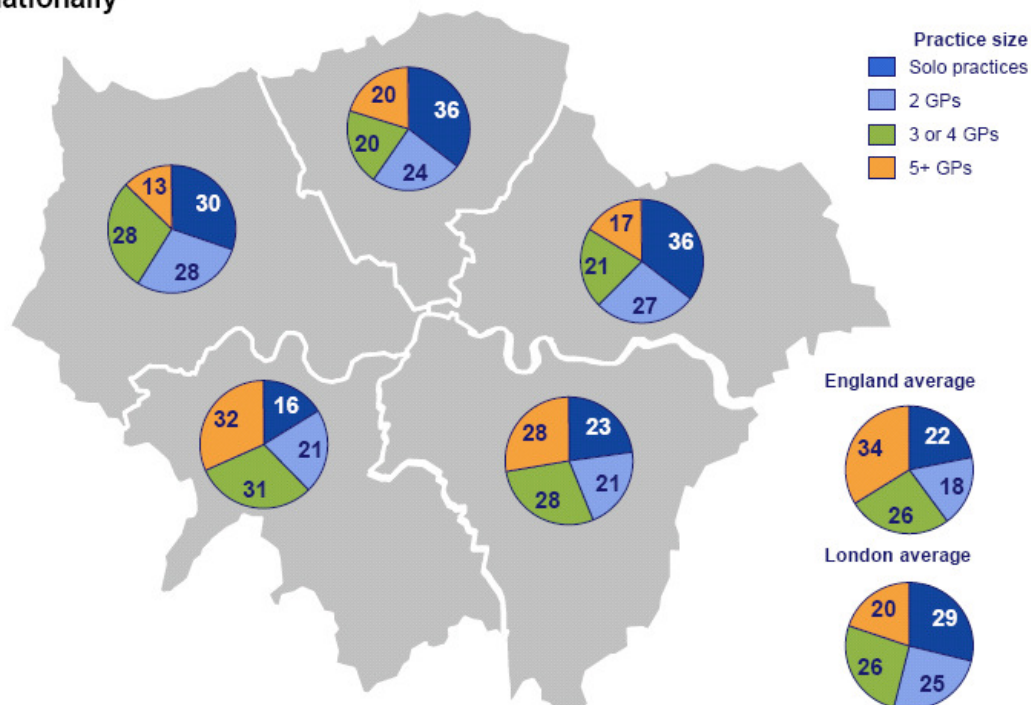
wide priority for 2009-10. A sector bid for a Trauma centre in NWL was submitted to Healthcare for London in November 2008. The sector bid did not pass the designation process, but Imperial College Hospital Trust was subsequently asked to resubmit a bid which has passed the designation process. Details on this initiative are contained in section 4.

Primary Care

Primary care is very varied in terms of the range and quality of services provided. The primary care estate is exceedingly mixed. The challenges are standardising quality of care and access as the current fragmented provision creates inefficiencies within the totality of the healthcare economy.

Fig. 17

Primary Care Evidence 1: London has more small GP practices than nationally



The analysis of primary care within NWL shows a higher proportion of smaller practices as compared with national averages. Although small list size practices have some advantages in terms of patient care, particularly the consistency with which one can see an individual practitioner, there are a number of consequences. Infrastructure in small practices is not as well developed as larger practices and the opportunity to offer a broader base and stability to multi-disciplinary teams in larger group practices builds capacity and access that is difficult in a smaller environment.

Primary care has moved forward substantially in terms of the new GP contract which has provided a national framework for commissioning outcome driven healthcare through the Quality and Outcomes Framework. However, the commissioning of primary care lags behind that of acute provision in terms of measurable activity and capacity.

The NHS Next Stage Review Interim Report (October 2007) carried out by Lord Darzi identified “improving access to primary care” as a key priority, to deliver more personalised care that meets the needs of individuals and communities, especially those in disadvantaged and deprived areas.

Equitable Access to Primary Medical Care (EAPMC) will play a significant role in achieving more personalised care and will address specific issues highlighted in the report. The programme will focus on achieving the visions of a fair and personalised NHS, whilst upholding the values of safe and effective primary care services.

The Government will be providing new investment to support PCTs to improve access to primary care, including:

“To establish at least one new GP-led health centre in each PCT in easily accessible locations, providing a flexible range of bookable appointments, walk-in services and other services for either non-registered or registered patients, based on the guiding principle of ensuring that the local public can access GP services any time from 8am to 8pm, seven days a week”.

The NHS Operating Framework 2008/09 mandated that all PCTs should procure new GP-led health centres during 2008/09. Details of the initiatives being developed in NWL are included in Appendix 3.

Within the Healthcare for London programme, polyclinics were identified as providing part of the solution to more flexible care by offering a much wider range of high-quality services, over extended hours, to the community – reducing the need for patients to visit hospitals and other services. Different types of polyclinic have been described: networked, same-site and front end of A&E. The Healthcare for London (HfL) Polyclinic project team has been working with all London PCTs to develop plans for polyclinics so that they will be introduced throughout London within the next 5 years. Two of the first five polyclinic schemes announced in September 2008 will be introduced in NWL:

- Alexandra Avenue, Harrow PCT
- Heart of Hounslow, Hounslow PCT

Further details on the development of Polyclinics in NWL are included in Appendix 4.

CLINICAL CAPACITY

The McKinsey review (2007) demonstrated that although NWL performs well against a number of access and capacity indicators compared to other sectors in London (Appendix 5), its performance is less well when compared to national averages in relation to:

- Rate of admission through A&E
- Day case rates
- Length of stay

and that improved efficiency, coupled with PCT demand management initiatives, would create excess capacity. The CRG recommended that there was scope to standardise clinical practice across the sector to ensure that patients accessing secondary care receive efficient, effective and integrated services.

Since this review was undertaken, the position across London in relation to these indicators has changed considerably, particularly in relation to growth in A&E attendances. Appraisal at a sector level suggested that the solution lay not in increasing capacity, but in changing the nature and delivery of care to ensure that patients attending A&E are seen by the most appropriate clinician and can access follow up care, where appropriate, in primary care.

Unscheduled Care

The NWL CRG highlighted in their report in October 2007 that the high dependence on A&E in London raises as many questions about the service models and access in the community as in our hospitals. The complexities of local health communities together with mismatches between access in primary care and out-of-hours primary care provision is well known. The capacity of primary care to shoulder its equitable share of the burden needs to be understood and commissioned appropriately. Supporting evidence was identified as follows:

- NWL A&E attendances are significantly higher than UK average
- There has been significant growth in NWL A&E attendances over the last 5 years, which has been at different rates in different Trusts
- The conversion rate of A&E attendances to admissions is significantly higher than the UK average
- Services are not currently being delivered in a cost effective way

More recent information extracted from the World Class Commissioning data pack demonstrates variability in clinical practice (in terms of access to primary care) across NWL PCTs (Table 33 and 34) and Providers (Table 35) with scope for improvement when compared against the best performing PCT or Acute Trust in London.

Table 33: Access to primary care

PCT	% satisfaction with phone access	% able to get an appointment within 48 hours	% satisfaction with opening hours
Brent	81.8	82.2	78.3
Ealing	82.1	79.4	77.2
Hammersmith & Fulham	82.3	77.6	80.2
Harrow	81.3	87.7	78.7
Hillingdon	85.8	79.6	79.9
Hounslow	81.3	75.8	77.8
Kensington & Chelsea	89.7	81.1	80.3
Westminster	90.6	77.6	81.3
Best performing PCT in London	71.4	89.8	82.6
Worst performing PCT in London	90.6	64.8	77.2

Source: GP Patient Survey 2007

Table 33 shows that Westminster PCT has the highest satisfaction rates in NWL in relation to phone access and opening hours and Harrow PCT has the highest satisfaction rates in NWL in terms of the ability to get an appointment within 48 hours. Hounslow PCT has the lowest level of satisfaction in NWL in relation to phone access and the ability to get an appointment within 48 hours and Ealing PCT has the lowest level of satisfaction with regard to opening hours.

Table 34: Appropriateness of Emergency Admissions

PCT	% admissions for ambulatory care sensitive conditions (ACS)	% admissions 0 and 1 day length of stay
Brent	10.7	50.8
Ealing	11.7	52.4
Hammersmith & Fulham	11	53.5
Harrow	10.9	51.8
Hillingdon	10.1	55.6
Hounslow	11.3	51.8
Kensington & Chelsea	9.3	47.7
Westminster	10.2	50
Best performing PCT in London	8.5	40.8
Worst performing PCT in London	13.6	59.7

Source: Secondary Uses Service extract 24/4/08 for calendar years 2005, 2006, 2007

The ACS indicator shows the number of avoidable admissions per NWL PCT. A low percentage represents good practice. All PCTs have scope to improve their performance against this indicator and to release resources as a result.

A high percentage of 0 and 1 day length of stay (LOS) admissions may indicate patients being admitted unnecessarily, possibly to achieve 4-hour A&E targets. Table 34 shows that Hillingdon PCT has the highest (55.6%) percentage of 0 and 1 day LOS admissions and K&C PCT has the lowest (47.7%) rate. All PCTs in NWL have rates higher than the best performing PCT in London.

Table 35: Non-elective admissions to hospital per A&E attendances

Trust	Ratio: non elective admissions per A&E attendance
Chelsea & Westminster NHS Foundation Trust	0.36
Ealing Hospital NHS Trust	0.23
Imperial College Healthcare NHS Trust	0.37
North West London Hospitals NHS Trust	0.28
The Hillingdon Hospital NHS Trust	0.3
West Middlesex University Hospital NHS Trust	0.29

Source: Secondary Uses Service extract 24/4/08 for calendar years 2005, 2006, 2007

A high ratio of admissions to A&E attendances could indicate a low threshold for emergency admission **or a more selective population accessing A&E**. Table 35 indicates that Chelsea & Westminster NHS Foundation Trust and Imperial College Healthcare NHS Trust have the highest ratio for admission to A&E attendances in NWL.

The Healthcare Commission (HCC) published the results of the 2007-08 Urgent & Emergency Care Review on 26th September 2008. This showed that the majority of services were performing well, with 60% of PCT areas scoring the top two ratings. The results for NWL PCTs are shown in table 36.

Table 36: HCC 2007-08 Urgent & Emergency Care Review results for NWL PCTs

PCT name	Overall Rating	Access	Integration and Effectiveness	Management	Overall Rating (Value)
Hammersmith and Fulham PCT	Best Performing	3.57	3.42	3.22	4
Kensington and Chelsea PCT	Best Performing	3.71	3.33	3.67	4
Westminster PCT	Best Performing	3.71	3.42	3.67	4
Brent Teaching PCT	Fair Performing	3.07	3.17	2.56	2
Hounslow PCT	Fair Performing	2.86	2.67	3.00	2
Ealing PCT	Least Well Performing	2.29	2.58	3.00	1
Harrow PCT	Least Well Performing	2.43	2.75	2.44	1
Hillingdon PCT	Least Well Performing	2.43	2.83	2.67	1

Source: HCC Urgent & Emergency Care Review 2007-08

Table 36 shows that in NWL three PCTs achieved a 'Best Performing' rating, three PCTs achieved a 'Least Well Performing' rating and two PCTs achieved a 'Fair Performing' rating. Further analysis is required to identify areas where best practice can be shared across NWL to realise improvements across the sector.

The development of urgent care centres was identified as a key initiative for the NWL CCI in 2007-9. This work is now dovetailing with the HFL programme and is described in more detail in section 4.

CLINICAL QUALITY

In prioritising their collaborative work programme for 2007-9, the CCG paid close attention to a number of reviews (Sentinel audit, Health Care Commission reviews) which demonstrated a high level of variability between services in the sector and a variation from national averages.

As for other sectors in London, a number of clinical service reconfigurations have been implemented in NWL over the last 5 years to address issues of patient safety, as well as clinical quality and to achieve better health outcomes (e.g. concentration of vascular surgery within a network arrangement; reconfiguration of NICU providers into a network; implementation of the recommendations in the Coronary Heart Disease NSF through the Cardiac network; merger of the St Mary's and Hammersmith Trust renal units to create a single lead centre for the sector etc.). These changes were supported by PCTs working with their providers to deliver improved clinical pathways with consideration of the access, capacity and workforce implications.

During 2005-7, the focus on commissioning of health services had been on the delivery of national access targets and on ensuring value for money. Over the last 12-18 months, the focus has changed, as a result of the work of the CRG, endorsed by the CCG, on improving the quality of services provided to the people of NWL. For example, improving access to primary care, maternity and neonatal care and reshaping unscheduled care services is known to improve both the quality and health outcomes from an intervention. A collaborative approach to commissioning paediatric surgery and acute stroke services both derive from evidence used successfully elsewhere to show that current service configurations do not yield the best outcomes.

The development of national standards of care has provided a means of measuring the quality of care provision (see data on stroke care as an example of this) and this approach is being adopted in Service Level Agreements (SLAs) to ensure that all

providers are working to deliver the same level of quality. The development of true outcome measures (as opposed to structure or process measures used as a proxy for outcome) is in its infancy. However, some excellent work on 'Monitoring Clinical Outcome, Patient Experience and Equality and Diversity Metrics for SLA 2008-2009' is underway as part of the SLA with Imperial Healthcare. This work has been tested during 2008-9 and will be rolled across the sector in 2009-10.

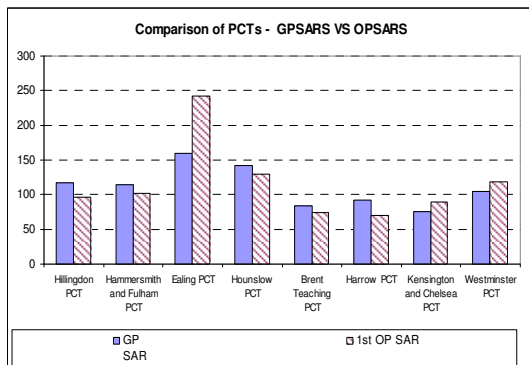
The CRG also agreed an ambitious programme of work during 2008-9 on understanding variability across patient pathways with the intention of developing dynamic pathway indicators to support targeted interventions, leading over time to **improvements in the quality of** care within NWL. This initiative is described further in section 4.

The initial phase of this work was completed in October 2008 (see sample cardiology pathway analysis below, fig. 18).

Fig. 18

Cardiology

PURCHASER/COMMISSIONER		SARs		Rates				PROVIDER				
PCT_Name	GP	1st OP	First to Followup	DNA 1stRate	DNA FURate	DNA C to C	Cardiology					
	SAR	SAR					DNA Rate					
Hillingdon PCT	117	96	2.85	13	26	37						
Hammersmith and Fulham PCT	114	102	1.64	23	32	38						
Ealing PCT	180	242	1.37	33	32	66						
Hounslow PCT	142	130	1.2	17	29	41						
Brent Teaching PCT	84	75	3.65	17	21	42						
Harrow PCT	92	70	3.91	11	20	32						
Kensington and Chelsea PCT	76	89	2.41	17	26	54						
Westminster PCT	105	118	1.97	17	26	54						
							Trust Name		1st attendances	Follow Up	New to Follow Up	% 1st C to C
							Chelsea and Westminster Hospital NHS Foundation Trust		9%	17%	1.9	52%
							Ealing Hospital NHS Trust		37%	38%	0.9	70%
							Imperial College Healthcare NHS Trust		18%	24%	1.7	50%
							North West London Hospitals NHS Trust		10%	15%	6.0	19%
							The Hillingdon Hospital NHS Trust		9%	8%	1.8	35%
							West Middlesex University Hospital NHS Trust		12%	17%	0.9	32%
							Grand Total		23%	22%	1.8	51%



* Note Grand total = Average across six provider trusts

Key Messages

- The high GP referral rates for Ealing and Hounslow PCTs
- The apparent lack of association between high referral rates and PCT N:FU rates
- A high 1st appointment DNA rate for Ealing (possibly associated with high referral rates) and high C2C rates.
- Higher C2C rates for Ealing, K&C and Westminster possibly relating to referrals to ICHT which requires further investigation.
- The very high N:FU ratio across all PCTs at NWLHT. This suggests a coding anomaly which requires further investigation.

It is this variation in performance and a commitment to achieving levels of health and health care comparable with the world's best which are the drivers for the NWL strategy over the next 5 years.

LOCAL AND NATIONAL HEALTH PRIORITIES

Three reports, and the World Class Commissioning initiative, set the national and local (London) context for strategic commissioning across NWL. These are:

- “High Quality Care For All. NHS Next Stage Review Final Report” (June 2008);
- Better Health, Better Healthcare (2008);
- **NHS Operating Framework 2009-10 (Dec 2008)**

High Quality Care For All

This builds on the reforms of the last 10 years and promises to have an even more profound affect on NHS services and people’s experience of them. If the challenge 10 years ago was capacity, the challenge today is to drive improvements in the quality of care. The NHS will be more personalised, responsive to individuals, focused on prevention, better equipped to keep people healthy and capable of giving real control and real choices over care and people’s lives.

The vision and key steps set out below mirror and complement the vision and values adopted by the NWL collaborative programme in 2007-9 and refined for the 2009-14 CCI plan. The information provided in the previous section, and within section 4. – Initiatives, demonstrates that PCTs across NWL are already making progress in delivering the Next Stage Review aspirations for the next 10 years.

The vision that the report sets out is of an NHS that gives patients and the public more information and choice, works in partnership and has quality of care at its heart – quality defined as clinically effective, personal and safe. It will see the NHS deliver high quality care for all users of services in all aspects, not just some.

The key steps to be taken to deliver the vision are set out in some detail in the document. Listed below are the headline areas with associated actions that may require collaborative working, or where work is already underway across NWL.

- “High quality care for patients and the public
 - Extend choice of GP practice. Patients will have greater choice of GP practice and better information to help them choose. We will develop a fairer funding system, ensuring better rewards for GPs who provide responsive, accessible and high quality services. The NHS Choices website will provide more information about all primary and community care services, so that people can make informed choices.
 - Ensure everyone with a long-term condition has a personalised care plan. Care plans will be agreed by the patient and a named professional and provide a basis for the NHS and its partners to organise services around the needs of individuals.
 - Guarantee patients access to the most clinically and cost effective drugs and treatments. All patients will receive drugs and treatments approved by the National Institute for Health and Clinical Excellence (NICE) where the clinician recommends them. NICE appraisal processes will be speeded up.”

- “Quality at the heart of the NHS
 - Getting the basics right first time, every time.
 - An emphasis on improvements in safety.
 - Greater emphasis on measurement of care as the basis for improvement in practice and outcomes.
 - Introduce a new strategy for developing the Quality and Outcomes Framework which will include an independent and transparent process for developing and reviewing indicators.
 - Developing new best practice tariffs focused on areas for improvement. These will pay for best practice rather than average cost, meaning NHS organisations will need to improve to keep up.
 - Strengthening the involvement of clinicians in decision making at every level of the NHS.
 - Ensuring that clinically and cost effective innovation in medicines and medical technologies is adopted.
 - Creating new partnerships between the NHS, universities and industry. These ‘clusters’ will enable pioneering new treatments and models of care to be developed and then delivered directly to patients”.

- “Working in partnership with staff
 - Placing a new emphasis on enabling NHS staff to lead and manage the organisations in which they work.
 - Re-invigorating practice-based commissioning and give greater freedoms and support to high performing GP practices to develop new services for their patients, working with other primary and community clinicians.
 - More integrated services for patients.
 - Implementing wide ranging programmes to support the development of vibrant, successful community health services.
 - A clear focus on improving the quality of NHS education and training. The system will be reformed in partnership with the professions”.

Better Health, Better Healthcare

Produced by Healthcare for London. this is an output of programme of reform run by the NHS and local communities in London. It will improve health services throughout the capital over the next 10 years. It will make a real change and deliver what we know patients want – responsive, safe, accessible and high-quality healthcare. The programme identified five Principles for health and healthcare in London:

1. Services should be focused on individual needs and choices;
2. Services should be localised where possible, or regionalised where that improves the quality of care;
3. There should be joined-up care and partnership working, maximising the contribution of the entire workforce;
4. Prevention is better than cure;
5. There must be a focus on reducing differences in health and healthcare across London.

Following consultation, five priority areas for action were identified:

1. Working together to help people stay healthy
2. Ensuring choice is a right, not an option
3. No compromise on care and safety
4. Healthcare where and when you need it
5. Tackling health inequalities

Importantly, the commitment is that the change will be led by clinicians and patients and services will be localised wherever possible. Improvements will be properly resourced, with a smooth transition when better services are introduced, with good planning being the key to success. By working together with voluntary organisations, staff, unions, councils, the public, patients and other partners a world class service for Londoners will be reality.

From these priority areas for action have grown a number of specific projects:

- Health improvement and wellbeing
- Stroke
- Trauma
- Care in Primary and Community care settings including polyclinics
- Care in local hospital settings
- Maternity services
- Children's services
- Mental Health Services
- Long term conditions
- End of life care
- Unscheduled care

NWL PCTs have been working both individually and collectively over the last 12 months to deliver the principles set out in the Healthcare for London programme and significant progress has been made in improving partnership working and reducing differences in healthcare. Our vision and values build on these principles, whilst the strategic objectives and initiatives outlined in section 4 demonstrate where we believe collaborative working will ensure delivery of the five priority areas for action outlined above and the specific programmes of work within the Healthcare for London programme.

The NHS Operating Framework 2009-10

The NHS Operating Framework 2009-10 **has as its focus 'Implementing High Quality Care for All'**. **Included within this an** approach to planning and managing priorities both nationally and locally – the “*vital signs*”. These describe three levels of priorities which PCTs (working with providers) need to explicitly plan to deliver. Tiers 1 and 2 cover existing and new national priorities, whilst tier 3 allows for local discretion in the monitoring of care.

PCT and provider performance as assessed by the Healthcare Commission (HCC) for 2007-8 is shown in Table 37 below.

Table 37

NWL Providers

	Chelsea & Westminster Foundation Trust	Imperial College Healthcare NHS Trust	Royal Brompton & Harefield	Ealing Hospital NHS Trust	North West London Hospitals NHS Trust	West Middlesex University Hospital
Quality of Services	Good	Good	Excellent	Fair	Fair	Fair
Use of Resources	Excellent	Good	Good	Good	Weak	Fair

NWL PCTs

	NHS Brent	NHS Ealing	NHS Hammersmith & Fulham	NHS Harrow	NHS Hillingdon	NHS Hounslow	NHS Kensington & Chelsea	NHS Westminster
Quality of Services	Weak	Fair	Fair	Fair	Fair	Fair	Good	Good
Use of Resources	Weak	Good	Good	Fair	Fair	Weak	Good	Good

London compared to the rest of the country:

This, the third year of the annual health check, is the first time that a gap has been seen between the performance of London trusts and those located in the rest of the country. This year 12 of the 73 (16%) trusts in London score excellent for quality of services, with a further 23 (32%) scoring good. This compares to 88 of the 318 (28%) trusts in the rest of the country scoring excellent for quality of services, and a further 116 (36%) scoring good

To examine further the difference in quality of services performance for London and the rest of the country, the HCC looked at performance against the three components that combine to form the overall quality of services score. For core standards, London trusts actually performed better than trusts in the rest of the country in 2007/08. It was comparatively poor performance against the existing and new national targets that impacted upon London's overall performance for quality of services. 38% of trusts in London scored "fully met" for existing national targets in 2007/08, compared to 65% of trusts in the rest of the country. For new national targets, 26% of trusts in London scored "excellent" compared to 40% of trusts in the rest of the country.

Differences also exist in the lower performance bands. 19% of trusts in London scored "not met" or "partly met" for existing national targets this year, compared to 9% of trusts in the rest of the country. For new national targets, 48% of trusts in London scored "weak" or "fair", compared to 27% of trusts in the rest of the country.

Given the marked differences in performance in the capital, the HCC drilled down further into the targets assessments to see if there were individual targets or indicators that were the primary cause of the disparity. For existing national targets, indicators where the London SHA area performed comparatively poorly included:

- A&E waiting times - London SHA area recorded the lowest proportion of trusts achieving the indicator, as well as the highest proportion of trusts failing the indicator, of any of the 10 SHA areas.
- Inpatient waiting times - London SHA area recorded the lowest proportion of acute and specialist trusts achieving the indicator, as well as the highest proportion of PCTs under-achieving the indicator, of any of the 10 SHA areas.

- Access to a GP - London SHA area recorded the highest proportion of PCTs failing the indicator, of any of the 10 SHA areas.

For new national targets, indicators where the London SHA area performed comparatively poorly included:

- Referral to treatment time milestones – London SHA area recorded the lowest proportion of trusts achieving the indicator, as well as the highest proportion of trusts failing the indicator, of any of the 10 SHA areas.
- Breast cancer screening – London SHA area recorded the lowest proportion of trusts achieving the indicator, as well as the highest proportion of trusts failing the indicator, of any of the 10 SHA areas.

This poor performance has continued in 2008-9 as evidenced by a review (Oct 2008) of performance across the capital (Appendix 6).

Fig. 19 below shows the PCT risk rating for Q2 of 2008-9 for all of the PCTs in London.

Fig. 19

PCT	Existing Commitments	National Priorities	Quality & Outcomes (NHSL assessment of year_end ratings based on Q2)	Quality & Outcomes (PCT self_assessments based on Q2 and revised plans)	Governance (PCT self_assessment with NHSL overview)	Finance (NHSL assessment based on PCT supplied information)	Financial Performance	Financial Management	Financial Standing cap
Barking & Dagenham			Fair	Fair		4			
Barnet			Fair	Fair		3			
Bexley			Fair	Good		3			3
Brent			Fair	Fair		2			
Bromley			Fair	Fair		5			
Camden			Fair	Good		2			
City & Hackney			Fair	Good		3			
Croydon			Fair	Fair		5			
Ealing			Fair	Fair		5			
Enfield			Fair	Good		3			3
Greenwich			Fair	Fair		4			
Hammersmith & Fulham			Fair	Fair		3			
Haringey			Fair	Good		5			
Harrow			Fair	Good		4			
Havering			Fair	Weak		3			
Hillingdon			Fair	Fair		2			2
Hounslow			Fair	Fair		2			2
Islington			Fair	Fair		4			
Kensington & Chelsea			Fair	Good		4			
Kingston			Fair	Good		3			
Lambeth			Fair	Good		5			
Lewisham			Fair	Good		4			
Newham			Fair	Fair		4			
Redbridge			Fair	Fair		5			
Richmond & Twickenham			Fair	Good		4			
Southwark			Fair	Fair		4			
Sutton & Merton			Fair	Fair		4			
Tower Hamlets			Fair	Good		5			
Waltham Forest			Fair	Fair		4			
Wandsworth			Fair	Good		4			
Westminster			Fair	Good		4			

Source: Performance & Risk Ratings 2008/09 Q2, NHSL (December 08)

There is significant variability in performance across the eight PCTs in NWL. Performance across the board has improved from Q1; however there is still considerable work to be done.

The CCG discussed performance in October 2008 and committed to work collectively to address poor and variable performance collectively through a process of 'do once and share'. This work will be developed to support the delivery of the CCI in 2009-10.

World Class Commissioning (WCC)

This establishes a strategic framework for healthcare commissioning with a clear vision as set out below:

- **Better health and well being for all**
 - People stay healthier for longer – “adding life to years.”
 - People live longer and health inequalities are dramatically reduced – “...and years to life”
- **Better care for all**
 - Services are of the best clinical quality and evidence based
 - People exercise choice and control over the services that they access so they become more personalised.
- **Better value for all**
 - Informed investment decisions
 - PCTs work across organisational boundaries to maximise effective care.

A key difference from current commissioning arrangements will be a shift towards a longer-term and more strategic approach to commissioning services. World class commissioners will focus on delivering improved outcomes and developing a pro-active, rather than a re-active health service.

In order to do this, commissioners will require outstanding knowledge management and analytical skills in order to develop a long-term view of community needs. They will also need to build on their position within the local community, developing closer relationships with key partners and playing a more pro-active role in shaping and defining local services. Key to success will be a PCT's ability to both listen and communicate back to its community partners.

Clinical involvement in particular will be critical to success. Their professional experience of delivering care, combined with their understanding of patients' needs, will be crucial to designing high-quality personalised health and care services.

Finally, in order to minimise risk, maximise value, and drive continuous improvement in quality and performance, commissioners will need to have outstanding negotiating, contracting, financial, and performance management skills.

The programme sets out 11 competencies against which PCTs will be assessed:

1. Are recognised as the local leader of the NHS
2. Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities
3. Proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health
4. Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design and resource utilisation
5. Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements
6. Prioritise investment according to local needs, service requirements and the values of the NHS
7. Effectively stimulate the market to meet demand and secure required clinical, and health and well-being outcomes

8. Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration
9. Secure procurement skills that ensure robust and viable contracts
10. Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes
11. Make sound financial investments to ensure sustainable development and value for money

The PCTs in NWL **were** assessed against these competencies during Dec-January 2008-9 and their individual CSPs and the NWL CCI formed a key component of the evidence base for the assessments. A high level self-assessment carried out in April 2008 suggested each of the PCTs had some way to go to achieve the baseline position overall, although there was considerable variation against the individual competencies. The NWL Collaborative Programme work to date, and planned approach for the next 5 years, provides a strong platform for delivery against competencies 2, 3, 4, 5, 8 and 10. In addition, the PCTs have agreed a structure for delivering WCC (outlined in Section 5) which will, ensure continuous improvement in practice.

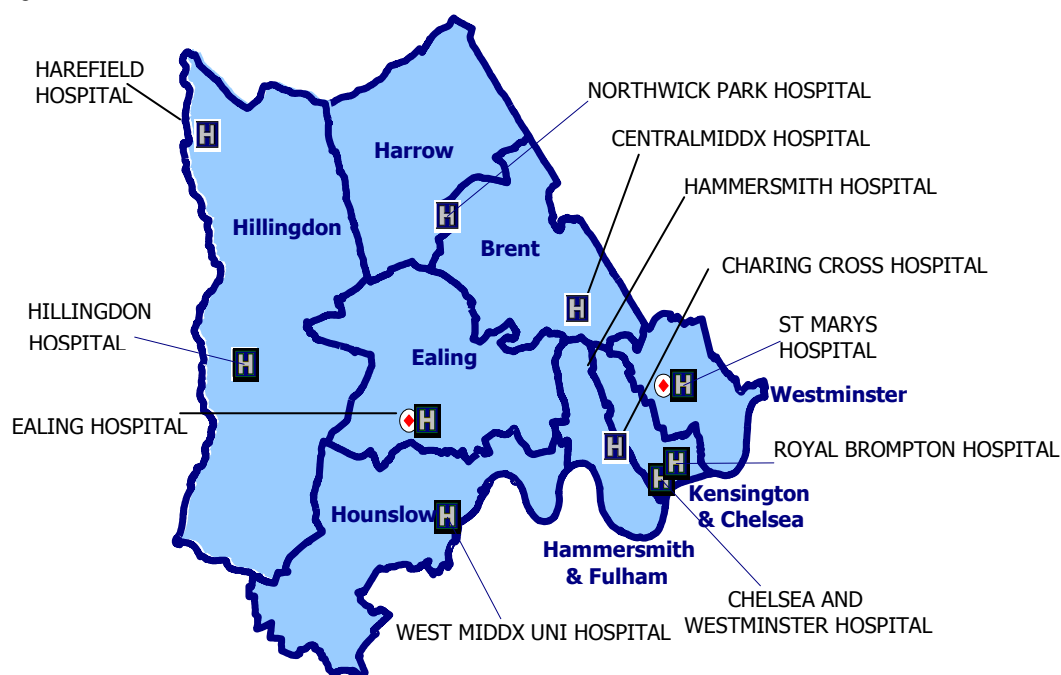
Assessment of risk

The NWL Collaborative Programme provides a framework for the delivery of national and local priorities over the next five years and commitment to resourcing the programme demonstrates the commitment of Commissioners in NWL to transforming care for its local populations.

Becoming World Class Commissioners and maintaining and improving performance are the greatest risks to the delivery of the vision. The WCC assessment will provide PCTs with a clear programme of action to support the delivery of their CSP and CCI and as the **Commissioning Partnership beds in, this will** be the vehicle for driving the required change. Improving performance has already been acknowledged as critical to reductions in variability of care and access. The CCG has committed to work collectively to address poor and variable performance through a process of 'do once and share'. This work will be developed to support the delivery of the CCI from 2009 onward.

PROVIDER LANDSCAPE

Fig. 20



NWL PCTs commission healthcare from a wide range of providers. Table 42 below provides a summary of the main providers including the number of sites the Trusts operate from, the type of care commissioned and the size of the 'business' (staff employed and income). Further detail in relation to each Trust is provided in Appendix 7 and in the previous section on healthcare provision.

The health system in NWL is highly complex – ranging from small GP practices providing **high quality** primary care **to their local population** to the UK's first Academic Health Science Centre, which brings together the delivery of healthcare services, teaching and research in a single organisation, in partnership with the wider west London healthcare community. There are 7 Acute Trusts, 2 Mental Health Trusts and **8 PCT provider services, which have formed 4 groupings: Inner NWL Alliance; Hounslow with Richmond & Twickenham; Ealing & Harrow; and two borough based APOs; Brent and Hillingdon.**

Risk Ratings

A summary of the provider risk ratings based on their 2008/09 Annual Plan is shown in tables 38a - 38c below:

Table 38a

Provider Risk Ratings 2008/09 Q1				
Trust	Financial risk rating	Governance risk rating	Services provided risk rating	Quality & Safety risk rating
Acute				
Ealing Hospital	4	G	G	A
Imperial College Healthcare	2	G	G	A
Hillingdon Hospital	3	G	G	R
North West London Hospitals	1	A	G	A
Royal Brompton & Harefield	3	G	G	A
West Middlesex Hospitals	2	G	G	A
Mental Health				
West London Mental Health	3	A	G	G

The table above shows that all of the acute non-FT Trusts are amber or red in relation to the quality and safety of their services. Three Trusts failed to meet the A&E 4 hour target and five Trusts declared not met/insufficient assurance on at least 1 national core standard, further detail is provided in table 38b below.

Table 38b

Q1 2008/09 Quality & Safety risk ratings - underlying data by exception for NWL Acute Trusts										
Trust	Maximum waiting time of 62 days from urgent referral to treatment for all cancers	Maximum waiting time of 26 weeks for in-patients	MRSA year on year reductions	18 weeks referral to treatment maximum wait	Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	Patients with operations cancelled for non-clinical reasons to be offered another binding date within 28 days	Minimising delayed transfers of care by 2008	Sexual health - 48 hour access to GUM clinics by 2008	Each National core standard	Overall rating
Ealing Hospital	0	0	0	1	0.4	0	0.4	0	0.4	2.2
Imperial College Healthcare	0	1	0	0	0	0.4	0	0	0.4	1.8
Hillingdon Hospital	1	0	1	0	0	0	0	1	0.4	3.4
North West London Hospitals	0	0	1	0	0.4	0	0	0	1.2	2.6
Royal Brompton & Harefield	0	0	0	1	0	0	0	0	0	1
West Middlesex Hospitals	0	1	0	0	0.4	0	0	0	0.4	1.8
Source: NHSL Board 23 October 2008										
Note: Each core standard not met or insufficient assurance incurs a score of 0.4 ie a score of 0.4 indicates one standard missed										

Table 38c

Foundation Trust	Finance	Governance	Mandatory Services
Chelsea & Westminster	5	G	G
Central & North West London Mental Health Based on Annual Plan	4	G	G

Summary of activity volumes 2007/08

A high level summary of 2007/08 outturn is shown by provider in Tables 39a – 39b below:

Table 39a

Acute Trusts 2007/08 Outturn							
Provider	Chelsea & Westminster NHS Foundation Trust	Ealing Hospital NHS Trust	Imperial College Healthcare NHS Trust	North West London Hospitals NHS Trust	The Hillingdon Hospitals NHS Trust	West Middlesex University Hospital NHS Trust	Royal Brompton and Harefield NHS Trust
Spells:							
Elective - in-patient	6443	15901	32,500	41,000	4,146	3387	10528
Elective - daycase	18337		46,545	43,000	15,127	10132	7433
Non elective	35398	21001	67,615	84,000	27,979	23700	4953
Total spells	60178	36902	146,661	168,000	47,252	37219	22914
Outpatient Attendances:							
First attendances	99536		217,383		80,861	80010	10960
Follow-up attendances	254885		428,716		175,860	138314	76193
Total OP attendances	354421	160008	646,098	332,000	256,721	218324	87153
A&E Attendances:							
Low tariff	54549				60,909	41713	
Mid tariff	12894				18,758	15036	
High tariff	31738				21,116	34104	
Total A&E attendances	99181	91200	217,274	191,000	100,783	90853	

Note: EHT data extracted from FT application – split for OP and A&E attendances not provided.

Table 39b

Mental Health Trusts 2007/08 Outturn		
Provider	Central and North West London NHS Foundation Trust	West London Mental Health Trust
Occupied Bed Days:		
High Secure: NB high secure commissioned on bed base	280,174	225752
Daycare Attendances:	50,572	17932
Outpatient Attendances:		
First attendances	9,894	2987
Follow-up attendances	41,996	37750
Total OP attendances	51,890	40737

NWL acute providers are projecting no growth in activity between 2008/09 and 2010/11. However, activity has increased above plan in recent years. Where growth is indicated it largely relates to marginal increases in elective activity and first out-patient attendances. CNWLFT has no planned growth except for community activity where a 5% annual increase in activity is anticipated. WLMHT is projecting marginal increases in occupied bed-days and out-patient attendances.

Plans to Achieve Foundation Trust Status

There are currently 2 Foundation Trusts that provide services to the population of NWL. C&WFT achieved Foundation Trust status in October 2006 and CNWL were authorised on 1st May 2007.

NHS London is currently undertaken a stock take of acute provider ability to achieve FT status in the light of HfL projects and changes to commissioning. This is likely to signal a strategic review of provider services within NWL. This has already been anticipated and an initiative is included within section 4 of the CCI.

The Benefits of an AHSC in NWL

In June 2008 Imperial College Healthcare NHS Trust and Imperial College London published a document that describes the vision and mission of the AHSC and outlines the ambitions and objectives for the next ten years. Extracts from this document are set out below.

The AHSC's vision is that the quality of life of our patients and populations will be vastly improved by taking the discoveries that we make and translating them into advances – new therapies and techniques – and by promoting their application in the NHS and around the world, in as fast a timeframe as is possible.

Distinctive features of the AHSC and are highlighted below along with further detail of how this will benefit the population of NWL:

- Greater focus and scale in translational research
Accelerating the translation of research into practical treatments and therapies, while maintaining safety standards and probity.
- Delivery of innovative and exemplary patient care
Active collaboration between researchers and clinicians, to lead the transition from basic research through to improved clinical outcome. Act as a focal point for the development of world class specialist clinical services in areas where the AHSC already has a world leading research presence (cardiovascular, endocrinology, diabetes and obesity, chronic inflammatory diseases and infectious diseases). The AHSC will continue to serve its local and national patient base with a broad range of services as agreed in collaboration with commissioners at the same time as fulfilling its intention of leading the world in its chosen areas of excellence.
- Local and national roles in the healthcare economy
Build on existing relationships with Acute Trusts, PCTs and GPs to support the development of a healthcare system that drives improvement throughout the NHS in line with Lord Darzi's vision.
- Attracting the best staff and educating the best students
Build on current status as the leading British centre of excellence for training clinical academics to educate students within the AHSC, the UK and beyond.

Much of this vision is yet to be realised, but steps toward building on relationships with partner organisations is underway. The role of the AHSC will also be critical to informing the initiative on the Provider Landscape in NWL.

Service Development

Service development plans outlined by NWL Acute and Mental Health providers include the following:

- ICHT is working towards the development of a 5-year integrated service, teaching and research strategy by Spring 2009. This may result in some changes to the configuration of services. Internal and external engagement, and where appropriate consultation, will be undertaken as required.
- Brent and Harrow PCTs and NWLH have commissioned an acute services review, which may lead to service changes.
- C&WFT plans to relocate the Victoria Clinic for sexual health services to new premises in Dean Street at the beginning of 2009. The Trust was awarded preferred provider status for bariatric surgery at the end of 2007/08 for patients in London, the South East and East of England by the South East Coast Specialist Commissioning Group. The Trust is working with 'The Kensington', a wholly owned subsidiary of the Chelsea and Westminster Health Charity, with a view to The Kensington running a private maternity service from Trust premises, and contracting with the Trust for the provision of support services.
- THH plans to develop elective and emergency sites with elective care undertaken by the treatment centre at Mount Vernon. Development of a midwifery-led model of care is planned to complement the existing obstetric service and meet increasing demand. The Trust is seeking to increase their market share of orthopaedic work and is working with Hillingdon PCT to repatriate non-complex work from other acute providers.
- RBHT plan to continue to operate from their existing sites and expand activity.
- WMUH is developing urgent care proposals with Hounslow PCT and Local Authority partners, an ISTC provided by Clinicentre and Medihome for care outside hospital. The Trust opened its Natural Birth Centre in October 2008.
- CNWLFT is taking forward development of an "early intervention in psychosis" service across all 5 boroughs, developing rehabilitation / continuing care services for people with challenging behaviour, through a £4.7m capital investment programme. Other initiatives include acquisition of a site to enable the relocation of the Tier 4 drug and alcohol detoxification service; development of Section 75 partnership agreements in Westminster, Brent and other boroughs; joint development of Community Forensic services with WLMHT and K&C and WPCTs; and a pilot for a stepped care service with GPs in Hillingdon.
- WLMHT has no plans to change significantly the supply of core services. However, the forensic service will wish to explore the option of a joint venture with partners as part of the provision of residential services in the community. Plans to develop new services include provision of a Crisis House in Ealing as a step down from acute care and step up from care through the Home Treatment Plan as well as plans to develop better care pathways between forensic and community care. In relation to local (non-forensic) services, the Trust is looking to move towards a community model of care. In H&F and Ealing, the Trust plans to expand its provision of psychological therapies.

PCT Provider Services Plans

NHS London has asked all PCTs to demonstrate how they will achieve full Autonomous Provider Organisation (APO) status for their provider arms by April 2009, and to complete the externalisation process by April 2010. Plans in NWL are outlined below.

Inner London Alliance

The Alliance for NHS Community Services in inner NWL brings together the provider services arms of the PCTs in Westminster, Hammersmith & Fulham and Kensington & Chelsea. The Central West London Community Service was formed in July 2008. The current Alliance falls short of full integration as statutory accountability for the performance of each of the provider services arms remains with the respective host PCT. However, it provides a framework within which to test future models to achieve full integration. A single over-arching management team has been established and a Joint Provider Committee (JPC) has been created as a formal sub-committee of each PCT Board.

Whilst the institutional end point for many community services within the Alliance is not completely clear, the three PCTs are currently exploring a range of organisational options for the future management and delivery of their community services. These include options within and external to the NHS, including joint ventures. **The JPC proposed the formation of a Community Foundation Trust (CFT) to the PCT Boards for consideration in January 2009. The proposal to form a CFT was accepted.**

The main aim of the Alliance is to increase the in-house providers' chance of making a successful transition into effective, clinically and operationally viable, arms-length providers, able to deliver world class health outcomes for community health services. Forming an alliance does not irrevocably join all the current PCT services together, nor does it rule out service level alliances with other partners including local authorities, PBC's, local acute hospitals or the independent sector.

In parallel with this work the three PCT's have undertaken a comprehensive programme of service reviews to determine the level of fitness for purpose of their provider services and will be agreeing development plans aimed at strengthening services or alternatively agreeing alternative provision options. This detailed scrutiny performed last year on an APO basis is being revisited in the context of the present commissioning negotiations and the Alliance framework. The current Programme of work identifies key services for integration, scale up and externalisation. This includes development plans to meet local needs of services providing community rehabilitation/stroke services.

The H&F arm of the Alliance is part of an Urgent Care partnership with Imperial Health Care and an Out of hours Service Provider to be provided on the Charing Cross site.

Outer NWL Federation

PCTs in outer NWL (Brent, Harrow, Hillingdon, Hounslow and Ealing) have established a range of vehicles to take their community services forward. Hounslow has linked with Richmond & Twickenham; Ealing has linked with Harrow; and two borough based APOs have been formed in Brent and Hillingdon. As with the inner grouping the aim is to create fit-for-purpose organisations that can compete in a market environment

Summary of activity volumes 2007/08

Table 40

PCT Provider 2007/08 Outturn						
Providers	Inner West London Alliance (H&F, K&C & WPCTs)	Outer NWL Federation				
		NHS Harrow	NHS Ealing	NHS Brent	NHS Hillingdon	NHS Hounslow
Total number of contacts	742,615	163,497*	724,025**	445,234***	247,558	397,665
Average number of contacts per 1000 weighted population	1,131	679	461	1,350	934	1,788
* face to face contacts						
** all contacts (face to face & non face to face)						
*** represents services that are computerised. Data is incomplete. Estimate that this figure represents 80% of all contacts. If the figure of 80% is factored in it would raise contacts per 1000 weighted population to 1690.						

Harrow PCT is projecting a 10% growth p.a. in the number of face to face contacts. Brent PCT data was not available to project future contacts. Hillingdon PCT is projecting 0% growth in 2008/09, future projections are yet to be confirmed. Future activity projections for Central West London Community Services and NHS Hounslow are not currently available.

Strengths and Weaknesses of current provision

The strengths and weaknesses of Provider services are described throughout the CCI. In this section, these are summarised at a high level.

Strengths: Three teaching hospitals, one of these is the UK's first AHSC
 Broad range of local provision
 Progress being made in terms of reducing waiting times for treatment

Weaknesses: Performance against HCC reports (Urgent Care & Maternity) and National Sentinel Stroke Audit is mixed with some providers achieving best performing and others least well performing.
 Two NWL Acute Trusts (NWLH & WMUH) reported material financial variance at Month 4. NWLH is forecasting to achieve a breakeven plan and WMUH is forecasting a £1m variance from plan.
 Provider arm capacity and understanding of services being provided.
 Fragmentation of services.

Market development plans

Market development plans are still in their infancy and have mainly been initiatives within individual PCTs. The externalisation of PCT Provider services is the first step in shaping the market for community care, although it is not anticipated that there will be major changes in service provision before 2010-11. The development of independent sector provision of acute care has not resulted in the expected level of change anticipated by the DOH and within NWL and there is sufficient capacity within the acute trusts to deliver 18 weeks resulting in under-utilisation of the DH agreed ISTC provision. The main drivers for change on the supply-side will be the HfL programme, particularly in relation to Stroke, Urgent Care, the Local Hospitals project and Polyclinics, and the development of a NWL Neonatal and Paediatric surgery network. Both the HfL and the Paediatric work is likely to lead to changes in the provider landscape within NWL.

A limited PEST analysis of the market environment identified several key issues which the JCPCT will need to consider as it develops and delivers its strategic plans.

Political

Current government priorities include a greater focus on prevention, empowering staff and empowering patients through Choice as well as tackling infections and safety and improving access to primary and secondary care.

No significant change to the overall reform programme is anticipated in the event of a change of government. Possible changes include:

- “End of political interference” through an economic regulator (tariff setting) and establishing an NHS Board (resource allocation)
- Full purchaser – provider split
- NHS Board to oversee commissioning
- PBC with ‘real’ budgets
- Providers allowed to discount
- Increased FT freedoms including vertical integration, increasing borrowing and removing the private income cap
- PCTs – change in resource allocation, more stable resourcing regime and an end to PCT provision
- Hospitals – more stable pricing regime, more opportunities for low cost providers and a tougher environment for high cost providers and greater opportunities for FTs to innovate.

Economic

The downturn in the world economy will have an effect on healthcare spend, although this is not expected to have a significant effect until 2012-13. Growth of 5.8% is predicted for the next 2 years with a reduction to 4% from 2012 onward. **Current predictions suggest a more pessimistic approach will be required.** Advice from NHSL in November 2008 was that “given the current economic uncertainty we think it would be prudent for PCTs to also do some additional outline scenario planning of the impact of an additional 1% downside and 1% upside on their allocation uplift for each of the next two years of the CSP period”. **This is also likely to change over the coming months.**

There is also an imbalance between Acute Trust and PCT financial positions in London. A medium term financial plan for London **has been agreed.** **This** may affect PCT’s ability to commit funds to developments in community care.

Social

The Operating Framework 2009-10 sets out a range of mechanisms (choice, competition and new contracts) that commissioners are expected to use to deliver national and local priorities. ‘Free choice’ of any provider for all patients requiring an elective procedure was implemented in April 2008. However, results from the DH national choice patient survey show that 61% of patients do not recall being offered a choice. PCTs are expected to make available comparative information about providers (including independent sector) e.g. through the use of NHS Choices and encouraging all GPs to offer choice to patients. Providers can also promote their services in line with the DH Code of Practice. Patients may not be given a choice in certain circumstances, when referred to mental health services or where speed of access is important (eg. suspected stroke, heart attack or cancer). Choice has also been rolled out to people with long-term conditions.

Technological

Technological advances have been one of the most significant factors in changing the delivery of healthcare over the last 30 years. Investment in IT, new types of intervention and drugs are likely to be major contributors to both demand and supply drivers.

Table 41

Type of Provider / Trust	No of Sites	Type of care provided	Size of the 'Business' 2007/08	
			No of staff (WTE)	Income (£'000)
Acute Providers				
Imperial College Healthcare NHS Trust – AHSC	5 hospitals on 4 sites	Major provider of local secondary services. Wide range of specialist / tertiary services provided including major trauma, neurosciences, robotic surgery, ophthalmology, orthopaedics, urology, vascular surgery, breast surgery including reconstruction, cancer centre, renal medicine and transplantation, Hepatopancreatobiliary surgery, high risk obstetrics and neonatology and paediatrics.	9,236	838,148
Chelsea & Westminster NHS Foundation Trust	1 main site – services provided from 3 other sites	Major provider of local secondary services. Specialist / tertiary services provided including HIV and sexual health, burns care and plastics, bariatric surgery, dermatology, hand management, cranio-facial surgery, high risk obstetrics and paediatrics.	2,535	258,200
Royal Brompton & Harefield NHS Trust	2 main sites	Cardio-respiratory specialist centre – local and national service for cardiology, cardiac surgery, thoracic surgery, respiratory medicine and transplantation.	3,000	230,000
NWL Hospitals	3 hospitals on 2 main sites - services provided from 2 other sites	Major provider of local secondary services. Specialist / tertiary services include regional head and neck services, clinical genetics and national gastro-intestinal services at St Mark's Hospital.	4,700	320,000
Ealing Hospital NHS Trust	1 main site	Provides a wide range of medical and surgical secondary services. Moorfields Eye NHS Foundation Trust provides ophthalmology services on site and ICHT provides a satellite renal dialysis unit at EHT	1,600	103,000
The Hillingdon Hospitals NHS Trust	2 main sites	Main provider of local secondary services including a treatment centre at Mount Vernon Hospital.	2,472	165,000
West Middlesex University Hospitals Trust	1 main site + outreach	Major provider of local secondary services. In addition, provide services in association with RBHT, GOS, C&WFT, RMH, EHT and ICHT.	1,750	128,000
Mental Health Trusts				
Central and NWL NHS Foundation Trust	Operating across 64 sites	One of the largest specialist mental health providers in London. Specialist services include substance misuse, pre-adolescent mental health, eating	3,400	212,000

Type of Provider / Trust	No of Sites	Type of care provided	Size of the 'Business' 2007/08	
			No of staff (WTE)	Income (£'000)
		disorders, learning disabilities and prison mental health services.		
West London Mental Health Trust	Operating across 32 sites	Provides local mental health services for 3 NWL boroughs, high secure services for men for London and South and South England including a DSPD unit. Two national services, gender reassignment and children's and families service.	4,000	237,000
PCT Provider Services				
Central West London Community Services	Operate from multiple GP surgery, health clinic / centre, hospital, nursing home sites as well as in peoples own homes. A full list of sites to follow.	Community –based NHS services across a range of service lines (see Appendix 7) are mainly provided in the 3 boroughs of Hammersmith & Fulham, Kensington & Chelsea and Westminster, although a few services are provided beyond this area to a wider catchment. Working towards APO status for the alliance. It is anticipated that the majority of services will merge to form a single organisation with a small number of services being managed by other organisations.	1,440	101,000
NHS Ealing	10 clinic / service locations in the community, IP & OP therapies at EHT and Clayponds Community Hospital, palliative care at Meadow House hospice and domiciliary care	NHS Ealing provider services provides a range of adult, children's and specialist services as well as community clinics, further detail is provided in Appendix 7. The catchment area includes residents of Ealing Borough and those registered with an Ealing based GP.	670	27,600
NHS Hillingdon	Operate from 16 clinics across the borough as well as seeing patients in a broad range of settings e.g. schools, nursing	Hillingdon provider services are commissioned to provide thirty-two services covering adult and children, young people and family services, further detail is provided in Appendix 7.	508.4	2,400

Type of Provider / Trust	No of Sites	Type of care provided	Size of the 'Business' 2007/08	
			No of staff (WTE)	Income (£'000)
	homes, acute setting, Children's Centres and patients' homes.			
NHS Harrow		Harrow provides a range of community and an intermediate care service in people's homes, clinics and bedded units and runs an urgent care centre. Harrow's service portfolio comprises a relatively large number of specialist nursing services which are typically resourced with one or two specialist practitioners.	218 (2006/07)	14,990 (2006/07)
NHS Brent	Operate from 10 sites	NHS Brent provider services provides a range of adult, children's and specialist services as well as an Urgent Care Centre at CMH and the Wembley WiC, further detail is provided in Appendix 7. The catchment area includes 281,000 population of Brent plus surrounding areas in NWL including Ealing, K&C, Harrow, Westminster, Barnet and Camden.	662	43,300
NHS Hounslow	Operate from 10 community health centre sites as well as in patients' homes, GP practices, day centres, residential homes, children's' centres, extended schools and hostels	NHS Hounslow provider services provide home based, clinic and outpatient community nursing, rehabilitation and therapy services for adults and children and their families. This includes some specialist services such as diabetes, continence and tissue viability. In addition, specialist children's services, audiology for children, sexual health services, learning disability services, health promotion including smoking cessation, community dentistry and wheelchair services are provided. Some of these services are delivered in close partnership with the Borough. Some therapy services are also provided to West Middlesex University Hospital as well as having some smaller SLA's with the Borough and neighbouring PCTs.	487.83	19,800

INSIGHTS FROM PATIENTS, PUBLIC, CLINICIANS AND PARTNERS

Sector-wide arrangements for engaging patients, the public, clinicians and partners

A NWL Public Engagement Reference Group (PERG) was established in April 08 to support patient and public engagement around the workstreams under the Collaborative Programme. The group comprises Public & Patient Involvement (PPI) and Communications leads from the 8 constituent PCTs and provides advice and guidance to the Programme on how and when to engage patients and the public. This is achieved through regular reports to the CCG as well as individual PPI leads sitting on workstream groups. PPI leads' support to the Programme has included supporting the development of stakeholder engagement plans for the projects and identifying appropriate patient and public representatives to sit on workstream groups. The PERG has developed a Public Engagement Policy which provides a framework for sector-wide engagement and this will be updated in line with more recent developments and the Patient and Public Engagement Initiative.

Patient/carer representatives sit on the various work stream groups as appropriate and are integral to the review and recommendation process. However, it has been acknowledged that much greater patient/public involvement in the planning, review and implementation of care is required. This will be achieved through a specific delivery initiative on Public Engagement (section 5).

The Collaborative Programme has taken a proactive approach to engaging **local clinicians** from both member organisations as well as local Trusts to ensure that service reviews are clinically informed. The NWL Clinical Reference Group (CRG) comprising local PEC Chairs and Medical Directors has remained an important and integral part of the Programme and has continued to play an active role in shaping the Collaborative Programme, particularly the **Improving** Clinical Practice initiative. Clinicians have also been engaged through providing clinical support to specific workstream groups, for instance the Paediatric Surgery initiative comprises a local PEC Chair, Medical Director, **Director of Public Health** and consultant Paediatricians. Other initiatives such as Stroke and Maternity both have joint-clinical leads assigned to the project groups as well as clinicians from the local Trusts. In September 2008, a workshop was held for local PEC members to discuss how best to take forward effective and meaningful clinical engagement. Attendees praised the proactive nature of the CRG, particularly with regard to the development and subsequent adoption of the CRG Recommendations. Attendees also embraced the need for a greater level of clinical leadership, particularly of front-line clinical staff. A programme to broadening engagement of clinicians will be developed further **during 2009**.

As well as engaging local provider Trusts at the clinical level, **Trusts** have also been proactively engaged at an organisational level through the NWL Provider Reference Group (PRG). As with the CRG, this advisory body to the CCG has been actively engaged on all aspects of the Programme and continues to provide a valuable arena for discussion and debate as well as collecting the views of local Trusts to inform and shape the direction of the Programme. In November 2008, a workshop was held for this group to explore different models of vertical integration. The outputs from the workshop will be built into the initiative on the Provider Landscape.

Engaging and informing wider stakeholders such as Local Authorities and OSCs: In June 08, the Programme team hosted a conference to inform stakeholders

of the various initiatives in the Programme as well as the vision and values of the collaborative work in NWL. The conference was attended by more than 130 representatives from local PCTs, Trusts as well as Local Authorities including a number of local Councillors, clinical networks, and local clinicians including Practice-based Commissioners. The event was positively received, particularly in regards to the workshops held on the specific initiatives where participants were able to provide input. **It is planned to hold similar events in the future.**

Engagement in the CCI planning process

All PCTs have involved their local clinicians, patients and public in the planning phase of their Commissioning Strategy Plans (CSPs) through a series of engagement activities and in turn, this has informed the development of the CCI. The findings from these events have been used to inform their priority setting, vision and values. As with most PCTs, the work around developing CSPs has been framed within the context of World Class Commissioning (WCC) and part of the engagement activities of some PCTs (Ealing and Brent) have included formative and deliberative events on WCC attended by a range of stakeholders. NHS Brent held a WCC stakeholder event in early September where strategic goals and a list of initiatives were discussed and agreed. A prioritisation process at the event resulted in a shortlist of initiatives.

A number of PCTs have actively engaged their local clinicians in identifying priority areas. For instance, Ealing PCT ran a workshop for local clinicians in September 2008 focussing on priority-setting. As a result of the workshop, a list of priorities were agreed based on improving health through evidence based interventions, reducing health inequalities and improving patient experience. Sustained clinical engagement and engagement of providers has also been demonstrated by PCTs. More specifically, NHS Harrow has engaged providers and clinicians in the development of its market management and procurement strategy; around maternity services within primary and community care; and new rehabilitation pathways for stroke and cardiac patients.

All PCTs have demonstrated an ongoing partnership with their Local Authorities in their CSP planning, through the development of Joint Strategic Needs Assessments (JSNAs). NHS Hillingdon and LB Hillingdon recently held a community engagement day on their JSNA. Findings from the event confirmed the need for the PCT and Local Authority to work jointly on improving health and wellbeing including promoting healthy eating, sexual health, reducing obesity and elderly care. The need for a greater level of 'joined-up' community engagement across the PCT and the local borough was also emphasised as well as the need to engage healthcare professionals and the commercial sector to play a wider part in 'borough life'.

Other PCTs undertook a number of engagement events around their CSPs throughout the autumn of 2008. NHS Hammersmith & Fulham carried out a number of focus group discussions about the CSP towards the end of November. Westminster PCT surveyed 1500 local people and held two deliberative consultation events to which patient and public representatives, local voluntary and community organisations, staff and clinicians were invited. Feedback from these engagement activities support the development of individual PCT CSPs and through this, informed the development of the CCI.

In addition to the engagement of patients, public and local clinicians by the PCTs, the NWL Programme Team has also involved a number of stakeholders including local NHS Trusts; local clinicians (through PEC Chairs); and funded clinical networks to

ensure that the CCI receives significant input around priority setting, vision and values from these local partners. An initial planning workshop was attended by colleagues from these stakeholder groups where process around the planning of the CCI was discussed and agreed. A number of representatives from these stakeholder groups, PEC Chairs and the Chair of the NWL Clinical Reference Group, were joined by PCT CEs, and PCT Chairs at a workshop to agree the vision and values, strategic objectives and prioritisation criteria for the CCI. Local NHS Trusts were also invited to comment and provide input to the draft vision and strategic objectives.

Previous engagement activity carried out by PCTs has also helped to inform individual PCTs' CSPs and in turn, the CCI. A number of PCTs have already completed, or are in the process of completing, evaluations of previous consultations and ongoing community engagement activity.

NHS Brent's review included Brent Youth Parliament, Residents' Surveys and public consultations around HfL and Local Involvement Networks (LINKs). Where this has shown common issues to be prioritised by different groups, the PCT have then used this analysis to inform the goals and long list of initiatives presented at the WCC stakeholder event as described above. Westminster PCT reviewed those areas where patient/public satisfaction was reported to be low to inform the development of its CSP. NHS Hammersmith & Fulham has undertaken a large community engagement review examining engagement processes and outcomes across both the PCT and local borough.

A number of PCTs have embraced innovative approaches to community engagement, adopting new methodologies such as social marketing to engage with their local populations. NHS Kensington & Chelsea recently commissioned the National Centre for Social Marketing to support a project around promoting access to NHS dentistry services. The approach adopted both qualitative and quantitative methods of research including surveys, 'street interviews' and focus groups with a wide range of service users including those from BME groups, parents, young people, and dentists. NHS K&C have also undertaken a 'consumer insight project' which examined the drivers of patients' perception and subsequent behaviours. The project also examined in great detail the 'drivers of belief' in the NHS such as clinical excellence, personalisation, pro-activeness and efficiency. The PCT has used the findings from this project to develop a series of initiatives looking at the ways in which communication with patient and certain services can be improved.

During the initial stages of developing the NWL Strategy in September 2007, all PCTs in NWL carried out an analysis of engagement activity over the previous two years and a pre-consultation on the Programme (then known as the NWL Strategy). Findings from this consultation were consistent with findings drawn from previous engagement activities.

Insights from PCT engagement activities

The key themes which PCTs have consistently found to be high-priority areas for local residents are strikingly similar and support the findings from both the HfL and nationwide consultations. Some of the key issues highlighted in PCTs' findings include:

- **Healthy living and prevention**, particularly the need for better information being available widely in the community for people to manage their own health and wellbeing.

- **Integrated service provision and the seamlessness of services.** Particular emphasis on the need for a stronger link between health and social care, with this extending to housing and education services is also often highlighted.
- **Access to primary care services**, particularly GP services and Out Of Hours (OOH) care. It has been generally found to be true that the local population of NWL would be willing to travel further in order to access a wider range of facilities such as diagnostic tests and procedures.⁵
- **Access to mental health services**, in some cases particularly for BME communities.
- **Improving the quality and safety of services.**
- Greater emphasis on **involving patients and the public.**
- People's **desire to control their own health and healthcare**
- The need for **greater access to and choice** of services.

The need to improve services for children, young people and mothers is consistently highlighted within PCTs' engagement activities. Key findings in relation to these services include:

- There is a general level of satisfaction with these services with the consistent exception being maternity services.
- Access to maternity services is a key issue – namely, registration with maternity units of the patients' choosing and levels of antenatal and postnatal service provision.
- More information is needed on how the services (across primary, community and secondary care) relate to one another.

Insights from pan-London and nationwide engagement processes

The extensive engagement of patients and the public, staff groups and other stakeholders around 'Our NHS, Our Future' highlights some key messages about what the public feels needs to be addressed in order to improve health and healthcare services. In particular, there are a number of issues which consistently arise across all groups, including:

- The need to address the variation in the quality of care across the NHS.
- The need for better information to enable patients to manage their own care.
- The need for new roles and partnerships involving a range of people and organisations across health and community services to enable the provision of personalised care closer to home.
- A greater emphasis of improving access to high quality local services.
- The need for a greater emphasis on preventative care and early intervention.
- The need for continued emphasis on upholding basic standards of care such as cleanliness and safeguarding the dignity and respect of patients and staff.⁶

The Healthcare for London consultation engagement activities highlighted a number of key issues that were consistently raised across many different groups both in regards to the pan-London review as well as health and healthcare services in general. This includes issues such as:

⁵ A telephone survey of 1000 local residents carried out by the Picker Institute in K&C to inform the PCT's primary care strategy found this to be particularly true.

⁶ 'NHS Next Stage Review Engagement Analysis: what we heard during the 'Our NHS, our Future' process' (DH, July 08)

- The need to understand what the pan-London work meant at a local level.
- The need to address access to GP services with a focus on the continuity of care, location of services and the potential duplication of hospital services.
- Transport - in regards to travelling further to access more specialist services as well as the provision NHS-transport for patients receiving services in the community. It was found, however, that there is a general consensus among patients that they would be willing to travel further for specialist treatment, provided that this would mean receiving better quality care.
- The need for a greater understanding around capacity issues to support the delivery of the changes around maternity services.
- The need for a greater emphasis on mental health in regards to mental health promotion as well as the provision of mental health services, particularly for people with moderate mental health needs.⁷

Insights from patient and public engagement within local Providers

Acute Trusts

All local provider Trusts reported compliance with the core standards around accessible and responsive care as part of their 07/08 Healthcare Commission Annual Health checks. More specifically, this refers to standards around patient and public involvement and equity and choice. On the whole, NWL Trusts have also reported compliance with the core standards around delivering patient-focused care.⁸ The high level of performance in these areas across all Trusts demonstrates an ongoing commitment to engaging patients.

A number of Trusts have ongoing engagement initiatives which are highly relevant to the collaborative work in NWL and more work is required to draw on the insights gained from these engagement activities. Trusts have demonstrated a high level of commitment to the continual improvement of how they engage with their patients to feed directly into the strategic planning and review of services. For instance, a number of Trusts already have, or are planning to, further develop patient panels. The Royal Brompton and Harefield Trust is currently recruiting parents and children to establish a Children's Services patient panel and a Children's Services PPI group has recently been established. Work has also been done in this Trust on examining the experience of parents and children in PICU. ICHT plans to pilot a 'patient experience tracker' to facilitate the collection of real-time patient experience in early 2009. The feedback from this will be regularly displayed in patient areas and will be used to inform service changes. Engagement activity in this Trust has consistently highlighted patients' needs for a greater level of information on ward routines to be available. The Trust has responded to this by planning to make information (such as meal times) more readily available to patients. The quality and accessibility of patient information is also addressed through the Patient Information Readers Group (as part of the Maternity Services Liaison Committee).

Trusts have also demonstrated a proactive response to the need for staff to be informed about the importance of patient experience and patient-centred care. ICHT has developed a simplified guide to the statutory duty for involving patients and the public (s.242, NHS Act 2006) and WMUH undertook a programme of examining the

⁷ 'Healthcare for London: report on the consultation and recommendations for change'

⁸ The only exception was in one Trust where there was not sufficient assurance provided against the standards for 'complaints response' and 'dignity and respect'.

links between staff engagement and customer satisfaction. This led to the development of the Trust's Customer Care plan and subsequently enabled the implementation of a programme to streamline processes in order to release more staff time to devote to direct patient care.

Mental Health Trusts

The Healthcare Commission recently published the findings from its 2008 patient survey of community mental health services in England which, most significantly for the NW sector, includes details about WLMHT and CNWL NHS Foundation Trust. The survey report shows how each trust scored for each question in the survey, in comparison with national benchmark results. The survey included 68 NHS trusts that provide secondary mental health services (including combined mental health and social care trusts, and primary care trusts that provide mental health services). More than 14,000 service users were included in the sample and the findings were based on respondents of working age (16-65).

The survey found that, on patients' overall satisfaction with NW sector mental health, services fell within the intermediate rating (60% of trusts surveyed). However, the survey also found that in both mental health trusts in NWL, improvements are required on involving patients in decisions about their care and treatment. This area of concern is also reflected across the whole of England with almost a quarter (24%) of respondents saying they were not involved in deciding what was in their care plan, 16% of service users saying that their diagnosis was not discussed with them and almost a third (32%) of those who had been given new prescriptions over the previous year saying that they were not told about possible side effects.⁹

The feedback from the specific PCT and Trust engagement activity was used to develop the Strategic Objectives for the CCI and has been used to inform the development and delivery of the strategic initiatives.

Next steps in engagement and plans for future consultation

In addition to all NWL PCTs carrying out pan-London formal public consultation on Stroke and Major Trauma in early 2009, a number of individual PCTs have planned programmes of engagement activities going forward which will continue to push patient and public engagement to the heart of PCTs' core business as well as reflecting the priority areas which the PCTs are working on collaboratively. Across all PCTs, there is a strong emphasis on an increased level of working in partnership with local boroughs and Local Involvement Networks (LINKs) to develop the engagement process and achieve meaningful engagement outcomes.

Westminster PCT has recently launched a 2-year programme entitled 'It's Your Choice: The Westminster Health Debate' which will emphasise a greater level of involvement of patient and public representatives and aims to provide a greater number of ongoing opportunities for patients and the public to be involved in shaping the PCT's commissioning plans and proposals.

As a result of a recent review of PCT and local borough community engagement commissioned by LBHF, NHS Hammersmith & Fulham has developed a Community

⁹ A full report of findings from the HCC 2008 Mental Health services patient survey as well trust-by-trust percentage results and feedback reports for individual trusts can be found at <http://www.healthcarecommission.org.uk/guidanceforhealthcarestaff/nhsstaff/nhsstaffandpatientsurveys/patientsurvey/mentalhealthservices.cfm>
T:\COLLABORATIVE COMMISSIONING INTENTIONS\CCI_2009-14\CCI_2009-14_DOCUMENT&SUPPORTING_APPENDICIES\AMENDABLE_VERSION\NWLCCI09-14_090315_V2.1_Final Draft.doc

Engagement Framework which sets out the ways in which patient and public engagement will be positioned at the heart of PCT investment and support the implementation of WCC through continually seeking and embracing opportunities for meaningful public engagement as well as working closely with the local borough and the Local Involvement Network (LINK). Similarly, NHS Kensington & Chelsea are working with RBKC as well as representatives from the voluntary sector, BME health forum and elsewhere in the local community to develop a shared framework for community engagement that places a strong emphasis on a multi-agency approach to engagement. This work will be completed by December 08 after which, a programme of engagement with service users and wider stakeholders will be initiated. NHS Kensington & Chelsea are also working closely with their Local Involvement Network (LINK) to further develop and achieve meaningful engagement with the local community.

Other PCTs have developed stakeholder engagement plans which demonstrate ongoing engagement with local populations around CSPs and will include future engagement or consultation around the CCI priorities as required.

At a sector-level, work will continue to develop leadership in Communications and Engagement through the PERG as well as ensure that there is significant and relevant public engagement within each of CCI priorities. This is likely to involve tightening the processes for ensuring that there is a greater level of robust and meaningful stakeholder engagement in all areas of the Collaborative Programme, particularly from patient and public representatives. This will be achieved through a specific Patient and Public Engagement Initiative (see section 5).

INVESTMENT IN HEALTHCARE

Table 42a: Summary Sector-wide Financial Performance 2009-10 and 2012-13

Summary of Financial performance	Hammersmith		K&C		Westminster		Ealing		Hounslow		Brent		Harrow		Hillingdon		CCG wide	
	FY 2009/10	FY 2012/13	FY 2009/10	FY 2012/13	FY 2009/10	FY 2012/13	FY 2009/10	FY 2012/13	FY 2009/10	FY 2012/13	FY 2009/10	FY 2012/13	FY 2009/10	FY 2012/13	FY 2009/10	FY 2012/13	FY 2009/10	FY 2012/13
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Brought Forward Surplus/(Deficit)	16,815	1,493	7,041	1,774	12,490	4,743	4,000	0	-8,800	0	11,442	8,672	1,718	1,150	0	0	-44,706	-17,831
Total Income	344,899	366,571	328,414	349,810	472,685	526,841	627,397	696,564	338,996	401,428	496,737	566,122	296,232	333,101	352,500	404,500	3,257,860	3,644,937
Total Expenditure	335,064	364,689	326,842	347,951	463,127	522,118	627,397	696,564	338,995	394,229	484,195	561,451	295,232	331,901	352,500	404,500	3,223,353	3,623,403
PCT Surplus/(Deficit) reported	9,835	1,882	1,572	1,858	9,558	4,723	0	0	0	7,199	12,542	4,671	1,000	1,200	0	0	34,507	21,533

Table 42a. shows the planned financial position for each of the 8 NWL PCTs and a consolidated NWL position for the financial years 2009-10 and 2012-13.

Total investment in healthcare in the sector will be around £3.3 billion in 2009-10 rising to £3.6 billion in 2012-13, a growth of 12% overall. The brought forward surplus at the end of 2008-9 is expected to be around £44 million. Over the 4 years period, this surplus is predicted to reduce by around 50%. Some of the surplus will be reinvested in direct healthcare and some in reducing underlying deficits. However, the current uncertainties around the medium to long term financing of the NHS suggests that the level of surplus will change over the CCI planning period.

The sector position was then analysed in more detail at a specialty level as shown in tables 42b. & c. below. Table 42b. shows the actual and % change in planned spend by specialty over the next 4 years. The greatest increases are in Paediatrics and Maternity followed by the main Medical specialties. Around £10M extra is being invested in maternity services of which £3.6M relates to the additional investment to ensure implementation of the recommendations in Maternity Matters. There is considerable variability in the level of increase in investment across the 8 PCTs. Further sector-wide work is required to link the CSP analysis to programme budgeting to understand the importance of the variability in terms of collaborative service planning and commissioning.

Table 42b: Sector total expenditure by specialty for 2009-10 and 2012-3¹⁰

Outpatients/Emergency/ Elective and Other	Hammersmith		K&C		Westminster		Ealing		Hounslow		Brent		Harrow		Hillingdon		CCG wide		
	FY 2009/10	FY 2012/13	FY 2009/10	FY 2012/13	FY 2009/10	FY 2012/13	FY 2009/10	FY 2012/13	FY 2009/10	FY 2012/13	FY 2009/10	FY 2012/13	FY 2009/10	FY 2012/13	FY 2009/10	FY 2012/13	FY 2009/10	FY 2012/13	
1.1 HRG Activity by Specialty	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	% change
Maternity	10,786	12,141	5,205	5,685	2,861	3,069	14,564	18,291	10,465	13,993	11,467	12,187	7,323	7,705	9,252	9,818	71,924	82,890	15.25%
Paediatrics	4,926	6,978	4,481	5,168	3,481	4,056	8,918	10,347	4,666	4,979	13,440	16,765	5,987	6,420	4,498	4,897	50,396	59,610	18.28%
General Medicine	10,196	11,557	12,524	12,278	16,928	18,744	29,139	32,752	18,144	21,059	21,599	25,788	13,347	13,831	16,604	17,842	138,481	153,851	11.10%
Elderly Care	1,597	1,862	2,443	2,597	1,690	1,766	2,716	3,034	831	962	2,239	2,991	1,399	1,731	4,805	5,297	17,719	20,240	14.23%
Other Medicine	19,276	22,126	32,809	33,146	21,362	23,120	61,437	68,597	12,496	14,749	36,465	46,298	27,316	30,267	24,754	26,703	235,914	265,005	12.33%
Cardiac	4,495	5,252	4,236	4,210	7,822	8,534	19,917	23,047	7,466	8,977	9,454	9,776	7,789	8,741	10,227	10,837	71,405	79,374	11.16%
General Surgery	16,963	18,419	5,814	6,598	3,023	3,219	14,200	16,010	7,034	7,604	13,325	14,881	8,551	9,063	11,510	12,323	80,420	88,118	9.57%
T&O	3,855	3,290	5,903	6,070	5,933	5,614	10,093	11,565	11,024	11,910	13,322	14,613	6,104	6,928	9,128	9,756	65,362	69,746	6.71%
Gynaecology	2,408	2,608	3,319	3,855	4,123	3,945	8,464	9,625	4,413	4,859	6,540	6,946	5,077	5,476	4,568	4,861	38,912	42,175	8.38%
Other Surgery	8,808	9,564	10,571	11,942	12,834	13,357	32,620	36,147	18,802	20,456	18,468	19,289	13,092	14,238	15,477	16,603	130,672	141,596	8.36%
Mental Health	35,450	37,255	35,445	37,964	48,048	50,920	49,294	54,821	-	-	53,569	61,448	17,946	18,826	22,256	25,290	262,008	286,524	9.36%
Other	9,801	12,640	19,780	22,416	37,036	43,001	109,285	118,161	9,011	10,017	20,160	21,775	12,516	13,458	32,068	32,677	249,657	274,146	9.81%
Total	128,561	143,692	142,529	151,929	165,141	179,345	360,647	402,397	104,352	119,565	220,046	252,757	126,447	136,684	165,148	176,905	1,412,871	1,563,274	10.65%
		11.77%		6.60%		8.60%	-	11.58%		14.58%		14.87%		8.10%		7.12%		10.65%	
1.2 A&E, Access and Other Non HRG Activity							-	-											
Total A&E Attendances (excluding Walk in Centres)	11,471	12,373	4,424	4,146	5,703	5,134	11,138	11,985	4,974	3,599	9,436	10,649	4,185	4,159	6,606	6,780	57,938	58,826	1.53%

¹⁰ The expenditure in these tables represents both acute and primary care spend. The activity in Table 43c. is for the acute sector only; so direct comparison is not possible.

Table 42c: Sector total acute activity by activity type and speciality for 2009-10 and 2012-3

	Hammersmith		K&C		Westminster		Ealing		Hounslow		Brent		Harrow		Hillingdon		CCG wide		
1.1 HRG Activity by Specialty	FY 2009/10		FY 2009/10		FY 2009/10		FY 2009/10		FY 2009/10		FY 2009/10		FY 2009/10		FY 2009/10		FY 2009/10		
Outpatients (Total Attendances)	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	000	
Maternity	25,787	28,096	13,696	15,442	20,781	20,643	30,362	34,410	34,993	37,684	20,198	19,957	12,900	12,900	22,553	22,548	181,270	191,680	5.74%
Paediatrics	7,086	7,947	3,391	3,823	7,750	8,614	17,462	19,853	9,678	10,817	9,739	10,816	9,326	9,220	10,205	10,525	74,637	81,615	9.35%
General Medicine	16,224	18,198	14,507	15,044	20,021	21,935	68,379	75,280	26,296	28,968	25,455	21,287	13,046	12,820	24,001	24,400	207,929	217,932	4.81%
Elderly Care	830	931	890	958	930	2,299	1,872	2,142	1,409	1,558	1,443	1,660	933	962	2,559	2,659	10,867	13,168	21.18%
Other Medicine	75,173	81,530	61,082	56,030	88,886	96,373	112,051	120,723	78,377	86,887	92,570	104,258	48,856	47,854	57,748	57,740	614,743	651,396	5.96%
Cardiac	8,281	9,289	5,583	4,952	10,064	10,558	27,545	32,002	11,532	12,528	13,727	14,508	11,053	11,718	14,818	14,276	102,603	109,831	7.04%
General Surgery	17,344	18,030	11,164	12,587	15,700	15,929	28,249	32,322	8,126	8,372	21,438	28,819	14,144	14,144	23,583	24,035	139,749	154,239	10.37%
T&O	15,235	6,938	11,840	7,062	17,482	10,506	37,575	42,980	24,553	25,322	29,101	30,470	19,366	19,036	33,793	34,356	188,945	176,670	-6.50%
Gynaecology	10,172	10,573	11,899	13,415	13,370	9,902	28,370	32,464	15,180	16,347	20,336	20,917	15,606	15,476	12,999	13,153	127,932	132,247	3.37%
Other Surgery	47,749	49,634	37,950	39,513	49,408	43,992	90,252	102,146	82,459	86,246	68,464	80,675	56,422	56,254	68,802	69,719	501,506	528,179	5.32%
Mental Health	1,629	1,668	62,152	62,789	26,645	27,401	73	80	-	-	360	374	316	316	36,294	40,264	127,469	132,892	4.25%
Other	2,925	3,244	15,099	15,026	26,161	26,844	-	-	780	911	517	536	5,571	5,693	26	27	51,079	52,281	2.35%
Total	228,435	236,078	249,254	246,642	297,198	294,996	442,190	494,402	293,383	315,640	303,348	334,277	207,539	206,393	307,381	313,702	2,328,728	2,442,129	4.87%
% increase		3.35%		-1.05%		-0.74%		11.81%		7.59%		10.20%		-0.55%		2.06%		4.87%	
1.2 A&E, Access and Other Non HRG Activity																			
Total A&E Attendances (excluding Walk in Centres)	55,410	49,942	48,574	21,389	86,314	99,919	148,650	151,640	80,396	72,396	93,864	86,438	53,854	53,614	90,871	87,556	657,933	622,894	-5.33%
1.1 HRG Activity by Specialty																			
Emergency Spells																			
Maternity	7,932	8,643	3,878	3,946	82	88	5,526	6,038	6,201	6,678	9,748	9,631	4,516	4,577	9,273	9,419	47,156	49,020	3.95%
Paediatrics	1,158	1,299	2,267	2,307	1,360	1,511	3,562	3,732	4,542	5,080	4,552	5,010	2,339	2,410	1,745	1,825	21,525	23,174	7.66%
General Medicine	3,385	3,719	3,763	3,731	6,069	6,170	14,732	15,461	5,435	6,042	5,864	6,328	3,926	3,631	5,568	5,709	48,742	50,791	4.20%
Elderly Care	530	595	843	857	488	366	860	902	201	222	519	598	263	271	1,172	1,233	4,876	5,044	3.45%
Other Medicine	26,188	29,375	1,885	1,918	2,461	2,475	7,496	7,813	1,941	2,133	2,971	3,343	2,014	2,010	2,422	2,511	47,378	51,578	8.87%
Cardiac	691	777	792	806	1,779	1,804	2,771	2,922	1,498	1,627	1,635	1,750	1,160	1,145	1,701	1,758	12,027	12,589	4.67%
General Surgery	7,268	7,554	1,058	1,077	134	136	2,342	2,457	1,754	1,815	2,262	2,340	1,580	1,580	1,830	1,859	18,228	18,818	3.24%
T&O	392	408	813	827	998	1,013	1,220	1,279	1,056	1,088	1,184	1,237	848	848	1,095	1,117	7,607	7,818	2.77%
Gynaecology	554	576	540	549	562	570	2,733	2,867	714	736	1,514	1,532	772	772	1,082	1,095	8,471	8,696	2.66%
Other Surgery	794	825	1,273	1,295	1,365	1,402	2,733	1,484	1,036	1,072	1,841	1,895	590	594	979	1,002	9,295	9,569	2.94%
Mental Health	292	299	54,346	54,596	65,484	66,443	3	3	660	711	8	8	8	8	-	-	120,801	122,068	1.05%
Other	9,242	10,366	3,383	3,405	8,176	8,296	-	-	7,900	9,224	7	7	1,908	1,908	4,905	5,022	35,521	38,229	7.62%
Total	58,426	64,436	74,841	75,315	88,958	90,274	42,663	44,958	32,939	36,428	32,106	33,679	19,923	19,753	31,772	32,550	381,627	397,393	4.13%
% increase		10.29%		0.63%		1.48%		5.38%		10.59%		4.90%		-0.85%		2.45%		4.13%	
1.1 HRG Activity by Specialty																			
Elective Spells																			
Maternity	167	181	120	135	6,345	6,850	291	318	1,092	1,176	500	494	216	216	188	190	8,919	9,561	7.19%
Paediatrics	386	434	361	407	4,075	4,529	1,666	1,734	826	924	919	1,021	808	832	418	433	9,460	10,314	9.03%
General Medicine	893	1,001	4,019	4,531	5,507	6,075	6,171	6,472	8,333	9,041	7,284	8,231	4,428	4,429	4,863	4,979	41,499	44,759	7.86%
Elderly Care	19	22	82	93	242	270	979	1,018	32	35	47	53	4	4	19	20	1,425	1,516	6.39%
Other Medicine	3,326	3,719	3,144	3,545	9,075	9,594	11,525	12,054	3,355	3,681	8,550	9,557	5,473	5,476	7,792	7,978	52,241	55,605	6.44%
Cardiac	391	439	669	755	1,384	1,406	2,350	2,490	2,170	2,357	1,667	1,232	934	941	1,239	1,277	10,805	10,898	0.86%
General Surgery	10,134	10,534	1,509	1,701	1,147	1,165	4,780	5,011	2,680	2,778	5,174	5,934	2,148	2,148	2,704	2,761	30,275	32,032	5.80%
T&O	107	111	1,067	1,203	598	607	915	958	3,544	3,654	3,662	3,821	412	412	842	858	11,147	11,624	4.28%
Gynaecology	566	588	1,576	1,777	2,556	2,596	1,996	2,093	2,641	2,744	2,798	2,894	1,504	1,504	1,545	1,566	15,182	15,761	3.82%
Other Surgery	2,681	2,785	4,989	5,625	7,489	7,684	10,812	11,333	14,145	14,837	12,264	12,788	6,477	6,504	7,757	7,972	66,614	69,527	4.37%
Mental Health	81	82	11,703	11,821	23,580	23,827	8	9	-	-	2	2	8	8	-	-	35,382	35,749	1.04%
Other	8	10	97	110	1,265	1,284	-	-	6	-	15	16	312	-	-	-	1,659	1,732	4.40%
Total	18,759	19,906	29,337	31,702	63,263	65,887	41,493	43,490	38,825	41,228	42,884	46,044	22,679	22,786	27,367	28,034	284,608	299,077	5.08%
% increase		6.11%		8.06%		4.15%		4.81%		6.19%		7.37%		0.47%		2.44%		5.08%	

Table 42c. shows the planned change in acute outpatient, emergency , elective and A&E activity over the next 4 years.

Outpatient activity is expected to grow by around 5% overall. However, this disguises considerable variability between PCTs with Ealing and Brent planning growth greater than 10%, whilst Harrow, Westminster and K&C are planning for negative growth which is more in line with planning assumptions around the move of activity from acute to primary care. Work being undertaken by the NWL Clinical Reference Group on managing variability in clinical practice should allow PCTs to identify in more detail where there are opportunities for disinvestment from the acute sector. Of particular note is the planned reduction in T&O activity which links directly to the development of musculoskeletal referral management systems in primary care.

A&E activity is planned to decrease by around 5% which is in line with PCTs plans to develop urgent care centres. This represents an actual reduction in attendances of between 10-15% when the current increase in demand for emergency care is taken into account.

Overall growth in emergency and elective spells is generally in line with expected, but again the sector averages disguise significant variability between PCTs which requires further investigation. The planned growth in Maternity spells does not correlate with the LHO predictions outline previously, but is more in line with local assumptions. This will be confirmed by early 2009.

Conclusion

The high level analysis of investment in healthcare across NWL provides an overview of the baseline and planned position across the sector for the period of the CCI. However, the information reveals considerable variability in planned investment between PCTs which will be influenced by the PCT's baseline position and the level of development and speed with which investment/disinvestment plans can be put in place. Further sector-wide work is required to link the CSP analysis to programme budgeting to understand the importance of the variability in terms of collaborative service planning and commissioning.

Each initiative within the CCI includes financial and activity analysis which is reflected in the individual plans. The impact of these is difficult to identify from PCT and sector level analysis because of the way activity is coded and consolidated within CSP plans. The sector-wide work will determine how to ensure that analysis being undertaken through the HFL and local initiatives work is reflected more clearly within commissioning plans.

SECTION 4

STRATEGY

INTRODUCTION

Having laid out the context for the CCI in section 3, section 4 outlines the NWL Collaborative plan to deliver the Vision over the next 5 years.

PRIORITISATION PROCESS

The CCI is a strategic framework for collaborative commissioning across NWL. It is a plan which describes activities that will be undertaken collectively because the PCTs believe they will be able to deliver the overarching vision more effectively through collaboration.

A workshop of Chief Executives, Chairs and PEC chairs was held in early Sept 2008 to discuss the Vision and Values and from these to agree the Strategic Objectives listed below. These drew on individual PCT Objectives which were then refined through discussions with members of the JCPCT. The final objectives listed below specifically focus on those areas where collaboration is required either at a sector or pan London level.

The JCPCT also agreed the prioritisation criteria to be used to create a list of collaborative initiatives to be considered for action over the five year period of the plan and from this the, up to, eight initiatives which form the body of work to be undertaken in 2009-10.

Criteria for prioritising collaborative initiatives to be included in the 2008-13 plan

- Effective commissioning of healthcare will only be achieved for a population of at least 1.3M (75% of the population served by NWL PCTs).
- There will be measurably greater benefit, in terms of resource utilisation, learning, symbiosis etc, in working collaboratively
- Delivers a key component of one or more of the Strategic objectives
- Can be implemented within a 5 year period.
- Has been identified, through public/patient engagement, as a key sector-wide priority
- Is consistent with the Next Stage Review and Healthcare for London priorities
- Patient flows require healthcare to be planned across a range of organisations
- Has been identified as a collaborative initiative by clinical leaders in NWL
- The initiative may result in substantial reconfiguration of health care across the sector/London

Criteria for prioritising, from the initiatives identified above, the initiatives to be targeted in 2009-10

- Will address an established gap in service provision within a 12-18 month timescale

- Clinically urgent (in relation to safety, meeting standards, access to care)
- Is consistent with the Next Stage Review and Healthcare for London priorities
- Delivery in year 1 will underpin work in years 2-5
- Existing CCI priority which it is anticipated will be delivered in 2009-10
- Part of a phased programme of work over a 3-5 year period.
- Delivery can realistically be achieved in 2009-10

STRATEGIC OBJECTIVES

The JCPCT has developed a focused set of objectives drawing on individual PCT objectives which were then refined through discussions with PCT Chairs, Chief Executives and PEC Chairs. The final objectives listed below specifically focus on those areas where collaboration is required either at a sector or pan London level.

The PCTs will work in collaboration, where this adds significant value, to:

Improve the health of the current and future population of NWL

Individual PCTs, in association with their local Boroughs, will be responsible for improving the health of the population. However, the JCPCT, in line with “Better Health, Better Healthcare”, will continue to monitor indicators of health across the whole population of NWL and will actively champion prevention and early detection strategies known to lead to significant improvements in health.

Reduce inequalities

Individual PCTs will focus on reducing inequalities in health (see above). This objective focuses on reducing inequalities in access to healthcare.

- Reduce inequalities in access to care and in access to certain treatments (eg. cancer drugs)
- Improve the life expectancy of patients with cancer, to below the England average, through the commissioning of patient pathways that are compliant with NICE Improving Outcomes Guidance and through delivery of the Cancer Reform Strategy 2008 goals regarding cancer waiting times and better treatment.
- Ensure that all collaborative initiatives (described later) identify and reduce inequalities in access to healthcare.

Transform the quality and delivery of health services

The PCTs will use the benefits of collaboration across a health system to proactively manage the local healthcare market and drive system reform. They will use the leverage gained from commissioning healthcare collectively to:

- Reduce variability in the quality of healthcare provision by continuous and systematic review of healthcare provision against national and international clinical best practice standards.

- By 2013 patients accessing healthcare in NWL will receive care commissioned against sector-wide patient pathways (within networks where appropriate).
- Improve the overall quality of healthcare for key groups of patients in line with national standards.
 - By 2014 improve health and social care services for children, young people and maternity services to the levels expected within the NSF for children, young people and maternity services (2004), Every Child Matters and “Better Health, Better Healthcare”.
 - Lead the local reconfiguration of services for patients with vascular disease in line with “Better Health, Better Healthcare”.

Stroke patients will have greater access to early detection services and will receive acute and rehabilitation care in line with the best in the world. Patients with cardiac disease will continue to have access to high quality care and cutting edge developments in acute care.

- Lead the local reconfiguration of Trauma care in line with “Better Health, Better Healthcare”.
- By 2011, ensure that the population has access to a range of appropriate (stand alone and networked), high quality and timely unscheduled care services.

Become World Class Commissioners

The PCTs will collaborate at a variety of levels across the NWL health system to achieve the transformation of health and healthcare for its population. Commissioning will be strengthened by:

- Building sustained commissioning capacity and capability within, and across, PCTs in line with the aims of ‘World Class Commissioning’.
- Developing health and healthcare information which supports determination of future trends, economic analysis and drives investment/disinvestment strategies.
- Development of strong partnerships between commissioner and patients/public, healthcare providers, local authorities and the third sector in the design and delivery of care.

INITIATIVES

The JCPCT plans to achieve its strategic objectives and overall vision through the execution of a targeted set of initiatives. The initiatives outlined below have been developed from a list of possible initiatives identified within PCT CSPs or through the HFL work programme which were then refined using agreed prioritisation criteria (see previously) into two lists.

List One describes areas of work where there is scope for collaboration on all or part of the programme and planning over, at least, a 5 year period is required.

Vascular Health – CHD, Stroke, Diabetes¹¹, Hypertension
Children, Young People and Maternity Services – delivery of the NSF
End of Life Care
Long term conditions
Unscheduled care
Major Trauma
Mental Health
Cancer – Delivery of the Cancer Reform Strategy
Provider Landscape

List Two describes those initiatives, drawn from the above list, which the JCPCT intends to focus on in year one of its Strategic Collaborative Commissioning Plan. These initiatives are outlined in detail below.

Cancer: IOG Implementation
 Cancer Waiting times
Maternity
Improving Surgical Services for Children and Young People in Hospital
Stroke
Major Trauma
Unscheduled Care
Standardising Clinical Practice
Strengthening the Provider Landscape

Each initiative is described in more detail below.

¹¹ Although diabetes has been identified as a major contributor to ill health and mortality across NWL, the focus in 2009-10 will be on improving risk and developing local services through CSPs

CANCER

Introduction

There are 5 sub-initiatives in this section, relating to Cancer Services. Two of these initiatives will be the focus of work in 2009-10. They are:

- IOG Implementation with a particular emphasis on:
 - Supportive and Palliative Care
- Cancer Waiting Times

The following section provides an overview of the cancer initiative with timescales and resources allocated to support delivery. Further detail is included under the sub-initiatives.

Context

The national agenda

The Cancer Reform Strategy (CRS) builds on the progress made since the publication of the NHS Cancer Plan in 2000 and sets a clear direction for cancer services for the next five years. It shows how by 2012 cancer services can and should become among the best in the world.

There has been considerable progress made on the detection and treatment of cancer over the past 7 years. NWL currently has the 4th lowest mortality in England. The reasons for this are multi-factorial and include reductions in smoking; more cancers being detected through screening; faster diagnosis and treatment and multi-disciplinary teams providing more co-ordinated care. A consistent theme in the NICE Improving Outcomes Guidance (IOG) is that cancer services are best provided by teams of clinicians - doctors, nurses, radiographers and other specialists - who work together effectively. Team working brings together staff with the necessary knowledge, skills and experience to ensure high quality diagnosis, treatment and care. It also helps to ensure the effective co-ordination and continuity of care for patients. The emphasis within each of the IOGs is a breaking down of organisational boundaries to ensure a seamless pathway of care for cancer and palliative care patients.

However, significant challenges and opportunities remain in the NWL sector. The incidence of cancer is increasing as people live longer and more survive cancer. Drugs and technologies are improving with new opportunities for prevention. Early diagnosis and better treatment means improved outcome for people who develop cancer. There is considerable potential to introduce new service models for cancer which will improve both convenience and outcomes for patients. There is also much to do to improve the experience of inpatient care for cancer patients. The Cancer Reform Strategy (CRS) sets out a programme of actions over the next five years across six areas to further improve cancer outcomes and to ensure delivery.

PCT cancer-specific commissioning responsibilities highlighted include ensuring progress on:

1. Prevention
2. Diagnosing cancer earlier
3. Ensuring better treatment
4. Living with and beyond cancer

5. Reducing cancer inequalities
6. Delivering Care in the most appropriate setting

Healthcare for London

Although the CRS sets out the national picture for cancer, the current focus in London is on the development of clinically effective pathways with a view to reducing pressure on traditional acute settings.

Not all cancer care needs to be undertaken in an Acute/ DGH setting. Some care can be undertaken in range of different settings (e.g. Polyclinic, Community Hospital diagnostic treatment centres, major acute hospital, as well as the home). Care can also be delivered by different providers. All cancer IOGs state that high quality cancer care should be delivered as close as possible to the patient's home and this is compatible with the direction of travel within Healthcare for London. Examples of localised specialist clinics could include some diagnostic; screening and follow up services in local community hospitals and selected polyclinics. Other cancer services which could fit this model are

- CT/MRI
- Opportunistic screening
- Post op follow up
- Blood transfusions/other low level monitoring of chemotherapy
- Health promotion, prevention and early presentation education.
- End of Life/Palliative Care services

Vision

By 2012 cancer services in NW London will be amongst the best in the world.

Aim

In line with the CCI vision, the aim of this programme of work is to reduce inequalities and significantly improve the quality and delivery of health services for people with suspected, or a diagnosis of, cancer.

Success Criteria

There are many ways to measure the success of cancer/palliative care services. Successful implementation of the CRS will be measured by monitoring the targets below.

CRS 1:Prevention	Four week smoking quitters
CRS 2:Diagnosing Cancer Earlier Breast Screening	Proportion of women aged 53-64 offered screening for breast cancer
	Proportion of women aged 65-70 offered screening for breast cancer
	Proportion of women aged 47-49 offered screening for breast cancer
	Proportion of women aged 71-73 offered screening for breast cancer
	The percentage of eligible women whose first offered appointment is within 36 months of their previous screen.
Cervical Screening	80% eligible women screened
	Women to get results within 2 weeks

Bowel Screening	60% uptake of FOB
CRS 3:Ensuring Better Treatment	14 Days : Urgent GP referral to Date First Seen
	Compliance against Cancer Peer Review
	31 days: Decision to Treat to First Treatment
	62 days: Urgent GP referral to First Treatment
	31 days: Second and Subsequent Treatments (Chemo & Surgery)
	31 days: Second and Subsequent Treatments (Radiotherapy)
	62 days Patients detected through national screening programmes
	62 days: Suspect cancer patients not referred urgently and upgraded by Consultants
	14 days: All breast symptom referrals
	National Lung Cancer Audit
	National Head and Neck Cancer Audit
	National Bowel Cancer Audit
CRS 5:Reducing Inequalities	Improving Outcomes Guidance
	Standard Mortality ratio
	1 Year Survival Rates
	3-5 Year Survival Rates
	Patient views of the service
CRS 6:Delivering Care in the most Appropriate Setting	Proportion of all deaths that occur at home

Summary of timescales

The work plan for delivery of the Cancer CCI/CRS is incorporated in Appendix 8. The plan sets the objectives for the next five years and describes the timetable for work and the milestones for delivery.

Stakeholder involvement in the formation of the initiative

The NWL Cancer Network brings together all the key stakeholders for cancer and palliative care services including lead clinicians, nurse specialists, managers, commissioners and users in the sector. This network of professionals and patients operates as a complex 'virtual organisation' of committed individuals and teams, who work in partnership to ensure the best possible care is delivered in a timely manner to patients when they need it. To do this the Network facilitates numerous groups, details of which can be found on the website. The groups are all involved in the development of the initiatives.

Expected outcome from the initiatives

Impact on patient outcomes and inequalities

The implementation of the national cancer plan has resulted in major improvements in cancer outcomes over the last 10 years. It is expected that by implementing the CRS there will be further reductions in mortality, improvements in palliation and earlier detection of disease. By working collaboratively, the CCG will be able to drive down inequalities and improve care for all. Further detail is provided in the individual initiatives.

Impact on activity and commissioning costs

There has been considerable central financial investment in cancer/palliative care within NWL over the past six years.

The NHS Cancer Plan brought significant investment with it. However, the same resources will not support the implementation of the CRS. As a sector it is important

to have an understanding of what should be commissioned collaboratively and what needs to be commissioned at a local level. The NWL Cancer network will work with the CCG to determine the level of investment needed at local and collaborative level.

The majority of costs for secondary and tertiary care for cancer are within PbR tariff or else assumed to be in PbR as updated by the generic inflator. The tariff for Palliative Care will be available from next year. Individual work streams will determine the impact on activity and costs.

However there are still many services within cancer/palliative that are outside the scope of PbR and therefore will need to be commissioned locally or collaboratively.

Investment/disinvestment requirements

It is acknowledged within the CRS that each Network/PCT will need to invest significantly in new cancer drugs, radiotherapy and digital mammography equipment to meet the ambitions of the strategy. There will also need to be investment in supportive and palliative care services. It is unclear if extra national funding will be used to support the CRS although it appears unlikely. The DH has acknowledged that a significant proportion of PCT funding for cancer is for in-patient stay and hopes the reduction in the in-patient stay will release savings which may be invested elsewhere. How this disinvestment and reinvestment will be co-ordinated has yet to be determined. In the meantime Appendix 8 gives an overview of the potential level of funding required.

Resources allocated to delivering the initiative

The Cancer Initiative will be led by the NWL Cancer Network on behalf of the CCG.

The NWL Cancer Network, is co-terminous with the 8 Primary Care Trusts (PCTs), and local boroughs in NWL. The Network serves a local resident population of 1.8 million, although for specialised services and less common cancers it has a larger catchment population. The Network comprises the 8 PCTs, Cancer Centre (Imperial) and associated cancer units within each of the remaining 5 NHS Trusts. The Network also links with academic partners, independent sector (specialist palliative care), primary care, volunteers and user representatives. All of the stakeholders act as a resource for the Network.

In 2008/09 work was undertaken to develop the Cancer Network management commissioning function with particular emphasis on developing its commissioning role. This work is ongoing.

In terms of governance the Network is accountable through the CCG to the 8 PCTs within the sector.

The network team will support the initiatives outlined below with support from the NWL Collaborative programme team and the CRG, as required, in the delivery of the programme of work.

1. IMPLEMENTATION OF IMPROVING OUTCOMES GUIDANCE

This initiative focuses on implementation of agreed IOG pathways in relation to Head and Neck, Skin, Sarcoma and Children & Young People's Cancer as well as developing new pathways in line with recent service development locally and across the NHS. The Supportive and Palliative Care IOG implementation is covered in detail in a sub-initiative (Appendix 9).

Context

IOG Pathways

Within the NWL Sector, concentration of specialist expertise needs to be fully implemented in the following treatment areas by 2009-10.

- Head and Neck (December 2008)
- Skin
- Sarcoma
- Children and Young People
- Supportive and Palliative Care
- Brain and CNS

Consideration will also need to be given to the implementation of any future IOG guidance. This initiative will take into account the emerging themes from Healthcare for London.

Vision

Care delivered by providers will be fully integrated with other services within the cancer network and will conform to national standards such as the Improving Outcomes Guidance (IOG).

Aim

To deliver high quality care in the most appropriate setting.

Objectives

1. Localise specialist clinics to include some diagnostic , screening and follow up services within local community hospitals and selected polyclinics where developed and where appropriate. This will potentially include the following:
 - CT/MRI
 - Opportunistic screening
 - Post op follow up
 - Blood transfusions /other low level diagnostics
 - Drive prevention and encourage early presentation
 - Focus of improved access from primary care to diagnostics
2. Localise chemotherapy closer to home setting with some chemotherapy being delivered in community clinics and, where appropriate, within the patient's home. This development needs to work in alignment with the National

Chemotherapy Advisory Group (NCAG) recommendations, which is due to report in October 2008.

3. Community settings /hospices/the home will become the chosen place of care for elements of palliative and End of Life care. Combined strategic plans between Trusts and PCTs must enable this move.

Years 2 and 3 will see the full implementation of each of the elements of redesigned care pathways, except where primary or community infrastructure (e.g. the creation of new polyclinics) means that a delay is essential. Because PCTs are presently considering the positioning of polyclinics across the sector and the development subject to formal consultation, it is not possible to produce definitive, costed plans at this stage.

Desired Outcomes

- Full implementation of the Head and Neck IOG by December 2008
- Full implementation of the Skin IOG (April 2009)
- Full implementation of Sarcoma IOG (December 2009)
- Full implementation of Childrens and Young People IOG (December 2009)
- Full Implementation of Supportive and Palliative Care IOG (December 2009)
- Full implementation of Brain and CNS IOG (December 2010)

Success Criteria

Progress with implementation of IOGs is formally communicated to the DH Cancer Action team who notify the London SHA and Healthcare Commission. Successful implementation is further monitored via the annual cycle of Cancer Peer Review. Specific targets are outlined in the introduction to this section.

Timescales

Refer to Appendix 8.

Stakeholder involvement

With the previous IOGs, local consultation has been minimal as NICE facilitates full user engagement at all stages of development of the national guidance. The Cancer Network has also consulted with cancer/palliative care patients across the sector. For HfL there will be appropriate consultation with the existing Cancer Network and through PCT mechanisms when plans are at a more advanced stage.

Expected outcome from the initiative

Impact of the initiative on patient outcomes and inequalities

High quality care as close as possible to the patients' home

- Improved quality of care for patients who require complex head and neck, skin, sarcoma, and children and young people's cancer. Centralisation of expertise brings together staff with the necessary knowledge, skills and experience to ensure high quality diagnosis, treatment and care. It also helps to ensure the effective co-ordination and continuity of care for patients.
- High quality sustainable care throughout the patient pathway.
- Improved local access to diagnostics and certain treatments.

- Increased specialism within Primary care ensuring local development.
- Reduction of inpatient stay.

Increased patient quality – improved survival rates

- In terms of outcomes it is well established that patients treated by specialist teams are more likely to survive. For the less common cancers such as upper gastro-intestinal, urological (covering prostate, bladder, kidney, etc.) and pancreatic, patients who receive their surgery and post-operative care in hospitals treating larger numbers of patients, are likely to do better.
- Delivering care in line with nationally benchmarked clinical pathways.

Equality Impact Assessments are being carried out by each tumour working group for each "Improving Outcomes Guidance for Cancer" as is appropriate.

Impact of initiative on activity and commissioning costs

The effect of this initiative on activity and commissioning costs has still to be fully quantified. Changes in referral routes will impact on activity and costs at an institutional level. Overall activity should not change significantly and any increased costs associated with care moving to a specialist centre may be offset by reduction in costs of care provided in community settings.

- Traditional referral routes from primary care will be redefined on the basis of the development of a specialist centre. This will impact on activity levels within acute Trusts as complex cancer surgery, in relation to these tumour groups, will be undertaken in one organisation only. Other Trusts in the locality will see a reduction in complex cancer surgical activity they undertake in this regard. Consideration will also need to be given to benign surgical work and whether this is reallocated to Trusts within the sector and how this impacts on activity levels.
- For the non IOG developments it is likely that location of activity will change significantly with activity transferring from a hospital setting to another location in the community. Transfer of activity from an acute Trust location to alternative providers has still to be quantified and costed.

Investment/disinvestment requirements

See above.

Resources allocated to delivering the initiative

Each of the IOGs has a tumour or site specific group of senior clinicians, managers and users. The Network facilitates these groups and ensures they respond appropriately to the national guidance. The resource to facilitate the groups comes from the Network core team funding. If consensus cannot be reached among the tumour working groups then the Network looks to the PCTs/CCG to support the implementation of the guidance.

In the case of rare cancers (Brain, Children, Sarcoma) the clinical groups will be facilitated on a Pan London basis.

Cancer Service Improvement monies are allocated to the implementation of contentious IOGs.

2. CANCER WAITING TIMES

Context

As in the previous initiative, there is a significant challenge for both acute and primary care trusts in sustaining high levels of performance by jointly establishing clinically effective care pathways and improving the quality of the patient journey. To ensure this happens targets have been set enabling patients to have faster access to high quality treatment for cancer.

Vision

The vision for improved cancer waits is that **patients with suspected, or diagnosed, cancer will be treated in a timely manner in line with, or exceeding, national standards of care.**

Aim

The aim of this work stream is to review constituent elements of the patient pathway to ensure access to treatment within the defined period.

- The 31 day standard will be extended to cover all cancer treatments
- All patients with suspected cancer detected through national screening programmes will enter the 62 day pathway
- Hospital specialists will have the right to ensure that patients who were not referred urgently by their GP are managed on the 62 day pathway
- All patients referred to a specialist with breast symptoms, even if cancer is not suspected, should be seen within two weeks of referral.

Objectives

1. Ensure GPs refer in line with Nice Guidelines for suspected cancer referrals to reduce number of inappropriate referrals and ensure assessment of suitability of referrals prior to definition.
2. Review the diagnostic pathway in its entirety with a view to streamlining and accelerating patients progress within this. Review opportunities for GPs to refer straight to test and improve partnership working between GPs and Consultants.
3. Commission community diagnostics to further reduce the length of the patient pathway. Support trust diagnostic clinics and confirm incidence of cancer prior to referral. This will require joint working on protocols and referral pathways.
4. Ensure good communication links between the screening and symptomatic cancer services.
5. Support Trusts to ensure any diagnosed cancer patient is referred to the appropriate MDT within the appropriate timeframe.
6. Jointly develop a patient pathway across Trust and community care settings to ensure patients are referred, diagnosed and treated as quickly as possible in the most appropriate location.

Desired Outcomes

Ensuring better treatment for cancer patients

Success Criteria

The cancer waiting times are monitored by the Cancer Network Board and breaches reported to the PCTs. The thresholds for meeting the waiting times targets are within the operating framework for each PCT.

Timescales

Refer to Appendix 8

Stakeholder involvement

No need for consultation has been identified at this stage. We will inform patient groups of opportunities in relation to redefining of patient pathways.

Expected outcome from the initiative

Impact of the initiative on patient outcomes and inequalities

- Equality Impact Assessments are being carried out for the cancer waiting times initiatives as appropriate.
- Achievement of targets long term and streamlining of patient pathways will ensure that patients are diagnosed quicker and treated faster.
- Patients are diagnosed more quickly and have access to specialist treatment in a more defined fashion which has improved survival rates.
- There has been recognised need across the locality to address this above other priority areas and this needs to be implemented to deliver the wider strategic objectives set out in the NHS Cancer Plan 2000. This is further underpinned by the Healthcare Commission in their rankings for PCTs this year.

Impact of initiative on activity and commissioning costs

Activity will increase in line with likely increase in incidence rates, leading to more patients having early stage diagnostics within primary care. This may increase pressure in the primary care setting, particularly as more patients will be transferred from Trusts to Primary Care at the other end of the care pathway. Detailed planning for this initiative is at an early stage and definitive changes to activity levels by provider are not available yet but they will be established with commissioners at an early stage.

Investment/disinvestment requirements

This initiative does not require investment at this stage.

Resources allocated to delivering the initiative

The Cancer Network team will support the initiative. Cancer Service Improvement monies will be allocated to Trusts as necessary.

MATERNITY

Context

The improvement of Maternity services has become a key priority for the NWL sector in 2008/09 and beyond. NWL PCTs had already identified Maternity Services as an area for review due to issues around projected growth and capacity and, more recently, the results of the Healthcare Commission review of Maternity Services which demonstrated the poor level of care provision and perceptions of care within NWL that need to be addressed.

Vision

The vision in NWL is that all women availing of maternity services should have access to standardised care and maximum choice. The JCPCT's ambition is to provide world class maternity care achieved through:

- Strong and sustained partnerships between commissioners and providers of maternity services across NWL working collaboratively on issues such as **standards of care**.
- The development of seamless care across the maternity pathway based on providers working collaboratively within a network.
- Ensuring that women get the best care possible, delivered to the highest standards in the most effective, efficient and personalised way.

Aim

The aim of the Maternity Services Improvement initiative is to improve maternity care in line with national guidance and standards and best practice and thereby improve choice, access and outcomes.

Objectives

Key objectives for the project are to:

- Improve outcomes for mothers and babies
- Fully understand the growing demand for maternity care and implications for service delivery
- Develop capacity plans that will meet the projected demand
- Meet national standards in relation to choice, access and care pathways. Key standards to be met are
 - The 3 manifesto commitments of Maternity Matters on Choice, Access and Continuity of Care **by the end of 2009**
 - 12 week access – the 2009-10 NHS Operating Framework requires PCTs to increase the percentage of women who have **seen** a midwife or a maternity healthcare professional for a health and social care assessment of needs, risks, and choices by 12 completed weeks of pregnancy
 - 1:1 care in established labour – The NSF for Maternity reports that one of the main things women want is to have one-to-one care from a named midwife throughout labour and birth, preferably **someone** they have got to know and trust throughout pregnancy.

- Women receiving the NICE recommended number of appointments, screening information and range of antenatal tests.
- To ensure standardisation across the NWL sector for ante-natal and post-natal care with clarity of function between obstetricians, midwives and GPs.
- To deliver sustainable solutions for the future

Desired Outcomes

- To develop and implement within 2009-10 SLAs a sector Quality Services Specification for the provision of effective, efficient and reliable maternity services in NWL over the coming years. The specification will draw on previous work of the former NWLSHA and incorporate the 'Core Offer' framework. The 'core offer' was developed by NHS London, in conjunction with the London Development Centre (formerly CSIP) and the London Commissioning Group, in a bid to strengthen commissioning of maternity services across London.

The specification will cover the entire maternity pathway focusing on four key components:

- Pre-conception
- Ante-natal care
- In Labour
- Post-natal care

As well defining overarching standards for:

- Stakeholder involvement
- Training & supervision
- Specialised care

- Implementation of a standardised referral form for access to antenatal services for both GPs and direct referral by women.
- Improved performance priority metrics for those Trusts identified as 'least well performing' in the HCC review. Key areas of improvement will include:
 - Increase in % of women being offered choice regarding place of birth early in pregnancy and receiving the necessary information to make an informed choice
 - Increase in the % of women receiving full health and social care assessment of needs by 12 completed weeks of pregnancy
 - Reduction in the number of women being left alone in labour
 - Increased continuity of care
- Establishment of NWL Network for Maternity Services working collaboratively to ensure the commissioning and delivery of a seamless pathway of care for all women accessing maternity services within the sector.

Success criteria

- NHS London intend to repeat the women's survey using key indicators from the HCC review outlined above. The results of the survey will demonstrate improvements in women's experience as the HCC action plans have been implemented. It will be expected that all Trusts improve their HCC score to at least 'Better Performing' by the next survey. The Project will identify priority

metrics that can be measured to show progress towards attainment of the improved ratings.

- By the end of 2009, women in NWL will have a choice of:
 - How to access maternity care;
 - Type of antenatal care;
 - Place of birth – depending upon circumstances; and
 - Place of postnatal care
- Achievement of Maternity Matters will be assessed by a patient survey commissioned by DH for end of 2009/2010.
- Pilot exercise for standardised ante natal form to be complete by June 2009 with 30% using the agreed sector referral form by Dec 2009; 50% by April 2010 and 95% by April 2011.
 - Sector quality specification included in all SLAs for 2009-10.
 - Maternity network in place by April 2010, at the latest.

Brief summary of timescales

A detailed breakdown of tasks and timelines are included in the PID (Appendix 10). Key timescales are:

Phase 1 (February – October 2008)

- Work undertaken to improve the understanding of the growing demand for maternity care and implications for service capacity requirements in the NWL sector, taking account of choice and need for quality assurance.
- LHO have produced birth rate projections by ethnic group, with an assessment of the impact on case mix. Following feedback from the sector, further work is underway on estimations that take into account of the impact of migration as the GLA information used does not account for this. It is intended that a proposed projection estimate for planning purposes will be recommended from the further work.
- A maternity project group has been established to take forward a collaborative approach for improvement in Maternity Services with representation from all 8 NWL PCTs and maternity units in the sector.
- A capacity planning sub-group has also been established and has been focusing on the data analysis required to robustly illustrate current maternity service provision and future requirements.

Phase 2 (November 2008 – March 2009)

Work will focus on strengthening commissioning of maternity services and will include:

- Development and implementation of a sector-wide Quality Services Specification for Maternity Services into SLA's for 2009-10.
- Development and implementation of a standardised GP referral form for antenatal care
- Exploration of opportunities for a centralised booking system to address issues of double booking and wasted capacity through attrition rates from number of bookings to actual births.

Healthcare for London established a maternity work stream (September 2008). The focus of their work will be on:

- Managed networks of care, their size and configuration, and the possible impact on safety and safe transfers;

- The configuration and impact of services which support the midwife as the first point of access in the community for women;
- The possible configuration of obstetric units given the potential changes in paediatric services; and
- The development of the workforce to deliver services within the agreed model of care and the anticipated increase in predicted deliveries.

The NWL Maternity Improvement project has already established links with HfL maternity workstream and will continue to work closely with them to ensure cohesion between the current sector improvement work and the longer term objective of addressing the increasing demand, variable access and performance shortcomings across London's maternity services.

Phase 3 (April 2009-March 2010)

- Capacity planning exercise to model the future demand, performance and capacity requirements.
- Roll-out of Standardised Referral Form for ante-natal services across sector following pilot site project.
- Development and establishment of a formal maternity network in NWL. Development work to consider:
 - Role and remit of the network
 - Benefits and outcomes/deliverables
 - Infrastructure and resources
- Scoping work for network to consider a structure that delivers the Children's NSF which covers services for Children, Young People and Maternity services.
- Review of Maternity service provision across the sector in light of the outputs from the Provider landscape initiative.

Stakeholder involvement in the formation of the initiative

- The Healthcare Commission's Review of Maternity Services deliberately made the experience of women central to the review. The review showed that most women are happy with the care they receive, but also provided examples of areas where trusts can improve and examine their services in more detail. Some areas where some of NWL London scored low included:
 - The offer of informed choice for screening tests
 - The extent of choice in labour including pain relief
 - The perception of quality of support in caring for the baby after discharge

Each Trust has produced an action plan for improvement, with specific focus on those issues assessed as falling below 'better performing'.

- A PPI lead sits on the Maternity Project Group. Their role is to advise on the level of engagement required for the group's proposals, as well as identifying the necessary resources to fulfil and exceed these requirements. A number of focus groups are planned to gain input and feedback from women on their experience and views of maternity services. It is intended that this information will be used to inform the design and review of maternity services in the future.
- Existing groups will also be utilised where possible to maximise engagement in the maternity workstream and ensure that future services are matched to local need. These may include Maternity Service Liaison Committees (MSLC), patient panels, Patient and Public Involvement Forums and the HfL Public and Patient

Advisory Group (PPAG). The maternity initiative will ensure that patient and public involvement is meaningful and that a robust feedback mechanism exists in regard to their input.

- Input and support from the Patient and Public Engagement CCI initiative to ensure a robust engagement process resulting in patients and the public in NWL being fully involved and in a strong position to contribute and respond to engagement activities occurring as part of the sector-wide collaborative work as well as pan-London work.

Expected outcome from the initiative

The impact of the initiative on patient outcomes and inequalities

There is a huge body of evidence to support improved outcomes and a reduction in inequalities for mothers and babies if care is delivered in a more cohesive and planned manner with access to expert advice and input at appropriate stages in the process.

This initiative will have a positive impact by addressing several of the objectives outlined in the CCI Vision, in particular the development of seamless networks of care. It will also ensure that care is standardised across the sector.

Relevant Equality Impact Assessments (EqIA) have been completed prior to the implementation of the Standardised Antenatal Referral Form and the NWL Maternity Service Quality Specification. EqIAs will continue to be an integral component of the initiative in relation to any further proposed changes to policies and practices in commissioning maternity services.

Impact on activity and commissioning costs

Most Trusts in NWL are planning to expand capacity. NWLH proposes to increase to 7,000 deliveries over the next 3 years. ICHT is planning to expand Consultant midwifery practice and establish a perinatal mental health service. WMUH is planning to accommodate an additional 1,000 births through the development of a Birthing Unit. EHT is building a midwifery-led unit (MLU) to increase overall capacity to c4,000 deliveries. THH is planning to build a MLU and a 2nd obstetric theatre. This growth in capacity may generate new business although the impact is more likely to be on providing greater choice.

Proposed increases in capacity will be considered in detail as part of the sector wide capacity planning exercise as well as the HfL work to define optimum levels of care for all the core elements of the maternity pathway including:

- Antenatal and postnatal provision
- Midwifery led units (co-located and stand alone)
- Obstetric units required (service model options, numbers and reconfiguration plans for secondary care services in line with safe practice (workforce levels) and paediatric reconfiguration).

Investment/disinvestments requirements

In January 2008 the Secretary of State announced that £330M additional investment funding had been made available over the next 3 years for the implementation of the national 'Maternity Matters' strategy. This equates to approximately £700k per PCT p.a. The funding is to target issues outlined below.

- LHO birth projections
- Capacity planning exercise

- Estates review
- Delivering maternity matters

Resources allocated to delivering the initiative

Lesley Young, NWL programme Manager leads the facilitation of the maternity services improvement work in NWL. **She will be supported by a part-time project manager in 2009-10.**

A Maternity Project Group has been established and is made up of:

- SRO – Paul Jenkins, **Deputy Chief Executive, NHS Westminster**
- Clinical Lead – joint role between Mr TG Teoh, Obstetrician, ICHT and Liz Stephens, Head of Midwifery, Ealing Hospital
- Wide representation of key stakeholders from across the NWL sector.

NHS London has **made** recommendations **that** each sector **should** establish a formal maternity network. This will require dedicated resources to support the agreed structure and remit of the network. The current make-up of the NWL Maternity Project Group lends itself well to a natural **evolution** into a Maternity Network.

IMPROVING SURGICAL SERVICES FOR CHILDREN AND YOUNG PEOPLE IN HOSPITAL

Context

There is a wealth of literature¹² demonstrating the deficiencies in general and specialised paediatric care, and outlining the standards to which services should aspire. By 2014 providers of paediatric services will be expected to comply with the standards described in the National service framework for children, young people and maternity services (2004) (NSF). PCTs, as the commissioners of care, are required to ensure that work is underway to ensure that the NSF is achieved by this date.

The NSF signals a fundamental change in thinking about children's health. It advocates a shift with services being designed and delivered around the needs of the child. It is a 10 year plan with delivery of the standards expected by 2014. The overarching message is that services should be integrated, planned and child-centred.

Standard 7: Children and Young People in Hospital, recommends that children and young people should receive high quality, evidence-based hospital care, developed through clinical governance and delivered in appropriate settings. The emphasis is on high quality, evidence-based care which is integrated and co-ordinated. The care must be delivered in a holistic manner as one part of a seamless mesh of services. The standard considers how hospital services can be child-centred; the quality and safety of care provided and the quality of setting and environment.

In its assessment of the provision of paediatric care in NWL in 2007, the NWL Clinical Reference Group made recommendations to co-locate paediatric and neonatal surgery with critical care services, with links to a major A&E and specialist medical services to ensure a high quality, risk minimised service. These recommendations resulted in complex in-patient neonatal & paediatric surgical care being identified as one of five priority areas to be addressed by the eight NWL Primary Care Trusts.

Local providers of these services were unable to agree on how and when the above co-located model of care could be achieved. As a result, the NWL JCPCT made a decision in February 2008 to establish a Paediatric Project Group to scope and specify the service required and make recommendations on action to be taken to improve the quality and safety of services. At this meeting it was also agreed to tender for a provider for the specialist element of paediatric surgery currently undertaken within the NWL sector.

In view of the concerns expressed by the NWL Clinical Reference Group about the need to co-located paediatric and neonatal surgery with paediatric (and neonatal) intensive care, the Paediatric Project group decided to approach the work in several phases outlined below.

Phase 1: To resolve the current fragmentation of specialist, in-patient neonatal and paediatric surgery by optimising the number of centres that provide a service and aligning paediatric and neonatal critical care with that centre.

¹² NWL Primary Care Trusts. Review of Children's Services – Compendium of Evidence
T:\COLLABORATIVE_COMMISSIONING_INTENTIONS\CCI_2009-14\CCI_2009-14_DOCUMENT&SUPPORTING_APPENDICIES\AMENDABLE_VERSION\NWLCCI09-14_090315_V2.1_Final Draft.doc

- Phase 2: To create a children's surgical provider network, co-ordinated by a lead centre, that ensures that that surgical care for children within NWL is children-centred, high quality, provided as close to home as possible, meets national standards and is sustainable within the context of the Children's NSF.
- Phase 3: To rationalise general paediatric care (medical and surgical) in line with the outputs from the Darzi review of healthcare in London.
- Phase 4: To develop a Managed Clinical Network for Babies, Children and Young People.

The project group made recommendations to the NWL JCPCT in October 2008 that Phases 1 & 2 should be combined and that this work should proceed urgently because of ongoing concerns about fragmentation of care. However, the process of developing a surgical network and any recommendations from it should be evolutionary and should dovetail with the emerging work from HFL.

Vision

Children and young people in NWL who require surgery will receive safe, high quality, timely and equitable care delivered through a network of care providers. The care will be integrated, planned and child-centred.

Aim

To transform surgical services for children and young people in hospital in a manner consistent with the standards, recommendations and guidelines of Medical Royal Colleges and those of other relevant statutory, regulatory, professional, or otherwise competent bodies relevant to the Services.

Objectives

- To resolve the current fragmentation of in-patient neonatal and specialist paediatric surgical care from critical care in NWL by April 2010;
- To designate a hospital as the lead centre for an evolving children's surgical provider network across NWL; and,
- To develop a Managed Clinical Network (MCN) for Children, Young People and Maternity Services. Work on developing a MCN will commence in April 2009.

Desired Outcomes

- All children and young people in NWL who require complex, specialist, in-patient neonatal and paediatric surgery will receive their care in an institution which has the appropriate co-located specialties and facilities, including NIC/PIC/HD care, by April 2010.
- A high calibre provider is selected to be the acute hub for in-patient care and to lead the children's surgical provider network.
- An appropriately resourced managed clinical network for Children, young people and maternity services is established to take forward the collaborative work on the NSF post April 2010.

Success criteria

Success criteria for this initiative broadly spit into three groups:

1. Criteria associated with the tender process

- Tender process completed with the agreed timescales
- Report from the Engagement Institute confirms that the public, service users, carers and staff fully were engaged in the process in line with best practice guidance
- Satisfactory gateway review
- Recommendations from the Project Group agreed by the JCPCT and NHSL
- Formal consultation undertake in line with the law and best practice
- Provider selected and SLA agreed
- Challenge to the process avoided
- Selected Provider commences service in line with SLA on 1 April 2010

2. Criteria associated with improving outcomes for children and young people

Key performance indicators will be included in the SLA for the service. These will cover:

- Patient Outcomes
- Patient Safety
- Patient Experience
- Effectiveness of Network

3. Criteria associated with the development of a managed clinical network (MCN) for children, young people and maternity services

- An appropriately resourced MCN will be in place by April 2010

A model similar to the Cancer Network is being explored and detailed success criteria, learning from the experience of clinical networks, will be established as part of this work stream.

Brief summary of timescales

This project commenced late 2007. Details of phase 1 of the work were included in the 2007-09 CCI (PID Appendix 11). A PID for the next phase of this work will be developed by the end of **March 2009**. This will include a detailed breakdown of tasks and timelines. Detailed below is a high level action plan for the project.

Review of current service activity (June – Oct 2008)

- Analysis of activity commissioned by NWL PCT for last 3 years
- Categorisation of in-patient activity to identify that which is defined as complex

Redefining & relaunching project (Oct – Dec 2008)

- Develop & agree a Memorandum of information
- Agree Public engagement plan
- Develop and agree an ITT
- Relaunch project

Tender process and public engagement (Jan – April 2009)

- Tender service
- Undertake a comprehensive programme of public engagement to include briefings, engagement events, focus groups and the development of a deliberative panel.
- Evaluate tender and make recommendations on a preferred provider.
- Review and update PID

Public consultation (April – July 2009, if necessary)

- Finalise public consultation document
- Undertake formal consultation for a period of 3 months
- Evaluate consultation responses
- JCPCT makes final decision about service configuration

Development of a managed clinical network for Children, Young People and Maternity Services (Jan – Sept 2009)

- Hold stakeholder event to agree scope and function of a network in light of national guidance
- Develop business case for establishment of a managed clinical network
- Establish a shadow network by September 2009.

Stakeholder involvement in the formation of the initiative

A patient/carer representative is a member of the project board.

External engagement experts have been appointed to support this project. A comprehensive engagement plan has been developed. This outlines the stakeholder involvement in the initiative (Appendix 12).

Expected outcome from the initiative

The impact of the initiative on patient outcomes and inequalities

The literature on specialist paediatric surgery and critical care makes a strong clinical and organisational case for the development of a Lead Centre for specialist, in-patient Paediatrics, which would be the 'hub' for a paediatric network, within a given geographical area.

Such an approach is known to reduce mortality and morbidity due to the concentration and co-location of facilities, skills and expertise. Changes in medical education and the effect of the European Working Time Directive (EWTD) will also dilute expertise in DGHs making it even more critical that specialist paediatric care is concentrated in a 'hub' with more routine care being provided in the 'spokes' with support being provided from the 'hub' as required.

A high level equalities impact assessment demonstrated that current service arrangements are inequitable across the main equity groupings in relation to access to an in-patient unit with co-located surgery and critical care and provision of facilities suitable for differing age groups in particular. The changes proposed will resolve the

issue of access to appropriate levels of care and, over time, through the implementation of the NSF, will resolve the differential negative impact of current service provision.

Impact on activity and commissioning costs

Phase 1 & 2 covers all Paediatric surgery regardless of site of delivery. It includes General Paediatric Surgery and Specialist Paediatric Surgery. This represents around 13,000 surgical cases (2007-8) at a cost of around £19M (excluding critical care costs)

The sub-set of complex, specialist in-patient surgery which is being specifically tendered represents around 650 surgical cases with an associated cost of around £1.8M.

Overall, this initiative will not have a material impact on activity and commissioning costs.

Investment/disinvestments requirements

It is likely that the tender process will result in some disinvestment/investment in services within NWL both in terms of revenue and capital. This cannot be fully quantified until the tender process has been completed, although modelling of potential impacts will be undertaken as part of the initiative.

Investment in the establishment of a Managed Clinical network will be required. This has yet to be quantified, but will be in the order of the investment required for a Cancer Network.

Resources allocated to delivering the initiative

Patricia Wright, Director, NWL Collaborative programme is the project lead for this initiative.

A project group has been established. The group is chaired by Dr Sarah Crowther (CEO, Harrow PCT) who is the SRO for the project. Membership includes clinicians, commissioners, patient/carer representatives, PPI lead, NIC/PIC network leads, public health, HFL and NHSL representatives. The group is responsible for managing the project and making recommendations to the Joint Committee of the PCTs.

Management consultancy and engagement support is provided by PriceWaterhouseCoopers and Participate. External clinical support is sought from named experts from outside London.

STROKE

Context

Huge variability in the delivery of stroke care and technological advances in the treatment of acute strokes, with resultant variability in patient outcomes, prompted the development of a Stroke Strategy for England (December, 2007). *'A Framework for Action'* recommended that a London stroke strategy be developed building on international best practice and taking account of the Stroke Strategy for England.

The HfL programme office has responded by initiating a pathway work stream on Stroke management. This work stream has developed challenging performance standards for all aspects of the stroke pathway.

Vision

To deliver improved outcomes for patients following stroke, or at risk of stroke within NWL, in line with national guidance and standards and best practice. This initiative also supports the HfL's vision for stroke which is to provide rapid access to the best treatment and care, in the nearest place, by multi-skilled, respectful people, and undertaken as a partnership between the person with stroke and the people providing care.

Aim

The vision will be achieved through:

- Strong and sustained partnerships between commissioners and providers (including LAS) of stroke services across NWL working collaboratively on issues such as hyper-acute services.
- Strong and sustained partnerships between health and social care particularly at the point of the transfer of care.
- Service improvement and development led by stroke clinicians in partnership with stroke survivors and carers, which is founded on international best practice and research
- The development of seamless care across the stroke pathway based on providers working collaboratively within a network.

Objectives

To review the current stroke care pathway and implement a future model of care for the appropriate management of patients presenting with a TIA or stroke in NWL that takes account of the Royal College of Physicians (RCP) guidance and the National Stroke Strategy and **the proposed HfL new model of stroke care. This will include:**

- Timely detection and effective management of patients at risk of stroke and TIA through the use of risk registers in primary care and managing risk factors such as hypertension and atrial fibrillation in line with clinical guidelines.
- Patients presenting with a TIA or minor stroke are assessed, imaged (brain and carotid) and follow the most appropriate pathway according to the level of risk.
- **Deliver a solution where all patients will be taken by ambulance to the nearest hyper-acute stroke unit. This will be located no more than 30 minutes away by ambulance. Further information on a network arrangement for stroke services**

in London, as recommended by HfL, is available from the HfL Programme office.

- All patients with suspected acute stroke are assessed by a specialist, have access to a brain scan and receive clot busting drugs (if appropriate) within 30 minutes.
- All stroke patients will spend their first 72 hours, or until they are stable, in the hyper-acute stroke unit and then be transferred to a dedicated local stroke unit in the same hospital or closer to home where they will receive continued specialist treatment and intensive rehabilitation.
- Identify and commission appropriate rehabilitation services, including vocational rehabilitation to maximise functional potential following a stroke and enable the individual to have the best chance to return to as normal a life as possible.
- To improve the performance of NWL Trusts against the RCP Sentinel Audit standards and the new HfL performance standards by 2011.
- To develop a sector-wide balanced score card to allow the CCG and individual organisations to monitor changes in the process and quality of care.
- To develop organisation level implementation plans to monitor an organisation's progress on delivering the new stroke services.

Desired Outcomes and Success Criteria

Clinical outcomes for patients following stroke, or at risk of stroke, will meet national standards and best practice through the provision of high quality, co-ordinated services. Specifically:

- TIA clinics established at designated Trusts which provide rapid assessment and access to a specialist within 24 hours (for high risk patients) or within 7 days (for low risk patients) NWL will provide a networked solution that dovetails with the outcome of the HfL consultation.
- Timely assessment and scanning to determine type of stroke and, therefore, appropriate care pathway.
- Increase in the number of patients receiving thrombolysis within the recommended time window (currently four and a half hours).
- Increase in the number of patients spending the majority of their time on a stroke unit in line with, or exceeding, current national targets (100% of patients spending at least 90% of their time on a stroke unit in 2010/11).
- Reduced length of stay.
- Improved patient outcomes e.g. reduced disability scores, as measured by the Barthel Index and Rankin Index, as a result of specialist rehabilitation input to maximise functional potential following stroke.
- Measurable improvements in the process of care as defined by the National Sentinel Audit.
- Improved patient / carer experience as a result of specialist care provided in a timely manner and close to home where possible.
- Sentinel audit scores across NWL improve to the current upper 25% quartile.
- Thrombolysis rates of 10% of those patients eligible are achieved before the sectors 5 year target.
- Access to vocational rehabilitation for patients following stroke

Brief summary of timescales

Mostly fixed by HfL timescales:

- Designation of TIA, Acute Stroke and Hyper Acute Stroke Units completed by end of December 2008.
- Public consultation Jan to May 2009
- Announcement of final decision following consultation July 2009
- October 2009 - April 2010 (newly) commissioned services start up with 18 month incremental development period as required
- April - October 2011 all services fully up and running and, where appropriate, services fully decommissioned.

The four network work streams all have work plans with local timescales. (Appendix 13a-d)

Stakeholder involvement in the formation of the initiative

An overarching public involvement strategy has been developed as part of the NWL Strategic programme. The Governance paper describes how partner organisations are involved in the development, agreement, implementation and monitoring of joint initiatives.

The NWLCSN has set up a Stroke Involvement Group (SIG) consisting of stroke survivors and carer representatives. A PPI lead sits on the stroke steering group. Their role is to advise on the level of engagement required for the group's proposals, as well as identifying the necessary resources to fulfil and exceed these requirements.

There has also been extensive stakeholder involvement in the development of the HfL Stoke project.

Expected Outcome from the initiative

The impact of the initiative on patient outcomes and inequalities

There is a large body of evidence that demonstrates that stroke care is not optimised in the UK. Evidence from the sentinel audit also suggests that care is not optimised in NWL (see Context section). There are currently inequalities in access to revascularisation within the sector and whilst the JCPCT and CRG recognise the urgent need to ensure that patients in NWL have access to cutting edge technologies, they also believe that this should not occur at the detriment of strategies for prevention, acute care where revascularisation is not the treatment of choice and rehabilitation.

NHS London has conducted an Equalities Impact Assessment which makes several recommendations on the Stroke pathway. Healthcare for London, in their document 'the shape of things to come' states that their proposals 'aim to reduce inequalities and improve access for everyone living in London. A series of assessments will compare the likely impact of the proposals on health equalities and inequalities'. HfL aims to publish their findings in March 2009 and make the report available to local NHS organisation. PCTs will need to undertake local impact assessments once this report has been published and the designation process has been agreed.

This initiative meets a number of the JCPCT's strategic goals in relation to the provision of world class healthcare, the need to work collaboratively on issues such as revascularisation and the need to learn from each other in relation to models of care for rehabilitation.

Impact on activity and commissioning costs

HfL have estimated that the additional cost of the acute element of the pathway (including hyperacute but not rehab. care) will be approximately £675k per PCT. This equates to a total of £5.4 million across the 8 PCT's in NW London.

It is not envisaged that there will be an impact on inpatient activity levels from this initiative however the activity will be delivered through a changed configuration of acute providers.

This initiative is likely to increase outpatient activity through additional referrals to TIA clinics as TIA's are better recognised in primary care, and through additional follow up appointments at acute providers and GP practices as described in The Stroke Strategy.

This initiative is also likely to increase rehabilitation activity as HfL and national performance standards are implemented. This increased activity is very difficult to quantify but PCT's should be aware of the likelihood of the need for additional investment.

Changes in activity and financial flows will be modelled in details within the individual work streams and through the HfL project.

Investment/disinvestment requirements

NWL will not know until after HfL designation is completed.

Resources allocated to delivering the initiative

Responsibility for delivering this initiative has passed to the NWL Cardiac and Stroke Network.

The Senior Responsible Officer (SRO) for the project is Sarah Whiting, Interim CEO, Hammersmith & Fulham PCT and chair of the NWL Cardiac and Stroke Network.

The Clinical Leads are Dr Diane Ames, Stroke Physician, Imperial College Healthcare Trust and Binnie Grant, Stroke Co-ordinator, Chelsea and Westminster NHS Foundation Trust..

A Stroke Steering Group (SSG) has been established as a sub-group of the NWL CRG and the NWL Cardiac and Stroke Network Board to provide clinical leadership and develop evidence-based recommendations to deliver improved outcomes for patients following stroke, or at risk of stroke, within NWL.

Additional resources for managing the stroke agenda were allocated from the DH to the networks in the last quarter of 2008/9. There will be further additional funding from the DH for the networks in 2009/10. **This is likely to be insufficient to manage the envisaged change and further bids for resources will be submitted to the NWL PCT's.**

MAJOR TRAUMA

Context

Healthcare for London: A Framework for Action identified significant deficiencies in the treatment and care of major trauma victims. The Acute Care Working Group identified what it felt to be overwhelming evidence that severe trauma should be dealt with by a few specialised centres, for example:

- Evidence that patients with severe brain injury have their mortality risk reduced by 10% when treated in a trauma centre;
- Evidence that units with higher volumes of trauma care reduce patient mortality and length of stay, compared to smaller units;
- Evidence that regionalisation of trauma care in Quebec resulted in a reduction in mortality from 52% to 19%.

Healthcare for London: A Framework for Action observed that the UK is almost alone amongst international comparators in not having a system of regional trauma centres. Data shows that current mortality for severely injured patients who are alive when they reach a hospital is 40% higher in the UK than in the US where regional trauma centres exist. The Royal College of Surgeons advocated the development of a systematic approach to trauma in 2000.

London currently has one trauma centre, at Barts and The London NHS Trust.

Vision

The HfL Trauma Project was commissioned to explore options for improving trauma care in London. A number of trauma networks will be established to provide coverage for the whole of London, each network containing a major trauma centre at its heart that will receive the most severe trauma cases, whilst lesser injuries will be handled by trauma centres within the network.

Aim

The overarching objective of the Major Trauma project is to design and, subject to the outcome of consultation, implement an inclusive trauma system that assures the optimal care of all injured patients at all stages of the patient journey. The main change as part of this will be the designation of a number of **major trauma centres** hosted by acute hospital trusts that will form centre of a trauma network supported by a number of **trauma centres**.

The project is assessing need and capacity of the full pathway, from primary & secondary prevention to long-term care, looking at it both from the provider and commissioner point of view.

Objectives

High level project objectives for Phase 1 are:

- Review and reaffirm the evidence base for delivery of an optimal trauma care pathway
- Develop a 'best-practice' pan-London trauma care pathway supported by key stakeholders

- Set out what a regionalised trauma system for London could look like, including population served and the services provided
- Establish the requirements and implications of commissioning and implementing the pathway, specifically:
 - The commissioning framework required
 - Implications for the provider landscape
 - Implications for workforce, training and education
 - Implications for information and IT
 - Implications for related services/pathways

High level objectives for Phase 2 are:

- Carry out a competitive designation process with NHS Hospital Trusts bidding to form a trauma network
- If it becomes a necessary part of the designation process, agree an approach and carry out a London-wide public consultation on the proposed trauma networks, working with the HfL Programme
- Develop a London trauma system business case
- Complete the design of the London Trauma system
- Develop a framework for system governance
- Carry out affordability modelling and develop options for a London Trauma tariff
- Working with the HfL Children and Young People's Services (CYPS) Project, develop the trauma system for paediatrics
- Develop a Prevention Delivery Plan
- Develop a detailed Pathway, Protocol and Algorithm Plan
- Carry out a rehabilitation needs assessment and develop a Delivery Plan
- Develop an implementation plan and transition plan

Desired Outcomes

Benefits and quality improvements are as follows:

- **Access:** All patients will have access to a major trauma centre (if appropriate to care needs) within 30 minutes with a blue light
- **Patient Experience:** Improved pathway for patients through the trauma system, in particular more appropriate levels of care for patient need (i.e. the distinction between a major trauma centre and a trauma centre). In the longer term, improved rehabilitation pathway and provision linked in to a trauma network.
- **Service Outcomes:** A more cohesive system of trauma networks better able to provide the best care for all Londoners at the most appropriate place for different severities of injury and a more comprehensive patient-centred rehabilitation system aiming to maximise recovery and rehabilitation;
- **Health improvements:** Working with local government, and other stakeholders, to reduce the environmental, social and physical risks that lead to all forms of trauma.
- **Use of Resources:** The new model of care will require an increase in investment to support more intensive rehabilitation for patients.

Success criteria

It is estimated that 400 lives could be saved and 1,600 severe disabilities prevented by regionalising trauma care across London. Specific benefits include:

- Higher quality service which is faster, providing the right care with better clinical outcomes, and patient satisfaction.
- Greater equality of access, care and rehabilitation
- Reduction in Length of Stay
- Reduced mortality and disability due to major trauma

Brief summary of timescales

The overall HfL Major Trauma Project is divided into a number of key delivery phases:

- **Phase 1:** Exploration – develop an optimal care pathway and set out what a trauma system for London could look like, informed by the outcome of consultation (November 2007 – July 2008)
- **Phase 2:** Taking into account the outcome of a public consultation; develop a definitive proposal to improve trauma care for London and carry out the designation process, informed by the outcome of the *Healthcare for London* models of care and phase 1 work of the major trauma project (August 2008 – July 2009)
- **Phase 3:** Implement the trauma plan and commission agreed trauma care pathways, based on the work from the previous two phases and outcome of all consultations. (Indicative timetable: August 2009 onwards).

Consultation on the HfL proposals for major trauma was launched in late January 2009. Three options have been considered. The preferred option proposes the establishment of four trauma networks across London comprising major trauma centres at:

- The Royal London Hospital;
- Kings College Hospital;
- St Georges Hospital; and
- St Mary's Hospital (part of Imperial College Healthcare NHS Trust)

The NWL trauma network bid submitted by ICHT showed that it would meet the clinical standards required by 2012, which is up to two years' later than the other three trauma networks. Consequently, it is proposed that the NWL trauma network cover the smallest population and that the Royal London extend coverage to parts of north and north-west London to maximise benefits of early implementation and minimise pressure on the fourth network.

Stakeholder involvement in the formation of the initiative

The organisations and relevant bodies that will be covered by the HfL project have been grouped as follows in order to facilitate stakeholder management and communications:

- Implementers – Organisations and bodies who will have to be part of the implementation of the proposed trauma system
- Developers – Organisations and bodies involved in the design and planning of the proposed trauma centres and who will need to agree the trauma system for London
- Influencers – Organisations who should influence the design of the trauma system and who will be affected by the proposed changes

The Major Trauma project team will continue to work with the central programme communications team to support appropriate communications. This will be particularly important leading up to and during the public consultation on the proposed trauma networks.

A detailed stakeholder analysis has been carried out and a dedicated member of the team will continue to engage with stakeholders.

Expected outcome from the initiative

Impact on patient outcomes and inequalities

Reduced mortality of patients and the proportion of people left with a permanent disability or impairment following major trauma (enabling more people to return to normal social and economic functioning).

The HfL proposals aim to reduce inequalities and improve access for everyone living in London. A series of Equality Impact Assessments will compare the likely impact of the proposals on health equalities and inequalities. Early findings will be published in March 2009 for consideration prior to submitting a response as part of public consultation. The final report will be provided to local NHS organisations to explain the implications of different options so that these can be considered when making decisions.

Impact on activity and commissioning costs

- Increase in volume of major trauma patients being cared for at specialist centres
- Decrease in volume of major trauma patients being cared for at trauma centres
- Increase in complex and long term care (rehabilitation) due to increased survival rates that result in a reduction in the proportion of people with a permanent disability or impairment.
- There is likely to be a shift in activity from the Trusts not designated as Major Trauma Centres (MTCs) to those designated as MTCs
- Major trauma is not clearly defined under HRG v3.5, although it appears to be better defined under HRG v4. This needs to be tested.
- A significant element of the cost of major trauma, especially for the more seriously injured, is recovered as ITU stays. There is conjecture, however, that the spell component does not adequately capture the multi-operation element of the care. This needs to be better understood.
- Possible reduction in use of diagnostic services at acute trusts although likely to be balanced by increased access in the community

Investment/disinvestment requirements

Providers:

- New major trauma centres will receive new activity and income (and expenditure) due to increased major trauma patient inflows.
- A potential increase in the income and cost of providing rehabilitation services due to the expected improvement in mortality rates for major trauma patients.

PCTs:

- Increased investment by PCTs to support rehabilitation of patients as activity levels increase due to improvement in survival rates

The level of investment/disinvestment cannot be quantified at this stage.

Resources allocated to delivering the initiative

Simon Robbins, Chief Executive of Bromley PCT is the Senior Responsible Officer (SRO) for the project and is accountable to the London Commissioning Group (LCG) for delivery of the project. A Major Trauma Project Board provides overall direction and management of the project and a Clinical Expert Panel and Commissioning and Finance Panel provide specialist advice to the Project Board.

Sarah Whiting, Chief Executive (Interim), Hammersmith & Fulham PCT and Richard Jeffrey, Deputy Director of Finance, Harrow PCT are members of the HfL Commissioning and Finance Panel.

UNSCHEDULED CARE

Context

The NWL CRG highlighted in their report in October 2007 that the high dependence on A&E in London raises as many questions about the service models and access in the community as in our hospitals. The complexities of local health communities together with mismatches between access in primary care and out-of-hours primary care provision is well known. The capacity of primary care to shoulder its equitable share of the burden needs to be understood and commissioned appropriately. Supporting evidence was identified as follows:

- NWL A&E attendances are significantly higher than UK average
- There has been significant growth in NWL A&E attendances over the last 5 years, which has been at different rates in different Trusts
- The conversion rate of A&E attendances to admissions is significantly higher than the UK average
- Services are not currently being delivered in a cost effective way

Healthcare for London: A Framework for Action proposed that improvements in accessing urgent care could be achieved in two ways: (1) face to face, by establishing urgent care centres at the front end of hospitals and in community settings and (2) over the 'phone by establishing an integrated "hear and treat" model across London so that people could ring a single number for urgent care, as well as 999 for emergencies.

In addition, the report made recommendations about establishing specialised centres (for stroke, major trauma, emergency surgery and children's services); developing the role of the London Ambulance Service; and improving the care of people with long-term conditions all of which encompass unscheduled care to a greater or lesser degree.

Subsequently, Healthcare for London (HfL) established an Unscheduled Care Project in 2008 as one of its early priorities as improving timely access to appropriate care was seen as important to improve outcomes, patient experience and to reduce costs. Phase 1 (February – September 2008) of the project was designed to improve understanding of current unscheduled care arrangements, which involved an in-depth examination of unscheduled care systems across six PCTs in London. Hammersmith & Fulham PCT was one of these. In addition, further pan-London analysis was undertaken as well as a review of key policy and literature and discussions with key stakeholders, which presented a strong case for change:

- Earlier intervention and support could prevent people choosing to enter or defaulting to the unscheduled care system to have their needs met
- Access to care needs to improve and be more responsive to patients' needs and expectations
- The system needs to be less complex and easier to understand and navigate for patients (and staff)
- Standards and quality can be more consistent and improved across the spectrum of care in community and hospital services
- Improving the way that the unscheduled care system works as a whole will improve care and patient experience and make better use of resources. The system should be designed around patients not organisational boundaries or institutions.

Vision

The NWL CRG recommended that:

- Primary care and other service providers must be commissioned to provide, in aggregate, a whole-system of urgent care that appropriately meets patients' needs.
- Each A&E to have a co-located primary care front-end that ensures an appropriate service response is available to those patients who require it (to include a co-located GP service, a single entrance and single triage).
- To undertake further work to understand the kinds and location of services that will be needed to support emergency care as acute services change, and in some instances, are concentrated.

The HfL programme has been informed by, and builds on, significant work that has taken place in developing unscheduled care across London. The proposed delivery model will lead to an enhanced and focused urgent care response through the establishment of Urgent Care Centres as the front end of emergency departments or by providing a range of urgent care services in community settings such as polyclinics.

Aim

The HfL Unscheduled Care (USC) Project aims to improve timely access to the most appropriate care in order to improve outcomes, patient's experience and make the most effective use of resources. Improving arrangements for unscheduled care also offers the potential for a wider beneficial impact across the care system.

Objectives

The HfL USC Project 's core objective is:

“to support PCTs to commission and develop integrated unscheduled care systems across London to provide timely, appropriate and high quality care for people who require, or perceive the need for unscheduled, including urgent and emergency, advice, care, diagnosis or treatment. Effective systems should ensure that people using services and their carers receive consistent and rigorous assessment of the urgency of their need 24/7 and an appropriate and prompt response to that need. They should also increase choice of access and maximise opportunities for providing care closer to home as safely as possible”.

Desired outcomes and success criteria

The expected benefits and quality improvements of the HfL USC Project are:

- **Access:** better access to GP/primary care services, to diagnostic services, to dispensing, to support and advice; more equitable access to a greater range of locally based services developments in areas of high deprivation
- **Patient experience:** greater choice and support to enable people to make an informed choice; more consistent response to assessed need; greater consistency in provision; greater clarity and understanding of services available, roles and access routes; earlier resolution of need and improved continuity of care; increase in community based care/care closer to/at home

- **Health improvements:** Quicker access to specialist opinion should enable earlier diagnosis and access to definitive care/treatment required; reduction in health inequalities through improved access to services; services that are more responsive and easier to access should reduce anxiety for individuals seeking care; better access to health care information and advice should improve self-care and well-being
- **Use of resources:** a whole systems approach will reduce duplication and enable better alignment of capacity and demand; some activity will shift to less acute settings; some activity will shift to scheduled care; there will be fewer repeat attendances

Brief summary of timescales

The HfL Project to improve unscheduled care in London will be delivered in two phases:

Phase 1 (February – September 2008)

Focused on improving understanding of the current unscheduled care arrangements and exploring how arrangements could be improved, which encompassed the following:

- In-depth examination of unscheduled care systems in six PCTs across London, including significant stakeholder engagement. H&F PCT was one of the six PCTs examined.
- Complemented by additional pan-London analysis, a review of key policy and literature and discussions with other stakeholders and a review of *Consulting the Capital* responses.
- A compelling case for change was identified.
- A delivery model has been developed based on a tiered approach within a whole systems model. It encompasses three broad responses to patients' unscheduled care needs: rapid/moderate, urgent and emergency. The new delivery model provides a framework for unscheduled care commissioning.

Phase 2 (October – December 2008)

Focuses on supporting implementation, strengthening commissioning of unscheduled care services, which will encompass the following:

- Developing tools and guidance to support commissioning of key elements of the unscheduled care delivery model.
- More detailed investigation to inform enabling strategies.

Separate and more detailed guidance was circulated in early October. This recommended that PCTs develop 5 year unscheduled care strategies with key milestones that support progression towards an integrated model of care. Priorities should be set locally.

Phase 2 of the project runs to December 2008. The Commissioning toolkit may be issued on a modular basis and we expect the **first module to be issued in Spring 2009**.

The new delivery model for London reflects the direction of travel for NWL PCTs, particularly in terms of establishing urgent care centres at the front-end of A&E departments. However, NWL PCTs are at different stages of implementation. For example, Hillingdon PCT commissioned an UCC at Hillingdon Hospital which commenced operation on 2nd April 2007 and a 12-month evaluation has been completed. NHS Hammersmith & Fulham's open tendering process completed in

November 2008. This encompasses new GP provision, UCCs, OOH and a single point of access telephone number. Ealing, Hounslow and Westminster PCTs are intending to tender services in 2009-10. In addition, all NWL PCTs have plans to increase access to primary care either through the development of polyclinics or GP-led health centres.

It is likely that further work will be necessary on a NWL basis to explore opportunities for greater integration and review the unscheduled care service offering within a community setting (e.g. polyclinic) to ensure a consistent approach and common standards.

The NWL USC Project Group will review the HfL commissioning guidance to be issued to London PCTs to support implementation of the new delivery model and ensure that robust plans are in place.

Stakeholder involvement in the formation of the initiative

The HfL USC Project Group has developed a clear stakeholder management and communication plan outlining key stakeholders, their influence, their current engagement and the proposed approach to engagement during the project.

The project in NWL will be informed by feedback from stakeholder events held in each of the PCT areas. Stakeholders will be involved in tender processes.

Expected outcome from the initiative

Impact on patient outcomes and inequalities

Outcomes will be improved through: effective assessment, triage and streaming of patients; earlier assessment and diagnosis following quicker access to specialist opinion; increase in pre-emptive and more joined up care; reduction in disability and mortality through establishment of specialised centres. Earlier intervention, better coordination and continuity of care; better outcomes for seriously ill patients

The HfL proposals aim to reduce inequalities and improve access for everyone living in London. A series of Equality Impact Assessments will compare the likely impact of local proposals on health equalities and inequalities.

Impact on activity and commissioning costs

Individual PCTs in NWL have assessed the likely impact of their local initiatives on activity and cost. Details are included in the CSPs

- Increase in GP / primary care attendances (scheduled and unscheduled care)
- Increase in urgent care centre attendances
- Increase in community based contacts and home support e.g. older people's teams, LTCs; self care advice; increased role of pharmacy
- Reduction in A&E attendances
- Reduction in repeat attendances (potential applies across the system)
- Reduction in unscheduled admissions, delayed discharges and LOS
- Reduction in LAS journeys to hospital. Increase in LAS community activity and in Cat C calls managed with clinical advice

Demand management across the system will be required to mitigate risk of better access increasing overall demand.

- Decrease in income (and expenditure) for Trusts particularly at lower rate A&E attendances, although anticipated changes in A&E tariff from 2009 - 10 will need to be factored into financial assessment when known
- Possible reduction in use of diagnostic services at acute trusts although likely to be balanced by increased access in the community

Investment/disinvestment requirements

Specific details are included in PCT CSPs.

Provider Services

- Secondary care services – decrease in activity (A&E attendances and admissions).
- Primary care/ community based services increase in activity e.g. Polyclinics, GP services, pharmacies, integrated health and social care teams
- Diagnostic services to be available at local level
- Workforce transformation required within LAS needs to be supported by alignment of education and training and service commissioning
- Capital development to establish urgent care centres

PCTs

- Investment required to commission urgent care centres and enhanced community provision
- Further investment in LAS likely pending implementation of clinically effective pathways for ambulatory sensitive conditions

The HfL USC Project Team have identified that the cost of implementing the delivery model will vary from PCT to PCT depending on existing arrangements. It is anticipated that there will be changes to the A&E tariff in 2009-10 and, therefore, the Project Team will undertake some initial work exploring the implications of the new tariff. Cost and affordability have been identified as a risk; however opportunities for efficiencies and more effective use of resources within the system may mitigate this risk e.g. minimising hospital attendance and admissions through more effective management of long-term conditions and ambulatory care sensitive conditions. The commissioning toolkit, which is likely to be issued to PCTs in early 2009, will include guidance in assessing and quantifying the costs and benefits of the delivery model.

Resources allocated to delivering the initiative

A NWL Unscheduled Care Project Group has been established consisting of USC Leads across the sector. It is chaired by Frankie Lynch, Director of Primary Care Commissioning, Kensington & Chelsea PCT and supported by a project manager from the NWL Collaborative Programme. Terms of Reference have been agreed and the group will meet on a quarterly basis. Monthly progress reports are provided to the NWL JCPCT, PRG and CRG for information.

IMPROVING CLINICAL PRACTICE

Context

Improving Clinical Practice is one of a number of collaborative commissioning initiatives (CCI's) prioritised by the North West London Collaborative Commissioning Group (CCG).

The principle driver for change in NWL has been the ambition of PCTs to ensure that the services they commission are of high quality, sustainable and economically viable. Despite the inclusion of a number of initiatives within SLAs over the last few years the impact has been limited and variable across PCTs. The CCG agreed that there was a need to develop a collective and consistent approach to commissioning across a range of clinical services across the sector and that this work should be founded on robust clinical criteria developed and agreed by clinicians and delivered by commissioners. The NWL Clinical Reference Group (CRG) are charged with taking forward this piece of important work.

The CRG are committed to driving forward this challenging agenda in order to improve patient care and strengthen the commissioning process in NWL. Collaborative working between clinicians, commissioners and providers will facilitate delivery of the highest possible care to our patients. The need to commission both acute and primary care services with equal enthusiasm will help to delineate minimum standards of care and service configuration within the health economy.

Vision

The vision in NWL is that patients will have access to the same standards of high quality care regardless of where they live, who their GP is or where their local hospital provider is located.

Lord Darzi's NHS Next Stage Review signalled the journey towards an improved NHS which is fair, personalised, effective and safe, and which is focused relentlessly on improving the quality of care. Strengthening commissioning through the World Class Commissioning (WCC) programme is at the heart of delivering this agenda.

The CRG's ambition is to ensure the local vision and wider imperatives outlined above are achieved through:

- strong and sustained partnerships between commissioners and providers in both primary and secondary care
- facilitative and supportive working relationships with established and evolving clinical networks
- the development of clinically informed and auditable measures to inform standardised commissioning processes across the NWL sector.

Aim

Analytical work already carried out by the CRG has shown that patients in NWL are subject to a degree of variation in the clinical care they receive. Therefore, the aim of this initiative is to identify and reduce inappropriate variation in clinical practice across the sector.

The work of identifying variability across NWL needs to take account of:

- the purchaser context.
- the provider context including primary, secondary and tertiary level services, as well as their inter-dependencies.
- the natural variation driven through patient specific issues.
- the portfolio of services and specialist services provided by hospitals.

Adopting a dynamic modelling approach which considers all the factors above very clearly identifies issues which warrant action.

In order to achieve this aim it will be important to create an environment that will encourage a change in clinical behaviour.

Objectives

Key project objectives are to:

- Ensure access to healthcare in line with local and national best practice.
- Reduce variation in the provision of healthcare (where appropriate).
- Improve quality of healthcare provision.
- Develop an appropriate educational and clinical leadership framework between primary and secondary care to make sustainable change happen and facilitate the appropriate transfer of information and support for the benefit of patient care.
- Ensure an appropriate clinical audit trail.
- Identify potential opportunities for re-investment through improved clinical practice in NWL.
- Strengthen commissioning.

Desired Outcomes

Improving clinical practice covers a broad spectrum of issues, as reflected by the original 2007 CRG recommendations which fell into two categories of a) High Impact and b) Supporting Care Outside Hospital.

In deciding the scope of the work streams for this initiative it was agreed to focus on those high priority actions across the primary and secondary care sectors where it has been established that a collaborative approach will have the most impact on patient outcome and/or care provision. This process has been informed by analysis and audits carried out in 2007-08 and 2008-09 and an assessment of achievable outputs based on available resources to take work streams forward over the next year.

The focus of this initiative is on five key work streams as follows:

Improving clinical practice work stream	Proposed target area for change
1. Review, and appropriate standardisation across the Sector, of a selected high volume patient pathways	Primary and secondary care
2. Review, and appropriate standardisation across the Sector, of GP referrals	Primary and secondary care
3. Reduction in variation across the sector against key Acute Trust performance indicators	Secondary care
4. Standardisation of hospital procedures with no routine follow-up	Secondary care
5. Standardisation of "priority setting" policies	Primary and secondary care

It has been agreed that the recommendations for improving clinical practice by supporting care outside hospital will not be covered in the PID at this stage but instead proposed for implementation on an individual PCT basis. This takes into account the fact that the wide scope of supporting care outside hospital recommendations are also covered by the Unscheduled Care CCI and HfL's plans for the development of the primary care strategy.

This should reduce health inequalities across the sector and improve patient experience, care provision and actual outcomes.

Success criteria

- Demonstration of standardised key referral, surgical threshold and follow-up activities for the cataract care pathway across the sector; in line with local and national best practice.
- Demonstration of standardised care pathways for a number of specialities across the sector in line with local and national best practice through measurement of key performance indicators:
- Reduction, as agreed in 2009-10 SLAs, for DNA first attendance and DNA follow-up attendances across the sector.
- Reduction, as agreed in 2009-10 SLAs, to less than 10% follow-up activity for the CRG's recommended eight procedures with no-follow-ups
- NWL prioritisation 'low priority procedures' and 'individual funding request' policies stand up to external scrutiny and are in line with local and national best practice.

Brief summary of timescales

This is an ongoing initiative which will be undertaken during the course of 2009-10. Each work stream is supported by a detailed action plan and timetable.

Stakeholder involvement in the formation of the initiative

Patients and the public will be involved in the initiative through participation (at PCT/Trust level) in the redesign of care pathways/processes; in focus groups and as members of a deliberative panel being developed to support the NWL collaborative programme. Stakeholders such as ophthalmologists, optometrists, GPs will be engaged in the process when necessary. PCTs will also be expected to be transparent about the decisions they are making about the effectiveness of treatments and pathways and the evidence on which they base those decisions. Therefore, the CRG will have a continuing role in debating these issues and evaluating impact and outcomes so that that information can be publicly shared.

Expected outcome from the initiative

The impact of the initiative on patient outcomes and inequalities

The initiative will ensure better outcomes by ensuring that right care is given to the right patient at the right time in the right place. This will free resources (physical and financial) which may then be reinvested in line with priorities/service developments.

Reduced variability of care will reduce the opportunity for confusion and difference in approach to these issues across the sector and best practice standards will be being achieved, or worked towards, in a consistent fashion to reduce inequalities.

Equality Impact Assessments (EqIA) have been carried out for the proposed NWL 'Interventions Not Normally Funded' policy; as well as for the recommendations on key performance indicators agreed to be included in the 2009/10 SLAs with NWL Acute Trusts. Further EqIAs will be carried out for each work stream as is appropriate.

Impact on activity and commissioning costs

These initiatives will all have impacts on the amount of activity commissioned from the acute sector. In some cases there will be an outright reduction in activity such as in the list of procedures that would only be commissioned on a named patient basis. Other initiatives in this basket, such as a reduction in follow up ratios, may require support from primary and community services that would necessitate a rise in investment in that sector.

Investment/disinvestments requirements

Outlined in the section above and in individual PCT CSPs.

Resources allocated to delivering the initiative

Key tasks required in the delivery of this initiative are co-ordinated through the NWL Clinical Reference Group which is chaired by Dr Stephen Jefferies. The CRG membership includes PCT PEC Chairs, Directors of Commissioning and Trust Medical Directors which ensures clinically informed recommendations. The CRG meets on a 5 weekly cycle.

The NWL Collaborative Programme provide facilitation and management support to the NWL Ophthalmology Network which is co-chaired by Philip Bloom, Ophthalmologist, ICHT and Nigel Davies, Ophthalmologist, Chelsea & Westminster Hospital.

Work on standardising clinical practice is facilitated by a Project Manager within the NWL Collaborative team. Bespoke analysis is commissioned from Dr Foster as required.

STRENGTHENING THE PROVIDER LANDSCAPE IN NWL

Context

The NWL PCTs provider landscape is predicted to change significantly over the next five years in line with PCT commissioning decisions if services are to remain high quality, clinically viable, sustainable and affordable. A number of national and local drivers for change will influence the shape of service provision in the future. These include the following:

- World Class Commissioning
- Patient Choice
- Darzi Next Stage Review / A Framework for Action
- Variability in performance and clinical quality across providers
- UK's first Academic Health Science Centre (AHSC) established in NWL
- The NHS Performance regime
- Plurality of providers
- PbR – HRG 4

It has been recognised, that local service review initiatives, coupled with the HFL programme (stroke, trauma, unscheduled care, polyclinics and the local hospital project in particular) and external drivers requires an urgent piece of work to ensure that provider services are fit for purpose for the future.

Local learning gained by West Middlesex University Hospital and Ealing Hospital Trust, who participated in the HfL Local Hospital Project; the implementation of changes to complex care (paediatric surgery, stroke and major trauma); the development of polyclinics; and the Brent & Harrow Acute Services Review will be used to inform this work.

It is anticipated that there will need to be an increasing emphasis on the development of networks of care where local and major acute hospitals work in partnership to ensure robust arrangements are in place to facilitate safe and effective transfers of patients in a timely fashion.

Vision

NWL PCTs will develop a robust strategy that will deliver world-class health services that meet the complex needs of diverse local populations and achieve a clinically and financially viable and sustainable provider landscape.

Aim

To achieve a clinically and financially viable and sustainable provider landscape based on the premise of “centralise where necessary, localise where possible”.

This will involve a sector-wide review of acute, mental health, primary and community services.

Principles on which the Programme is Based

1. **Commitment to quality, best outcomes, safety and sustainability of clinical services as the key driver for service reconfiguration.**

2. Commissioners and providers working in partnership so that the needs of patients and communities are prioritised over organisational boundaries.
3. Defined project brief and clarity regarding the issues that require resolution.
4. Realistic scope and scale of the project within a deliverable timeframe.
5. No hospital closures are proposed, however the nature and range of services delivered from individual sites may change in the future.
6. Implementation of the Healthcare for London programme.
7. Open and transparent process.
8. Recognition of the requirement to meet the needs of different stakeholders including the SHA.
9. Services will be procured in a way that complies with DH guidance including the “Principles and Rules for Co-operation and Competition” while recognising the need for a managed market in the NHS.
10. Commitment to sharing the costs of undertaking the work amongst the organisations involved.

Objectives¹³

High level objectives include:

- Establish baseline service configuration across the sector. Identify strengths and weaknesses in relation to local and external drivers.
- **Assess the robustness of current plans for FT status for each organisation.**
- Explore how world-class provision can be achieved in NWL by maximising the benefits of the AHSC and determining the future role of major acute and local hospitals.
- Assess the clinical and financial impact of service reconfigurations e.g. stroke, trauma and unscheduled care on the sustainability of local hospitals.
- Identify the potential to shift activity to community settings.
- Identify the potential to shift activity from specialist providers to local hospitals
- Identify opportunities for integration (vertical and horizontal).
- Stimulate the market to meet demand and improve clinical, health and well-being outcomes (externalisation of PCT provider services, review new market entrants e.g. independent sector provision)

These objectives will be supported by the outputs from the strategic and delivery initiatives described elsewhere in the CCI.

Desired Outcomes

To develop world-class commissioning intentions that deliver world-class healthcare in the context of a sustainable provider landscape.

Success criteria

- **Robust plans for FT development across NWL.**
- **Discussion document outlining the case for change and potential scenarios for reconfiguration.**
- **Business Case and consultation document.**
- Services planned across the patient pathway, where possible in line with centralise where necessary and localise where possible.
- Role of healthcare facilities clearly defined.

¹³ These will be further refined as the detailed PID is developed

- Healthcare resources are appropriately invested.

Brief summary of timescales

Phase 1 (Dec 2008 – April 2009)

- Scope project. It is anticipated that this will focus predominantly on the acute and community provider landscape in the first instance.
- Agree project structure.
- **Commission consultancy support.**
- **Produce an options appraisal report for the NHS community in NWL that assesses various FT configuration solutions. To be submitted to NHS London by Easter.**

Phase 2 (May 2009 onward)

Will be determined by the outcomes of Phase 1

Stakeholder involvement in the formation of the initiative

PCT and Provider Chairs and Chief Executives were invited to a meeting with the London Provider Agency on 27 November 2008 to discuss the challenges faced by the sector and identify mechanisms to take the NWL strategic work forward.

Wider stakeholder groups will be involved in the development of the initiative as it develops and are already part of the CCI initiatives which will drive the changes.

Expected outcome from the initiative

Impact on patient outcomes and inequalities

To be determined

This initiative will produce a strategy that delivers world-class health services that meet the needs of diverse local populations in NWL and is clinically and financially sustainable. An Equality Impact assessment will be carried out to determine the impact, for each key specialty grouping within the potential reconfiguration scenarios, on inequalities both in terms of vulnerable groups and geography where services may be provided from different locations.

Impact on activity and commissioning costs

To be determined.

Investment/disinvestments requirements

To be determined.

Resources allocated to delivering the initiative

A project structure will be established in line with Prince II methodology. The initiative will be supported by the NWL Collaborative Programme office.

- The Chief Executive's of NHS Brent and NHS Westminster will act as joint SRO's.
- The NWL Provider Reference Group, a forum for NWL PCT and Acute Trust CE's to advise on the potential implications of the Collaborative Programme, will be the Project Forum.
- The NWL Clinical Reference Group, which brings together primary and secondary care clinicians, will provide clinical leadership and expert advice.
- Existing arrangements for public engagement will be used and stakeholders will be briefed as the work develops.
- KPMG have been appointed to provide management consultancy support.
- It is likely that a number of work streams will need to be established.

OVERALL IMPACT, BY STRATEGIC OBJECTIVE

Introduction

This section provides a summary of the CCI initiatives and assesses their collective impact on the delivery of the vision and objectives described in the plan.

The initiatives were selected from a range of initiatives identified by the PCTs in NWL because they meet agreed prioritisation criteria, including delivering a key component of one or more Strategic Objectives, and because collaboration will deliver the overarching vision more effectively.

Individually, the work streams have, and will be the catalyst to achieving significant improvements in the commissioning and delivery of healthcare for the population of NWL and will contribute to the vision set out in Better Health, Better Healthcare over the next 5 years. The two delivery initiatives (section 5) have also been included in this review as they too, will contribute to achievement of the strategic objectives.

Impact on quality, health outcomes and inequalities

Initiative	Mapping to Strategic objectives							
	Improving health	Reduce inequalities		Transform quality and delivery of health services		Supports World Class Commissioning		
		Access	Life expectancy	Reduce variability	Improve quality	Build comm. Capacity & capability	IM&T	Partnership
Cancer:	✓		✓		✓			
IOG Implementation	✓	✓	✓	✓	✓			
Cancer Waiting times		✓	✓	✓	✓			
Maternity		✓		✓	✓	✓	✓	✓
Improving Surgical Services for Children and Young People in Hospital		✓		✓	✓	✓		✓
Stroke	✓	✓	✓	✓	✓	✓		✓
Major Trauma		✓	✓	✓	✓	✓		✓
Unscheduled Care		✓		✓	✓	✓		✓
Standardising Clinical Practice		✓		✓	✓	✓		✓
Strengthening the Provider Landscape		✓			✓	✓		✓
Engagement		✓		✓	✓	✓		✓
IM&T				✓	✓	✓	✓	

All of the initiatives are expected to improve the quality of care, health outcomes and inequalities as illustrated in the table above. In summary, it is anticipated that the following general improvements in quality and outcomes will be achieved across all initiatives:

- Improved access to care, both in the sense of physical access to, and in the timeliness of interventions
 - Reduction in cancer waiting times
 - Health needs assessment completed by 12th week of pregnancy
- Reduction in the variability of service delivery
 - Improved care pathways
- Significant improvements in standards of care
 - Achieving **quality, safety and access** standards for trauma and stroke
- Improvements in clinical outcomes
 - Reduced morbidity and mortality following a stroke

The JCPCT believes that collectively, these initiatives will reduce health inequalities by:

- Improving access (centralise where necessary, localise where possible)
- Increasing life expectancy
 - Cancer
 - Stroke
 - Major trauma
- Addressing issues of equity in relation to ethnicity, age etc.

Impact on activity

Detailed information on investment in healthcare in NWL is included in section 3. The table below summarises the expected impact on activity for each of the initiatives.

Initiative	Impact on activity		
	Activity +/-	Shifts in activity	Commentary
Cancer	No planned growth	Shifts to tertiary centres and primary/community care	Traditional referral routes from primary care will be redefined as more specialist centres are created. For less specialist care, activity will move from hospitals to locations in the community such as polyclinics.
Maternity	+	Antenatal and post natal care to community settings	Birth rates are predicted to peak by around 2012 in NWL with a gradual fall thereafter. This does not reflect current demand for maternity care in the sector. This is being confirmed through the NWL project. A number of PCTs are exploring opportunities to provide antenatal and post natal care in community settings.
Improving Surgical Services for Children and Young People in Hospital	No planned growth	Around 650 complex surgical cases	Around 650 complex, specialist inpatient neonatal and paediatric surgical cases will be included in the tender. However, the tender process will determine whether this activity continues to be provided within the sector or there is a move in activity between providers within the sector. As the clinical network develops it is anticipated that there will be some repatriation of activity back into the sector.
Stroke	No planned growth (IP activity) ++ (OP and Rehab)	To be determined through the designation process	It is not anticipated that there will be an impact on in-patient activity levels from this initiative. However, activity will be delivered through a changes configuration of acute providers. The initiative is likely to increase OP activity through improved detection and referral to TIA clinics. Rehabilitation activity is likely to increase as national standards are implemented
Major Trauma	Stable	Between acute	The main impact will result from shifts in activity to specialist

		and specialist providers	services.
Unscheduled Care	No planned growth	Shifts from acute to primary & community care	This initiative aims to ensure that care is provided in appropriate settings by suitably qualified staff. It is anticipated that activity will move between settings, although management of demand will be essential to mitigate improved access increasing overall demand.
Improving Clinical Practice	--	Shifts from acute to primary & community care	Reduction in OP follow up activity Reduction in referrals

Impact on commissioning costs

Detailed information on investment in healthcare in NWL is included in section 3. The table below summarises the expected impact on activity for each of the initiatives.

Initiative	Impact on commissioning costs		
	£ +/-		Commentary
Cancer	+		There has been significant investment in cancer over the last 8 years. The two initiatives planned for 2009-10 are unlikely to increase costs. However, implementation of the CRS will require investment over the next 5 years. This has still to be fully quantified
Maternity	+		There will be some increase in commissioning costs associated with growth in birth rate. Each PCT is required to invest around £700k to ensure the delivery of Maternity Matters.
Improving Surgical Services for Children and Young People in Hospital	None		Cost of the 650 cases is around £1.8M
Stroke	++		HfL has estimated that the additional cost of the acute element of the Stroke pathway (including hyper-acute care but not rehab) will be £5.4M across NWL. Shifts in commission costs associated with changes to care pathways may have a destabilising effect on acute providers.
Major Trauma	+		Any impact on commissioning costs will be in relation to shifts in activity. There may be some need to invest in additional Critical care and rehab activity. This has still to be quantified.
Unscheduled Care	+		Provided there is no increase in demand due to improved access, commissioning costs should not change significantly. Shifts in commission costs associated with changes to care pathways may have a destabilising effect on acute providers.
Improving Clinical Practice	--		Potential to release resources has been identified with the work streams, but further work is required to validate this information.

Overall impact on the provider landscape

The impact on the provider landscape is highlighted in the activity and financial summary tables above and within the Provider landscape section of the CCI. At this stage it is not possible to summarise the overall impact of the initiatives on providers.

The NWL PCTs provider landscape is predicted to change significantly over the next five years, in line with PCT commissioning decisions, if services are to remain high quality, clinically viable, sustainable and affordable. A number of national and local drivers for change will influence the shape of service provision in the future. These include the following:

- World Class Commissioning
- Patient Choice

- Darzi Next Stage Review / A Framework for Action
- Variability in performance and clinical quality across providers
- UK's first Academic Health Science Centre (AHSC) established in NWL
- The NHS Performance regime
- Plurality of providers
- PbR - HRG 4

It has been recognised, that local service review initiatives, coupled with the HFL programme (stroke, trauma, unscheduled care, polyclinics and the local hospital project in particular) and external drivers requires an urgent piece of work to ensure that provider services are fit for purpose for the future. A specific initiative is, therefore, being developed to address this. Finance and activity information from each initiative will feed into this initiative.

SECTION 5

DELIVERY

PAST DELIVERY PERFORMANCE

The NWL sector has had a reputation for poor strategic planning and lack of ability to deliver change. However, over the last 18 months the position has changed as the PCTs have strengthened their approach to collaborative commissioning through the funding of a dedicated NWL Collaborative Programme Team and, more recently, through funding of **dedicated programme team to support the Strengthening Commissioning agenda in NWL.**

The main body of work during 2007-8 focused on establishing the infrastructure to support the delivery of change; developing PIDs for key initiatives and identifying the body of evidence and baseline position to support the need for change. Stroke, Unscheduled care and Neonatal and Paediatric surgery initiatives will all move to the tender/designation phase over the next 6 months with implementation of change, subject to consultation, by March 2010.

In 2007/2008, Hammersmith and Fulham and Westminster PCTs worked together to develop a commissioning structure which would serve to effectively commission, contract and monitor performance of services from Imperial College Healthcare NHS Trust (ICHT) for 2008/2009. The structure established was based on discussion that took place in workshops with key clinical, commissioning and finance stakeholders.

Hammersmith and Fulham PCT is the “co-ordinating” commissioner and informal agreements were made between Westminster and H&F PCTs to jointly resource the commissioning structure. Agreement was reached with NWL PCTs to provide resources to these arrangements; however, these were not drawn upon. The arrangements put in place served the Sector well and the SLA was agreed with ICHT in line with the national timetable. Within that there were some considerable achievements:

- harmonisation of prices between St Mary’s and Hammersmith Hospitals
- good clinical engagement
- agreed quality indicators
- agreed follow up ratios, based on national benchmarks, and contract exclusions
- agreed approach to high cost drugs

Looking to the future the PCTs in NWL have agreed to form a NWL Commissioning Partnership which will strengthening the commissioning of acute care. Further details are provided below.

ORGANISATIONAL ARRANGEMENTS

The NWL sector has agreed a delivery structure which builds on the strength of existing Borough and local relationships whilst creating the capacity, authority and governance arrangements to commission strategically for services that are best dealt with at a sub-sector, sector or pan-London level. The aim is to minimise duplication of transactional and analytical processes and maximise access to scarce or expensive

capabilities and commissioning skills. The following section describes the evolving commissioning arrangements in NWL.

NWL COLLABORATIVE COMMISSIONING

The NWL Strategy Board was established in 2007 to oversee the work of the CCG and steer the strategic agenda across the NWL sector.

In August 2008, the eight PCTs in NWL agreed to form a Joint Committee of the PCTs to:

- oversee the identification and delivery of collaborative commissioning intentions (CCI) in NWL
- to lead the implementation in NWL of Healthcare for London (HfL)
- to lead any formal consultations relating to the CCI or HfL required across the sector to deliver service change

Scope of the NWL JCPCT

The NWL PCTs have established a Joint Committee to improve collaboration on issues of major strategic change in the sector. A Joint Committee will allow speedier decision making whilst providing a visible, accountable mechanism to deliver change and improvements in services. The JCPCT will lead the development of, and approve sector wide plans, in response to the Healthcare for London framework. Additionally it will lead the development of, and approve collaborative commissioning intentions, including any sector wide response to Strengthening Commissioning, for PCTs in the sector. It will be the consulting body for any of these plans which lead to consultation by member PCTs on service change. Decisions made by the JCPCT will be binding on all member PCTs. Commissioning plans of individual PCTs will, therefore, be consistent with and support the service models and standards agreed by the JCPCT. The JCPCT will also be responsible for ensuring the timely delivery of agreed plans, including the achievement of expected service outcomes.

Principles of Joint Working

The organisations within NWL recognise that to deliver successful partnership working it is important to develop good formal and informal working relations that build trust and share responsibility, whilst respecting difference. For instance, commissioning is most successful when providers' views about implementation are taken into account. To facilitate this, both commissioners and providers party to these arrangements commit to adopt the following principles in their dealings with each other:

- building trust and a mutual respect for each others' roles and responsibilities
- openness, honesty and transparency in communications
- top level commitment
- a positive and constructive approach
- commitment to work with and learn from each other
- early discussion of emerging issues and maintaining dialogue on policy and priorities
- commitment to ensuring high quality outcomes
- where appropriate, confidentiality and agreed external positions
- making the best use of resources
- ensuring a 'no-surprises' culture.

- the creation of a management infrastructure which supports the delivery of agreed initiatives (see later).

A governance framework (Appendix 1) outlines how these joint arrangements operate.

NWL COMMISSIONING PARTNERSHIP

The North West London Acute Partnership is being formed to strengthen commissioning for all PCTs in the sector. The prime focus of the partnership is to improve acute sector performance and delivery. It will do this in three ways:

- determining a viable provider landscape configuration in the sector
- agreeing acute sector contracts
- performance monitoring and management of acute sector contracts

Driven by the needs of its constituent PCTs, the Partnership will deliver both individual and collective commissioning intentions for Brent, Ealing, Harrow, Hounslow, Hillingdon, Hammersmith and Fulham, Kensington and Chelsea and Westminster PCTs and their PBC Clusters.

Bringing together commissioning expertise and scarce skills; the Partnership will be designed to ensure that each PCT develops its performance under the World Class Commissioning Framework. A creative career structure will be designed to ensure that key and scarce staff are recruited effectively and retained to ensure continuity and delivery.

Of paramount importance is that the partnership reflects the clinical priorities of the Sector PCTs and has clinical engagement at the highest level. PEC/CEC Chairs will direct the design of effective clinical engagement for the Partnership. The design will include the role for a sector-wide clinical reference group to set sector wide standards, and will ensure local PBC and PEC members are engaged with local pathway design.

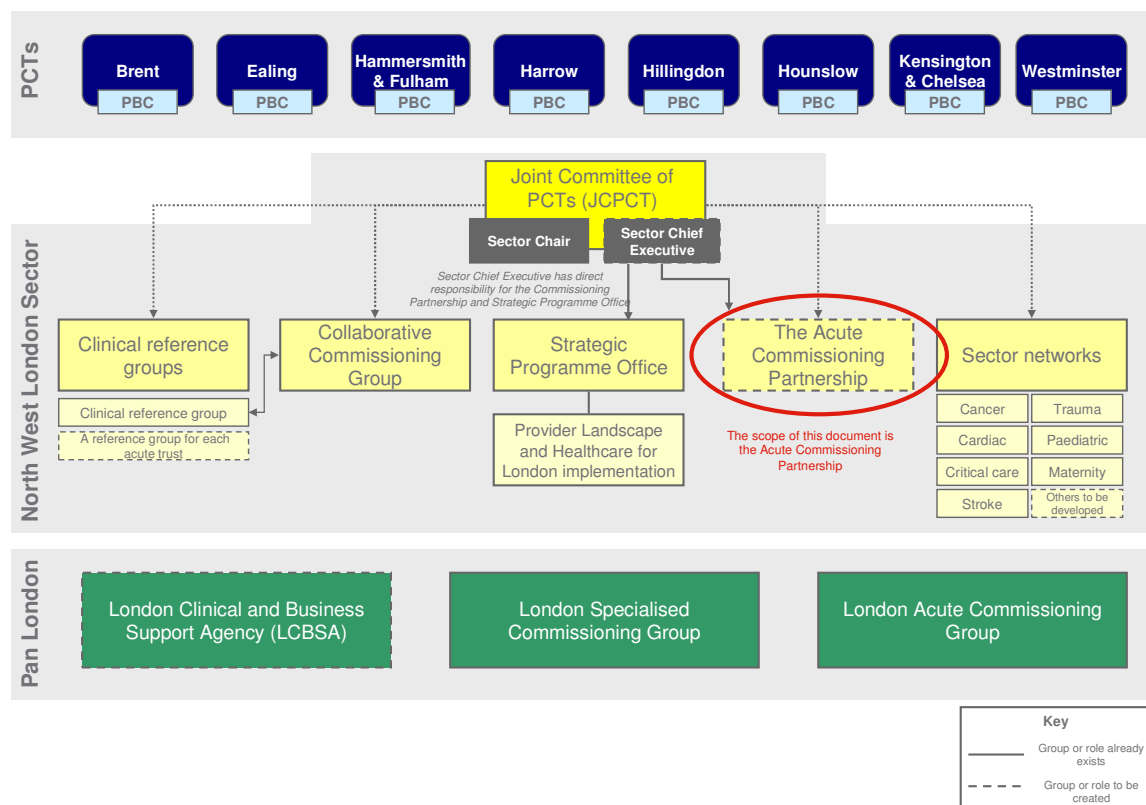
To ensure focus and drive, the partnership will be overseen by a single Joint Committee of PCTs (JCPCT), a single Chair and a sector Chief Executive.

Performance management will be key to everything that the partnership does. This falls into four headings:

- performance management of acute contracts
- improved performance of individual PCTs
- performance of the partnership itself of delivering benefits to individual PCTs
- performance management of the hub and its interaction with the partnership

Bringing together commissioning skills and resources will ensure that commissioning throughout the Sector is strengthened for the benefit of patients. The Partnership represents a real opportunity to deliver excellent results for patients and position PCTs at the leading edge.

The Figure below details the North West London sector arrangements and the relationship between the Commissioning Partnership and existing sector-wide commissioning functions.



Further information is provided in the North West London Commissioning Partnership Outline Business Case March 2009 (Appendix 16).

STRENGTHENING BOROUGH RELATIONSHIPS

Each PCT has a different focus depending on the degree of maturity of their relationship with their Borough. The current position and key areas for action are outlined below:

NHS Hammersmith & Fulham

A feasibility study to review possible options for strengthening borough relations has been completed. The proposal for integration in Hammersmith and Fulham is for a unified executive team supporting the two statutory organisations with a shared vision on health outcomes. In practice, the unified executive team will mean a single Chief Executive covering both statutory organisations - supported by a unified

management team. The proposal will be discussed at the Borough and PCT Board meetings in March 2009.

NHS Kensington & Chelsea

Proposals include:

- increasing the number and scope of jointly managed functions
- appointment of a PCT Director level post, working closely with the Council, to oversee all out of hospital healthcare commissioning
- closely aligning staff responsible for research, planning, customer surveys and consultation, potentially under contract
- The PCT is committed to including its local PBC in further joint working with the Borough
- The PCT strongly supports the Children's Trust model, and has worked closely with it in drawing up successful business cases for increased investment in children's services in 2008/9.

NHS Westminster

Proposals include:

- Joint Strategic Needs Assessment – Adults and Children – will underpin all commissioning and local priority setting; joint public health consultant in post
- Revise Section 75 agreements to allow more joint and lead commissioning with a focus on Long Term Conditions
- Consideration of asset/ estate management and joint service delivery points.
- Commissioning common care pathways with Practice Based Commissioners
- Strengthening joint commissioning for Children's services with potential Children's Trust
- Transformation of adults services to take forward *personalisation* for both social care and health
- Joint work to establish Local Involvement Network (LINK) for health and social care.

NHS Brent

Relationship much improved following PCT Turnaround and Continuing Care Dispute. Current joint commissioning posts in place for mental health; older people; learning difficulties; children; and drug & alcohol service. JSNA and Health & Well-being strategy agreed.

- Agreement to review partnership arrangements and enhance borough-level commissioning
- Joint appointment of Director of Public Health & Regeneration
- Council has been taken through PUK review of provider services and asked for expression of interest in providing

NHS Ealing

Top level commitment and leadership – effective LSP, Health and Wellbeing Board, joint work on LAA/CAA. Council Leader and relevant Cabinet Member are active associate members of PCT Board. Long and strong experience of joint commissioning. Current joint posts in place for older people, children, LD, PD, mental health, drugs and alcohol, sexual health and supporting people.

- Joint review of opportunities for further collaboration recently launched, covering: commissioning, provision, health improvement, citizen engagement, support services, emergency resilience, co-location
- Top level steering group, early outcomes due in December 2008.

NHS Harrow

Historical difficulties with LBH due to financial difficulties for both parties. An agreement in March 2008 resolved the majority of financial disputes. This provides a base for future joint commissioning. Both PCT and LBH CEOs committed to greater integration not just in commissioning but also in wider policy shaping and economic development.

- Harrow PCT, the local authority and police have agreed to form a joint analysis unit to share local information to aid priority setting and joint working
- Currently discussing changes to the LSP governance arrangements, putting in place a Public Sector Leadership Board, comprising the LA CEO, PCT CEO and Borough Commander. Will support delivery of LSP Partnership Boards and LAA.
- Children's Trust to be established from 1 April 2009. Governance arrangements being discussed and likely to see transition over 2 year period to joint commissioning arrangements. Likely to be linked to a Learning Trust for education commissioning.
- Plans for LBH to take lead role for LD commissioning and PCT lead for Mental Health services from 1 April 2009. Discussing a framework agreement for S75 arrangements to fit into providing clearer governance.
- Discussing a joint committee arrangement across integrated commissioning agenda as part of LSP governance arrangements.

NHS Hillingdon

The ambitions of the PCT and LBH are politically well aligned despite a relatively turbulent recent history. Routine liaison arrangements are in place between the Chair of the PCT and the Leader of LBH and these are supported by the organizations respective Chief Executives and senior management teams.

Jointly agreed overarching strategy with LBH to develop a sustainable community. This includes a joint vision for health and well being and references very directly the PCT's strategy for health. The joint commissioning arrangements for children and adults health services and also for health improvement have recently been strengthened and further joint appointments are in train. The Joint Strategic Needs Assessment sets the scene for partnership development and underpins the PCT's work with LBH incorporating the ambitions of Practice Based Commissioners to improve local services and health outcomes.

The Sustainable Community Strategy (SCS) has been developed by Hillingdon Partners and is the natural successor to previous community strategies which

articulated a long-term vision for the borough. This was fully supported by all partners including the PCT.

The PCT has recently agreed with LBH a revised arrangement for liaison and decision making for its executive and senior management team covering both adult social care and education and children services.

T

The PCT and LBH have a well integrated, jointly funded team covering:

- | | |
|-------------------------|-------------------------------------|
| ▪ Older People | ▪ Physical and Sensory Disabilities |
| ▪ Mental Health | ▪ Drugs and Alcohol |
| ▪ Children and Families | ▪ Carers |
| ▪ Learning Disabilities | ▪ Continuing care |
- The PCT and LBH are also pursuing joint appointment to the position of Director of Public Health and will consider other senior joint appointments in due course.
 - Key Directorates of the PCTs commissioning arrangements covering Out of Hospital Commissioning and Public Health will shortly re-locate to the Civic Centre enabling more integrated working with LBH colleagues.

NHS Hounslow

Joint Commission Older persons, mental health, learning disability and substance misuse services already in place.

- Children's services to be added from 2009-10.
- Joining with the Borough in their Pride In Hounslow campaign which will look across public services and revisiting the role and make up of the LSP accordingly.
- Exploring the possibility of collocating the PCT HQ in the Civic Centre as well as other commercial options.

STRATEGIC ALLIANCES

All PCTs

All five PCTs have agreed to commission external support to review performance across Outer NWL and to develop a performance improvement plan.

Brent & Harrow PCTs

A joint acute strategy review between the two PCTs and NWL Hospitals Trust formally launched on 1 November 2008.

The aim is by the spring to issue a discussion document making the case for change and setting out possible options for review. Thereafter the project will move through the business case and formal consultation stages.

In the interim, the PCTs are acting as "single payor" to NWL Hospitals Trust i.e. two commissioning teams act as body to trust in terms of strategy, contract negotiation, remediation and performance and the two DPHs are working on a proposal to create a public health R&D function across all three organisations.

Hillingdon & Hounslow

Hillingdon and Hounslow PCTs are focusing on achieving break-even in 2008-9 and are implementing systemic changes to sustain financial recovery. This includes sharing lessons learnt from data validation and use of information.

CLINICAL NETWORKS

These are specialist clinical networks which aim to support the equitable provision of high quality, clinically effective services. They were mainly established in response to National Service Frameworks or DOH guidance to review and make recommendations on the delivery of care for a specific disease group or care process. They have a funded management structure. The funded networks relevant to the NWL collaborative work are:

- Cancer
- Cardiac/Stroke
- Critical Care
- PIC
- NIC

The networks are responsible for advising the CCG on the delivery of clinically effective services within their remit. They provided, at least, an annual update to the CCG on progress with their agreed work programme. The CCG may also request that they undertake specific pieces of work on behalf of the NWL Collaborative Programme.

The membership of clinical networks is outlined in their terms of reference. All funded networks are chaired by a Senior Responsible Officer who is a Chief Executive within NWL.

The Cardiac & Stroke and Cancer networks are facilitating specific initiatives in the CCI. Details of how the Critical Care network plans to support the delivery of the CCI and World Class commissioning is detailed in Appendix 14.

ENABLING INITIATIVES

This section outlines two initiatives which aim to support the delivery of the Strategic initiatives in section 4 of the plan.

PATIENT & PUBLIC ENGAGEMENT

Context

The 2007-9 CCI identified “the development of a patient involvement strategy which truly involves patients and the public in, and makes them equally accountable for, the continuous improvement in health and health care” as a key enabler for the delivery of the Vision. To support this, the NWL Public Engagement Reference Group (PERG) was established as part of the governance arrangements of the NWL Collaborative Programme. This comprises PCT PPI and Communications leads and functions to advise the CCG on broad engagement issues and to support individual initiatives. The group also produced the NWL Public Engagement Policy in 2008 (Appendix 15).

Recent policy changes and initiatives have strengthened the duty to involve patients and the public in planning, review and development of services. The duty for NHS organisations to involve and consult patients and the public has now been strengthened under s.242 of the NHS Act 2006. This has been underpinned by a number of other policy changes and initiatives such as the introduction of Local Involvement Networks, the NHS Constitution, the Next Stage Review and World Class Commissioning.

This initiative describes the next phase of collaborative engagement work across NWL to support the delivery of the CCI initiatives, as well as aid PCTs in fulfilling the requirements around the strengthened duty to involve and World Class Commissioning.

Vision

To fully involve patients and the public¹⁴ in the planning, review and implementation of changes to services or introduction of new services; the development and consideration of proposals for changes in the way services are provided and decisions affecting the operation of services.

Aim

To **consolidate** and implement relevant and meaningful processes to enable a continuous dialogue with the population of NWL, bringing sustainable 'added value' to the PCTs in NWL.

Objectives

- To establish **the necessary infrastructure and expertise to support the delivery of the CCI initiatives. Specifically this refers to the implementation of HfL's proposals for stroke and trauma services as well as the pre-consultation phase of the CCI initiatives on the provider landscape, paediatrics and maternity services.** This may include the establishment of a web-based consultation system and a deliberative panel which will enable the development of a sector-wide 'virtual network' of patients and carers.
- To deliver a common 'toolkit' for patient and public engagement for PCTs across NWL that is embraced as integral to the commissioning process.
- To maximise the capacity and capability of PCT PPI leads through identification of expertise across the sector, reducing duplication and enabling sharing of best practice.

Desired outcomes

- Patients and the public in NWL are fully involved in and are in a strong position to contribute and respond to engagement activities occurring as part of the sector-wide collaborative work as well as pan-London work.

¹⁴ by 'patients' we mean both existing and potential service users and carers. By 'public' we mean general members of the population in NWL, staff, clinicians, partner organisations such as local Trusts and wider stakeholders such as Local Authorities and local community and voluntary groups

- Patients and the public are actively involved at the heart of PCT commissioning activity in NWL, particularly in respect to the CCI initiatives.
- Patient and public involvement in NWL reflects best practice (not minimum requirements).
- PCTs in NWL meet and exceed their statutory duty to involve and consult their residents.

Success criteria

- **A robust engagement process is achieved in each CCI initiative, supporting the effective delivery of the CCI. Measured by:**
 - Accreditation for the engagement process by the Consultation Institute, if applicable (cf. Appendix 12).
 - Positive outcomes of formal consultations, if applicable.
- Well-informed patients and the public who understand the difference between substantial and minor change. **Measured by:**
 - **Level of discussion on the web based consultation system**
 - **Qualitative data gleaned from focus groups and workshops with members of the deliberative panel**
- Continuing meaningful engagement with patients and the public, rather than consultation, is the norm. **Measured by:**
 - **Level of engagement material included in re-consultation business cases**
 - **Overall increase in the level of engagement with the public at PCT and NWL sector level. A qualitative assessment, rather than a quantitative assessment will be used to determine this.**

Summary of timescales

Action	Timescale
Establish the NWL Public Engagement Reference Group (PERG)	April 08
Develop a sector-wide Public Engagement Policy	June 08
Establish a 'NWL 'virtual network' of patients and the public to be used as a sector-wide resource for engaging relevant people	Dec 08 onward
Develop and launch an NHS-facing web portal to strengthen NWL NHS organisations' capability of sharing information	March/April 09
Develop and launch a public-facing e-consultation system for communicating with and collecting views and opinions from the public	Nov-Dec 08
Develop a programme of shared learning for PCT and Trust PPI leads	Jan 09 onward
Develop a NWL deliberative panel as part of the Paediatric initiative and thereafter to support the other initiatives , where relevant	Jan 09-Apr 10

A detailed plan of action is included in the PID for this initiative

Stakeholder involvement in the formation of the initiative

PCT PPI and Communications leads have been involved in the development of this initiative. As the initiative itself develops there will be a greater level of engagement with Trust PPI and Communications leads as well as other stakeholders such as Local Involvement Networks.

Patient and public involvement will be integral to the initiative.

Expected outcome from the initiative

The impact of the initiative on patient outcomes and inequalities

The initiative will aim to ensure that PCTs are much better informed about their local populations' views and opinions of local services and be better positioned to build these into future planning, review and delivery of services.

Impact of initiative on activity and commissioning costs

None

Investment/disinvestments requirements

None identified at this stage, although it is anticipated that high quality engagement will support investment/disinvestment decisions.

Resources allocated to delivering the initiative

This work will be coordinated through the NWL PERG, chaired/led by the NWL Programme Director.

Participate Ltd has been appointed to support the engagement process for the 'Improving Surgical Services for Children and Young People in Hospital' initiative. This will include delivering a programme of engagement activity as well as developing and implementing a deliberative panel and e-consultation system and **ensuring accreditation of** the engagement process for this initiative.

It is envisaged that this piece of work will also extend to other initiatives under the NWL collaborative programme, supported by Participate or a similar organisation.

The CCG has also agreed to invest in an NHS-facing web portal to strengthen NWL NHS organisations' capability to share information.

Funding is allocated within the Programme budget to support the development of PPI leads.

INFORMATION MANAGEMENT AND TECHNOLOGY (IM&T)

Context

The NHS Operating Framework for 2008/09 identified the need for sustained focus on information management and technology (IM&T) in the NHS to deliver better, safer care. IM&T investment and exploitation now forms part of mainstream NHS planning in support of health service priorities and reform.

The expectation is that individual organisations will work collaboratively within community-wide governance arrangements to produce an inclusive IM&T plan that

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effectively supports the delivery of high quality services for patients and provides front-line staff with the tools and information they need to provide these services; that local IM&T plans will meet the national expectations set out in the Operating Framework for 2009-10 and will make available the funding and capacity, including clinical time, to do so; and IM&T planning will be further integrated with mainstream NHS service planning.

More recently, the *Next Stage Review (June 2008)* highlighted the challenge of “health in an age of information and connectivity” and the need for information was a recurring theme throughout the report. To support this, the Dept of Health published the Health Informatics Review in July 2008 which outlines the informatics requirements of the *Next Stage Review*. Further guidance will be issued in due course.

NWL PCTs identified the development of health and healthcare information which supports investment/disinvestment strategies and is owned by commissioners, providers and users or services as a key enabler for the successful delivery of the vision in the 2007-9 CCI. A meeting of key individuals from the sector was held on 10 Sept 2008 to identify the issues that need to be addressed. It was agreed that where existing Local Health Community (LHC) arrangements were in place and working well, this infrastructure should be supported and developed. In addition, each CCI initiative would identify IM&T needs to deliver the required change and would, either work this up through the project or request support through the LHC arrangements.

A number of areas where working collectively would add value have been identified:

- Developing informatics specialists
- Joint help desks – particularly out-of-hours
- Join working with Connecting for Health
- Information governance
- Information to support clinical pathways/networks
- Do once and share
- Standardisation of data sets
- Development of a contract management info system
- Standardising electronic communications between PCTs and Providers, particularly in relation to discharge and referral
- Joint approach to disaster recovery, back up data centres, data warehousing
- Data sharing agreements

Vision

High quality, integrated healthcare supported by appropriate and timely information.

Aim

To ensure that the informatics requirements of the *Next Stage Review* are implemented in NWL.

Objectives¹⁵

- Develop information rather than systems led plans that are integral to local service plans for the delivery of the vision set out in High Quality Care for All: The NHS Next Stage Review, the local SHA vision and the achievement of World Class Commissioning (WCC) competencies.
- Establishing robust LHC structures and governance arrangements which deliver plans that are inclusive of all key organisations and deliver informatics developments to support the multi-professional patient pathways across health and social care settings.
- Ensuring that informatics capability and capacity is expanded at all levels to make available the knowledge, skills and resources to support the long term vision.
- Ensure information assessments are included in all CSP and NWL collaborative initiatives.

Desired Outcomes

- Individual LHCs develop and deliver robust Informatics plans which support the delivery of CSP and CCI initiatives.
- Greater use of appropriate healthcare information **in the planning and delivery of care.**

Success criteria

- Health and healthcare information supports investment/disinvestment strategies and is owned by commissioners, providers and users of services.
- Systems are procured and implemented that aid healthcare integration and allow transfer of patient information between providers in a timely manner.
- Year on year improvement in the quality and level of information used to inform commissioning decisions and monitor care.

Brief summary of timescales

LHCs have agreed action plans with associated milestones. Timescales associated with CCI initiatives are described in Section 4.

Stakeholder involvement in the formation of the initiative

Stakeholder involvement will be through individual initiatives.

Expected outcome from the initiative

The impact of the initiative on patient outcomes and inequalities

The need for high-quality information has never been greater. There is an increased demand for information to inform patient choice and professional-led quality improvement. Alongside this, providers and care pathways are more diverse and increasingly cut across health, social care and geographical boundaries.

The delivery of this initiative will support improved patient outcomes in terms of timely gathering and analysis of information about the process and quality of care. Although

¹⁵ Extracted from the draft 2009-10 Informatics guidance

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a specific Equality Impact Assessment has not been undertaken (and may not be necessary at this level), current knowledge of the variability in delivery of Connecting for Health across the sector; the poor integration of information systems between primary and secondary care and between health and social care and the dearth of care pathway indicators to measure the delivery and quality of care means that there is already a high level of inequality across the sector. This initiative should ensure a reduction in inequalities in relation to ethnic origin, age, disability etc. through greater integration of care, improved information about care and greater standardisation of care pathways (where appropriate) across the sector.

Impact on activity and commissioning costs

This has still to be quantified. It is anticipated that improved information will support investment/disinvestment strategies and identify resources for reinvestment in patient care.

Investment/disinvestments requirements

This will be quantified within LHC plans.

Resources allocated to delivering the initiative

LHCs are resourced by the constituent organisations. Resources allocated to CCI initiatives are outlined in Section 4.

RISK MANAGEMENT

Each initiative has a risk log which identifies all of the risks associated with the work stream. The risks outlined below represent the high level, critical risk factors across the initiatives in the CCI. These risks will be monitored closely by the JCPCT.

Initiative	Risk	Severity	Likelihood	Mitigating Actions
Overall CCI	Organisational change detracts from focus on CCI	4	2	Commissioning Partnership arrangements across NWL will strengthen the governance arrangements which support the delivery of the CCI.
	Financial restraint reduces ability to implement CCI initiatives	4	3	This is unlikely to have a serious impact in 2009-10. 2010-11 plans will include much greater detail on investment/disinvestment requirements. Financial risk pool has been agreed pan-London to support the implementation of the key HfL initiatives.
Cancer	Lack of capacity to deliver CRS	3	2	WLCN has identified likely funding required to implement CRS. Business Case developed to implement digital mammography.
	New tariff will not cover full scope of palliative care services	4	3	Network to continue to work with commissioners to identify areas that need to be commissioned locally.
	Lack of capacity to implement IOG and reduce cancer waiting times by delivering care closer to home	4	3	WLCN to work with PCTs to consider alternative settings as part of polyclinic developments
Maternity	Lack of capacity to meet the projected rise in demand	4	2	Sector-wide capacity planning sub-group established to model future demand and

Initiative	Risk	Severity	Likelihood	Mitigating Actions
				capacity requirements.
	Poor performance against national standards across NWL providers	4	3	Develop a quality services specification to be implemented in 2009/10 SLAs. Develop priority metrics to monitor provider performance.
Improving surgical services for children and young people in hospital	Failure to designate a lead centre	4	2	Develop a robust tendering process. NWL JCPCT to determine configuration.
	Lack of stakeholder support	4	2	Develop a robust engagement plan.
Stroke	Designated HASU/s & SU fail to meet the needs of patients in NWL	4	2	Provide support to providers to prepare bids (SCRG, NWLC&SN & NWLCP). Commissioners to take a view on bids to inform the HfL process. NWL representatives on pan-London JCPCT to determine final configuration. NWL representatives on HfL Clinical Expert Panel and Commissioning and Finance Panel. Develop robust arrangements to monitor performance against required standards following implementation.
	Lack of capacity to deliver rehabilitation performance standards	4	3	Rehabilitation work stream has mapped current services and will identify gaps against new standards. PCTs & providers to develop costed plans to achieve standards. Additional funding to be used to address priority areas.
Major trauma	Designated major trauma / trauma centres fail to meet the needs of patients in NWL	4	2	Providers presented bid to secure commissioner support in advance of submission. NWL representatives on pan-London JCPCT

Initiative	Risk	Severity	Likelihood	Mitigating Actions
				to determine final configuration. NWL representatives on HfL Commissioning and Finance Panel. Develop robust arrangements to monitor performance against required standards following implementation.
Unscheduled care	Benefits of the new model are not realised e.g. reductions in A&E attendances and financial savings.	3	3	PCTs to develop a robust local clinical model and undertake activity and financial modelling to predict future requirements. PCTs developing an UCC and embarking on procurement process to learn lessons from PCTs that have undertaken this work. HfL commissioning toolkit to be used as necessary.
	Variability in performance as seen in HCC review continues	3	2	USC leads project group established to share best practice and learn lessons from best performing organisations.
Improving clinical practice	Appropriate standardised pathways agreed across specific specialties fail to deliver anticipated benefits e.g. reduced DNA rates, reduced hospital follow-up ratios.	3	2	Detailed activity analysis undertaken by specialty across the patient pathway to identify areas for further work and investigation in primary and secondary care. CRG to provide clinical advice regarding thresholds / targets to be included in 2009/10 SLAs. Regular audits to be undertaken to monitor performance with exception reports to CCG.
Strengthening the provider landscape	Sustainability of acute services	5	3	Project management arrangements to be established - PRG to act as Project Board. Robust PID to be developed.

Modified Australia / NZ risk matrix

IN-YEAR MONITORING

Responsibility for monitoring the delivery of the CCI rests with the Joint Committee of the PCTs (JCPCT) supported by the CCG and its sub-groups. Governance arrangements are outlined in Appendix 1. Appendix 4 of the Governance framework outlines how initiatives are developed from ideas into detailed plans and the process by which changes are implemented and monitored.

The JCPCT has responsibility for approving the Project Initiation documentation (PID) for each initiative. Each PID is supported by a detailed project timetable and an agreed set of metrics against which progress is monitored. The JCPCT receives monthly updates on all initiatives. A standard reporting proforma is used (Appendix 16). In addition, each initiative has a Senior Responsible Officer (SRO) who is accountable for its delivery. Each initiative is reviewed at least annually, or more regularly as circumstances change.

SECTION 6

DECLARATION

The North West London Collaborative Commissioning Plan is the product of joint working between the eight PCTs and their respective partner organisations; the public and clinicians. The work is overseen by the Collaborative Commissioning Group (CCG) which is the Executive arm of the Joint Committee of the NWL PCTs (JCPCT).

The JCPCT signed off the final draft plan at its meeting on 5 December 2008. The final plan (following comments from NHS London) will be approved by the JCPCT in **May** 2009.

The JCPCT will be responsible for monitoring the successful delivery of the CCI and will receive monthly updates on progress from the Programme team/SRO.