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A programme to improve healthcare for two million people in North West London

March 2012

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Welcome

Anne Rainsberry

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Gavin Grey

Agenda for this afternoon

13:30	Welcome	Anne Rainsberry and Gavin Grey
13:35	Review of feedback from last event	Daniel Elkeles
13:45	Out-of-hospital progress update	Dr Tim Spicer
14:10	Introduction to feedback system	Gavin Grey
14:15	Options development	Dr Mark Spencer
14.40	Round table discussions	
14:55	*Break*	
15:10	Introduction to the criteria used to get from medium list to short list	Dr Mark Spencer
15:20	Breakout on detail of short-listing criteria	Gallery walk
16:15	Feedback	Gavin Grey
16:30	Q&A	Dr Mark Spencer, Dr Susan LaBrooy, Dr Tim Spicer
16:45	Next steps	Dr Mark Spencer

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Review of feedback from 15 February event

Daniel Elkeles

Attendees at the event

- Patients, patient representatives and the public:
  - Representatives from all eight LINKs patient groups from across North West London
  - Representatives from all eight local authorities in North West London, including elected councillors
  - Patient groups including Age UK, Mencap, MIND and the Patients Association

- Local Clinicians:
  - GPs from across North West London including those from the new Commissioning Consortia in each borough
  - Clinicians representing every NHS NWL service provider, including hospitals and community health services

What was discussed at the event

- The case for change
- Our proposals for improving out of hospital care
- Our proposals for improving hospital care
- The evaluation criteria we might use to assess options for change in the way we provide hospital care
- There was also a Q&A session with programme leaders

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How we are addressing the concerns raised about out of hospital care

You said:

- Current out-of-hospital services **inconsistent and uncoordinated**
- Patients are not able to **see one GP on a consistent or regular basis**
- **Communication** between patients and clinicians, between clinicians and between systems **is a key area for improvement**;
- Healthcare should be better coordinated and the **patient placed at the centre**.
- **Integrated IT systems** are essential to facilitate joint working
- **Access** needs to improve - particularly ease with which a patient can get an appointment or speak to a healthcare professional.

We have incorporated into our Out of Hospital Standards

A copy of the latest standards is in your pack

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Participants at the last engagement event ranked the criteria that were most important to them

	Criteria	Count of 'votes' as indicated by stickers: Public	Public	Clinicians	Clinicians
1	Quality of care	24%	199	28%	227
2	Access to care	10%	84	6%	45
3	Affordability	7%	58	11%	88
4	Capacity	4%	33	4%	33
5	Deliverability	8%	69	7%	57
6	Workforce	10%	82	14%	111
7	Education and Research	7%	58	10%	84
8	Alignment with other strategies	8%	68	4%	31
9	Patient Choice	8%	64	3%	22
10	Patient Experience	13%	108	13%	107
	Total votes		**823**		**805**

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Additional criteria suggested during the event included…

From the patients, patient representatives and the public

	Votes
Integration	18
Equalities (in health choice)	15
Supporting preventative care and patient self-management	9
Additional - operates 24/7 basis	5
Patient user consultation before change	5

From clinicians

	Votes
Impact on other co-dependent services	7
Self-treatment, independence and self-force/ patient education	6
Integrated care – collaborate	5
Full range of services	5
Flexibility across pathway	4

Suggested criteria have been reviewed and included where appropriate

FOR EXAMPLE:

Suggested criteria	Where this has been included
Risk to existing services	Deliverability criteria
Impact on other co-dependent services	Deliverability criteria
Career experience	Quality criteria
Expertise – who, where is this	Workforce criteria
Distribution of services meets local needs	Access criteria
Flexibility across pathway	Patient choice criteria

Some criteria were not included because they would not differentiate between different options

Examples of suggestions	Reasons why these were not included
• Integration of services	• Out of Hospital strategy
• Health equality across NWL	• Out of Hospital strategy. • Equalities impact analysis on the shortlisted options and identify actions to address any adverse impacts on specific groups.
• Support for preventative care and help for patients to manage their own conditions, encouraging independence	• Out of Hospital strategy

Other feedback and how we have responded

- Tell us more about how and when **transformation of out-of-hospital services** will be achieved
- Important that patients, and their relatives and friends **can easily get to the services** and sites that they need
- **Integration of health and social care** will need committed joint-working and better sharing of resources. Programme should be integrated with other aspects of care (e.g., mental health, cancer, end-of-life)
- The programme is **ambitious in its scale –** any changes need to be carefully considered
- Need to **describe the programme** more clearly – be less technical

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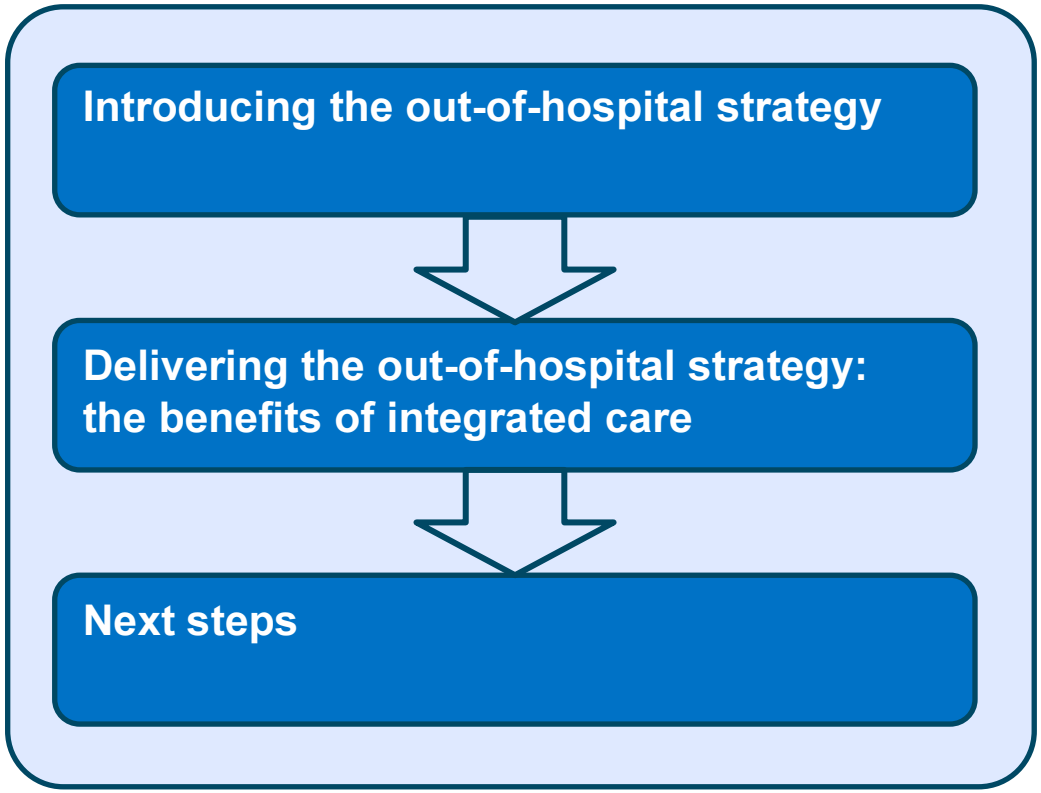
Out-of-hospital progress update

Dr Tim Spicer

Delivering the out-of-hospital strategy



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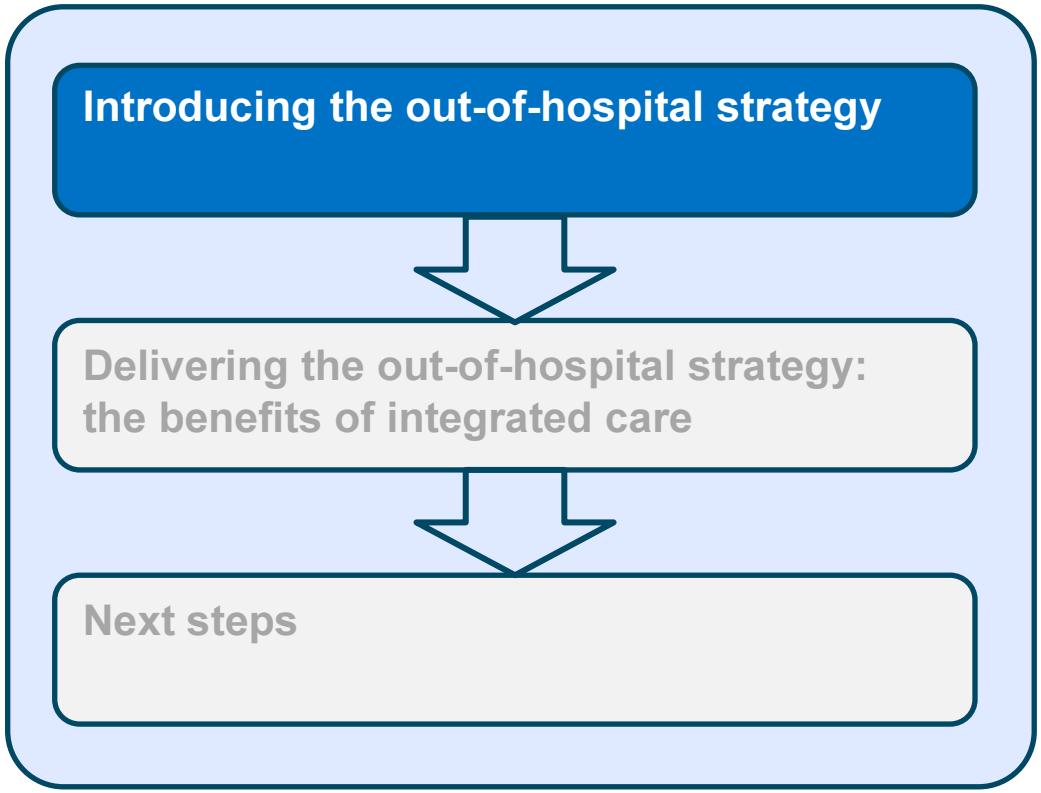
Delivering the out-of-hospital strategy



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Why do we need an out-of-hospital strategy?

Changing needs; improving patient experience; improving quality; affordability

The residents of North West London have **changing health needs**, as people live longer and live with more chronic and lifestyle diseases - putting pressure on social and community care

When my mother, who is elderly, needed care recently **she seemed to fall through the cracks**. I had to call multiple services to find who should be helping her at home.

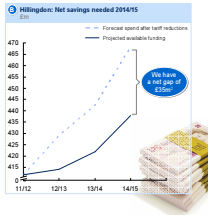
This was a stark contrast to my experience elsewhere in the UK, where they have **joined up services**, and **specialist plans** in place for patients with long term conditions.

My mother should have had a **single place to call**, from which her **care should have been owned and coordinated**.

Workshop participant, Hillingdon

Our healthcare provision is **fragmented** and people have **very different experiences** in different locations; in other words, we sometimes fail our patients

Across the UK we know that care can be delivered out of hospital with better outcomes for the patient and at lower cost. We are highly reliant on **hospital care**



We will have to adhere to the national imperative to provide **high-quality care more affordably**

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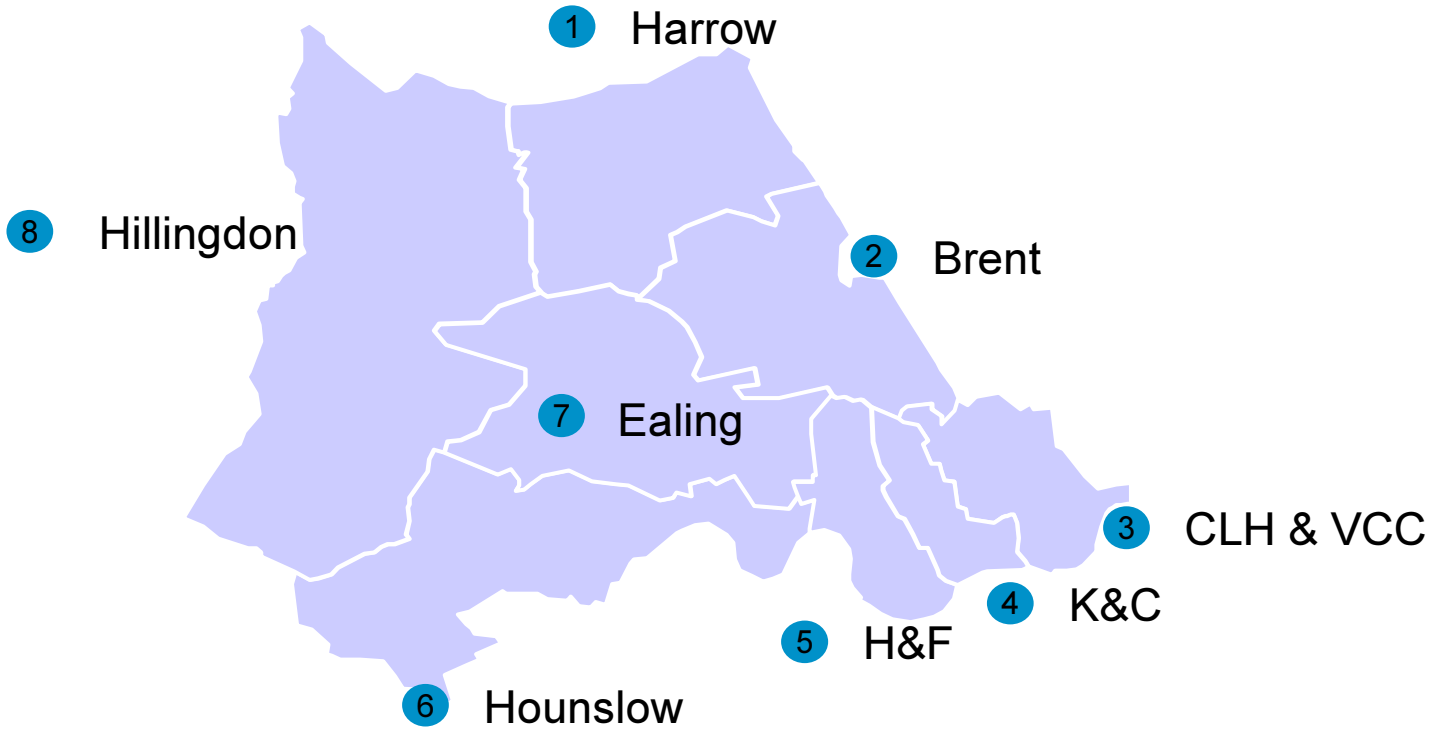
All 8 CCGs have been developing an out-of-hospital strategy

A real plan describing the care that is needed, who does it and where it will take place



CCGs have been investing time to think strategically about what is needed over the next 3 years

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All 8 CCGs have been developing an out-of-hospital strategy

A real plan describing the care that is needed, who does it and where it will take place

Vision beyond 12/13- Agreed goal, key themes, initiatives

15+ CCG Workshops - to develop and engage

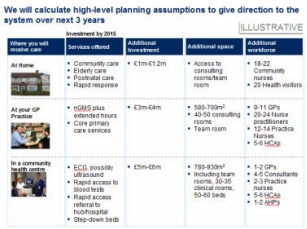
We have already started thinking about our vision for care closer to home….

We are committed to deliver care at the right time across integrated care pathways, which coordinate the health, social, community and voluntary sectors. We will put our patients at the *centre* and *develop a* system that delivers recovery-focused patient outcomes

New initiatives to get there – rapid response, MDTs, redesign of pathways, telehealth

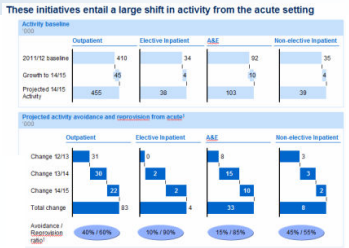
Engaging providers & stakeholders – Out-of-hospital working group

Organising care – how to coordinate care around the patient



Key enablers – Described the governance, IT, incentives needed to drive change

Quantifying investment – What workforce is needed, what estates



New ways of working – Smarter working not more of the same, new roles (Care co-ordinators, hybrid workers)

Set standards – Commitment to higher standards of care

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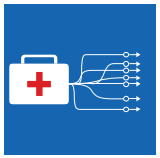
What stage are we at now?

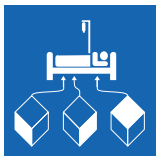
Key themes are emerging from each CCG's out-of-hospital strategy

Easy access to **high quality, responsive care** to make out of hospital care first point of call for people

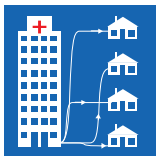


Clearly understood planned care pathways that ensure out-of-hospital care is not delivered in a hospital setting

Rapid response to urgent needs so fewer people need to access hospital emergency care



Providers working together, with the patient at the centre to proactively manage **LTCs, the elderly and end of life care** out-of-hospital



Appropriate time in hospital when admitted, with **early supported discharge** into well organised community care

Out-of-hospital quality standards

The quality standards underpin each of the five themes

Individual Empowerment & Self Care	Individuals will be provided with up-to-date, evidence-based and accessible information to support them in taking personal responsibility when making decisions about their own health, care and wellbeing
Access, Convenience & Responsiveness	Out-of-hospital care operates as a seven day a week service. Community health and care services will be accessible, understandable, effective and tailored to meet local needs. Service access arrangements will include face-to-face, telephone, email, SMS texting and video consultation.
Care Planning & Multi-Disciplinary Care Delivery	Individuals using community health and care will experience coordinated, seamless and integrated services using evidence-based care pathways, case management and personalised care planning. Effective care planning and preventative care will anticipate and avoid deterioration of conditions
Information & Communication	With an individual's consent, relevant parts of their health and social care record will be shared between care providers. Monitoring will identify any changing needs so that care plans can be reviewed and updated by agreement. By 2015, all patients will have online access to their health records

What opportunities are there to improve integrated working?

A year in the life…

Date	Type	GP	Contact from	Notes
18/11/2010	Letter	GP 5	Haematology	OP letter - vomiting - on lots of meds? Rv 4/12
22/11/2010	Phone	GP 6	Patient	Med req - for visit
01/12/2010	Home visit	GP 5	Patient	No reply re-booked for 08.12.11
08/12/2010	Home visit	GP 3	Patient	Pain control, bloods taken
09/12/2010	Letter	GP 3	Patient	tci for bloods and flu jab
15/12/2010	Home Visit	GP 3	Patient	Nausea; metaclopramide changed to domperidone
22/12/2010	Phone	GP 6	Patient	Pain control - increase tramadol
17/02/2011	Consultation	GP 2	Patient	Dosset box has old dose of tramadol
16/03/2011	Phone	GP 6	Acute	OGD report - gastritis
18/03/2011	Letter	GP 2	Acute	CT head report - nil new
21/03/2011	Phone	GP 1	Discharge Team	Request discharge summary
21/03/2011	Letter	GP 2	Patient	Med request; meds not as per discharge
23/03/2011	fax	GP 4	Patient	Medication clarification
05/04/2011	Phone	GP 1	Care Agency	Unable to contact patient
12/04/2011	Phone	GP 5	Acute	Discharge summary 30.03-11.04 - abdo pain N&V
14/04/2011	Letter	GP 5	Acute	correct dose prednisolone
30/04/2011	Letter	GP 4	Patient	re medication review
09/05/2011	Letter	GP 4	A&E	Abdo pain
12/05/2011	Letter	GP 4	CARS	Hx mechanical falls - assess safe mobility
16/06/2011	Phone	GP 1	Patient	Gastritis - increase omeprazole
22/06/2011	Home visit	GP 2	Patient	advice re N&V management
26/06/2011	Home visit	GP 2	Patient	ongoing stomach problems
26/06/2011	Letter	GP 4	Patient	re carer's credit
06/07/2011	Letter	GP 1	Rehab	referred 11.05.11 assessed 11.06.11 discharged 17.06.07
09/08/2011	Phone	GP 6	Social Care	returning call from support worker - no answer - no answerphone
17/08/2011	Letter	GP 6	Patient	Flu letter invitation
11/09/2011	Letter	GP 5	A&E	Fall
12/09/2011	Letter	GP 3	Patient	Medication request
13/10/2011	Phone	GP 3	Patient	phonecall attempted
14/10/2011	Home visit	GP 1	Patient	constipation - abdo pain - ? Uti
14/10/2011	Phone	GP 3	Social Care	Dysuria - req home visit
16/10/2011	Letter	GP 6	A&E	attended with abdo pain
16/10/2011	Home visit	GP 6	Patient	Abdo pain ? Prostatis
19/10/2011	Letter	GP 3	DN	constipation - urgent referral
19/10/2011	Phone	GP 3	Patient	consitpation
31/10/2011	Home visit	GP 2	Patient	Abdo pain (phone 1 week)
03/11/2011	Letter	GP 4	Haematology	req review
07/11/2011	Letter	GP 4	H@H	report of referral from DN to H@H - constipation
07/11/2011	Letter	GP 1	DN	flu immunisation notification
07/11/2011	Phone	GP 5	H@H	Concerns re med compliance
07/11/2011	Phone	GP 4	Patient	patient not heard from DNs - (will chase)
09/11/2011	Consultation	GP 2	H@H	Medication review
11/11/2011	Letter	GP 4	Rehab	Discharge from community rehab - patient unwell
14/11/2011	Phone	GP 3	H@H	Fall-accidental at night
14/11/2011	Phone	GP 6	Patient	Attempted - no reply
15/11/2011	Phone	GP 2	H@H	Pt admitted CXH - abdo pain

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15/11/2011	H@H	Pt admitted CXH - abdo pain

What opportunities are there to improve integrated working?

A year in the life…

What are the opportunities?	Relevant quality standards
• There were **9 different agencies** involved in the patient's care	
• **Information flow was poor**; better information might have prevented the first admission	→ Information & Communications
• **A delay in service provision** led to the second admission	→ Access, Convenience & Responsiveness
• There were 6 different GPs involved, but **no care plan**	→ Care Planning & Multi-Disciplinary Care Delivery
• **Lack of patient empowerment** throughout	→ Individual Empowerment & Self Care

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Responding to the challenge

The integrated care pilot is an important first step towards improving out of hospital care

The ICP changes the way that healthcare is provided in an out of hospital setting

1. Patient registry
2. Risk stratification
3. Care pathways
4. Work planning
5. Care delivery
6. Case conference
7. Performance review

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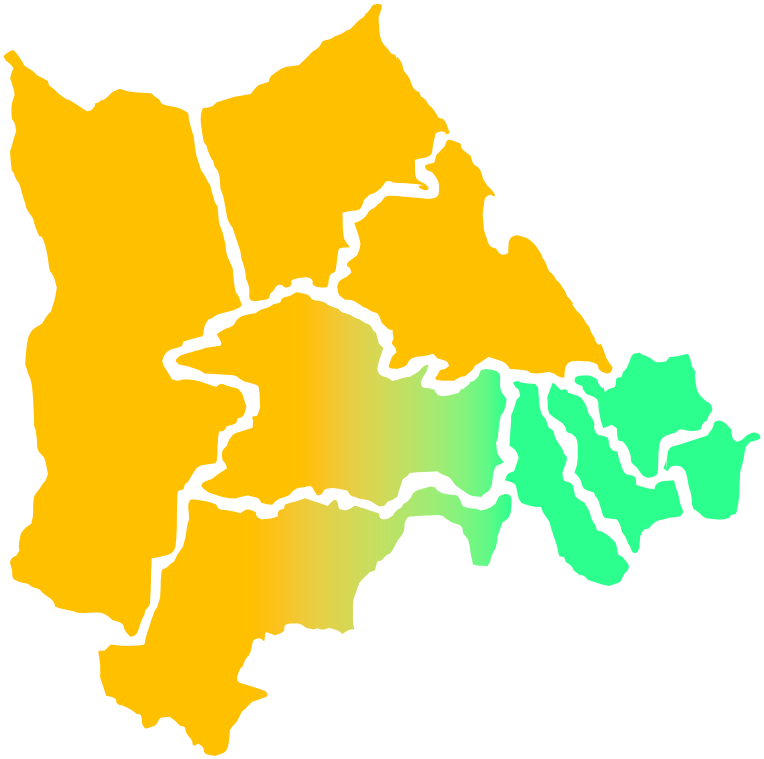
Inner NWL ICP is already operational; Outer NWL is due to commence soon



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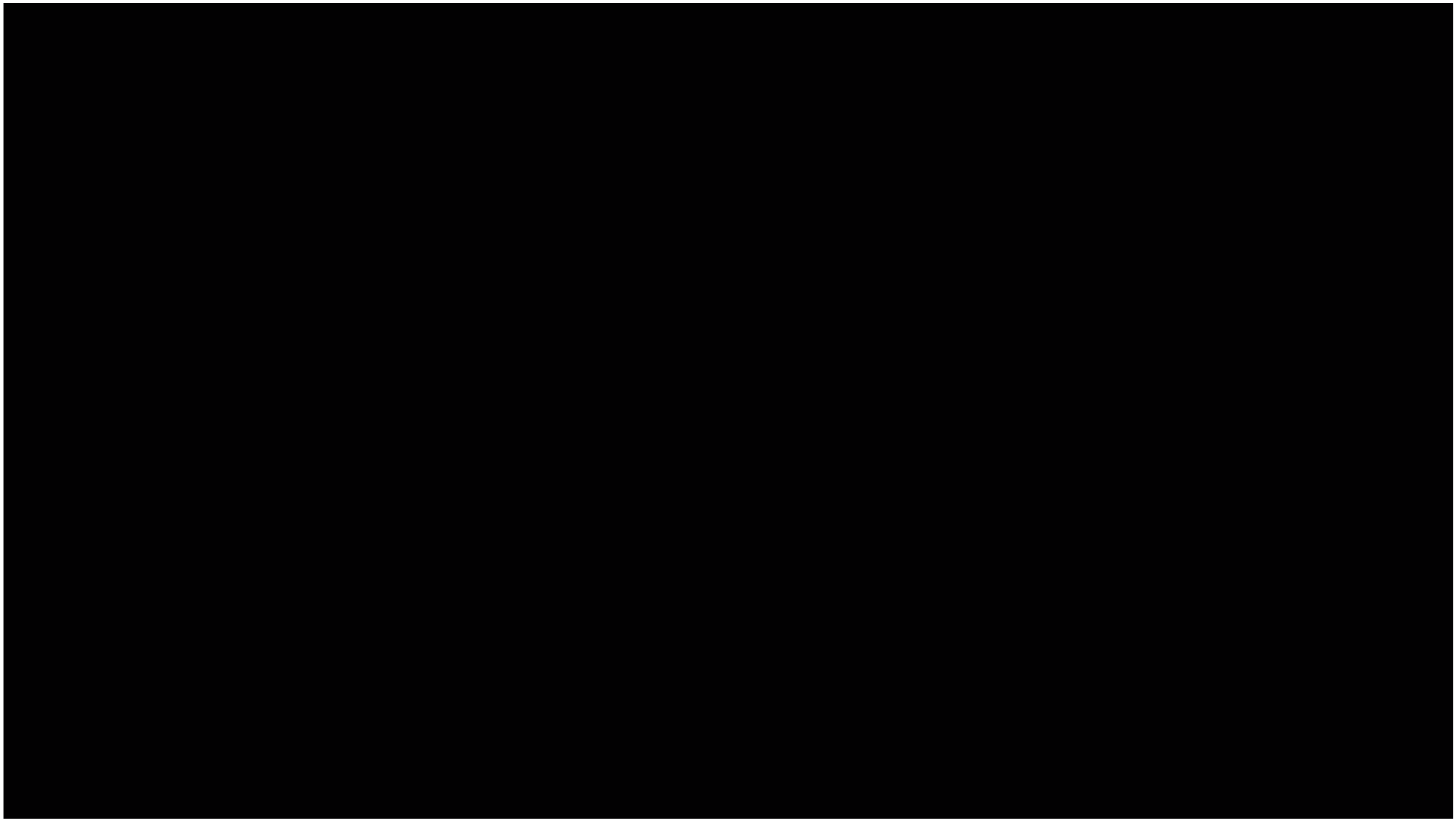
Responding to the challenge

The integrated care pilot is an important first step towards improving out-of-hospital care



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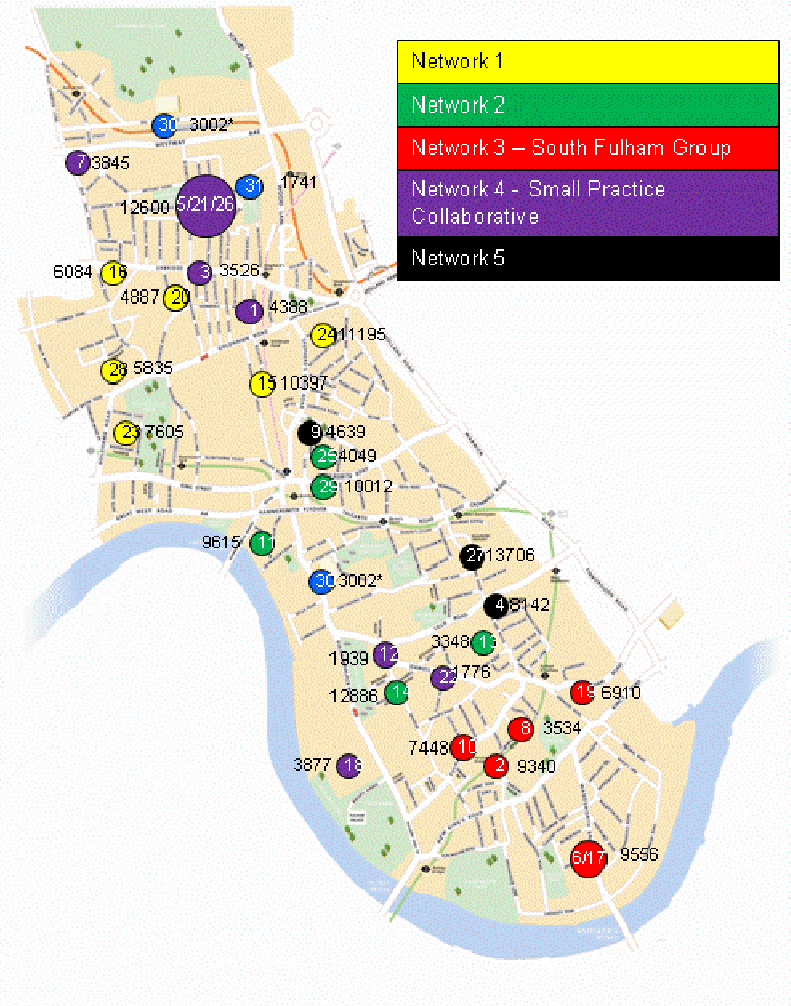
‘Whole systems’ integrated care

Provider networks offer a new way of organising out-of-hospital care

Primary Care networks are already a reality in many parts of NWL



- Integrated care will be delivered within networks of practices, serving patient populations
- 5 networks
- Networks will have a role in both **commissioning** and **provision** of care
- Each network will have one integrated health and social care team aligned to network
- These teams will be physically based in a ‘centralised’ network location

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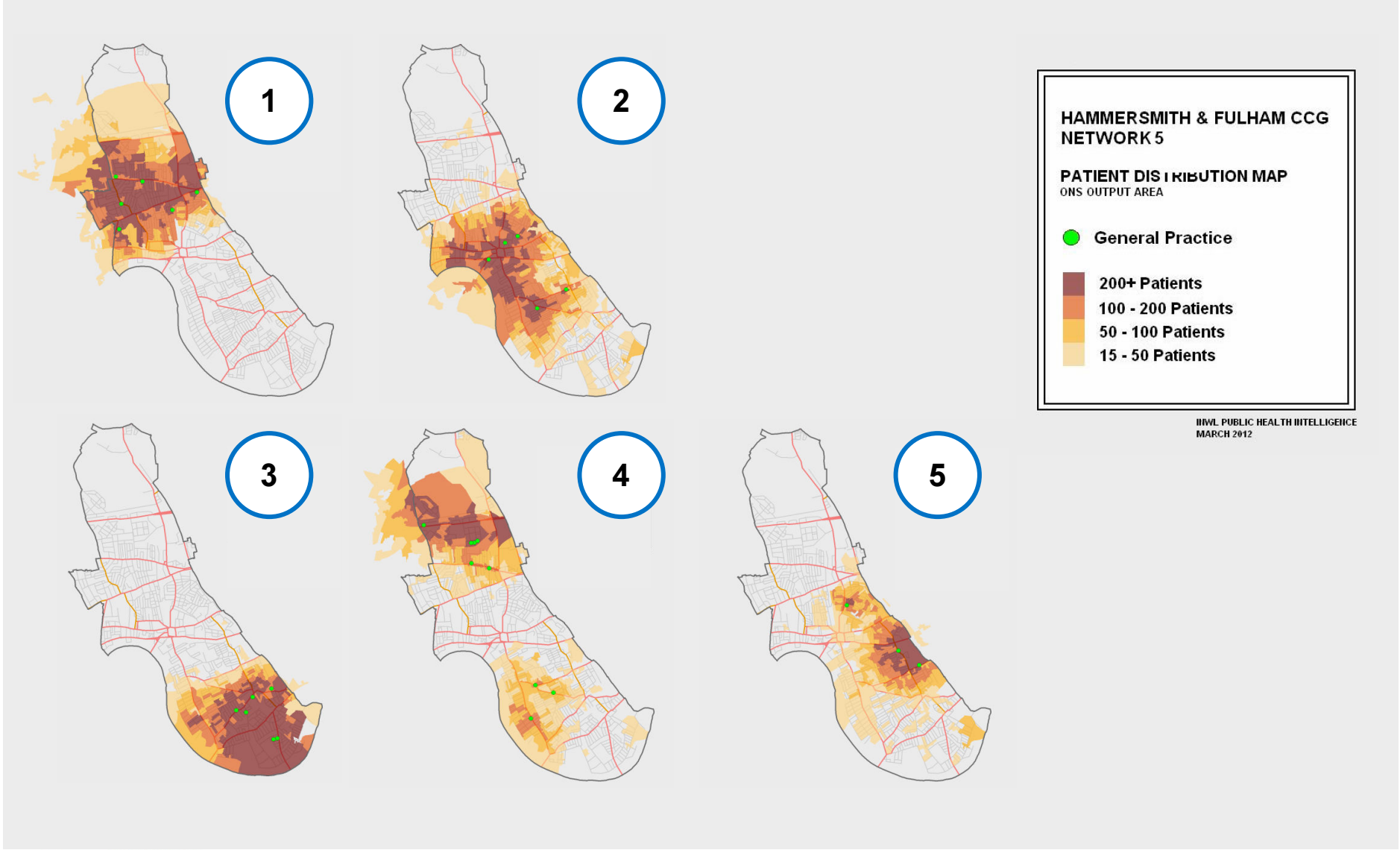
‘Whole systems’ integrated care

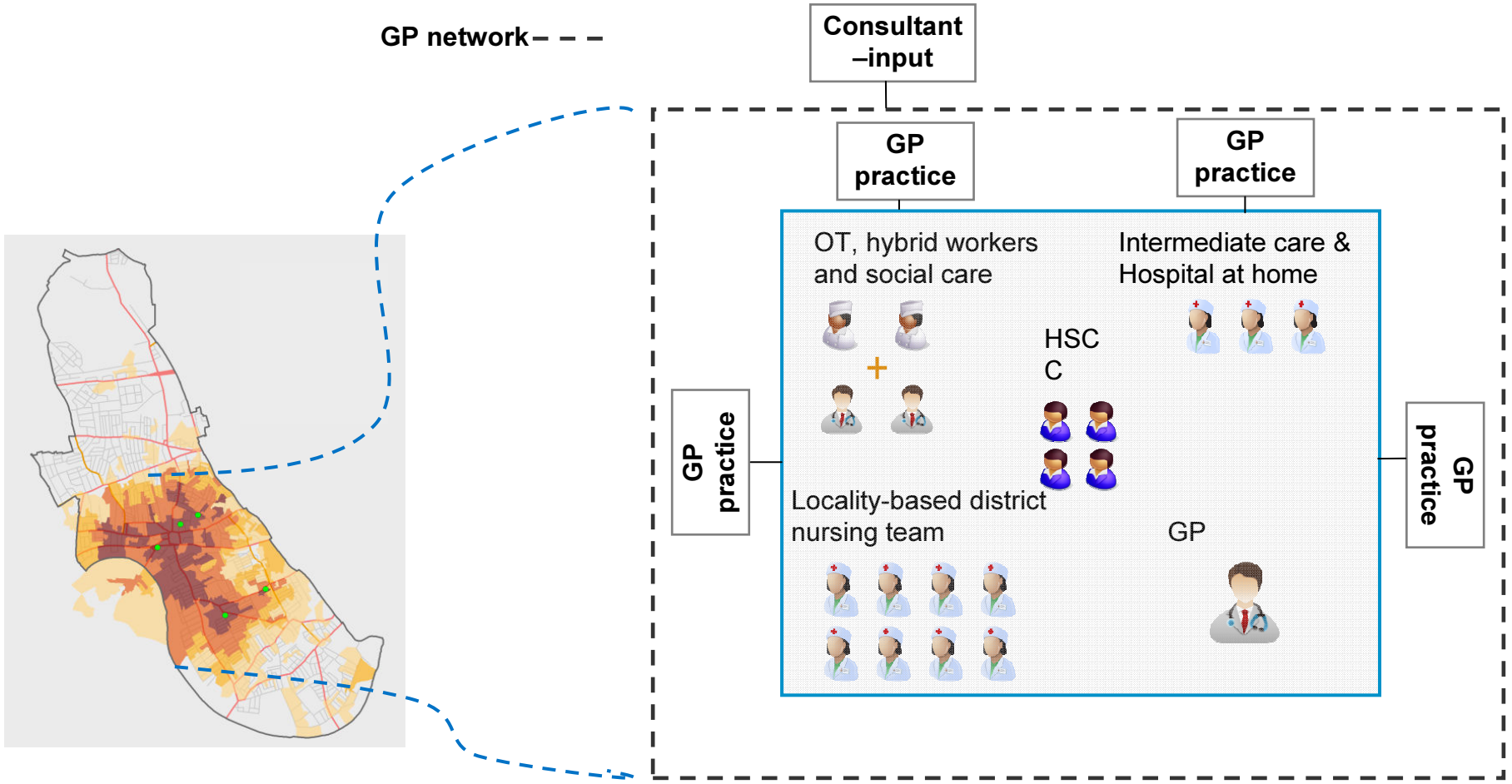
Provider networks offer a new way of organising out-of-hospital care

Networks support patients in a locality by coordinating their care more effectively



A ‘whole systems’ approach to integrated care in networks

Community services will be reorganised to work directly with networks



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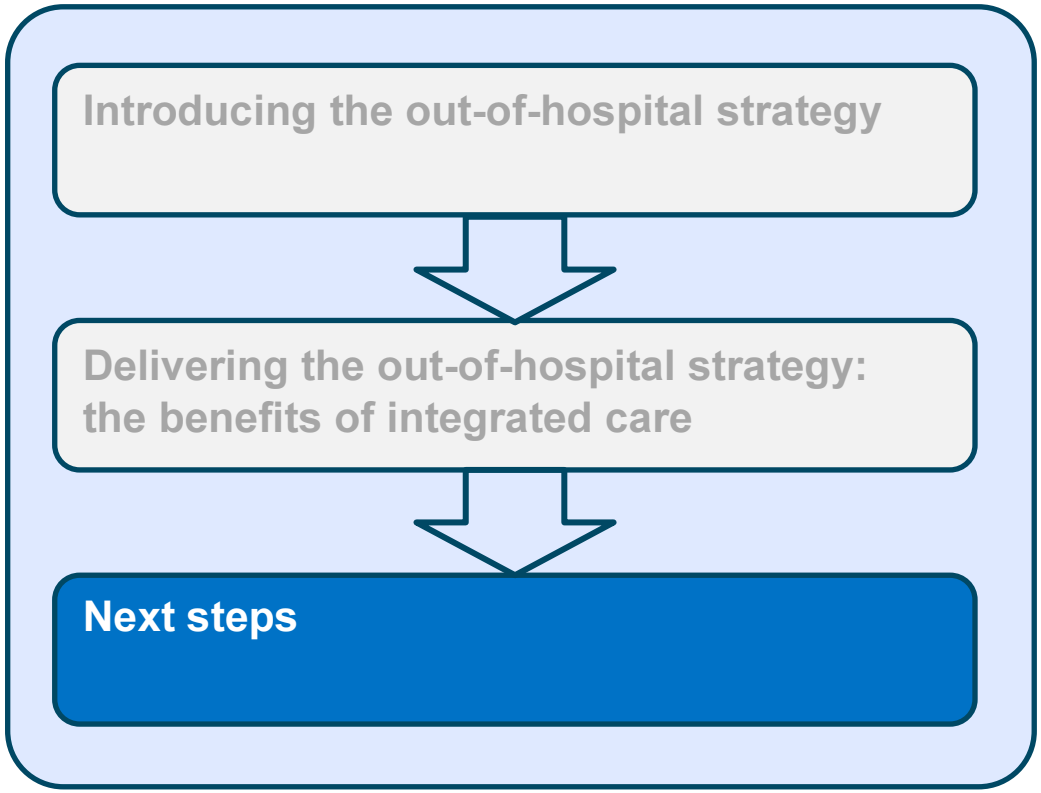
Delivering the out-of-hospital strategy



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All 8 CCGs will complete their out-of-hospital strategies in April

Vision beyond 12/13- Agreed goal, key themes, initiatives

Ongoing engagement plans

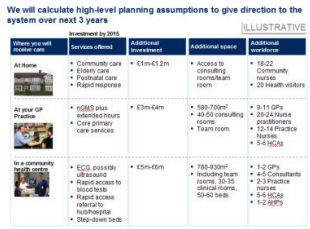
We have already started thinking about our vision for care closer to home….

We are committed to deliver care at the right time across integrated care pathways, which coordinate the health, social, community and voluntary sectors. We will put our patients at the *centre* and *develop a* system that delivers recovery-focused patient outcomes

Plans to deliver new initiatives

Engaging providers to realise delivery

Organising care – how to coordinate providers around the patient



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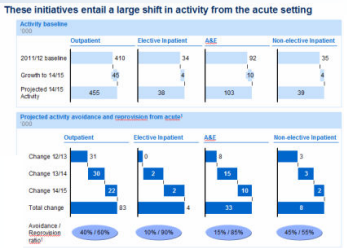

New ways of working – Smarter working not more of the same, new roles (Care co-ordinators, hybrid workers)

Set standards – Commitment to higher standards of care

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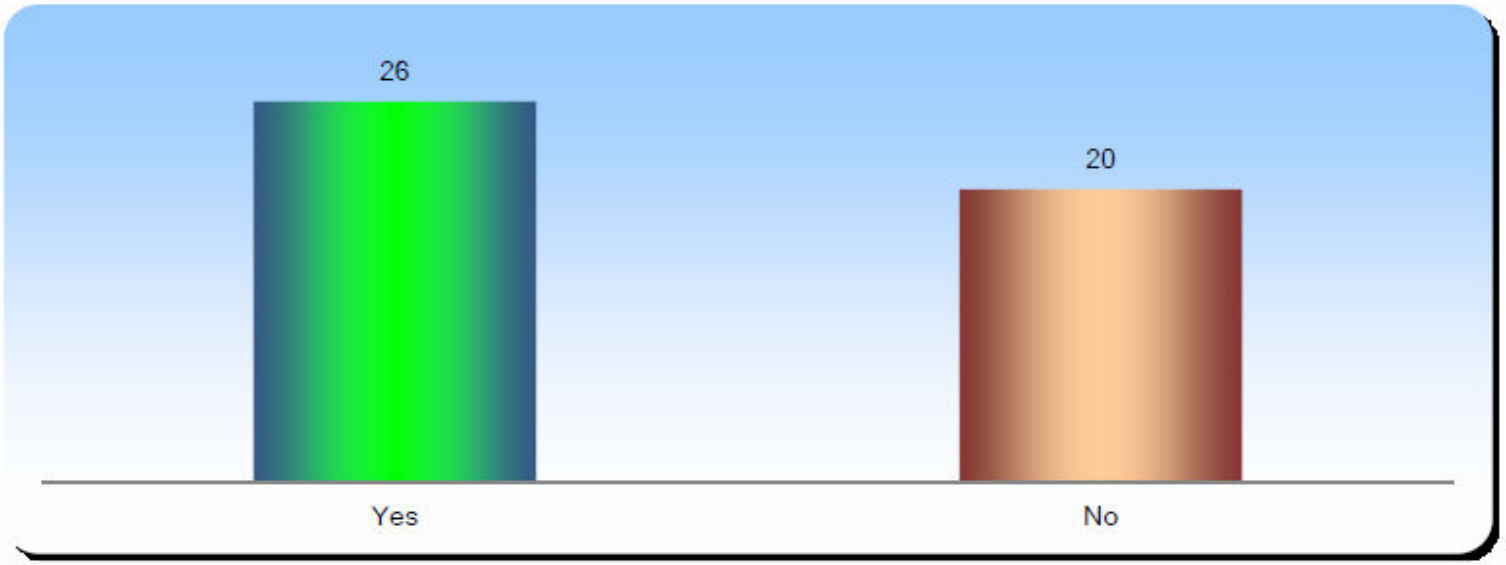
Introduction to feedback system

Gavin Grey

Did you use public transport to get here today?

	Count	Percent
Q1. Did you use public transport to get here today?		
Yes	26	56.52%
No	20	43.48%
	46	100.00%



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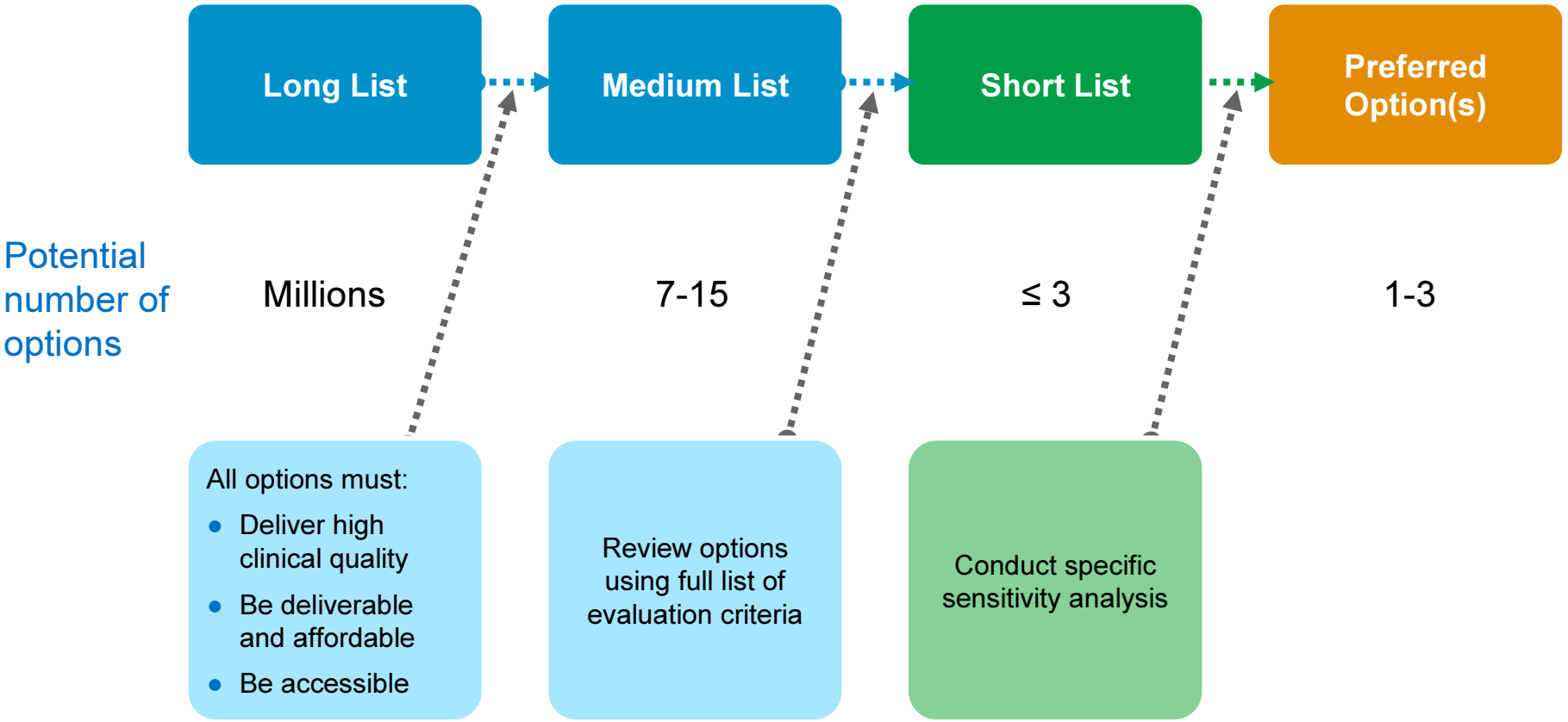
Options development

Dr Mark Spencer

Evaluation process for options



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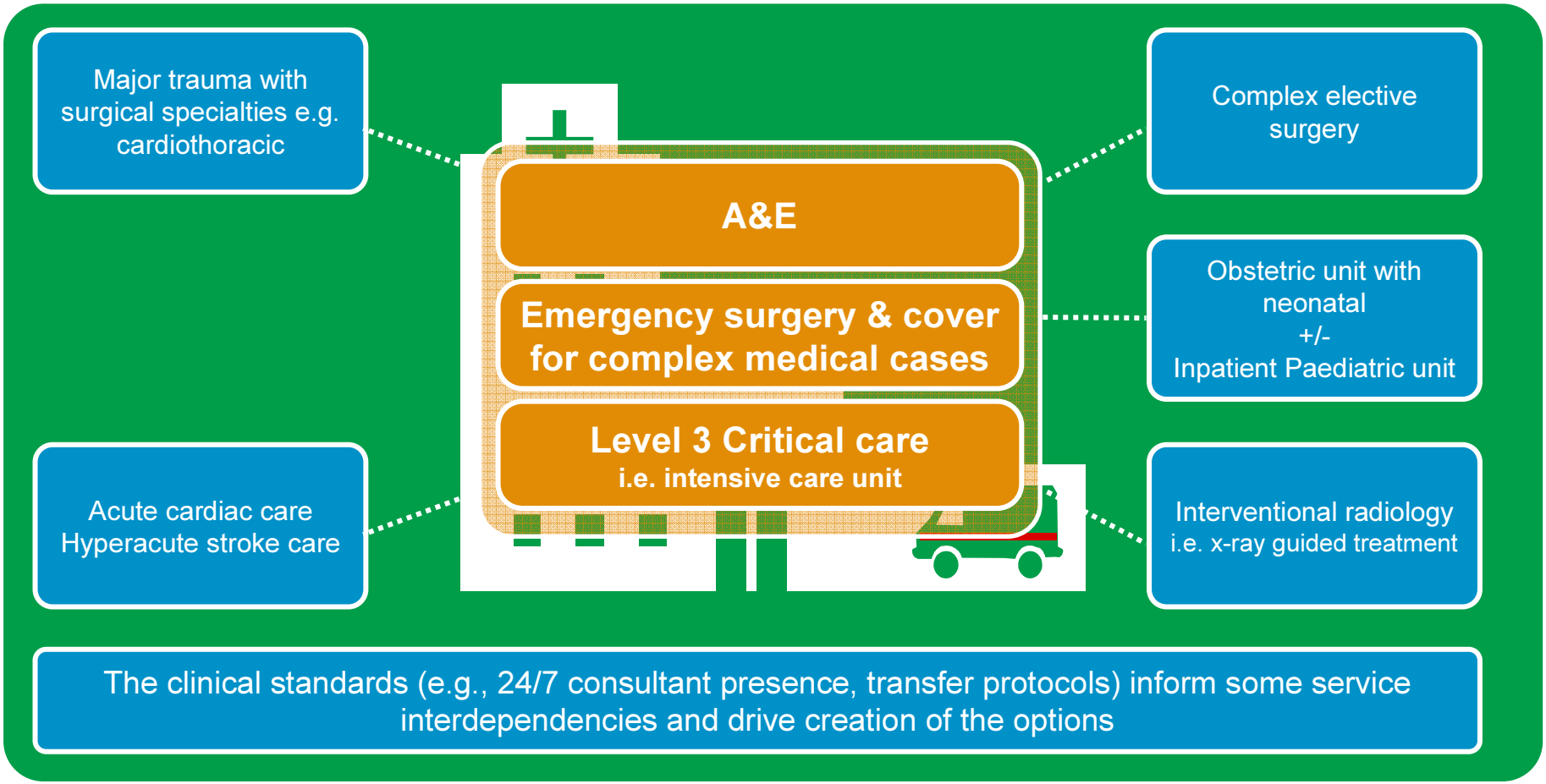
Some services rely on others…



Driver of service model

Adjacent services requiring access to emergency surgery and/or ICU, level 3

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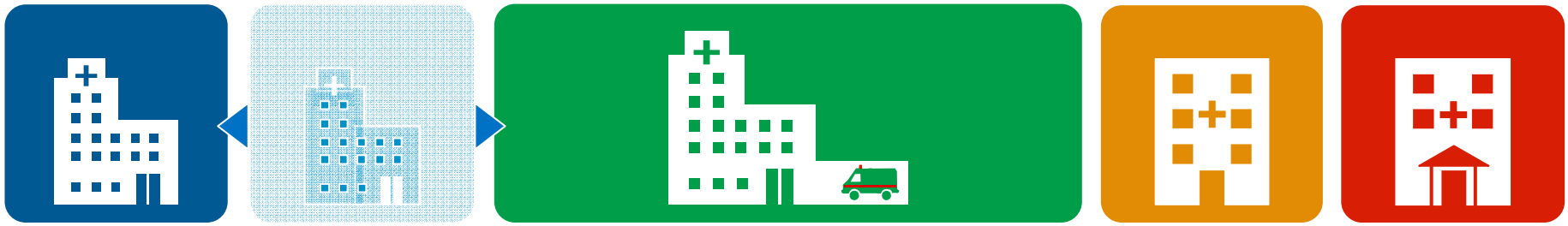
The range of services offered at each type of care centre is different



Local Hospital (SDM1)	Transition State	Major Hospital (SDM3)		Elective Hospital (SDM4)	Specialist Hospital (SDM5)
UCC	UCC/MAU	24/7 A&E	Complex surgery	Elective surgery (including day case)	Examples:
Outpatients & Diagnostics	Outpatients & diagnostics	UCC	Major Trauma Centre	Elective medicine	Cardiothoradic
Rehabilitation	Urgent medicine	Outpatients & diagnostics	Inpatient paediatric	Outpatients & diagnostics	Cancer
Minor trauma	ICU, level 2 + Obstetrics/ Midwifery unit	Urgent surgery	Obstetrics & Midwifery unit	Rehabilitation	Orthopaedics
Midwifery unit	NICU level 1/2	Urgent/complex medicine	Interventional radiology	ITU/HDU	
Minor procedures		ICU, level 3	HASU	UCC	
GP beds		Psychiatric Liaison Service	Acute Cardiac Services		
		Trauma unit	NICU level 2/3		

Essential service Optional service

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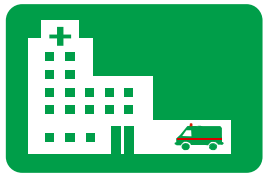
We need to review Major Hospital (SDM3) sites to identify a proposed 'medium list' of reconfiguration options on which to do more detailed analysis, but…

- Out-of-hospital services will be expanded and improved in all areas

- All 9 current sites will retain Local Hospital (SDM1) services, providing c. 75%[1] of all current activity (excluding specialist activity)

- All Specialist Hospitals (SDM5) will remain

- The care provided at Elective Hospitals (SDM4) will continue on the Central Middlesex site



- This presentation is about Major Hospital (SDM3) services

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1 As measured by units of activity (Includes inpatient admissions, outpatients spells and A&E attendances)

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Clinical Board Rationale 1 for selection of medium list

		Number of options
1	• A **major hospital is required** to ensure high quality care	Millions

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Clinical Board Rationale 2 for selection of medium list

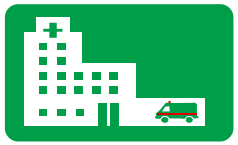
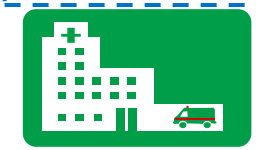
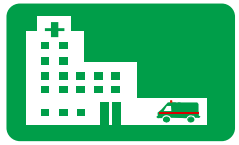
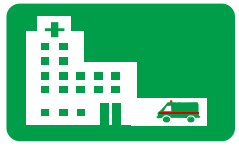
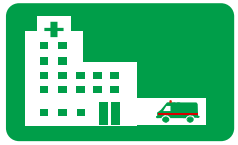
		Number of options
1	• A major hospital is required to ensure high quality care	Millions
2	• Consider the 9 existing major hospital sites only and not **new locations** due to the time required to find and develop a site and to manage the risk of access to capital	**Millions**

Clinical Board Rationale 3 for selection of medium list

		Number of options
1	• A major hospital is required to ensure high quality care	Millions
2	• Consider the 9 existing major hospital sites only and not new locations due to the time required to find and develop a site and to manage the risk of access to capital	Millions
3	• There should be **three to five major hospitals in NW London** to support the population of 1.9m. This is based on; available evidence, patient volumes, effect on the clinical workforce and the fact that some services rely on others and require clinical support. Having more than five major acute hospitals would result in unsustainable clinical rotas.	336

Rationale 3 supporting example

The Programme and Clinical Boards recommend that only options with three to five Major Hospitals should be considered

	Min. required emergency surgeons for rota cover	Implied catchment
 x 9 current	▪ 45 current	▪ 238,000
 x 6	▪ c. 62 WTE	▪ 317,000
 x 5	▪ c. 50 WTE	▪ 380,000
 x 4	▪ c. 40 WTE	▪ 475,000
 x 3	▪ c.30 WTE	▪ 630,000

"National shortages of some clinical staff groups, such as paediatricians, midwives, radiologists and pathologists, due to the numbers of individuals currently entering training, are expected to continue in the future.

Even if there were more suitably trained staff in place, they would quickly begin to lose their skills as they would not be seeing sufficient volumes of patients."

- Case for Change

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Rationale 3 supporting example

Several sites have low levels of emergency surgeons and not all are able to conduct laparoscopic procedures

	Total number of emergency surgeons	% laparoscopic trained
Northwick Park	12	83%
Chelsea and Westminster	9	89%
*	7	100%
*	6	100%
*	6	33%
*	5	100%
NWL Total (Average)	**45 (7.5)**	**84%**

Clinical Board Rationale 4 for selection of medium list

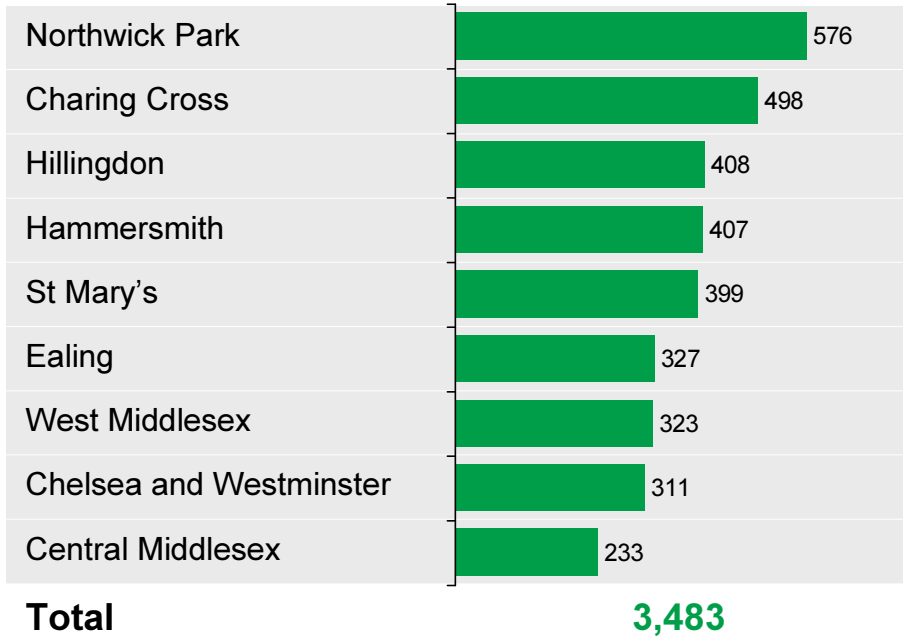
		Number of options
1	• A major hospital is required to ensure high quality care	Millions
2	• Consider the 9 existing major hospital sites only and not new locations due to the time required to find and develop a site and to manage the risk of access to capital	Millions
3	• There should be three to five major hospitals in NW London to support the population of 1.9m. This is based on; available evidence, patient volumes, effect on the clinical workforce and the fact that some services rely on others and require clinical support. Having more than five major acute hospitals would result in unsustainable clinical rotas.	336
4	• **Only options that have five major hospitals are viable** in the medium term. Moving to three or four sites would cause major disruption to existing services which could affect the consistent delivery of high quality services. It would also require transferring a large number of services simultaneously across the region increasing the likelihood of: – A long implementation timeframe (~7+ years) and period of change – A large investment to develop infrastructure on some sites during a period when access to capital investment is severely constrained	126

Rationale 4 supporting example

No sites currently have the capacity to deliver the volume of activity needed in a model with less than five major hospitals

No. of beds needed per major hospital if there are five or less in the area:	
Three major hospitals	~ 800-1000
Four major hospitals	~ 600-700
Five major hospitals	~ 500-600

Current Bed Capacity, No. of beds



Note: There may also be SDM5 (specialist) and SDM4 (elective) sites so therefore the change in total bed base across the sector cannot be calculated using only these numbers

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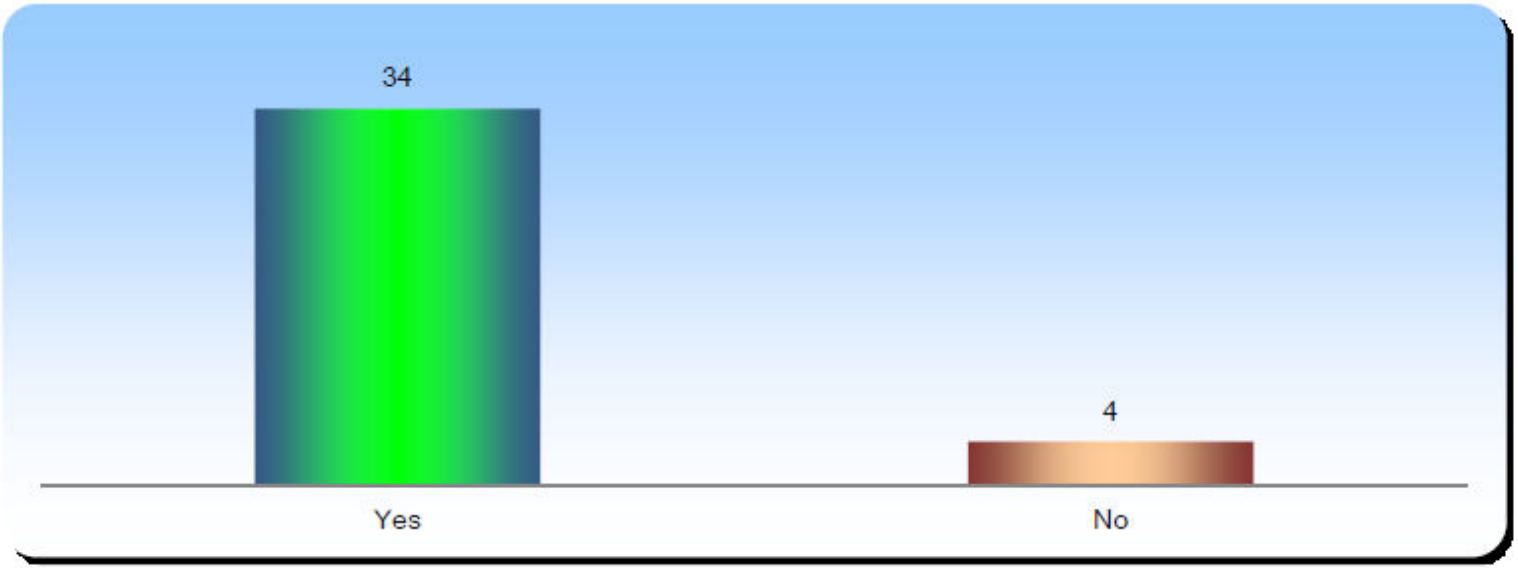
FEEDBACK

Have you understood the process we have described so far?

Q2. Have you understood the process we have described so far?		
Yes	34	89.47%
No	4	10.53%
	38	100.00%



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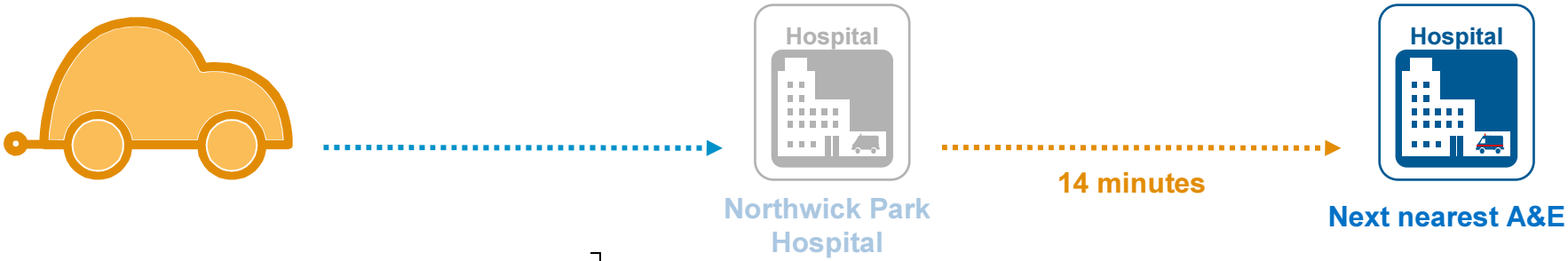
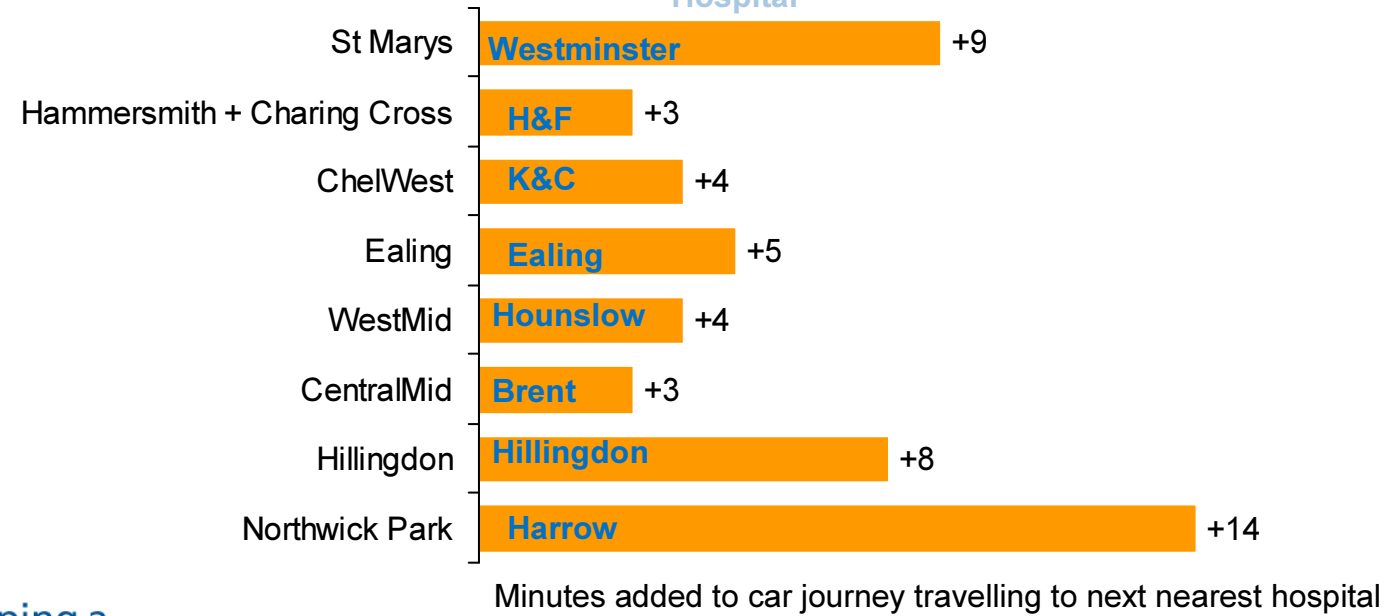
Clinical Board Rationale 5 for selection of medium list

		Number of options
1	• A major hospital is required to ensure high quality care	Millions
2	• Consider the 9 existing major hospital sites only and not new locations due to the time required to find and develop a site and to manage the risk of access to capital	Millions
3	• There should be three to five major hospitals in NW London to support the population of 1.9m. This is based on; available evidence, patient volumes, effect on the clinical workforce and the fact that some services rely on others and require clinical support. Having more than five major acute hospitals would result in unsustainable clinical rotas.	336
4	• Only options that have five major hospitals are viable in the medium term. Moving to three or four sites would cause major disruption to existing services which could affect the consistent delivery of high quality services. It would also require transferring a large number of services simultaneously across the region increasing the likelihood of: • A long implementation timeframe (~7+ years) and period of change • A large investment to develop infrastructure on some sites during a period when access to capital investment is severely constrained	126
5	• To minimise impact on access, the Clinical Board proposes that **Northwick Park and Hillingdon should be major hospitals** in all options because they are geographically remote	35

Rationale 5 supporting example

Impact on average borough car travel times (peak) when A&E destination is changed





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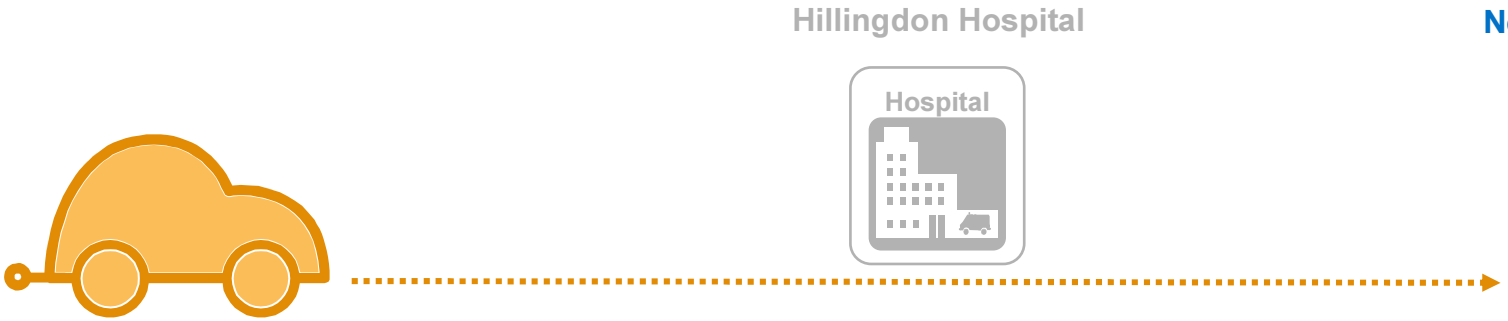
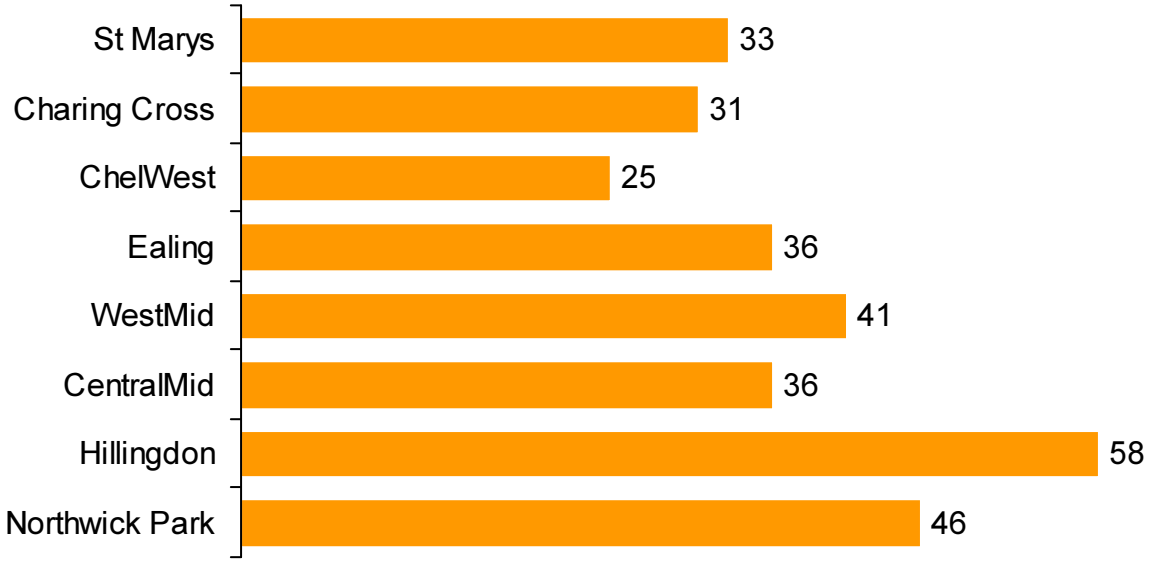
Rationale 5 supporting example

Impact on maximum borough car travel times (peak) when A&E destination is changed





Maximum car journey time travelling to next nearest hospital

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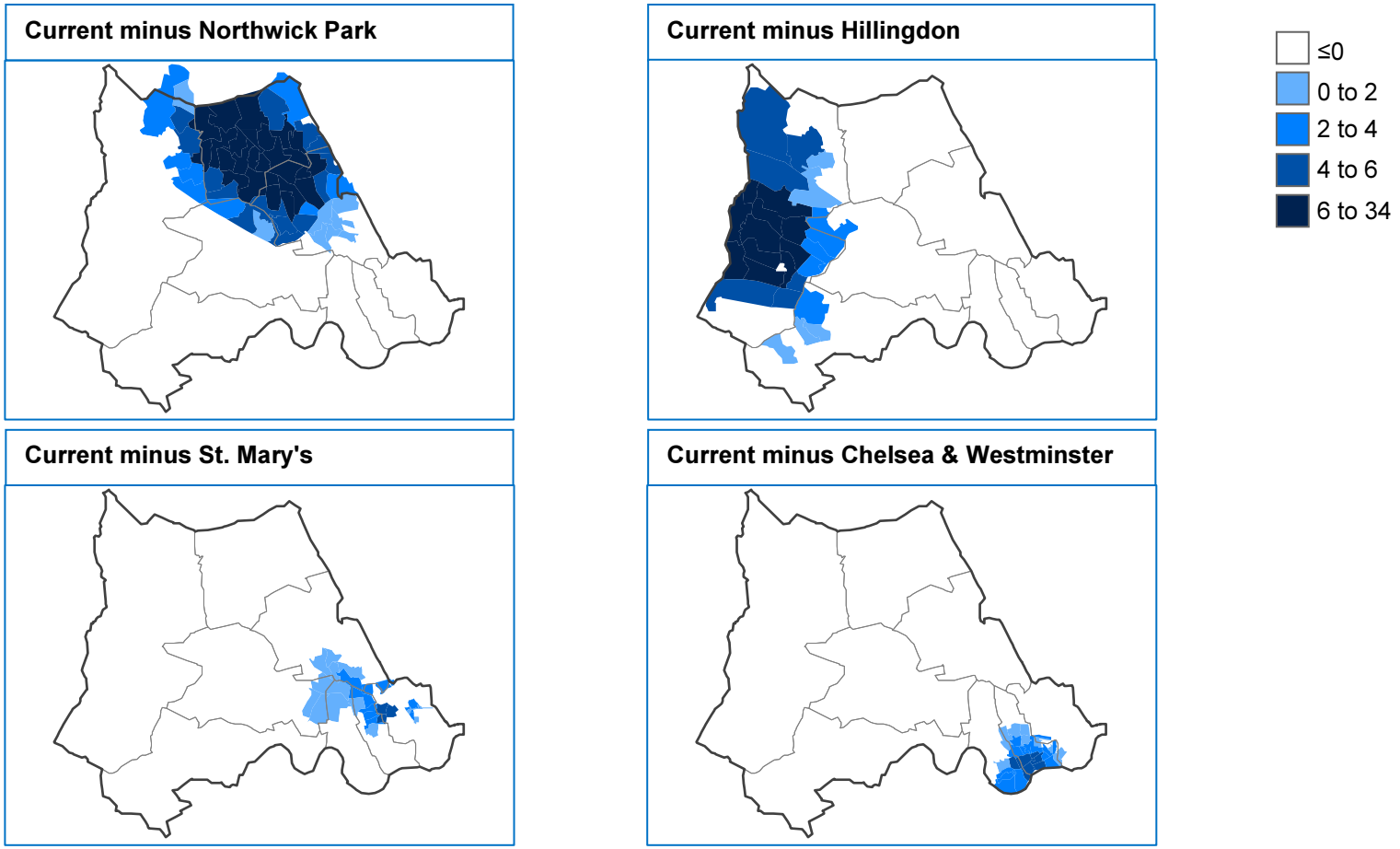
Rationale 5 supporting example

Impact on blue light travel times in each borough when A&E destination is changed



Absolute change in Blue Light travel time vs. current configuration (mins)

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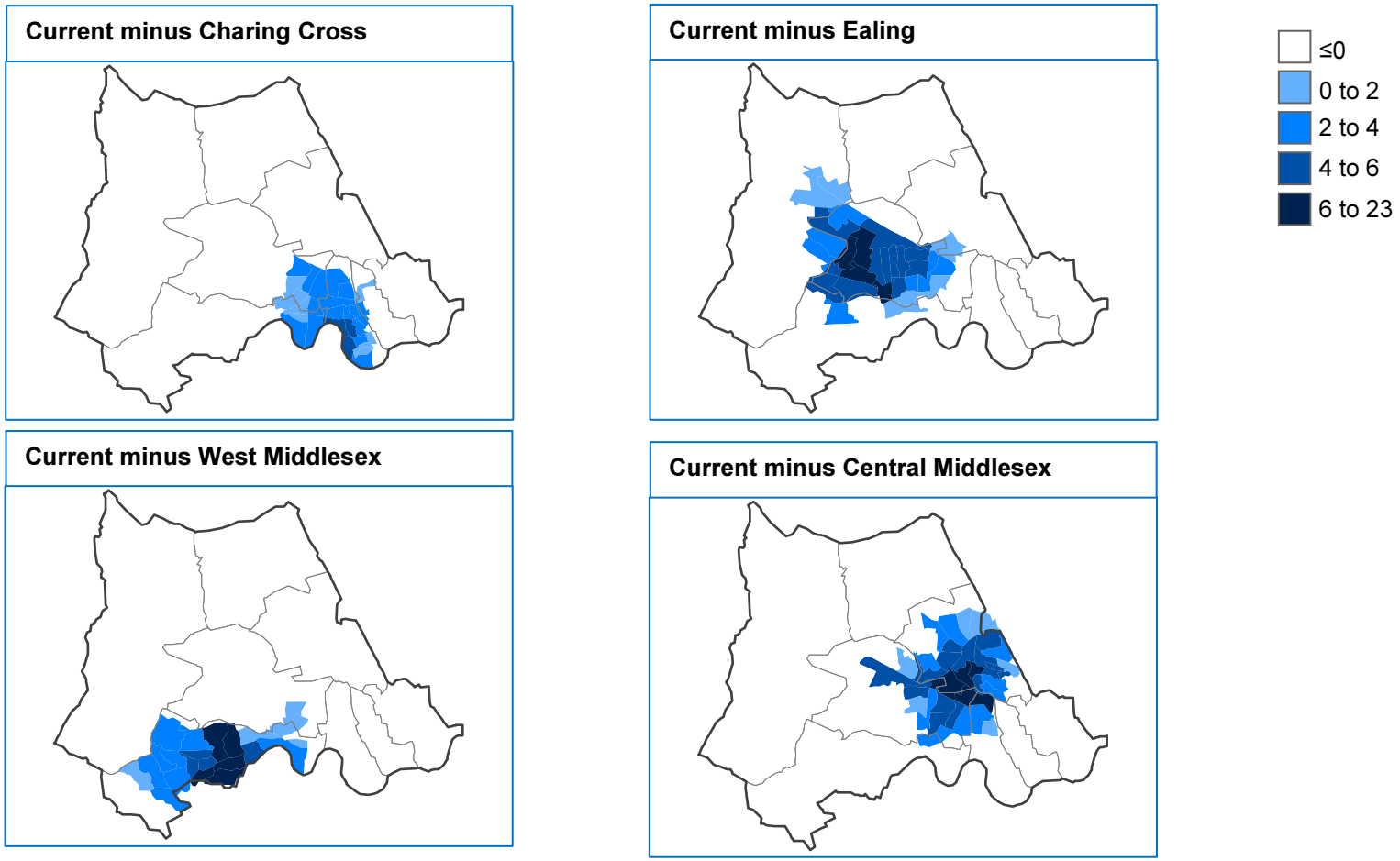
Rationale 5 supporting example

Impact on blue light travel times in each borough when A&E destination is changed



Absolute change in Blue Light travel time vs. current configuration (mins)

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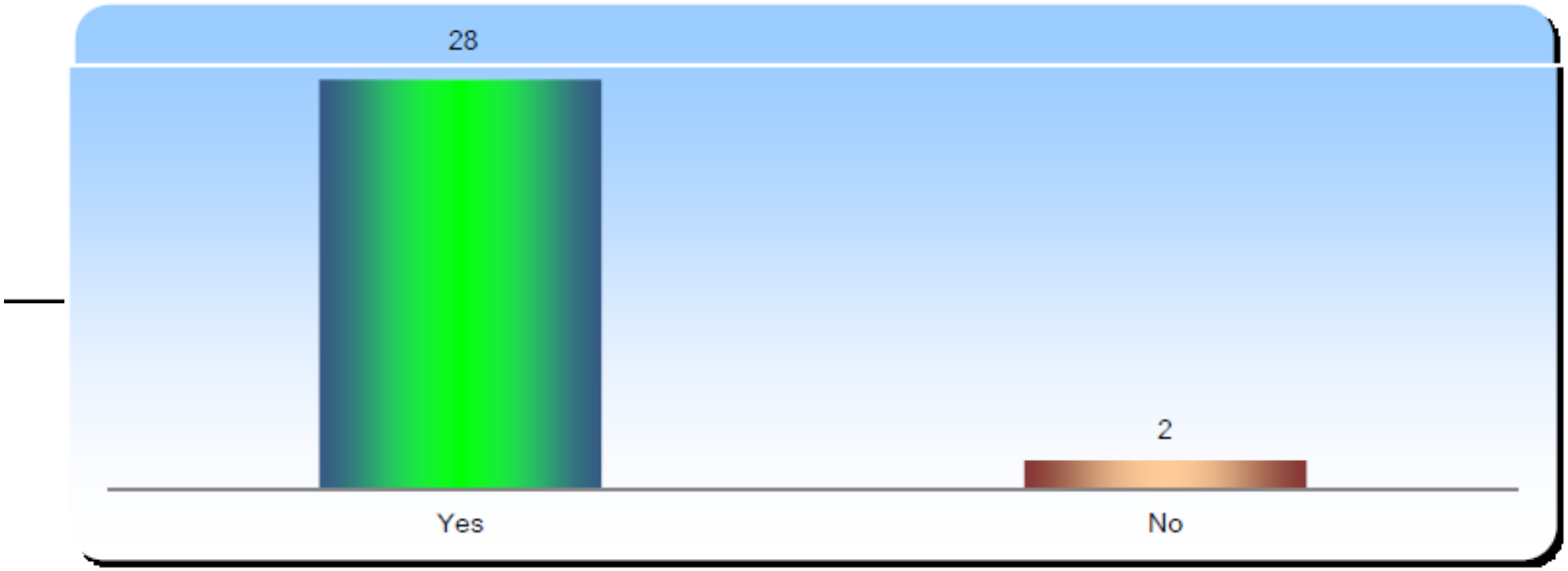
Have you understood the process we have described so far?

Q3. Have you understood the process we have described so far?		
Yes	28	93.33%
No	2	6.67%
	30	100.00%



Clinical Board Rationale 6 for selection of medium list

		Number of options
1	• A major hospital is required to ensure high quality care	Millions
2	• Consider the 9 existing major hospital sites only and not new locations due to the time required to find and develop a site and to manage the risk of access to capital	Millions
3	• There should be three to five major hospitals in NW London to support the population of 1.9m. This is based on; available evidence, patient volumes, effect on the clinical workforce and the fact that some services rely on others and require clinical support. Having more than five major acute hospitals would result in unsustainable clinical rotas.	336
4	• Only options that have five major hospitals are viable in the medium term. Moving to three or four sites would cause major disruption to existing services which could affect the consistent delivery of high quality services. It would also require transferring a large number of services simultaneously across the region increasing the likelihood of: • A long implementation timeframe (~7+ years) and period of change • A large investment to develop infrastructure on some sites during a period when access to capital investment is severely constrained	126
5	• To minimise impact on access, the Clinical Board proposes that Northwick Park and Hillingdon should be major hospitals in all options because they are geographically remote	35
6	• **Central Middlesex should not be considered for a major hospital site** because several services that would be required are already not delivered there and it would require the largest expansion of any site as it is the smallest of the nine acute sites in NW London	20

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Clinical Board Rationale 7 for selection of medium list

		Number of options
1	• A major hospital is required to ensure high quality care	Millions
2	• Consider the 9 existing major hospital sites only and not new locations due to the time required to find and develop a site and to manage the risk of access to capital	Millions
3	• There should be three to five major hospitals in NW London to support the population of 1.9m. This is based on; available evidence, patient volumes, effect on the clinical workforce and the fact that some services rely on others and require clinical support. Having more than five major acute hospitals would result in unsustainable clinical rotas.	336
4	• Only options that have five major hospitals are viable in the medium term. Moving to three or four sites would cause major disruption to existing services which could affect the consistent delivery of high quality services. It would also require transferring a large number of services simultaneously across the region increasing the likelihood of: • A long implementation timeframe (~7+ years) and period of change • A large investment to develop infrastructure on some sites during a period when access to capital investment is severely constrained	126
5	• To minimise impact on access, the Clinical Board proposes that Northwick Park and Hillingdon should be major hospitals in all	35
6		
7	• The Clinical Board proposes **geographic distribution of the remaining three major hospitals** to minimise the impact of changes on local borough residents. – Either Hammersmith or St Mary's – Either Ealing or West Middlesex – Either Charing Cross or Chelsea & Westminster	8

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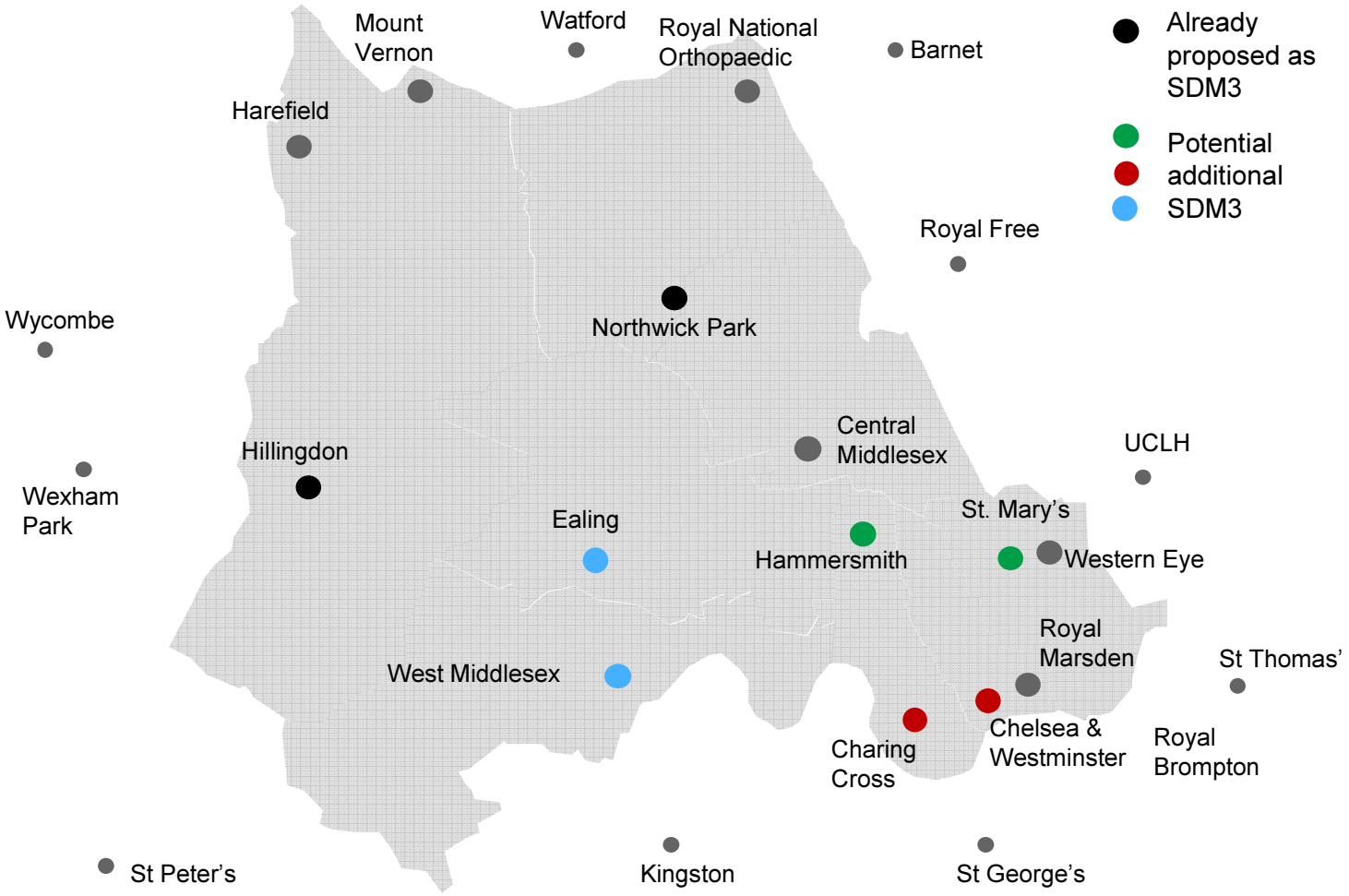
Rationale 7 supporting example



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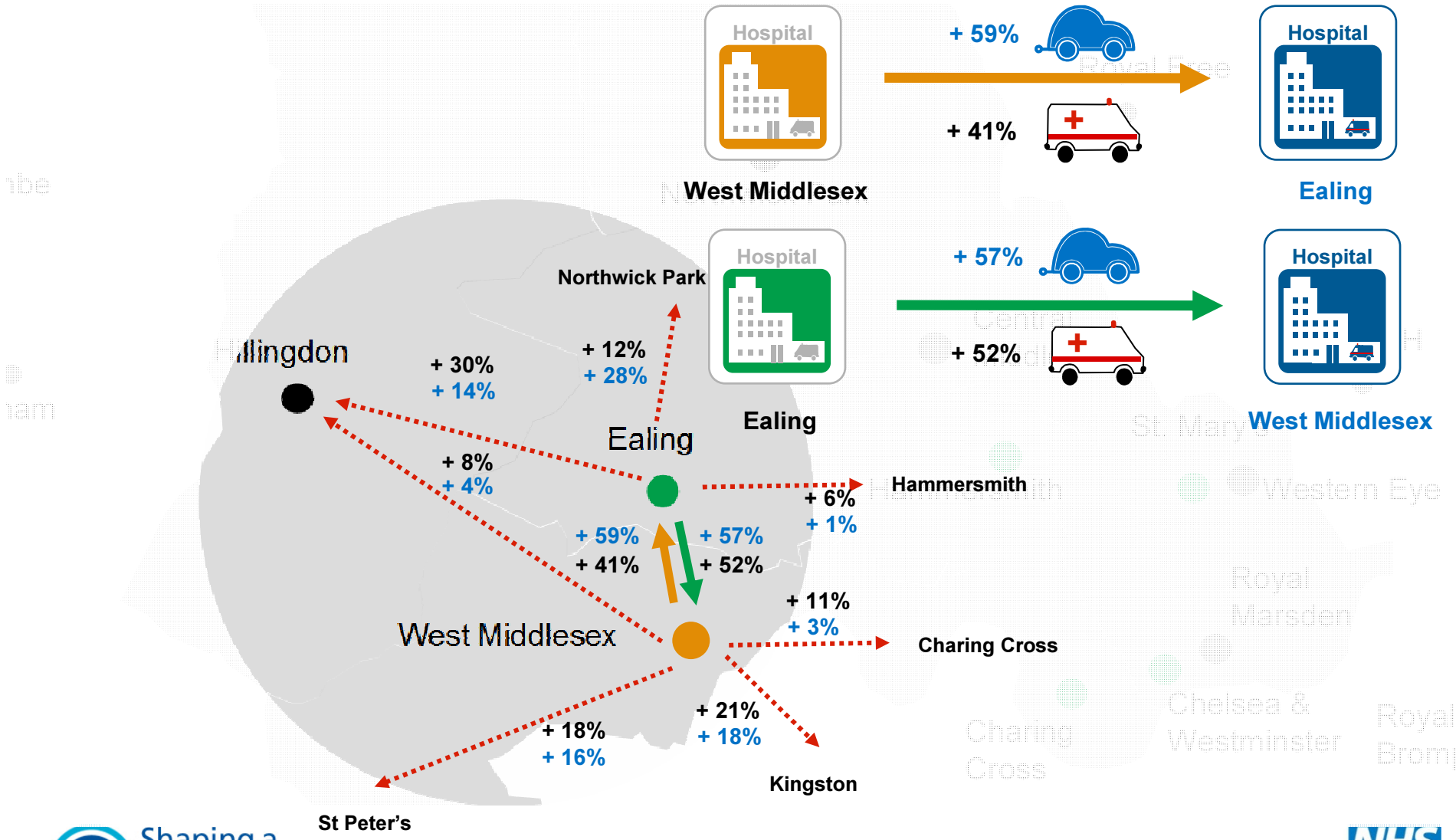
Rationale 7 supporting example

Patient/ travel flows between key hospitals



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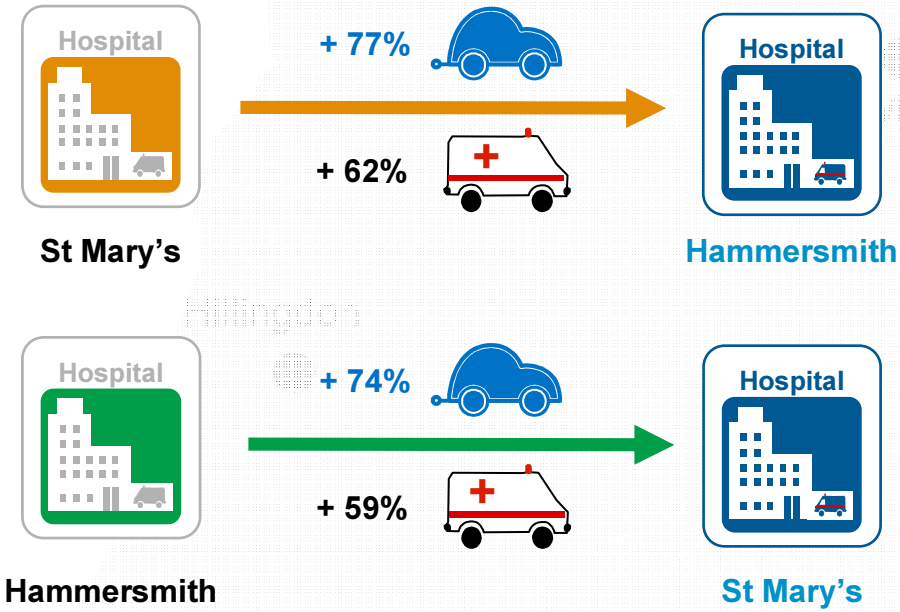
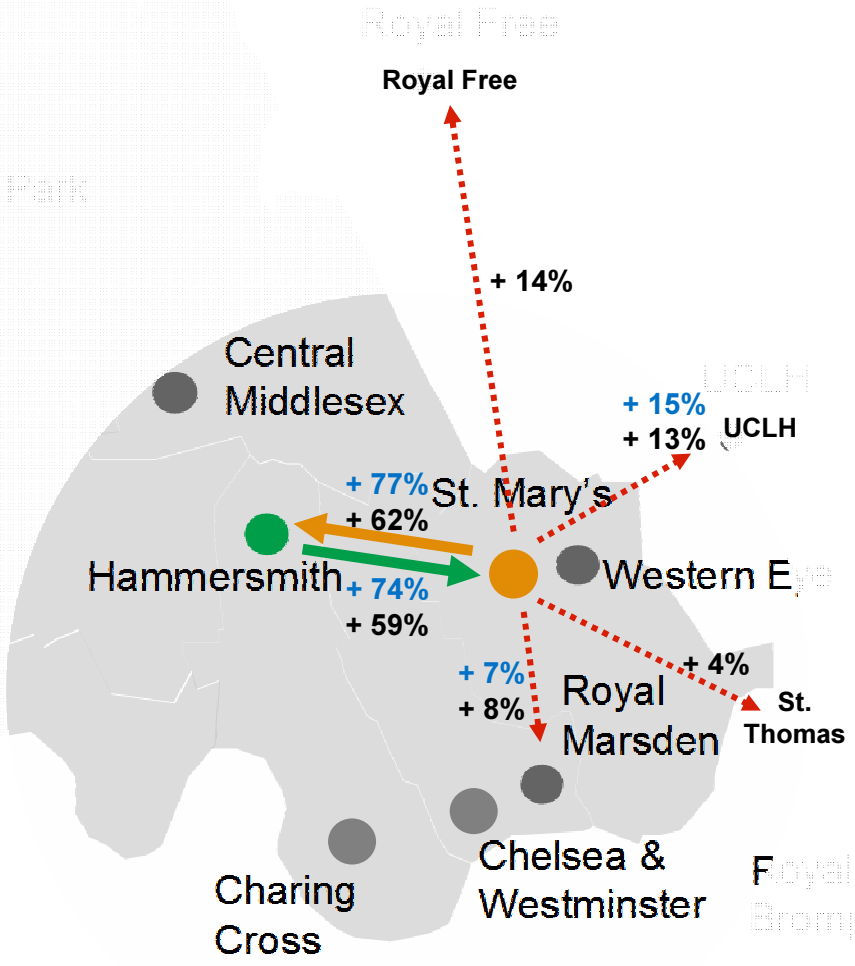
Rationale 7 supporting example

Patient/ travel flows between key hospitals





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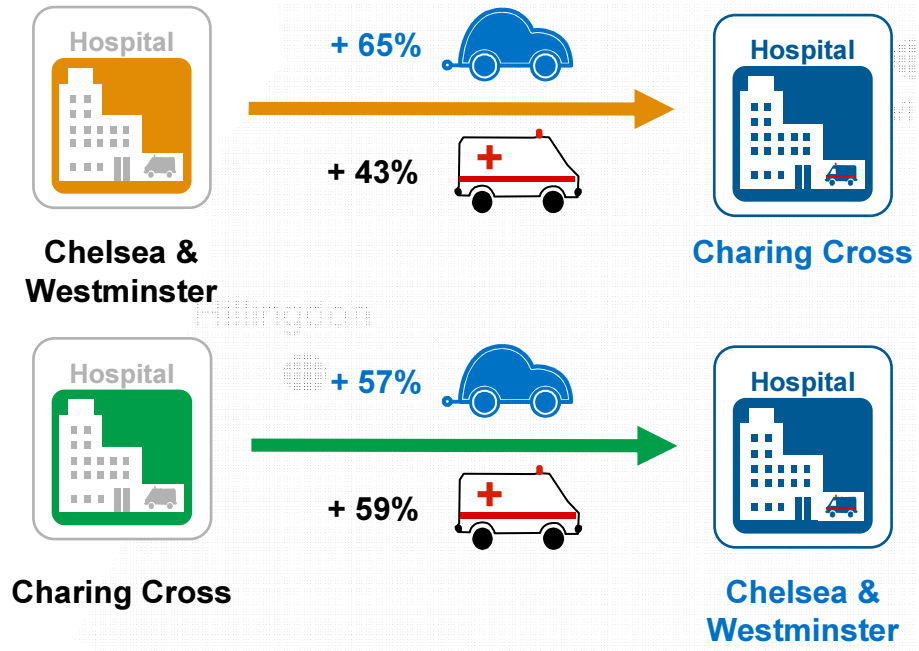
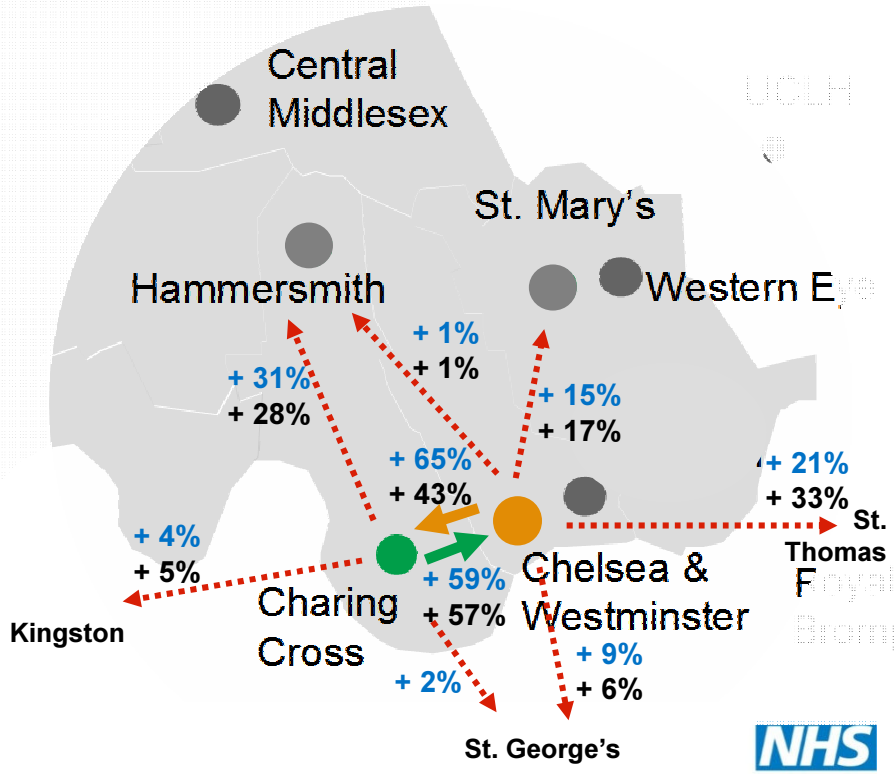
Rationale 7 supporting example

Patient/ travel flows between key hospitals





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Clinical Board Rationale for selection of medium list

		Number of options
1	• A acute hospital is required to ensure high quality care	Millions
2	• Consider the 9 existing major hospital sites only and not new locations due to the time required to find and develop a site and to manage the risk of access to capital	Millions
3	• There should be three to five major hospitals in NW London to support the population of 1.9m. This is based on; available evidence, patient volumes, effect on the clinical workforce and the fact that some services rely on others and require clinical support. Having more than five major acute hospitals would result in unsustainable clinical rotas.	336
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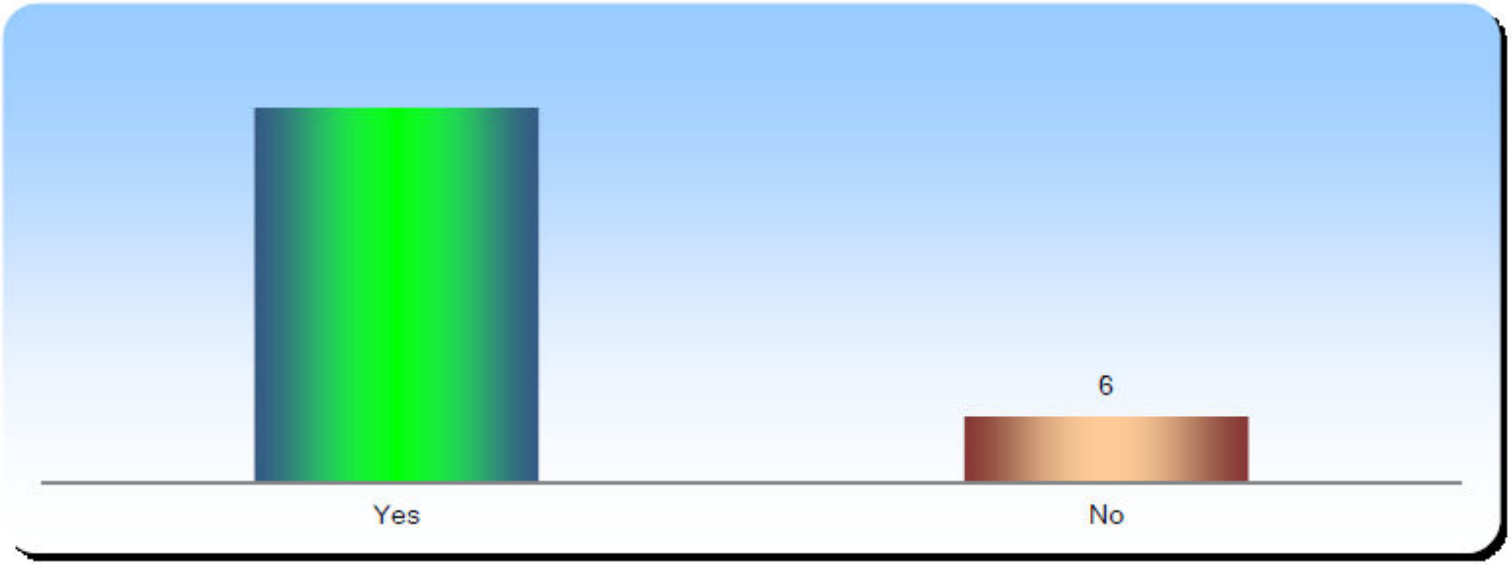
6	• Central Middlesex should not be considered for a major hospital site because several services that would be required are already not delivered there and it would require the largest expansion of any site as it is the smallest of the nine acute sites in NW London	20
7	• The Clinical Board proposes geographic distribution of the remaining three major hospitals to minimise the impact of changes on local borough residents. – Either Hammersmith or St Mary's – Either Ealing or West Middlesex – Either Charing Cross or Chelsea & Westminster	8

FEEDBACK

Have you understood the process we have described to get from the long to medium list?

Q4. Have you understood the process we have described to get from the long to medium list?		
Yes	34	85.00%
No	6	15.00%
	40	100.00%



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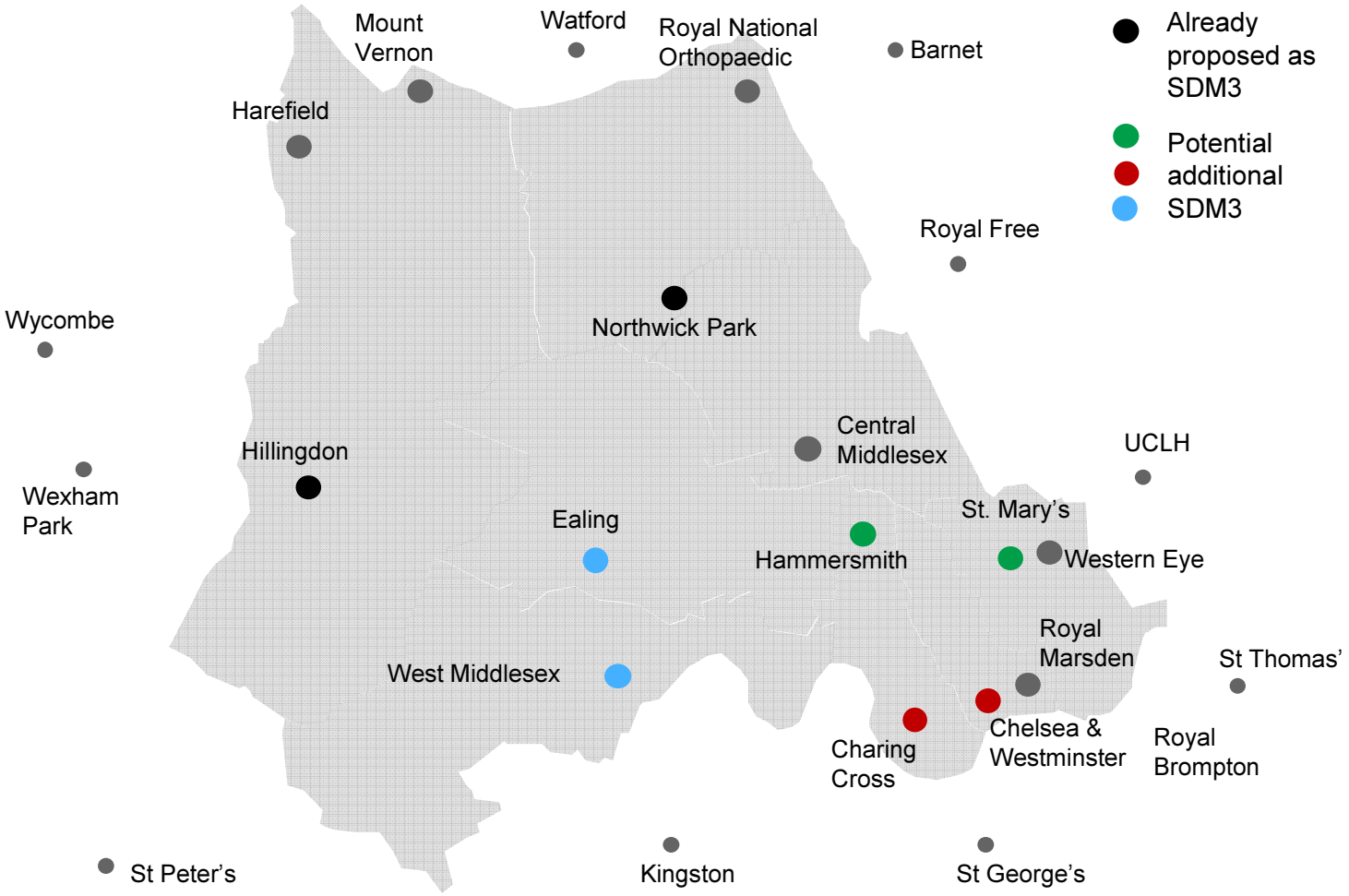
Medium list of options



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After the break we will look at the criteria used to get from the medium list to the short list for public consultation

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Round table work

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Break

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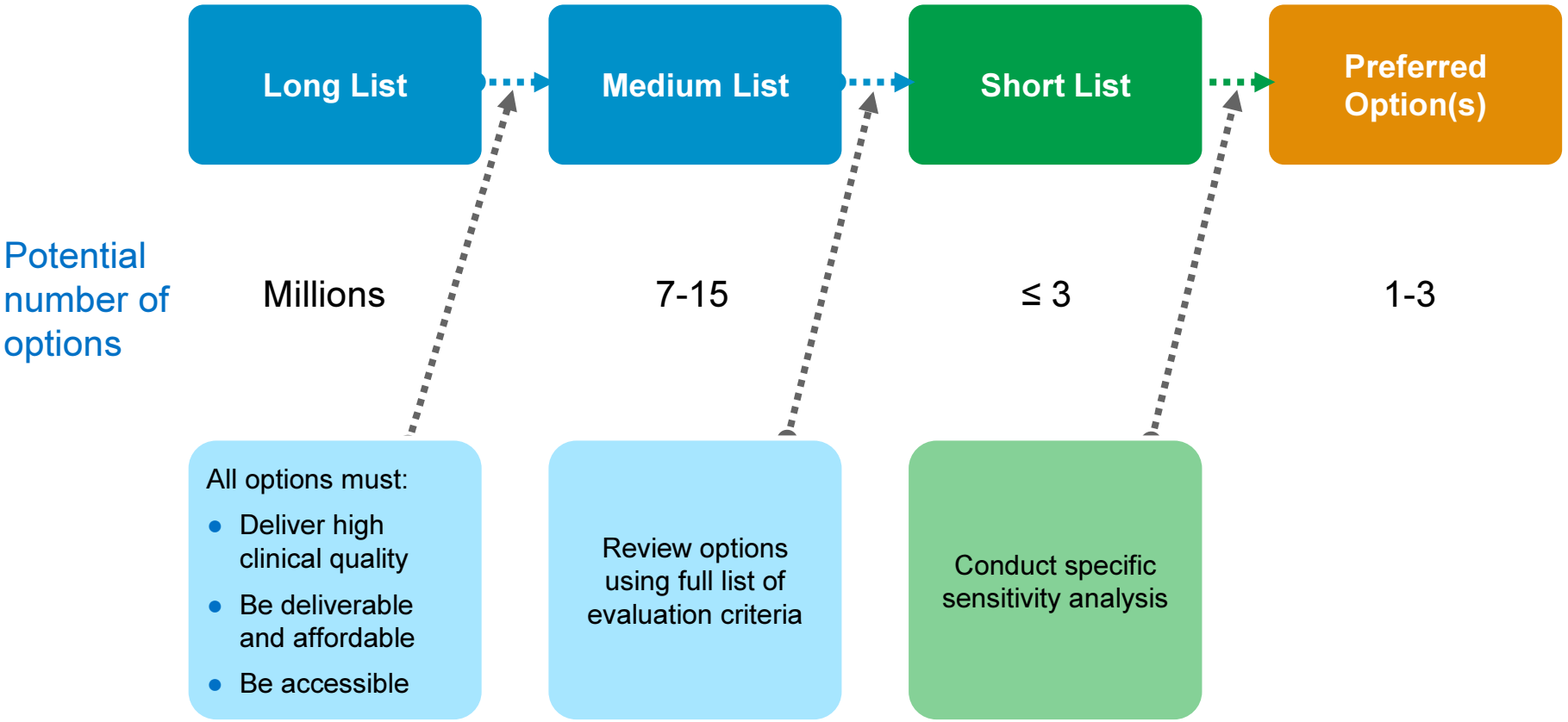
Introduction to the criteria used to get from medium list to short-list

Dr Mark Spencer

Evaluation process for options



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Participants at the last engagement event ranked the criteria that were most important to them

	Criteria	Count of 'votes' as indicated by stickers: Public	Clinicians
1	Quality of care	24% 199	28% 227
2	Access to care	10% 84	6% 45
3	Affordability	7% 58	11% 88
4	Capacity	4% 33	4% 33
5	Deliverability	8% 69	7% 57
6	Workforce	10% 82	14% 111
7	Education and Research	7% 58	10% 84
8	Alignment with other strategies	8% 68	4% 31
9	Patient Choice	8% 64	3% 22
10	Patient Experience	13% 108	13% 107
	Total votes	**823**	**805**

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Additional criteria suggested during the event included…

From the patients, patient representatives and the public

	Votes
Integration	18
Equalities (in health choice)	15
Supporting preventative care and patient self-management	9
Additional - operates 24/7 basis	5
Patient user consultation before change	5

From clinicians

	Votes
Impact on other co-dependent services	7
Self-treatment, independence and self-force/ patient education	6
Integrated care – collaborate	5
Full range of services	5
Flexibility across pathway	4

Suggested criteria have been reviewed and included where appropriate

FOR EXAMPLE:

Suggested criteria	Where this has been included
Risk to existing services	Incorporated into deliverability evaluation criteria
Impact on other co-dependent services	Part of deliverability criteria
Career experience	Included in quality criteria
Expertise – who, where is this	Addressed partially through the clinical standards and through workforce evaluation
Distribution of services meets local needs	Part of access criteria; primary and community care access being addressed as part of the out of hospital strategy
Flexibility across pathway	Addressed through patient choice

Some criteria were not included because they would not differentiate between different options

Examples of suggestions	Reasons why these were not included
• Integration of services	• This is a major focus for NHS NW London and is in the Commissioning Strategy Plan (CSP). We've been working with providers to support the development of integrated care services. • It was not included in the criteria as it should be possible under all options and was not considered a factor that would set apart different options
• Health equality across NWL	• Health inequalities and life expectancy differences are addressed through prevention programmes, easy access to good quality primary care, our integrated care programmes and borough-level out-of-hospital strategies. • Hospital access is not a driver and so this criteria would not differentiate between options however we will do an equalities impact analysis on the shortlisted options and identify actions to address any adverse impacts on specific groups.
• Support for preventative care and help for patients to manage their own conditions, encouraging independence	• These are important priorities for NHS NW London and are outlined in the CSP however these criteria do not differentiate between the options for change.

We have now refined this list into 5 key areas

	Criteria	Sub-criteria
1	Quality of care	• Clinical quality • Patient experience
2	Access to care	• Distance and time to access services • Patient choice
3	Affordability	• Recurrent cost to system • Capital cost to system • Financially sustainable Trusts • Transition costs
4	Deliverability	• Workforce • Expected time to deliver • Co-dependencies with other strategies
5	Research and Education	• Education and research

Gallery walk

Instructions

- Please go first to the stand corresponding to the coloured dot on your badge
- Please take a few minutes to review the posters:
  - The first poster describes the proposed approach to applying the criterion to evaluate the options
  - Subsequent posters contain data proposed to assess each criterion
- Please write down any comments you have on the post it notes and stick to the relevant poster
- There will be a person on each stand with detailed knowledge of the criterion and analysis who can answer any questions you might have
- After 10 minutes, you will be directed to the next stand – you will visit all stands
- There will be time at the end for general discussion and to ask any further questions

1 **Quality of care**

2 **Access**

3 **Affordability**

4 **Deliverability**

5 **Research & education**

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Breakout session on the detail of short-listing criteria

Gallery walk

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Feedback

Gavin Grey

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Q&A

Dr Mark Spencer
Dr Susan LaBrooy
Dr Tim Spicer

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Next steps

Dr Mark Spencer

Next steps

- Feedback from today's event will be fed back to our Clinical Board and our Programme Board to inform our ongoing work including planning for public consultation

- The next stage of work and emerging plans for consultation will be shared at our next event on Tuesday 15 May – please see cards in your delegate packs for registration details

- Materials from today's event and a short report will be published on the website:
  - http://www.northwestlondon.nhs.uk/shapingahealthierfuture/

- In the meantime, please do not hesitate to contact the team either via the comments cards in your packs or using the contact details supplied