London Borough of Hammersmith & Fulham

Housing, Health And Adult Social Care Select Committee

Agenda

Tuesday 17 July 2012
7.00 pm
Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

Administration:	Opposition	Co-optees
Councillor Lucy Ivimy (Chairman) Councillor Joe Carlebach Councillor Oliver Craig Councillor Peter Graham Councillor Steve Hamilton Councillor Peter Tobias	Councillor Iain Coleman Councillor Stephen Cowan Councillor Rory Vaughan	Maria Brenton, HAFAD

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Date Issued: 05 July 2012

London Borough of Hammersmith & Fulham

Housing, Health And Adult Social Care Select Committee

Agenda

17 July 2012

Item		Pages
1.	**MINUTES AND ACTIONS**	1 - 10
	To approve as an accurate record, and the Chairman to sign the minutes of the meeting of the Housing, Health & Adult Social Care Select Committee held on 17 April 2012.	
2.	**APOLOGIES FOR ABSENCE**	
3.	**DECLARATIONS OF INTEREST**	
	If a Councillor has a disclosable pecuniary interest in a particular item, whether or not it is entered in the Authority's register of interests, or any other significant interest which they consider should be declared in the public interest, they should declare the existence and, unless it is a sensitive interest as defined in the Member Code of Conduct, the nature of the interest at the commencement of the consideration of that item or as soon as it becomes apparent. At meetings where members of the public are allowed to be in attendance and speak, any Councillor with a disclosable pecuniary interest or other significant interest may also make representations, give evidence or answer questions about the matter. The Councillor must then withdraw immediately from the meeting before the matter is discussed and any vote taken. Where Members of the public are not allowed to be in attendance and speak, then the Councillor with a disclosable pecuniary interest should withdraw from the meeting whilst the matter is under consideration. Councillors who have declared other significant interests should also withdraw from the meeting if they consider their continued participation in the matter would not be reasonable in the circumstances and may give rise to a perception of a conflict of interest. Councillors are not obliged to withdraw from the meeting where a dispensation to that effect has been obtained from the Audit, Pensions and Standards Committee.	
4.	**MEMBERSHIP AND TERMS OF REFERENCE**	11 - 19
	This report sets out the new membership of the Committee and the terms of reference of the Council's Overview & Scrutiny Board and the three select committees as agreed at the Annual Council meeting held on 30 May 2012.	

5. APPOINTMENT OF CO-OPTED MEMBERS

The Committee is asked to agree the re-appointment of Maria Brenton, HAFAD as a non-voting co-opted member for the 2012/2013 municipal year.

6. APPOINTMENT OF VICE-CHAIRMAN

The Committee is asked to elect a Vice-chairman from amongst its members for the 2012/2013 municipal year.

7. CENTRAL LONDON COMMUNITY HEALTHCARE NHS TRUST: APPLICATION FOR FOUNDATION TRUST STATUS 20 - 49

The committee is asked to respond to Central London Community Healthcare NHS Trust consultation on its Foundation Trust plans.

8. SHAPING A HEALTHIER FUTURE: NHS PUBLIC CONSULTATION 50 - 134

The consultation document sets out proposals to re-configure NHS services in North West London.

The proposed options include the closure of Charing Cross, Hammersmith or Chelsea and Westminster Hospital.

9. IMPERIAL COLLEGE HEALTHCARE NHS TRUST

The Chairman will provide an oral update on the recommendations made at the meeting of the City of Westminster Adult Services & Health Policy & Scrutiny Committee, which was attended by representatives from the London Borough of Hammersmith & Fulham and the Royal Borough of Kensington & Chelsea.

10. HOUSING STRATEGY 2007-2014 135 - 177

The seven year Housing Strategy sets out how the Council will meet the housing challenges facing the borough and how it will provide opportunity in terms of the housing and housing services provided currently and into the future.

11. TASK GROUP: REPAIRS & MAINTENANCE 178 - 180

The Committee is asked to recommend to the Overview & Scrutiny Board the establishment of a Task Group: Repairs & Maintenance, with the attached terms of reference and membership.

12. WORK PROGRAMME AND FORWARD PLAN 2012-2013 181 - 189

The Committee's work programme for the current municipal year is set out as Appendix A to this report. The list of items has been drawn up in consultation with the Chairman, having regard to relevant items within the Forward Plan and actions and suggestions arising from previous meetings of the Committee.

The Committee is requested to consider the items within the proposed work programme and suggest any amendments or additional topics to be included in the future. Members might also like to consider whether it would be appropriate to invite residents, service users, partners or other relevant stakeholders to give evidence to the Committee in respect of

any of the proposed reports.

Attached as Appendix B to this report is a copy of the Forward Plan items showing the decisions to be taken by the Executive at the Cabinet, including Key Decisions within the portfolio areas of the Cabinet Member for Housing and the Cabinet Member for Community Care, which will be open to scrutiny by this Committee.

13. DATES OF NEXT MEETINGS

The Committee is asked to note that the dates of the meetings scheduled for this municipal year are as follows:

11 September 2012

14 November 2012

22 January 2013

19 February 2013

09 April 2013

London Borough of Hammersmith & Fulham

Housing, Health And Adult Social Care Select Committee

Minutes

Tuesday 17 April 2012

PRESENT

Committee members: Councillors Lucy Ivimy (Chairman), Michael Adam, Stephen Cowan, Oliver Craig, Charlie Dewhirst, Steve Hamilton and Rory Vaughan

Co-opted members: Maria Brenton (HAFAD)

Other Councillors: Councillor Joe Carlebach (Cabinet Member for Community Care) and Councillor Andrew Johnson (Cabinet Member for Housing).

Officers: Mel Barrett (Executive Director Housing and Regeneration), Stephen Kirrage (Director of Asset Management and Property Services) and Michael Carr, (Scrutiny Development Officer).

NHS Representatives: Sarah Whiting (Chief Executive Inner North West London PCTs), Dr Tim Spicer (Chairman, Hammersmith and Fulham Clinical Commissioning Group) and Daniel Elkeles (Director of Strategy NHS North West London).
Imperial College NHS Trust: Professor Davis Taube (Medical Director, Clinical Services), Bill Shields (Chief Financial Officer) and Eric Gatling (Acting Director of Performance and Contracting).

58. MINUTES AND ACTIONS

RESOLVED THAT:

The minutes of the meeting held on 22 February 2012 be approved as a correct record subject to the following amendments:

- minute number 53, to include "Councillor Cowan raised concerns at the effectiveness of benchmarking as being used as the only tool in raising standards,
- minute number 54, paragraph 16, replace "paid tribute to the" with "noted the more" effective work done.

59. APOLOGIES FOR ABSENCE

Apologies were received from Councillors Iain Coleman and Peter Tobias.

60. DECLARATIONS OF INTEREST

There were no declarations of interest.

61. SHAPING A HEALTHIER FUTURE FOR NORTH WEST LONDON

Sarah Whiting, Dr Tim Spicer and Daniel Elkeles provided an oral update on the 'Shaping a Healthier Future' hospital reorganisation programme, focusing on the range of services to be offered at each type of hospital and options for development. They outlined the different options and service models proposed and the analysis behind these proposals.

A Joint Health Overview and Scrutiny Committee (JHOSC) was being established by the North Wets London health scrutiny committees was currently meeting in shadow format.

They outlined the process for deciding upon the location of the major hospitals. Of nine existing major hospital sites, there would be three/five designated as major hospitals in North West London and it was asked how it would be decided where the major hospitals. It was responded that the proposed process was to choose between 3-5 of the current locations.

They were asked which hospitals they intended to put forward as the major hospitals. There was no answer available to that at that time, as there was a need to factor in the financial analysis to determine the 5 most suitable sites. The next meeting of the Shadow Joint Overview and Scrutiny Committee (JHOSC) would be provided with the final proposals to be put out to consultation.

The future vision was; localising routine medical services to provide better access closer to home and an improved patient experience, centralising most specialist services to provide better clinical outcomes and safer services for patients, and integrated primary and secondary care, with involvement from social care, to ensure seamless patient care.

Councillor Cowan suggested that the central premise of the proposals was that specialisation is the way forward because it saves lives. It was responded that they were saying that patients get the best care if they get to see the right person and that there were not currently the right amount of skilled people and clinicians at certain sites, because they were spread across different hospital centres. It was suggested that it would be useful to consider the number of patients verses the number of specialist staff and clinicians in different models of services proposed compared with the current situation. The report outlined the number of service clinicians available to different numbers of catchment populations under different scenarios.

It was asked why the focus of the proposals was on hospitals and not NHS Trusts. It was responded that this was because the proposals were focused on service delivery models and not organisational forms. They highlighted the inter-dependencies between services and the range of services hospitals can have. Councillor Cowan asked if there were not other options that could be considered, besides the proposals which only provided options for reducing the number of accident and emergency sites. It was responded that these particular proposals had been drawn up because there was a need to make sure that the service models put forward were efficient and productive with service staff treating the maximum number of patients.

Councillor Cowan queried how long they had been working on the proposed service changes. They said that it had started November 2011 but the strategy had been worked up for two years previously.

The context and case for the proposed service reorganisation and development changes were outlined. This included a growing population, an extra 113,000 people in North West London over the next ten years, an ageing population, with 31% of the population with long term chronic conditions such as heart disease, diabetes and dementia conditions, which required longer term care and management. It was explained that the NHS in North West London was facing big challenges, including the rising cost of health care and drugs and technology and workforce shortages in some hospital specialities. They said that the way hospitals and primary care were organised would not meet the needs of the future.

There was more hospital space in North West London than in other parts of the country and a greater proportion of the NHS budget was on hospital care than the national average; but this did not represent the best use of resources. Three quarters of hospitals required upgrading to meet modern standards, at an estimated cost of £150m. Hospitals in North West London faced significant financial challenges even if they maximised efficiency.

It was asked how large the Charing Cross hospital was. Approximately 536 beds. It was asked how much of a challenge it would be for Chelsea and Westminster hospital to upgrade to a larger site. It was replied that this would involve transferring a 100 bed capacity, however, if the proposed strategy was implemented it would produce efficiencies and that would require less beds capacity overall.

Hospitals varied in the quality of care and the time it took for them to see and treat patients. A study had shown that patients treated at weekends and evenings in London Hospitals, when fewer senior staff were available, stood a higher chance of dying than if they were admitted during the week. This indicated that there was a need to ensure that senior doctors and teams were available more often at all times. Changes over the previous few years to London's heart attack, stroke and major trauma services had demonstrated how more lives could be saved.

They said that the vast majority of people used local hospital services and that 20% to 30% of patients who were admitted to hospitals in North West

London as emergencies could be more effectively cared for in their own community.

Members queried the impact of the need to find financial savings on the proposals. It was responded that the primary reason for the proposed programme was to improve the quality of care and that improving access to accident and emergency services was the key driver for reorganisation. They said that patients that required basic urgent care should be able to access their own GP, or if this was not feasible, through a neighbouring GP practice or an Urgent Care Centre. If patients needed to go to hospital, they should have quick access to high quality urgent care through an Accident and Emergency clinic, backed up by appropriate services.

There was some discussion on whether the report had dealt adequately with the levels of financial savings expected, although the Committee had been informed that financial modelling had not yet been completed or factored into the analysis. They said that they had however modelled what would happen financially if no action were taken; a £1.8 billion deficit.

Councillor Cowan asked if they were saying, in effect, that they were proposing to make financial cuts but that services would be improved. It was responded that there was a need to concentrate services by reducing the number of accident and emergency sites.

Councillor Cowan suggested that there was no mention of downsides to the proposals and that he would suggest that potential risks are fully highlighted in the analysis of the different service models. He said that he was concerned that this optimism was being driven by the need to make £1.8 million of financial savings. He said that he would prefer to receive a more holistic report, which included any negative implications.

They said that under the proposals, 65-70% of patients in Urgent Care Centres could be treated in an Urgent Care Centre. It was asked if there was a group of people that would face delays under the new proposals. It was responded that a small amount of people; between 5-15% might need to transfer between an Urgent Care Centre and an Accident & Emergency department, but that the quality of care and outcomes would be improved even if there were delays.

It was asked what was meant by being “seen”, it was replied that it meant being seen by somebody who can assess what care you need and then make sure that you receive it. It was responded that what was envisaged was that instead of being seen by a junior doctor who does not know about a patients details or case history, something similar to the 111 telephone number, where it would be possible for the consultant to bring up the patients records and refer and book the patient with the appropriate care.

It was commented that it could take generations to get the message across to people that they can dial the 111 number and that the NHS IT systems can sometimes hide poor performance. The Chairman enquired if anyone can call up and access patient records via the 111 number. They agreed that IT

did not have a great tack record in the NHS, but that they now had a technology available that can provide patients information readily and only with the patients' consent.

It was asked what happens if something goes wrong at a local hospital. It was responded that it would always be possible to refer patients to a major hospital.

They outlined the evaluation criteria used. These included quality of care, access to care, affordability, deliverability and research and education. It was asked if, under the "affordability" criterion, Public Finance Initiative (PFI) schemes had been taken into account, since ongoing PFI costs would still have to be met even if the site was not used or sold.

They outlined the analysis of the comparative impact on maximum journey times when a major accident and emergency destination was changed. It was asked if they had consulted with the council highways departments, as they would have knowledge about traffic conditions and variable journey times. They said that they had not, but had used data provided by Transport for London and hospital data. It was asked if the relative patient travel flows between hospitals had been taken into account. They had and this was outlined within the report.

It was asked if the impact of exceptional circumstances, such as traffic jams and road works, on journey times had been taken into account. It was responded that the analysis provided traffic times under different scenarios at peak times. They said that the reason for doing this analysis was to attempt to understand and minimise the risk to patients and to improve services and that whichever way service provision was modelled, it was impossible to take into account every single permutation of what could possibly go wrong.

It was asked if there had been any risk analysis of people dying in a traffic jam. It was responded that this particular analysis had not been carried out but that they believed that the number of lives saved would outweigh negative risks.

It was asked if there were any plans to sell real estate from existing hospital sites in the future. It was responded that it would not be possible to sell any of the sites as there was a commitment within the proposals to maintain a hospital at each of the sites, but that it would be possible to sell of part of some sites and re-invest revenue into other services.

The arrangements for wider consultation were discussed and the impact on particular groups, the costs of car parking and the impact of disabled people. The Chairman concluded that the Committee would need to consider a list of key lines of inquiry that should be considered during the NHS Shaping a Healthier Future consultation and the Joint Health Overview and Scrutiny Committee scrutiny inquiry.

The Committee considered the nomination of members of the Joint Health Overview and Scrutiny Committee being established between the 8 north west London boroughs affected.

RESOLVED that:

1. Hammersmith and Fulham Council agree to participate in the Joint Health Overview and Scrutiny Committee,
2. Councillor Lucy Ivimy be nominated as the voting member and Councillor Rory Vaughan as the non-voting member of the Joint Health Overview and Scrutiny Committee,
3. A full impact assessment on proposed budget savings be provided to the Committee and included in evidence to the Joint Health Overview and Scrutiny Committee,
4. Further analysis of road traffic flow implications and journey times to hospital be provided on the different proposals and models for service re-organisation, including consultation on this with the Council's Transport and Highways department,
5. Analysis on the impact of disabled service users be provided and included in evidence to the Joint Health Overview and Scrutiny Committee
6. The NHS North West London consultation and the associated Joint Health Overview and Scrutiny Committee be a regular agenda item throughout the consultation.

62. IMPERIAL COLLEGE HEALTHCARE NHS TRUST : WAITING LISTS

The Chairman had agreed to the addition of this item as a matter of urgency because of the serious concerns about the accuracy of waiting list performance data, which had given rise to a suspension and review of the recording and performance management of the hospital's waiting lists. Imperial College Healthcare NHS Trust (ICHT) representatives had been asked to explain the issue, how the issue had occurred, the current number of patients waiting a long time, the current veracity of the data, the data validation process and what action was being taken to resolve the problems.

Mr Shields stated that the Trust had been attempting to get back into a situation where the veracity of the hospital waiting list data was sound. In order to achieve this, NHS London had approved a reporting break to allow for corrections in the data and a review of the data systems, processes and training systems for all the staff involved in booking management and data entry. In the interim the Trust management was continuing to treat patients and were keeping a close watch to provide assurance about the quality of care. The Trust had a completely "open book" approach with the PCT to allow for external view of its systems review.

A clinical review was being undertaken. A governance review was also to be undertaken by an external expert. The Cabinet Member for Community Care suggested that the Trust consider bringing in a senior judicial figure to review governance. The Board had previously been under the misapprehension that all was well with the performance data and systems, which became clear was

not the case. Some patients had been waiting for more than 18 weeks. Mr Gatling commented that there were problems with the data reporting systems, so that entries were not starting and ending when they were supposed to, giving false results. This problem had developed over a period of time.

The review of the performance data systems was a big project and involved carrying out a lot of administrative validation to track through the system to make sure that there were no patients that were not being recorded. It involved approximately 100,0000 patients a year, of which approximately one quarter were from Hammersmith and Fulham. Professor Taube commented that the validation of the administrative system and data was on a consultant by consultant level.

The Chairman queried whether there was a problem with the whole historic data set and data system. It was responded that it would be difficult to determine categorically all of the problems with the data system, but it was likely that the training of staff who used the data entry system had not been as good as it should have been and there was a need to improve training and to replace the old computer software system, which was 10 to 15 years old. Another problem was that there had not been a universal software system across all hospital sites.

Councillor Dewhurst asked if the Trust intended to publish the findings of the review. It was intended that the clinical review would be published, but it was not decided whether the governance review would be published immediately as it would need to be determined if there was any action to be taken against any individuals, which may be hindered or prejudiced by publication.

It was asked what the timetable was for the various aspects of the reviews. It was responded that the governance review would be finalised by the end of May and the clinical review by the end of June. Systems review would be ongoing.

Councillor Cowan asked how confident they were that they had identified the underlying causes of the problem. They responded that the key issue was the information system. There were two to three different systems that brought data together. Training was also an important issue. Not all staff had understood how significant and important data entry was. They said that it was also fair to say that there had been a lack of clinical responsibility. Councillor Cowan suggested that this indicated a problem with performance management; they agreed and said that they were very clear about putting in place robust systems on performance management.

Councillor Cowan asked what additional financial burden these problems were imposing on an already financially challenged organisation. They said that the Trust's financial position had improved; the deficit had been reduced and the Trust had agreed to a medium term financial strategy.

Councillor Adam enquired to what extent patients were aware that they were not being seen on time and if patients were make aware of the standard

waiting times. They said that there had not been a significant increase in complaints from patients because they were not being seen on time.

RESOLVED THAT:

i The oral update be noted.

ii ICHT be requested to provide an update on the Trust waiting lists at the first meeting of the Committee in the next municipal year.

iii The committee recommended that:

a) the Trust carry out a review of its governance arrangements and procedures

b)the Trust appoints a senior judicial figure to review its governance arrangements.

c) the Trust provides a comprehensive review report of what went wrong in the waiting list performance data collection, monitoring and review processes

d)the Trust provides greater clarity on performance reports and procedures into the future.

63. HOUSING PERFORMANCE INDICATORS

Mr Barrett highlighted the key issues. There had been some improvements over performance last year but that performance was generally below targets. Sickness absence in particular was still below target. There was deemed to be a significant amount of non-reported sickness absence in the past, which might make improvements in performance data more challenging. The Chairman enquired as to whether the overall performance was distorted by a small number of long term sickness cases. Yes; one particular individual had accrued several hundred days sickness absence. The department were also working through a serious backlog of cases.

Councillor Cowan enquired about performance management issues. They said that they had gained a good understanding of the main issues, some of which were cultural, understanding management roles for example. Some cases of poor performance had not been picked up and acted upon early enough. Councillor Cowan asked how they were assessing management skill sets. These were being assessed through performance appraisals, staff volunteering to attend training courses, making sure management staff are clear on key management roles, specifically; budget management, managing outcomes and managing attendance. It was noted that there was a need for objective assessment, with advice from the Council's Human Resources department, of the management skills available within the department.

In accordance with paragraph 27 of the Overview and Scrutiny Procedure Rules, the Committee extended the meeting by 30 minutes.

64. RE-PROCUREMENT OF HRA REPAIRS AND MAINTENANCE SERVICES

Mel Barrett and Stephen Kirrage presented a report to consider the re-procurement of the Housing and Regeneration department's repairs and maintenance contracts.

They said that performance for repairs and maintenance was a major driver of how the service contract is managed, but that current perceptions by residents were often that these are poor services and very expensive. They said that the department was engaging with a residents' panel to hear their views.

There was a combined expenditure of £49 million per annum for these services. They said that if they went to the market for a new contractual partner they would be seeking particularly high value for money and to inject new skills and innovation into the process. Submissions for tenders were anticipated for October 2012. In October 2013 the service would proceed with the new contract and partner.

The report outlined residents reported experiences of the services. These included "missed appointments", "failure to get repairs done right first time", "contractors getting paid before residents have signed off repairs as complete". The report also outlined future expectations under the new contract.

Councillor Cowan asked about corruption checks. They said that one area of concern was where the pricing mechanism did not allow for any penalties if a job was not carried out correctly or not done, so that contractors get paid even if they do not do the job; they can merely excuse this by claiming that they could not get access to the property. Councillor Cowan asked how it would be evaluated if a job had been carried out correctly. The new contractual regime would include spot checks and new external market testing mechanisms. The department was also considering other elements that could be included as part of the contract, for example, that contractors pick up on other works that need to be carried out whilst they are on site.

The Committee considered the establishment of a scrutiny Task Group which could input into the re-procurement process. It was suggested that the terms of reference for a scrutiny Task Group inquiry might include examination of the procurement contracts, examination of "free market" models and methodology for procurement, detailed policies and procedures for performance monitoring procedures and rewards and penalties. It was suggested that evidence considered might include a system graph to show the procedure followed when a problem was reported until it was signed off and sight of detailed contractual specifications, especially the performance monitoring, the rewards and penalties systems.

RESOLVED that:
proposals for a scrutiny Task Group on re-procurement of the HRA repairs and maintenance services be considered at the next meeting of the Committee.

65. WORK PROGRAMME AND FORWARD PLAN

The indicative items for July meeting of the Committee were noted to include: Shaping a Healthier Future NHS Consultation and scrutiny inquiry, Imperial College Healthcare NHS Trust Waiting Lists, and the Re-procurement of the

HRA Repairs and Maintenance Services Scrutiny Task Group Proposal. A report on the transition of young people from Children's Services to Adult Social Care was also requested for the next meeting of the Committee.

The Committee also considered other items for its 2011-2012 Work Programme. Proposals were: the Meals on Wheels contract and the housing allocation and revised tenancy strategy.

RESOLVED that:
the draft work programme for 2012-2113 and the additional items suggested by the Committee be noted.

66. DATE OF NEXT MEETING

This was the last meeting of the municipal year.

Meeting started: 7.00 pm
Meeting ended: 10.30 am

Chairman .....

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London Borough of Hammersmith & Fulham

HOUSING HEALTH & ADULT SOCIAL CARE SELECT COMMITTEE

DATE	TITLE	Wards
17 July 2012	Membership and Terms of Reference	All Wards

SYNOPSIS

The report sets out the new membership of this Committee and its terms of reference, as agreed at the Annual Council Meeting held on 30 May 2012.

CONTRIBUTORS

Finance and Corporate Services

RECOMMENDATION(S):

The Committee is asked to note its membership and terms of reference.

CONTACT

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Committee Co-ordinator
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NEXT STEPS

N/A.

1. INTRODUCTION

1.1 The Council agreed the membership and terms of reference at the Annual Council Meeting held on 30 May 2012.

2. MEMBERSHIP

2.1 The membership of this committee is as follows:

Nine voting Councillors including the Chairman and Vice Chairman in the ratio of 6 Administration members and 3 Opposition members.
Councillor Lucy Ivimy (Chairman)
Councillor Joe Carlebach
Councillor Oliver Craig
Councillor Peter Graham
Councillor Steve Hamilton
Councillor Peter Tobias
Councillor Iain Coleman
Councillor Stephen Cowan
Councillor Rory Vaughan

Co-optees
Each Overview and Scrutiny Committee may co-opt a number of people in a non-voting capacity, the number of which shall be determined by full Council.

2.2 Another report on this agenda deals with the appointment of the co-opted members of this committee.

3. TERMS OF REFERENCE

3.1 Introduction

Overview and Scrutiny is an important element of the Council's Constitution. Overview and Scrutiny Committees, known in Hammersmith & Fulham as the Scrutiny Board and Select Committees, represent influential public forums through which Councillors can:

- Support the Executive in Policy Development
- Review the impact of decisions and policy
- Hold the Executive to account for their decisions and actions
- Make representations on the exercise of the Council's functions and other matters of concern to the local community

Overview and Scrutiny is concerned with the overall wellbeing of Hammersmith & Fulham, including not only Council services but those

of a wide range of other public agencies - in particular those responsible for community safety and the delivery of health services. Scrutiny Committees provide an important mechanism for Councillors to represent their wards and are a focus for stakeholder and community involvement.

This Article outlines the basic elements and functions of Overview and Scrutiny in Hammersmith & Fulham. It should be read in conjunction with the Overview and Scrutiny Procedure Rules set out in Part 4 of this Constitution.

3.2 **Terms of reference**

The Council will appoint Overview and Scrutiny Committees, as set out below, to discharge the functions conferred by section 21 of the Local Government Act 2000, and regulations under section 32 of the Local Government Act 2000 or Local Government and Public Involvement in Health Act 2007.

Committee	**Scope**
Scrutiny Board	The coordination, and development of the Council's Scrutiny function and the monitoring of its performance Any aspect of the Council's strategic policy formulation, setting and monitoring of the corporate budget, oversight of finance and use of resources, performance management (including external assessment of the Authority and its services) human resources, central support services, and organisational development and strategic partnerships outside the scope of any other Scrutiny Committee, including the Local Area Agreement. Reviewing the adequacy of the steps taken and decisions made in response to petitions made under the Council's Petitions Scheme, in cases where a review has been requested. Monitoring the development, implementation and operation of the governance, structure and processes in respect of joint working with other authorities, save for matters within specific service areas which fall within the remit of other Select Committees. Other functions of the Council (including major cross-cutting issues). Lead responsibility for scrutinising the relevant Cabinet Member(s).

Transport, Environment and Residents Services Select Committee	Any aspect of policy, provision and performance related to : • the local environment and economy, including matters relating to the Street Scene, parks and open spaces, recycling and environmental sustainability, parking policy, waste disposal, street cleansing, refuse collection, cemeteries, biodiversity, transport and planning. • quality of life, including policing, community safety, tackling anti-social behaviour, licensing and gambling, employment, adult education, cultural services and registration. The discharge of the functions and responsibilities of a Crime and Disorder Committee in accordance with section 19 of the Police and Justice Act 2006 and regulations made under section 20 of the Act. The discharge of functions contained in s.9FH of Schedule 2 to the Localism Act 2011 to review and scrutinise the exercise by flood risk management authorities of flood risk management functions which may affect the local authority's area. Any other matter allocated by the Scrutiny Board Lead responsibility for scrutinising the relevant Cabinet Member(s).
Education and Children's Services Select Committee	Any aspect of policy, provision and performance related to the education of children and young people in the borough and the education budget, children's services including social care and the exercise of statutory responsibilities in relation to the scrutiny of children's health matters as set out in paragraph 6.03 (c) below. (Matters relating to general health strategies and services not specifically for children and young people shall be within the scope of the Housing, Health and Adult Social Care Select Committee.) Any other matter allocated by the Scrutiny Board Lead responsibility for scrutinising the relevant Cabinet Members(s).

Housing, Health and Adult Social Care Select Committee	Any aspect of policy, provision and performance relating to housing, health and adult social services in the borough, including the exercise of statutory responsibilities in relation to the scrutiny of health as set out in paragraph 6.03 [c] below and also the voluntary and community sector. (Matters relating to health strategies and services specifically for children and young people shall be within the scope of the Education and Children's Services Select Committee.) Any other matter allocated by the Scrutiny Board Lead responsibility for scrutinising the relevant Cabinet Member(s)

3.3 **General role**

The Overview and Scrutiny Committees will be appointed in accordance with the political proportion of the Council as a whole. Within their terms of reference, these Committees will:

i) review and/or scrutinise decisions made or actions taken in connection with the discharge of any of the Council's functions;

ii) make reports and/or recommendations to the Executive and/or the full Council in connection with the discharge of any functions or to a Member or officer exercising the relevant delegated powers;

iii) consider any matter affecting the area or its inhabitants arising from the Forward Plan or otherwise;

iv) call-in, for reconsideration, decisions made but not yet implemented by the Executive and, if necessary, refer them back to the Executive or Full Council;

v) monitor and review the outcomes of recommendations arising from Scrutiny activity; and

vi) consider any petitions or deputations on a relevant matter, and any request for a review of the steps taken and decisions made by the Council in response to a petition when so directed by the Scrutiny Board, in accordance with the Overview and Scrutiny Procedure Rules in Part 4 of this Constitution.

3.4 **Specific functions**

(a) **Policy development and review –** Overview and Scrutiny Committees may:

i) assist the Council and the Executive in the development of its budget and policy proposals by in depth analysis of policy issues;

ii) conduct research, and other consultation in the analysis of policy issues and possible options;

iii) consider and implement mechanisms to encourage and enhance community participation in the development of policy options;

iv) question the Leader, other members of the Executive and chief officers about their views on issues and proposals affecting the area; and

v) liaise with other external organisations operating in the area, whether national, regional or local, to ensure that the interests of local people are enhanced by collaborative working.

(b) **Scrutiny** – Overview and Scrutiny Committees may:

i) review and scrutinise the decisions made by and performance of the Leader, other members of the Executive and Council officers, both in relation to individual decisions and over time;

ii) review and scrutinise relevant aspects of the policy, services and performance of the Council, its partners, other public bodies in the area or matters which affect the authority's area or its inhabitants and, where appropriate, prepare and publish reports and recommendations;

iii) question the Leader, other members of the Executive and chief officers about matters within their portfolio, their decisions and performance, whether generally in comparison with service plans and targets over a period of time, or in relation to particular decisions, initiatives or projects;

iv) make recommendations to the Executive and/or the Council arising from the outcome of the scrutiny process;

v) question and gather evidence from any person;

vi) appoint a joint Overview and Scrutiny Committee with one or more other local authorities and arrange for the relevant

functions of those authorities to be exercised by the joint committee;

vii) require the provision of information from, and attendance before the Committee by, any such person or organisation under a statutory duty to comply with the scrutiny function and request information from, and attendance before the Committee by, any other person or organisation;

viii) make reports or recommendations to any outside body on matters within the remit of that outside body or which relate to the business or activities of that outside body and which affect the Council's area or its inhabitants; and

ix) make recommendations to the Scrutiny Board for the establishment of task-orientated time-limited groups (Task Groups) to review in depth and report on topics within the Committee's terms of reference.

(c) **Scrutiny of health -** With regard to the scrutiny of health, the Housing, Health and Adult Social Care Select Committee has the powers to:

i) review and scrutinise any matter relating to the planning, provision and operation of health services in the area;

ii) make reports and/or recommendations to the local NHS bodies, the Secretary of State and the Council on any matter reviewed or scrutinised pursuant to regulations under Sections 7 and 8 of the Health and Social Care Act 2001;

iii) make comments on any proposals consulted on by a local NHS body concerning a substantial development of the health service in the area or for a substantial variation in the provision of such service;

iv) arrange for relevant functions in respect of health scrutiny to be exercised by an Overview and Scrutiny Committee of another local authority where the Council considers that another local authority would be better placed to undertake those relevant functions, and that local authority agrees to exercise those functions; and

v) appoint a joint Overview and Scrutiny Committee with one or more other local authorities and arrange for the relevant functions of those authorities to be exercised by the joint committee.

vi) The Overview and Scrutiny Board may exercise these powers in the approval of commissioned Task Group reports and recommendations.

The same powers apply to the Education and Children's Services Select Committee in respect of the scrutiny of health matters which relate specifically to children and young people.

(d) **Scrutiny of children's health and welfare** - The Education and Children's Services Select Committee has power to review and scrutinise any matters relating to the Children's Trust Board and to make reports and/or recommendations to the Children's Trust Board.

3.5 **Scrutiny Board**

In addition to the functions above, the Scrutiny Board may also:

i) approve for reporting to the Council the annual report of the Scrutiny function;

ii) co-ordinate scrutiny activities, including the assignment of cross cutting tasks, to the most appropriate Select Committee and the establishment of task orientated time-limited groups (Task Groups) in accordance with the arrangements set out in the Overview and Scrutiny Procedure Rules in Part 4 of this Constitution;

iii) Coordinate the annual input of Overview and Scrutiny Committees to the budget formulation process;

iv) Appoint task-oriented time-limited groups (Task Groups) to review in depth and report on topics within the terms of reference of any Select Committee.

v) Keep the full range of Task Group activities under review to ensure that the number of active Task Groups does not exceed the capacity of Councillor members and officers to support their work;

vi) Consider references from the Council and Executive for the conduct of in depth scrutiny reviews on any matter of policy or service development;

vii) Promote the development of the Scrutiny function within the Authority, including the identification and coordination of relevant Member and co-optee learning and development, and the promotion of good scrutiny practice;

viii) Consider strategies for the use of the scrutiny function as means of encouraging public participation in the Council's decision making processes;

ix) Work with the Leader of the Council, other members of the Executive, senior officers and senior representatives of partners to champion the role of Overview and Scrutiny; and

x) Manage and develop protocols to facilitate aspects of the scrutiny process.

3.6 **Proceedings of Overview and Scrutiny Committees**

Scrutiny Committees will conduct their proceedings in accordance with the Overview and Scrutiny Procedure Rules set out in Part 4 of this Constitution.

LOCAL GOVERNMENT ACT 2000 – BACKGROUND PAPERS

No.	Description of Background Papers	Name/Ext. of holder of file/copy	Department/ Location
1.	Annual Council Meeting Agenda for 30 May 2012.	Sue Perrin, Committee Co-ordinator, ext 2094	Room 133a, Hammersmith Town Hall

London Borough of Hammersmith & Fulham

HOUSING HEALTH & ADULT SOCIAL CARE SELECT COMMITTEE

DATE	TITLE	Wards
17 July 2012	Central London Community Healthcare NHS Trust (CLCH): Application for Foundation Trust Status	All

SYNOPSIS

CLCH is working towards becoming an NHS Foundation Trust in the summer of 2013. All NHS organisations like CLCH are required to either become an NHS Foundation Trust by 2014 or become part of another NHS Foundation Trust. As part of its application process CLCH is consulting on its Foundation Trust plans. Foundation Trust status would mean that CLCH:

- Would remain part of the NHS, providing NHS care free of charge.
- Can reinvest any savings into further improving local patient care.
- Would have a local membership made up of local people, staff, and patients – who have a say in the future of the organisation.
- Would have governors elected by its members as well as appointed governors.
- Would be more accountable to the people who use its services, its staff and local communities.
- Would have greater freedoms and flexibility in how things are done.

Like traditional NHS organisations, Foundation Trusts provide NHS care free of charge to NHS patients. They operate within a national framework of standards and inspections, but

London Borough of Hammersmith & Fulham

HOUSING HEALTH & ADULT SOCIAL CARE SELECT COMMITTEE

Foundation Trusts are regulated by Monitor, the Independent Regulator of NHS Foundation Trusts.

Foundation Trusts differ from traditional NHS organisations because they have greater autonomy and freedoms. As a result they are able to be more innovative in how they develop their services, and in how they respond to the changing healthcare needs of their local communities. For example, Foundation Trusts are able to establish long-term contracts, partnership working arrangements, and research and development initiatives. They are also able to invest money gained through sound financial management to improve existing services and to develop new ones.

Foundation Trusts have a membership, made up of local people, patients and employees. This membership elects Governors who sit on the Council of Governors together with Appointed Governors from partner organisations. Governors actively work with the trust, influencing the way that services are developed and run on behalf of the membership. This means that Foundation Trusts provide their local communities with a say in the way their healthcare needs are met. In addition, Governors have statutory duties including appointing the Chair and other Non-Executive Directors and approving the appointment of the Chief Executive, providing them with real influence.

CONTRIBUTORS

RECOMMENDATION(S):

The committee is asked to respond to the consultation on the Foundation Trust plans. (Attached)

Central London Community Healthcare NHS
NHS Trust

Barnet | Hammersmith and Fulham | Kensington and Chelsea | Westminster

"GET INVOLVED"

Have your say on our Foundation Trust plans

Public consultation –
From Tuesday 08 May 2012 to Tuesday 31 July 2012

Central London Community Healthcare NHS Trust aims to become a Foundation Trust during 2013. If you live in the London Boroughs of Barnet, Hammersmith and Fulham, Kensington and Chelsea, or Westminster, or receive care from us, we would like to hear your views on our plans. If you or someone you know needs help understanding this document, or if you would like this information in another format such as large print, easy read, audio, braille or other languages, please contact our Membership Manager on **0800 169 6134** or by email at **ft.consultation@clch.nhs.uk**

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تهدف العناية الصحية لمجتمع مركز مدينة لندن (NHS) ان تصبح مؤسسة انتمانية (Foundation Trust) وذلك خلال عام 2013 . فاذا كنت تسكن في مناطق بارنيت (Barnet)، هامرسميث (Hammersmith) وفولهام (Fulham) ، كنسفتون (Kensington) و تشيلسي (Chelsea)، أو ويستمنستر (Westminster) أو انك تحصل على العناية الصحية من قبلنا فاننا نود سماع وجهة نظرك بشأن خططنا. فاذا كنت أو اي شخص آخر تعرفه بحاجة للحصول على المساعدة من اجل فهم هذه الوثيقة، أو اذا رغبت الحصول على هذه المعلومات بصيغة أخرى مثل ان تكون بطبعة كبيرة، سهلة القراءة، صوتية، بريل (Braille) أو بلغات أخرى، عندها نرجو الأتصال بالمدير المعني على هاتف رقم **0800 169 6134** او على عنوان البريد الألكتروني **ft.consultation@clch.nhs.uk**

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مراقبت های پزشکی عمومی مرکز لندن خدمات بهداشت ملی (NHS) قصد دارد که در طی سال 2013 به تراست بنیادی (Foundation Trust) تبدیل گردد. اگر در مناطق شهرداری های بارنت (Barnet)، همراسمیت و فولهام (Hammersmith and Fulham)، کنزینگتون و چلسی (Kensington and Chelsea) یا وست مینستر (Westminster) زندگی می کنید و یا از خدمات ما بهره مند می شوید، ما مایلیم که نظر شما را در رابطه با برنامه هایمان بشنویم. اگر کسی را می شناسید که برای فهم این سند نیاز به کمک دارد، یا اگر مایل هستید که این اطلاعات را به شکل دیگر، مثل چاپ با حروف بزرگ، ساده تر، نوار صوتی، حروف نابینایان و یا به زبان های دیگری دریافت کنید، لطفا با مدیر بخش عضویت ما با شماره تلفن **0800 169 6134** یا ایمیل **ft.consultation@clch.nhs.uk** تماس بگیرید.

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সেন্ট্রাল লন্ডন কম্যুনিটি হেলথকেয়ার এন.এইচ.এস ট্রাষ্ট ২০১৩ সালের মধ্যে ফাউন্ডেশন ট্রাষ্টে পরিণত হতে চায়। আপনি যদি বার্নেট, হ্যামারস্মিথ ও ফুলহাম, কেনসিংটন ও চ্যালসী বা ওয়েষ্টমিনষ্টার ইত্যাদি বারোতে বাস করেন বা আমাদের সেবা গ্রহণ করেন, তবে আমরা আমাদের পরিকল্পনার উপর আপনার অভিমত জানতে চাই। আপনি বা আপনার পরিচিত কারো যদি এ দলিল বুঝতে সাহায্যের প্রয়োজন হয় অথবা এসব তথ্য অন্য কোন মাধ্যমে যেমন বড় ছাপা, সহজপাঠ্য, অডিও, ব্রেইল বা ভিন্ন কোন ভাষায় পেতে চান তবে দয়া করে আমাদের মেম্বারশিপ ম্যানেজারকে **0800 169 6134** এ নাম্বারে বা **ft.consultation@clch.nhs.uk** এ ইমেইল ঠিকানায় যোগাযোগ করুন।

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倫敦中心社區醫療國民保健信託會預定在2013年期間成為一個基金信託會機構。如果你在倫敦巴納特、哈默史密斯 - 富勒姆、肯盛頓 - 切爾西、或威斯敏斯特市政區範圍內居住，或者接受我們提供的照料，我們想知道你對我們的計劃有什麼意見。如果你或你認識的某人需要幫忙以明白這份文件的內容，或者你需要以另一種格式說明這些訊息，譬例如大字體印刷、易讀版、錄音、盲人點字或其他的語言，請致電 **0800 169 6134** 與我們的會員事務經理聯絡，或者電郵 **ft.consultation@clch.nhs.uk**

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El Community Healthcare NHS Trust del centro de Londres, (Asistencia Sanitaria Local de la Seguridad Social), tiene como objetivo convertirse en fundación durante el año 2013. Si usted reside en uno de los siguientes distritos municipales: Barnet, Hammersmith y Fulham, Kensington y Chelsea o Westminster, o recibe asistencia nuestra, nos gustaría conocer su opinión a cerca de nuestros planes. Si usted, o alguien que usted conozca, necesita ayuda para entender este documeto, o quisiera recibir esta información en un formato distinto, como por ejemplo, impresión más grande, lectura fácil, audio, braille o en otro idioma, por favor póngase en contacto con nuestro Membership Manager (director de asociados) llamando al número **0800 169 6134** o por correo electrónico: **ft.consultation@clch.nhs.uk**

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Central London Community Healthcare NHS Trust tem como objetivo tornar-se uma Fundação sem fins lucrativos durante 2013. Se você vive nas municipalidades londrinas de Barnet, Hammersmith e Fulham, Kensington e Chelsea, ou Westminster, ou recebe nossos serviços de assistência, nós gostaríamos de ouvir sua opinião sobre nossos planos. Se você ou alguém que você conhece precisar de auxílio para compreeender este documento, ou se quiser estas informações em outro formato, como letras grandes, fácil de ler, áudio, braille ou em outras línguas, por favor contate nosso Gerente de Associação no número **0800 169 6134** ou por email para **ft.consultation@clch.nhs.uk**

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Central London Community Healthcare NHS Trust zamierza stać się Foundation Trust w 2013 roku. Jeżeli mieszkasz w dzielnicy Londynu takiej jak Barnet, Hammersmith i Fulham, Kensington i Chelsea czy Westminster, lub otrzymujesz od nas opiekę, chcielibyśmy usłyszeć Twoją opinię na temat naszych planów. Jeżeli Ty lub ktoś kogo znasz, potrzebuje pomocy w zrozumieniu tego dokumentu, albo jeżeli chciałby otrzymać te informacje w innym formacie np. dużym drukiem, w systemie easyread (łatwe czytanie), audio, Braille'am lub w innym języku, prosimy o kontakt z naszym Membership Managerem pod numer **0800 169 6134** lub e-mailem na **ft.consultation@clch.nhs.uk**

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Adeega Caafimaadka ee 'Central London Community Healthcare NHS Trust' waxa ay doonaysaa in ay noqoto 'Foundation Trust' sanadka 2013. Hadii aad markaasi ku nooshahay degmooyinkan London ee Barnet, Hammersmith and Fulham, Kensington and Chelsea, ama Westminster, ama aanu daryeel kuu fidino, waxa aanu jecel nahay in aanu ogaano aragtidaada ku aadan qorshahan. Balse hadii adiga ama qof aad taqaano ay dhib ku qabaan in ay fahmaan dokumantigan, ama aad rabto in macluumadkan laguugu soo qoro hanaan kale, tusaale ahaan xaruuf-fidsan, sahal loo akhrin karo, farta-indhoolayaasha, ama luqad kale laguugu soo turjubaano, fadlan la soo xiriir Maareeyaha Xubnaha (Membership Manager) Tel: **0800 169 6134** ama email-kan kusoo codso **ft.consultation@clch.nhs.uk**

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સેન્ટ્રલ લંડન કમ્યૂનિટિ હેલ્થકેર એનએચએસ ટ્રસ્ટ (Central London Community Healthcare NHS Trust) 2013 માં ફાઉન્ડેશન ટ્રસ્ટ (Foundation Trust) બનવાનો લક્ષ્ય રાખે છે. જો તમે લંડન બરોઝ બારનેટ, હેમરસ્મિથ અને ફુલ્હમ, કેનઝિંગ્ટન અને ચેલસી અથવા વેસ્ટમિન્સ્ટરમાં રહેતા હો અથવા અમારા તરફથી કેર (સંભાળ) મળતી હોય તો, અમને અમારી યોજના વિષે તમારા અભિપ્રાય મેળવવાની ઇચ્છા છે. જો તમને અથવા તમે જાણતા હો તેવી કોઇ વ્યક્તિને આ દસ્તાવેજ સમજવામાં મદદની જરૂર જણાય અથવા તમને આ માહિતી મોટા છાપેલા અક્ષરો, સહેલાઇથી વાંચી શકાય, ઓડિઓ, અંધલિપિ (બ્રેઇલ) અથવા બીજી ભાષાઓની રચનામાં જોઇતી હોય તો, કૃપા કરી **0800 169 6134** ઉપર અમારા મેમ્બરશીપ મેનેજરનો સંપર્ક કરો અથવા ઇમેઇલ કરો **ft.consultation@clch.nhs.uk**

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सेंट्रल लंदन कम्युनिटी हेल्थ केयर ऐन ऐच ऐस ट्रस्ट का उद्देश्य 2013 के दौरान एक फाउंडेशन ट्रस्ट बनने का है। यदि आप लंदन की बारनेट, हैमरस्मिथ और फुलहम, केंसिंगटन और चेलसी या वेस्टमिनिस्टर बोरो में रहते हैं या हमसे केयर (देखभाल) प्राप्त करते हैं तो हम अपनी योजनाओं के बारे में आपके विचार जानना चाहेंगे। यदि आपको या आपके किसी जानने वाले को इस दस्तावेज़ को समझने में मदद चाहिए या यदि आप यह जानकारी किसी और रूप में जैसे बड़ी लिखाई, आसानी से पढ़ी जाने वाली, ऑडियो (सुनने वाली टेप या सी डी), ब्रेल में या किसी और भाषा में चाहिए तो कृपया हमारे मेंबरशिप मैनेजर को **0800 169 6134** पर फ़ोन करें या इस पते पर ईमेल करें **ft.consultation@clch.nhs.uk**

CONTENTS

NHS FOUNDATION TRUSTS

- Are part of the NHS, providing NHS care free of charge.
- Can reinvest any savings into further improving patient care.
- Have a local membership – which has a say in the future of the organisation.
- Are more accountable to the people who use the services.
- Are governed by local people, staff and other stakeholders.
- Have greater freedoms and flexibility in how things are done.

There is more about what makes an NHS Foundation Trust different on page 12.

INTRODUCTION

Central London Community Healthcare NHS Trust provides out-of-hospital, community-based NHS healthcare services for nearly one million people. If you live in the London Boroughs of Barnet, Hammersmith and Fulham, Kensington and Chelsea, or Westminster you are likely to receive care from us at some point in your life. We also provide healthcare for many people who come into our boroughs to work each day.

Our health visitors look after the health and wellbeing of families, our school nurses care for children and young people as they grow, our rehabilitation services get people back on their feet following serious accidents or surgery, our district nurses help maintain the health and independence of people as they grow old, and our palliative care service looks after people at the end of their lives.

We believe that as an NHS Foundation Trust we can continue to provide you with the very best care and treatment, by really focusing on community-based services. We would be even more responsive to your healthcare needs, because you and other local people would be part of the organisation helping to shape local community services. It will also give us the additional advantage of having the freedom to invest in state-of-the-art care and treatment for you.

Anne Barnard –
Acting Chair

James A. Reilly –
Chief Executive

All NHS organisations, like ours, are required to either become an NHS Foundation Trust by 2014 or become part of another NHS Foundation Trust. For us, this would mean merging with an organisation providing hospital or mental health services, and losing the ability to focus purely on community healthcare.

Your opinion matters to us - we would really value hearing your thoughts on our plans. If you live in one of the four boroughs we serve, receive healthcare from us, work in partnership with us, or are employed by us, please get in touch with us.

Our consultation on our Foundation Trust plans starts on 08 May 2012 and continues for 12 weeks until 31 July 2012. This consultation document contains information and thirteen questions on our Foundation Trust plans. At the end of the document there is a FREEPOST form, which you can use to send us your views. If you prefer to complete this consultation online it is available on our website at **www.clch.nhs.uk**

Shortly after our consultation finishes we will publish a report telling you what people have said about our plans, and how they have been shaped to take account of your views.

We hope that you find the information in this consultation document interesting and informative, and we look forward to receiving your comments.

ABOUT US

An important part of people's lives

We are the largest community healthcare organisation in London, and we were the first in London to be awarded NHS Trust status. As such, we are at the forefront of changing the way community healthcare services are provided to achieve the best possible results for our patients.

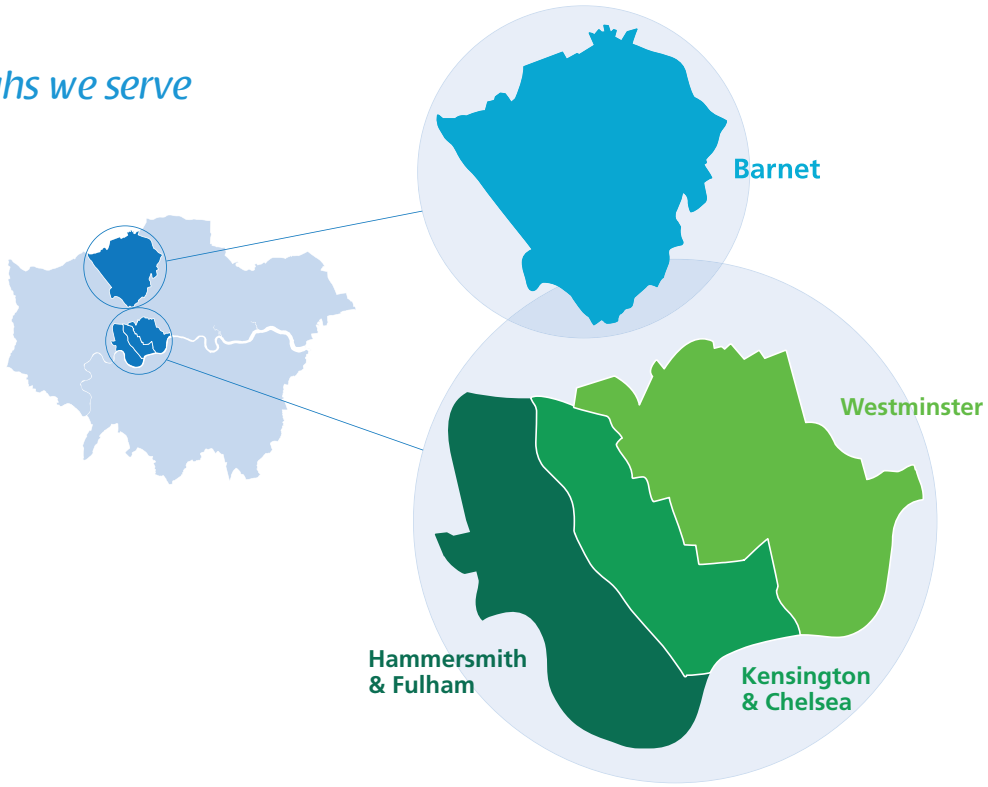
We employ more than 2,600 community healthcare professionals who provide out-of-hospital, community-based healthcare services for nearly one million people who live and work in the London Boroughs of Barnet, Hammersmith and Fulham, Kensington and Chelsea, and Westminster.

We provide healthcare from more than 160 locally situated sites and in many cases from people's homes to make access to our services as easy as possible.

"You get an insight into the difficulties and challenges families face, and if you can help them, that's a great thing".

Frits – School Nurse Team Lead

The Boroughs we serve



The services we provide

Our services fall into eight main areas

ADULT COMMUNITY NURSING SERVICES	Including 24 hour district nursing, community matrons and case management.
CHILDREN AND FAMILY SERVICES	Including health visiting, school nursing, children's community nursing teams, speech and language therapy, blood disorders, and children's occupational therapy.
REHABILITATION AND THERAPIES	Including physiotherapy, occupational therapy, podiatry (foot health), speech and language therapy.
END OF LIFE CARE	For people with complex, substantial, on-going needs caused by disability or chronic illness.
OFFENDER HEALTH SERVICES	At HMP Wormwood Scrubs.
CONTINUING CARE	Services for older people who can no longer live independently due to a disability or chronic illness, or following hospital treatment.
SPECIALIST SERVICES	Including elements of long-term condition management (diabetes, heart failure, lung disease), community dental services, sexual health and contraceptive services.
WALK-IN AND URGENT CARE CENTRES	Providing care for people with minor illnesses, minor injuries and providing a range of health promotion activities and advice.

There is much more about what we do on our website at www.clch.nhs.uk

Our Journey

We were formed in 2008 from the three healthcare organisations which were formerly part of the primary care trusts in Hammersmith and Fulham, Kensington and Chelsea, and Westminster. In November 2010 we became a standalone NHS Trust. Then in April 2011 Barnet Community Services also joined us to become part of our single organisation.

Our journey so far

MARCH 2009 – Central West London Community Services is granted single autonomous provider organisation (APO) status by NHS London.

NOVEMBER 2010 – We are established as a new NHS Trust. As the first and largest community healthcare trust in London, our new name becomes Central London Community Healthcare NHS Trust (CLCH).

APRIL 2011 – Barnet Community Services joins CLCH.

JUNE 2011 – Our first Quality Account is published, following input from patient representative groups and other stakeholders.

SEPTEMBER 2011 – We publish our first Annual Report as an NHS Trust.

MARCH 2012 – First submission of our Integrated Business Plan and Long Term Financial Model to NHS London, making good progress towards becoming a Foundation Trust.

APRIL 2012 – We continue to seek further opportunities to work in an integrated way with adult social care and acute colleagues.

We are one of only two NHS Trusts in London that exclusively deliver out-of-hospital, community-based NHS healthcare services, and one of 18 across England. Most community healthcare services have been merged into either hospital trusts or mental health trusts.

We aim to become a Foundation Trust during the summer of 2013, which is why we want to work with you to build a membership, made up of local people, patients, and employees. Together we will improve the high standards of patient care and treatment delivered in the community.

Next Steps

MAY-JULY 2012 – Our public consultation on our Foundation Trust plans is launched and runs for 12 weeks.

JUNE 2012 – We mark one year since the launch of the North West London Integrated Care Pilot; an innovative multi-disciplinary programme for older people and those with diabetes.

JULY 2012 – We put in place our plans to support the London 2012 Olympic and Paralympic Games.

OCTOBER 2012 – We achieve our target number of members, giving patients, staff and stakeholders greater involvement in community healthcare.

MAY-JUNE 2013 – Our Shadow Council of Governors is in place.

SUMMER 2013 – We are awarded Foundation Trust status.

THROUGHOUT 2013 – We continue building strong relationships with our members.

Our Vision: *to lead out-of-hospital community healthcare*
Our Mission: *to give children a better start and adults greater independence*

We want to continue to deliver the very best healthcare and treatment to people in the community. We recognise how important it is for us to strengthen our partnerships with hospitals, GPs, social care, the voluntary sector and our communities in order to make a real difference to people's lives.

Our values

Our values drive the culture of our organisation. Together with our vision and mission, they frame the way our staff work and how our services are delivered. They are central to everything we do and are underpinned by our behaviours towards each other, and with our patients and partners.

Values	Quality	Relationships	Delivery	Community
	We put quality at the heart of everything we do	We value our relationships with others	We deliver services we are proud of	We make a positive difference in our communities
Behaviours	• I take responsibility for the standard and outcomes of my work • I provide services which are safe, effective and a good experience • I use best practice and feedback to innovate and constantly improve my service	• I work collaboratively and in partnership • I treat people with courtesy, dignity and respect • I am caring, compassionate and kind	• I work hard to achieve the aims of my service and the organisation • I make the best use of resources and provide value for money • I support the development of skills, talent and abilities	• I am visible, accessible and approachable • I ensure our service users/ customers are actively included in planning services/care • I embrace difference, diversity and fairness

" Falls are not an inevitable part of getting older. I enjoy seeing clients progress', improve, return to independence, get their confidence back and reduce their anxiety around the fear of falling".

Claire – Specialist Occupational Therapist

Our plans for the future

By providing children with the best possible start in life we help them to live more active, longer and happier lives. We work with young people to help them to make the best health choices, which promote a lifetime of wellbeing.

By providing community-based, healthcare services at home and closer to home, we give the people we care for greater personal control and choice, helping them to stay independent and ensuring the dignity to which they are entitled, whatever their health circumstances.

We will work to further strengthen our core services, develop into new areas and build a reputation for expertise in community-based healthcare – always aiming to improve your experience of using our services.

We believe that focusing on the following areas will help us achieve this goal.

Health and social care working together

There are many different kinds of health and social care available from many organisations. But it can be frustrating and confusing dealing with the many different providers of these services. We believe that everyone responsible for your care should work closely together as one team to review your needs and provide you with the most appropriate care, support and help. So we are working closely with our local authorities to bring health and social care closer together. For example:

- We are supporting North West London's Integrated Care Pilot which is creating single teams made up of GPs, community health professionals, social care co-ordinators and hospital doctors to work with individual patients to co-ordinate the right care for them.
- We are creating new health and social care co-ordinators who are working in hospitals to improve the way in which patients are discharged into the community.
- We are locating community health and social care teams alongside local GP practices to ensure everyone works better together.

***Q1.** To what extent do you agree with our plans to improve integration across health and social care?*

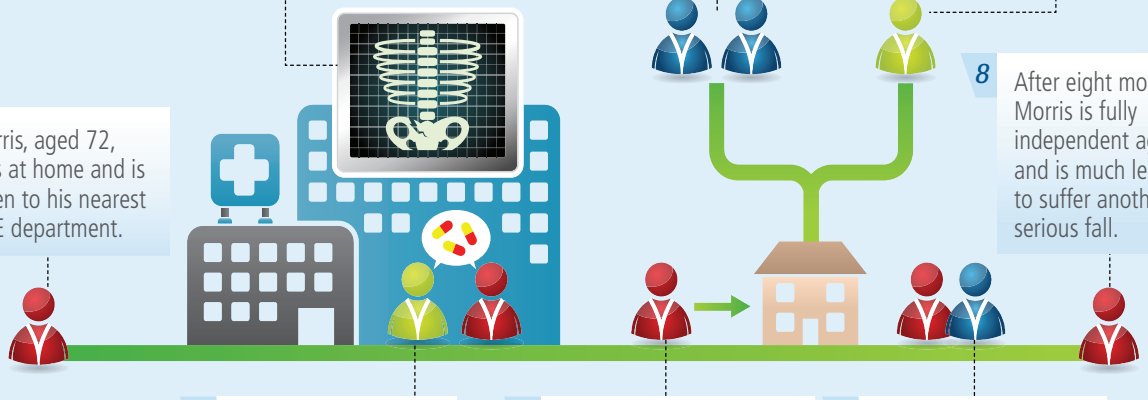
Complete care tailored for the individual

Our patients are at the heart of everything we do. Our ambition is to move further towards services that work together to deliver care that meets your specific needs as an individual. This means:

- Providing support to people to manage their long-term conditions or complex on-going health needs.
- Supporting older people to stay independent in their own homes for longer and avoiding the need for admission into hospital or long-term care.
- Helping people to return home more quickly after a stay in hospital.
- Focusing on early support for children and their families.
- Involving a wider range of views from the communities we serve when developing services.

The following stories show how we want all our services to work to meet individual needs.

Morris's story



1 Morris, aged 72, falls at home and is taken to his nearest A&E department.

2 He is found to have fractured his hip and is admitted to hospital.

3 Morris has been taking medication and this is investigated as a possible cause of his fall.

4 Morris is keen to return home as quickly as possible. The community health team work with Morris, his family, the hospital, the local authority and his GP so this can happen.

5 The falls prevention team look into other factors contributing to Morris's fall, offer advice on preventing further falls, diet, exercise and safety in the home.

6 A district nurse visits Morris on a regular basis to monitor him and to ensure he is receiving the correct amount of medication so that he remains stable.

7 Morris receives regular visits and physiotherapy at home, avoiding lengthy trips to and from hospital for treatment.

8 After eight months Morris is fully independent again and is much less likely to suffer another serious fall.

Sasha's story

1 During Sasha's eight-month health check the health visiting team sees that she is not sitting up properly, reaching out for toys, or starting to babble.

2 Sasha is referred to our specialist child development team led by a paediatric consultant and nurse specialist.

3 Sasha is found to have a development delay.

4 A key worker from the voluntary sector helps co-ordinate Sasha's treatment and support for her family.

Sasha's care focuses on helping Sasha and her family to get the most out of her social and educational experiences.

5 She receives joint occupational therapy and physiotherapy appointments at a local health centre which improve her movement and co-ordination and reduces the number of appointments she has to go to. Sasha receives speech and language therapy which helps her communication.

Sasha receives music therapy at a children's centre which improves her socialisation and communication.

6 Sasha is now eight; she enjoys an active life and attends a mainstream school with the help of a statement of needs, she has access to the support of the school nursing service and specialist after school clubs for children with a range of disabilities.

Q2. To what extent do you agree with our plans to adapt the way we work to be more centred around our patients?

WHAT IS AN NHS FOUNDATION TRUST?

Like traditional NHS organisations, Foundation Trusts provide NHS care free of charge to NHS patients. They are required to meet the highest standards of patient experience, quality and safety of services, financial management and governance.

Foundation Trusts differ from traditional NHS organisations because they have greater autonomy and freedoms. As a result they are able to be more innovative in how they develop their services, and in how they respond to the changing healthcare needs of their local communities.

Foundation Trusts have a membership, made up of local people, patients and employees. This membership elects Governors who sit on the Council of Governors together with Appointed Governors from partner organisations. Governors actively work with the trust, influencing the way that services are developed and run on behalf of the membership. This means that Foundation Trusts provide their local communities with a real say in the way their healthcare needs are met. In addition, Governors have statutory duties including appointing the Chair and other Non-Executive Directors and approving the appointment of the Chief Executive, providing them with real influence.

Additionally, Foundation Trusts are able to establish long-term contracts, partnership working arrangements, and research and development initiatives. They are also able to invest money gained through sound financial management to improve existing services and to develop new ones.

"As children grow you can see the difference you have made and how the work of breast feeding support builds mum's confidence and self-esteem".

Sarah – Health Visitor

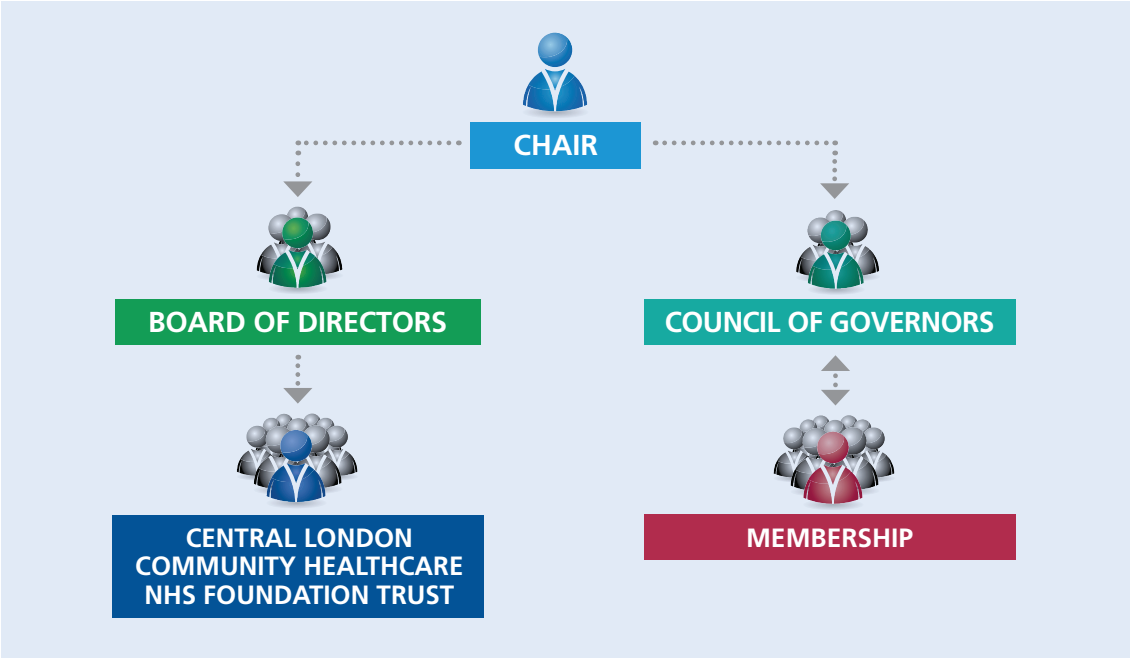
WHY WE WANT TO BECOME A FOUNDATION TRUST

As a Foundation Trust, the people we care for, our partners, commissioners, employees and local communities will have a real say in how our services are developed and run through members and Governors. We believe that involving local people in our organisation will help us to understand our communities better and make us more able to meet local health and wellbeing needs.

- For the people we care for this will mean that we will be able to develop more customised, targeted services based on their individual needs.
- For our partners and commissioners this will mean that we will work more closely with them to develop services, establish long-term contracts and further strengthen our existing relationships and build new ones.
- For our staff this will mean that they will be empowered with more say in how the services they deliver are developed. They will also have more opportunities to innovate, which will help them to improve services.
- For our organisation this will mean greater accountability to our local communities, with greater freedom to invest to improve services on your behalf.
- For operating as a provider of choice in the new NHS landscape created by the Health & Social Care Act 2012, this will mean that we will be in the best position to provide integrated care with our partners and meet the challenges of the new Act.

THE WAY OUR NEW ORGANISATION WILL BE RUN

As an NHS Foundation Trust the way that our organisation is run will change. In addition to the current Board of Non-Executive and Executive Directors, led by our Chair and Chief Executive, we will have a Council of Governors elected by our members. The following section describes how we will operate as a Foundation Trust.



Membership

It's easy to become a member and it's completely free. There is an easy to complete form later in this document. As a member you can play an important part in influencing the way that our local community healthcare services are developed and run, and you can get involved as much or as little as you like.

Membership is what you want it to be!

Members will be asked to indicate which level of membership they would like to have when they join. As a member you can change your level of membership at anytime:

INFORM - receive information and updates from us about important changes to healthcare.

INVOLVE - receive information, and occasionally get involved in activities, such as focus groups, surveys, consultations and be invited to attend health events.

INFLUENCE - receive information and regularly get involved in activities, such as volunteer to support a service; help to collect views from other local people on a range of issues; and a whole range of other activities. You may also want to consider standing for election as a Governor.

We are proposing three membership constituencies.

- **PUBLIC** – people who live in the boroughs we work in.
- **PATIENTS, SERVICE USERS AND CARERS** – people who use our services or care for someone who does.
- **STAFF** – people who work for us.

Public, Patient and Carer constituencies

Anyone can become a member if they live in the London Boroughs of Barnet, Hammersmith and Fulham, Kensington and Chelsea, or Westminster. You can also become a member if you don't live in one of our four boroughs but use our services. You may travel into the area to work and receive care from us while you are here, at one of our Urgent Care or Walk-in Centres for instance. You can be a member of more than one Foundation Trust, which means that even if you are already a member of another trust, you can still join us.

Q3. To what extent do you agree with the areas we have chosen for our public constituencies?

We provide services for people of all ages and we value their views. We are not proposing an upper age limit for membership, but as part of this consultation we would like you to help us decide on what the minimum age should be. We are suggesting 12, 14, or 16 years. We are committed to engaging with our service users and carers, regardless of their age. Staff in the services we provide for children and young people already use a variety of creative methods to engage with their patients, and work in close partnership with community groups such as Youth Parliaments. This is something that we will continue to develop as we move towards becoming a Foundation Trust. We want to be clear that, whatever the minimum age agreed for membership of our organisation, we will continue to engage with children younger than this age to ensure their views are heard.

Q4. To what extent do you agree with our plans for our public, patient and carer membership?

Q5. Should the minimum age for membership be 12, 14 or 16?

Staff constituency

Our staff are at the heart of our organisation. They are our main contact with the people we care for and are highly regarded by the communities we serve. For this reason it is essential that they are fully involved in the development of our organisation. This is why we would like to automatically make them members if they are employed under a permanent contract of employment or have a fixed term contract of at least 12 months.

Our staff will be able to opt-out if they choose.

We are proposing that our staff constituency is divided into two groups. These are:

- Clinical.
- Administration.

It is important that we represent the skill mix of our organisation on the Council of Governors. This will be achieved by a ratio of four Clinical Staff Governors to one Administration Staff Governor.

There are other people that do not fall into the criteria above but are equally important to us and the people we care for, such as volunteers. We hope that they will join us as public members.

Q6. To what extent do you agree with our staff constituencies?

Q7. To what extent do you agree with our plans to automatically make our staff members?

Council of Governors

If you are a member you can put yourself forward as a candidate to become a Governor or you can vote to elect a candidate who you feel best represents your views.

Once elected, our Governors will play an important role in helping to develop our organisation. We propose there be 29 Governors in total, made up of five Public, ten Patient, five Staff and nine Appointed Governors. We are proposing that Barnet has two public Governors, and our other three boroughs have one public Governor each. This recognises that Barnet has a larger population than each of the other boroughs we serve.

In deciding which of our partner organisations to invite to join our Council of Governors, we have carefully considered the relationship we have with them and the types of decision our Council of Governors will be required to make. We value highly the relationships that we have with our partners in the voluntary sector and are particularly keen that the voice of the voluntary sector is represented on our Council of Governors and in our membership. We are proposing that each borough will have an Appointed Governor from a voluntary sector organisation. We think that a representative could be identified through the existing borough-based voluntary sector networks; but are keen to hear your views on how this could work.

Our Local Authority and Primary Care Trust/Clinical Commissioning Group partners will also have the opportunity to appoint representatives from their organisations to the Council of Governors.

"We help people understand and manage their condition in their real life situations. It is about helping people take control of their own lives".

Miranda – Diabetes Specialist Community Nurse

Elected Governors			
Constituency	**Sub-constituency**	**Number of Governors**	**Total**
PUBLIC	Barnet		
	Hammersmith and Fulham		
	Kensington and Chelsea		
	Westminster		
PATIENT	Adults		
	Children & Family		
	Carers		
STAFF	Clinical		
	Administration		

Appointed Governors			
Stakeholder Groups/ Partner Organisations	**Sub-group**	**Number of representatives**	**Total**
LOCAL AUTHORITY	Barnet		
	Hammersmith and Fulham		
	Kensington and Chelsea		
	Westminster		
PRIMARY CARE TRUSTS/CLINICAL COMMISSIONING GROUPS	*Primary Care Trust/Clinical Commissioning Groups		
VOLUNTARY SECTOR REPRESENTATIVES	Barnet		
	Hammersmith and Fulham		
	Kensington and Chelsea		
	Westminster		
		Total	**29**

**Primary Care Trusts are due to be abolished with effect from April 2013. Their commissioning responsibilities will be taken over by Clinical Commissioning Groups.*

Initially, our Council of Governors will be elected for a period of up to three years which will enable us to have continuity going forward without the whole Council having to be re-elected. If Governors wish, they will be able to stand for re-election. If re-elected they will be able to be a Governor for up to three more years. The maximum time that anybody can be a governor is six years. We are proposing that the minimum age for governors should be 16.

Q8. To what extent do you agree with our minimum age for governors?

Q9. To what extent do you agree with our election plans?

Our Governors will work closely with our Board of Directors. They will contribute ideas and advice to ensure that our services are developed and run in ways that are most beneficial for the people we care for, our partners, commissioners, staff, and local communities. Our Governors will be actively involved in advisory groups and other forums. They will also play a part in reviewing our membership strategy and developing and delivering our membership recruitment plans.

Our Council of Governors will be responsible for:

- Participating directly in discussions and debates about how we develop our organisation and the services we provide.
- Representing the interests of the members that have elected them.
- Responding to consultations on proposed service changes.
- Appointing (and if necessary, removing) our Chair and our Non-Executive Directors.
- Agreeing pay, allowance and other terms and conditions of office for our Chair and our Non-Executive Directors.
- Approving the appointment of our Chief Executive.
- Appointing (and if necessary, removing) our auditors.
- Receiving and considering documents such as our Annual Reports and Accounts, and Quality Account.
- Assisting with the preparation of our Annual Plan.

Following implementation of the Health and Social Care Act 2012 (the timing of which is still to be confirmed), governors will have a general duty to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and to represent the interests of the Foundation Trust's members as a whole and the interests of the public.

Governors will also have a specific role in relation to Constitutional changes: more than half the Council of Governors voting will need to approve changes to the Constitution and, where the changes affect the powers and duties of the Council of Governors or its role, then at least one member of the Council will attend the next members' meeting to present the change to members, who will vote on it.

In relation to transactions, the Council of Governors will need to approve entry by the Foundation Trust into a "significant transaction" (which will be defined in the Constitution), and also on any merger, acquisition (of an NHS Trust) or separation (of the Foundation Trust into two or more new NHS Foundation Trusts).

Q10. To what extent do you agree with our plans for our Council of Governors?

Q11. To what extent do you agree with our plans for appointed Governors?

Q12. Do you have any ideas for how a voluntary sector representative should be selected from each borough to sit on the Council of Governors?

Board of Directors

As a Foundation Trust we will continue to have a Board of Directors made up of Non-Executive Directors and Executive Directors. They will be legally accountable for the running of our organisation. They set our strategic aims and objectives, and ensure that we perform well and meet our targets.

THE CHAIR

Our Chair is a Non-Executive Director. As well as being the Chair of our Board of Directors they will also be the Chair of our Council of Governors once we become a Foundation Trust. This dual role ensures a direct link between our Directors and Governors by ensuring that our Governors are involved in and can contribute to our future plans.

NON-EXECUTIVE DIRECTORS

Our Non-Executive Directors are appointed from outside our organisation. They have significant experience and specialist expertise gained from a wide range of backgrounds. They use their experience to help improve our organisation by providing challenge to the development and implementation of our plans. They use their specialist expertise to support our Executive Directors in specific areas of their work, and scrutinise their performance.

EXECUTIVE DIRECTORS

Our Executive Directors are responsible for the day-to-day running of our organisation. They have specific areas of expertise and are each responsible for specific areas of the business.

There is more about our Board of Directors on our website at www.clch.nhs.uk

Q13. To what extent do you agree with our plans for the way we will be run?

GET INVOLVED

Have your say on our plans

We would like you to get involved by having your say on our Foundation Trust plans. Our consultation takes place from 08 May 2012 to 31 July 2012. During this time there are a number of ways that you can share your views with us.

You can complete the consultation form at the back of this document and return it free of charge to the FREEPOST address printed on the back of the form.

Email us at ft.consultation@clch.nhs.uk

Visit our website at www.clch.nhs.uk and complete our consultation online.

Come along to one of our community consultation events.

We will be holding five events at the times and dates below. Please come along. We will be happy to discuss our plans with you in person and respond to any questions you have.

Date: Wednesday 30 May 2012

Time: 7pm – 8pm
Venue: Parker Morris Hall
The Abbey Community Centre
Address: 34 Great Smith Street
London SW1P 3BU

Date: Thursday 14 June 2012

Time: 7pm – 8pm
Venue: The Small Hall, Kensington Town Hall
Address: Hornton Street, London W8 7NX

Date: Thursday 21 June 2012

Time: 7.30pm – 8.30pm
Venue: Sangam Association of Asian Women
Address: 210 Burnt Oak Broadway, Edgware, Middlesex HA8 0AP

Date: Wednesday 27 June 2012

Time: 7pm – 8pm
Venue: Avenue House Estate Trust, Avenue House
Address: 17 East End Road, Finchley Central, London N3 3QE

Date: Thursday 05 July 2012

Time: 7pm – 8pm
Venue: Hammersmith Town Hall
Address: King Street, Hammersmith, London W6 9JU

Community groups.

If your community group would like to hear more about our plans and respond to our consultation we are happy to arrange a time to meet with you or attend one of your existing meetings. Please send us an email to **ft.consultation@clch.nhs.uk** if you would like us to arrange this.

What happens next?

Between 08 May 2012 and 31 July 2012 we will collect your responses to our consultation on our Foundation Trust plans. Once the consultation period is complete, we will collate and carefully review what you have told us.

Your views will then be fed into our Foundation Trust application to the Department of Health. We will also publish a report that explains how we have taken your feedback into account in our application.

It is planned that the Secretary of State for Health will review our application in the early part of 2013.

If approved by the Secretary of State, our application will then be assessed by Monitor, the Independent Regulator for NHS Foundation Trusts, who will decide if we can become a Foundation Trust.

We hope to gain Foundation Trust authorisation during summer 2013.

"We believe in giving the best care for our diverse population. We give people more independence by empowering them to take responsibility for their care".

Ravi – District Nurse Team Lead

CONSULTATION RESPONSE FORM

Simply complete the attached form and send it back to us **FREEPOST**. There is no need to attach a stamp. We really value your views, so please ensure your consultation form is returned to us before our consultation closes on 31 July 2012.

Alternatively you can complete our online consultation at **www.clch.nhs.uk**

Please detach here.

Consultation response

If you would like your consultation responses to remain anonymous, please tick here ☐.

About Yourself

Collecting this basic demographic information helps us to make sure our consultation process is inclusive and representative of the local population.

My post code is:

My gender is:

☐ Male ☐ Female
☐ Prefer Not to Say

My date of birth is: / /

My ethnicity is:

Asian or Asian British

☐ Bangladeshi ☐ Indian ☐ Pakistani
☐ Any Other Asian Background
(Please state)

Black or Black British

☐ African ☐ Caribbean
☐ Any Other Black Background
(Please state)

Mixed

☐ White & Asian ☐ White & Black African ☐ White & Black Caribbean
☐ Any Other Mixed Background
(Please state)

White

☐ White British ☐ White Irish
☐ Any Other White Background
(Please state)

Other Ethnic Group

☐ Chinese
☐ Any Other Ethnic Group (Please state)

I am responding to this consultation as:

☐ A member of the public
☐ A service user/patient
☐ A Carer
☐ A member of staff
☐ A community group/organisation
(if so, please give the name)

If you are a service user/patient can you let us know which service you used

and when was the last time you used this service

Q1. On a scale of 1-5 to what extent do you agree with our plans to improve integration across health and social care?
(with 1 representing 'do not support at all' and 5 representing 'fully in support')
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Please explain why you gave this response

Q2. On a scale of 1-5 to what extent do you agree with our plans to adapt the way we work to be more centred around our patients?
(with 1 representing 'do not support at all' and 5 representing 'fully in support')
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Please explain why you gave this response

Q3. On a scale of 1-5 to what extent do you agree with the areas we have chosen for our public constituencies?
(with 1 representing 'do not support at all' and 5 representing 'fully in support')
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Please explain why you gave this response

Q4. On a scale of 1-5 to what extent do you agree with our plans for our public, patient and carer membership?
(with 1 representing 'do not support at all' and 5 representing 'fully in support')
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Please explain why you gave this response

Q5. Should the minimum age for membership be 12, 14 or 16?
☐ 12 ☐ 14 ☐ 16 ☐ other
Please explain why you gave this response

Q6. On a scale of 1-5 to what extent do you agree with our staff constituencies?
(with 1 representing 'do not support at all' and 5 representing 'fully in support')
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Please explain why you gave this response

Q7. On a scale of 1-5 to what extent do you agree with our plans to automatically make our staff members?
(with 1 representing 'do not support at all' and 5 representing 'fully in support')
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Please explain why you gave this response

Q8. On a scale of 1-5 to what extent do you agree with our minimum age for governors?
(with 1 representing 'do not support at all' and 5 representing 'fully in support')
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Please explain why you gave this response

Q9. On a scale of 1-5 to what extent do you agree with our election plans?
(with 1 representing 'do not support at all' and 5 representing 'fully in support')
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Please explain why you gave this response

Q10. On a scale of 1-5 to what extent do you agree with our plans for our Council of Governors?

(with 1 representing 'do not support at all' and 5 representing 'fully in support')

☐1 ☐2 ☐3 ☐4 ☐5

Please explain why you gave this response

Q11. On a scale of 1-5 to what extent do you agree with our plans for appointed governors?

(with 1 representing 'do not support at all' and 5 representing 'fully in support')

☐1 ☐2 3 ☐4 ☐5

Please explain why you gave this response

Q12. Do you have any ideas for how a voluntary sector representative should be selected from each borough to sit on the Council of Governors? please list below.

Q13. On a scale of 1-5 to what extent do you agree with our plans for the way we will be run?

(with 1 representing 'do not support at all' and 5 representing 'fully in support')

☐1 ☐2 ☐3 ☐4 ☐5

Please explain why you gave this response

Please add any other comments below:

Become a member

We would like you to get involved by becoming a member. We want as many local people as possible to become a member of our Foundation Trust. Membership is free and it's easy to join! Simply fill in your details below, and choose the level of membership that suits you from the three options below. Alternatively, you can join online at **www.clch.nhs.uk**

Title:

First name:

Last name:

Address:

Postcode:

Email:

Telephone number:

Mobile number:

We would prefer to send you information about the Foundation Trust and membership issues by email. If you would prefer to receive this by post, please tick here ☐.

Membership is what you want it to be!

☐ Inform - receive information and updates from the organisation about important changes to healthcare.

☐ Involve - receive information, and occasionally get involved in activities, such as focus groups, surveys, consultations and be invited to attend health events.

☐ Influence - receive information and regularly get involved in activities, such as volunteer to support a service; help to collect views from other local people on a range of issues; and a whole range of other activities. You may also want to consider standing for election as a Governor.

We want to build a membership that is representative of the community we serve. The following information will help us know if we have achieved this (optional).

1. Do you consider that you have a disability?

☐ Yes ☐ No ☐ Rather not say

1b. If yes, do you have a:

☐ Physical Impairment
☐ Sensory Impairment
☐ Learning Disability
☐ Mental Health Condition (Long-term)
☐ Other Health Condition (Long-term)

2. Please indicate your religion or beliefs

☐ Agnosticism ☐ Buddhism
☐ Christianity ☐ Hinduism
☐ Humanism ☐ Islam
☐ Jainism ☐ Judaism
☐ Sikhism
☐ Any Other Religion/Belief (Please state)

☐ No Religion or Belief
☐ Rather not say

3. Please indicate your sexual orientation

☐ Bisexual ☐ Gay Man
☐ Heterosexual
☐ Lesbian/Gay Woman ☐ Other
☐ Rather not say

4. Are you currently providing support to a partner, child, relative, friend or neighbour who could not manage without your help or/and support?

☐ Yes ☐ No ☐ Rather not say

Public register

We are required to keep a public register of our members. If you do not wish your name to be included on this register, please tick here ☐.

Please note that your information will be held on a confidential database in accordance with the Data Protection Act 1998.

Please moisten to seal

FREEPOST FOUNDATION TRUST CONSULTATION

Central London Community Healthcare NHS Trust
7th Floor, 64 Victoria Street, London SW1E 6QP
Tel: 020 7798 1300 **Fax:** 020 7798 1301

www.clch.nhs.uk

Public consultation on our Foundation Trust Plans – From Tuesday 08 May 2012 to Tuesday 31 July 2012

London Borough of Hammersmith & Fulham

HOUSING HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE

DATE	TITLE	Wards
17 July 2012	Shaping a Healthier Future: NHS Public Consultation	All

SYNOPSIS

The consultation document sets out proposals to re-configure NHS services in North West London.

The proposed options include the closure of Charing Cross, Hammersmith or Chelsea and Westminster Hospital.

CONTRIBUTORS

NHS North West London

RECOMMENDATION(S):

The Committee is asked to respond to the consultation.

CONTACT

NHS North West London

NEXT STEPS

N/A

Crystal Mark 20288
Clarity approved by Plain English Campaign

NHS
North West London

Shaping a healthier future

Consultation document

Shaping a healthier future

Contents

What this document is for

This document sets out proposals to improve your local NHS services in North West London as part of a programme called 'Shaping a healthier future'.

It is a consultation document and we would like to hear your views on the changes that we propose to make. We have distributed the document widely throughout North West London and neighbouring areas where people use services in North West London. The London boroughs defined by the NHS as North West London are Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea, and Westminster.

'Shaping a healthier future' is being taken forward by eight clinical commissioning groups (CCGs), made up of GPs representing NW London's eight primary care trusts (PCTs). They have worked with hospital doctors, nurse leaders, providers of community care such as mental-health services, social services, patient and volunteer groups and charities to develop the proposals.

If you would like to know more about the extensive work behind this document, please read our pre-consultation business case (PCBC). You can find this on our website at www.healthiernorthwestlondon.nhs.uk

Or, you can order a copy from our Freepost address or Freephone number which are both shown on the next page.

?

Throughout this document you will see a number of questions in boxes, looking like this. These questions relate to the response form that comes with this document, which contains the actual consultation questions we would like you to answer.

Please read the consultation document all the way through and then, in the response form, give us your answers to these questions. In the response form we have shown which sections of the document cover the issues raised by each of the questions. Please refer back to these sections as you answer the questions.

If you want to explain any of your answers, or you feel the questions have not given you the chance to give your views fully, or if you think there are options we have not considered that we should have done, please say so in the box at the end of the response form.

You can fill in the questions on the printed response form and post it to our Freepost address:

FREEPOST SHAPING A HEALTHIER FUTURE CONSULTATION

This must be written exactly as it is shown above (in capital letters and on one line) and you will not need a stamp.

Or, you can fill it in online on our website:

www.healthiernorthwestlondon.nhs.uk

If you have any complaints about the consultation please contact:

Lynne Spencer,
Head of Corporate Affairs,
NHS NW London,
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We must receive your response form by no later than 8 October 2012.

This document is also available in other languages, in large print, and in audio format. Please ask us if you would like it in one of these formats.


0800 881 5209


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Foreword

Foreword by the chairs of the NW London clinical commissioning groups

Our aim is to deliver the best possible healthcare to our patients. But people's health needs are changing, and we aren't able to deliver care to the standards we would like. We believe we need to change the way we deliver healthcare now, so that we can provide high-quality care in the medium and long term.

This need for change in the NHS is partly a response to ongoing changes in the population. NW London is growing, people are living longer, and more people are developing conditions such as diabetes and obesity. This is putting pressure on our health services. We need a system where we can deliver the right kind of healthcare, in the right setting.

In many cases, the best setting isn't in hospitals. We know that increasing the amount of care delivered closer to your home will help care to be better co-ordinated, and improve the quality of that care and its value for money. When people do need hospital care, we have shown that making some services more central will mean that patients always have access to the best possible care.

As the chairs of the eight clinical commissioning groups for NW London, and leaders of this programme to deliver this change, we have made four main commitments which support our vision for how services should work in the future.

The first is a commitment to help people take better care of themselves, understand where and when they can get treatment, and understand different options for treatment.

Secondly, when patients have an urgent

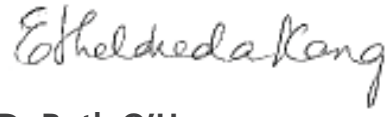
healthcare problem, we are committed to making sure they can easily consult a GP or community-care provider 24 hours a day, seven days a week by phone, email or face-to-face.

Our third commitment is that if patients need to see a specialist or receive support from community or social care services, this will be organised quickly and GPs will be responsible for co-ordinating their healthcare.

Finally, if patients need to be admitted to hospital, we are committed to making sure the hospital will be properly maintained and up to date and a place where they can receive treatment delivered by specialists, 24 hours a day.

We will need to make significant changes to achieve these commitments, and we will have to make some difficult decisions, but we believe the changes are essential. The changes may be substantial, but the rewards of getting it right will be too, with better healthcare, better support, more lives saved, and a sustainable, efficient system.

Dr Ethie Kong
NHS Brent CCG Chair



Dr Ruth O'Hare
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NHS Hammersmith and Fulham CCG Chair

Dr Amol Kelshiker
NHS Harrow CCG Chair

Dr Ian Goodman
NHS Hillingdon CCG Chair

Dr Nicola Burbidge
NHS Hounslow CCG Chair

Foreword by the Medical Director of 'Shaping a healthier future'

Dr Mark Spencer

As a doctor trained at Charing Cross Hospital and as a GP trained at Hammersmith Hospital, I have been a GP in Acton for 23 years. I reluctantly became involved in buying services for my patients as a fundholding GP in the 1990s, but found that my patients benefited if I paid more attention to information that showed where the best care was available and that together we could work with hospitals to improve some stages of care.

Over the last 10 years it has become increasingly clear that the health system locally needs to change – and not just a little bit.

As I talk to people, they complain about access to their GP practice, and about a poorly co-ordinated system, and while they sometimes talk about spectacularly great treatment, they too often tell me about the lack of care and communication.

But as I look at the examples of best practice, and evidence that shows that specialist teams can do better in some conditions when working as part of a larger team, I realise that the good outcomes we sometimes get are more often because doctors, nurses and other care workers make that happen despite the organisations they work for, rather than being supported by them.

We have too many small hospital units in North West London that can't provide the best specialist care or make sure that an expert is available round the clock. This provides average, rather than the best, care. By concentrating specialist care onto fewer major hospitals and still providing excellent access to networked care at local hospitals we can get better care. This also allows investment into community and primary care, which is where most patients are treated.

I was leading a local group of GPs, but have had the opportunity over the last year to co-ordinate and work with GPs with similar cares and concerns for people across North West London. We have worked with hospital doctors and nurses and considered how we can make things better, and affordable. It is this group of GPs, supported by senior doctors from every hospital in the region, that has led this work and drawn up these recommendations.

Change is rarely welcomed, and many attempts have been made in the past to improve care in North West London. But as clinicians come together to take on the responsibilities of making sure the best care is available for the local population, we have an opportunity that we must take. If we don't take this opportunity we will face thinly spread services or unplanned closures on safety grounds. But if we work to make these changes, we will save many lives and improve the care that people experience every day. This is an opportunity not to be missed.

I do hope that you read this document, consider and discuss it. We really haven't made any decisions yet – our recommendations will benefit from your response.

Dr Mark Spencer
Medical Director, *Shaping a healthier future*

Foreword by the Chair of the Joint Committee of Primary Care Trusts

Jeff Zitron

For those of us who live in North West London, having a strong local NHS is a top priority. Many residents owe their lives and good health to the quality of our staff and facilities. However, others are not able to access the services they need or do not always receive the highest standard of care.

Demands on the NHS are increasing because of its very success – for example, people are living longer and medical advances mean more conditions can be treated than ever before. As a result, standards of care keep on rising, so the NHS must change to keep pace.

This document explains why and how health services in North West London need to change, and describes options for achieving this. The proposals within the document have been developed by local doctors, nurses and other healthcare staff, in consultation with patients, councils and care organisations. We propose major changes to how services are provided in hospitals and within the community. The proposals draw on experience – in North West London and beyond – of how health services can be improved by making better use of staff expertise, buildings and funds.

Before any decision is made on these proposals, we are asking the public in the areas affected for their views. This consultation is being overseen by the NHS primary care trusts (PCTs) in North West London, together with other PCTs whose residents may be affected by the proposed changes. The joint committee formed by these PCTs will consider the results of the consultation, and will then decide whether changes should be made and, if so, what these changes should be.

We are very keen to hear your views. As well as reading this document, we hope that you are able to take part in other consultation events (see our website at www.healthiernorthwestlondon.nhs.uk for more details). 'Shaping a healthier future' is about planning how we can have the strongest local NHS possible in the years ahead and I hope you will be able to contribute to this.

Jeff Zitron
Chair, NHS North West London and the Joint Committee of Primary Care Trusts

Summary

'Shaping a healthier future' proposes changes that will improve care both in hospitals and the community and will save many lives each year. This summary explains how.

We look after nearly two million people in NW London and have high aims for the way they are cared for and the services they receive. Our staff are totally committed to this high-quality care, but need to have the right workforce, skills and surroundings to deliver this for patients. Increasingly, a number of different factors in NW London are making it very difficult for us to look after patients in this way.

These factors include the challenges of looking after a growing and ageing population, with too few specialists in hospitals to provide high-quality round-the-clock care, working from inadequate NHS facilities, and working within an increasingly tight budget. These challenges need to be met – or the NHS and its services in NW London will deteriorate. This would mean inequalities continuing, people dying unnecessarily, hospitals and other services failing, hospitals being unable to recruit and keep staff, and some NHS trusts facing severe financial pressure.

Since it would be irresponsible not to tackle these challenges and simply allow patients to get a worse service, we (GPs, hospital doctors, community providers, nurses, and wider NHS staff) have looked at ways in which health services are being improved in London and around the world to develop a vision for healthcare in NW London.

We have based this vision on the principles that you should have:

- the support you need to take better care of yourself;
- a better understanding of where, when and how you can be treated;
- the tools and support you need to better manage your own medical condition;
- easy access (24 hours a day, seven days a week) to primary-care clinicians such as GPs – by phone, email or in person – when you need to be seen urgently;
- fast and well-co-ordinated access to specialists, community and social-care providers, (this access would be managed by GPs); and
- properly maintained and up-to-date hospital facilities with highly trained specialists available all the time.

The way in which we would deliver this vision, which would meet all these demands, is by:

- bringing care nearer to you so that as much can be delivered as close to your home as possible;

- centralising hospital care onto specific, specialist sites so that more expertise is available more of the time; and

- incorporating all of this into one co-ordinated system of care so that all the organisations and facilities involved in caring for you can deliver high-quality care and an excellent experience, as much of the time as possible.

We have developed standards based on the best available evidence to make sure that quality improves wherever care is being delivered, whether that is close to home, in emergencies, or in situations where specialist treatment is needed. We have developed new patient pathways – that is, the different stages of NHS care you may go through as a patient – to improve the ways different types of common conditions are treated. When they are put in place they will help us to improve the way you are cared for, and save more lives.

Delivering this vision will not be easy. It will mean changes to the way in which people work, where money is invested and the settings (places) in which healthcare is delivered.

As part of our proposals, we have described eight settings of care –your home, your GP's practice, another nearby GP practice (care network), a health centre, a local hospital, a major hospital, an elective hospital and a specialist hospital.

GP practices will work together to serve their patients, making the best use of their skills and resources to improve quality and access to services. Networks of GP practices will work with other providers of health and social care services to deliver co-ordinated healthcare to the local community. We have developed plans to put this in place for each borough. We have set aside up to £120 million to deliver the changes.

Hospitals will also need to change in order to improve quality. We have recommended that all nine current acute hospitals in North West London (Charing Cross Hospital, Chelsea and Westminster Hospital, Central Middlesex Hospital, Ealing Hospital, Hammersmith Hospital, Hillingdon Hospital, Northwick Park Hospital, St Mary's Hospital and West Middlesex Hospital) should continue to provide local hospital services, including an urgent care centre and outpatient and diagnostic services. (This urgent care centre is one which is open 24 hours a day, seven days a week.) We also recommend that five of these hospitals are major hospitals, providing a full A&E service, emergency surgery, maternity and inpatient paediatric services.

We have recommended that specialist hospitals should all stay largely as they are. The Hammersmith Hospital will become a specialist hospital, keeping all its current specialist services, as well as providing local hospital services including an urgent care centre on or very near to the current site.

We have recommended that Central Middlesex Hospital be an elective hospital as well as a local hospital with an urgent care centre. It should not be a major hospital because essential services for a major hospital – emergency surgery, paediatrics (children's services) and maternity – are not provided on-site, and because patients could use these major emergency care services elsewhere in other nearby hospitals. This means Central Middlesex Hospital will continue to provide most of the services it does already and will provide an expanded range of planned care.

We have also recommended that Hillingdon Hospital and Northwick Park Hospital should be major hospitals. This is due mainly to their location. If either of these hospitals did not

provide this more complicated healthcare, people in surrounding areas would, on average, have to travel too far to get to the next hospital providing those kinds of services.

If these proposals are accepted – with two of the five proposed major hospitals at Northwick Park Hospital and Hillingdon Hospital, and Central Middlesex Hospital as an elective hospital – we propose that services at the remaining three major hospitals should be distributed evenly across NW London to keep the effect of changes on local residents to a minimum. This means that there would be a choice of:

- one major hospital at either Charing Cross Hospital or Chelsea and Westminster Hospital;
- one major hospital at either Ealing Hospital or West Middlesex Hospital; and
- one major hospital at either Hammersmith Hospital or St Mary's Hospital.

We have assessed these choices in detail, looking at which would deliver the best clinical quality of care and access to care, whether they are affordable and can be delivered, and which would be best for research and education, and this has resulted in three options for the public to consider.

	Option A	Option B	Option C
St Mary's	Major hospital	Major hospital	Major hospital
Hammersmith	Specialist hospital	Specialist hospital	Specialist hospital
Charing Cross	Local hospital	Major hospital	Local hospital
Chelsea & Westminster	Major hospital	Local hospital	Major hospital
West Middlesex	Major hospital	Major hospital	Local hospital and elective hospital
Ealing	Local hospital	Local hospital	Major hospital
Central Middlesex	Local hospital and elective hospital	Local hospital and elective hospital	Local hospital and elective hospital
Northwick Park	Major hospital	Major hospital	Major hospital
Hillingdon	Major hospital	Major hospital	Major hospital

We prefer option A because it:

- will improve quality of care;
- makes good use of buildings;
- represents the best value for money;
- is the easiest option to carry out; and
- supports research and education.

We have considered carefully whether there should be a 'preferred option' to put to the public, since the three options – A, B and C – are all potentially suitable. However, because the Joint Committee of Primary Care Trusts, who will make the final decision on any changes, believe that option A would give the greatest benefits for NW London, it would be misleading not to say so. However, this is also a consultation aimed at gathering people's views. So we are putting all three options forward and inviting your views on which option will have the greatest benefits.

If Charing Cross Hospital is not a major hospital, we are proposing that the hyper-acute stroke unit at Charing Cross Hospital moves to be alongside the major trauma centre at St Mary's Hospital. The London-wide stroke and major trauma consultation carried out in 2009 by NHS London preferred putting hyper-acute stroke units on the same site as major trauma centres, as they need similar back-up and support.

Finally, we propose that the Western Eye Hospital is moved to be alongside the major hospital at St Mary's Hospital. This will improve the quality of care for patients.

We are now consulting everyone in NW London about these options for change to give them the chance to give their views and comments. We have not made any decisions and your feedback and explanations of how we could do things differently or better really can make a difference. In this document, we have asked you specific questions on each of the changes that we are proposing. The consultation will run from 2 July to 8 October 2012. We will then spend a few months looking at your responses, and make a final decision in early 2013.

If these changes are agreed, it will take at least three years to put them in place. We are already putting in place services that can be provided in the home, GP surgeries and health centres and only once these services are running successfully will we make changes to hospitals.

1. Describing the NHS in NW London

We look after nearly two million people in NW London, providing the best possible care with the resources available.

Local GPs, hospital doctors and other clinicians – including nurses, midwives, pharmacists, those providing community services, and many others – are devoted to delivering the highest-quality services they can.

We do this because we are committed to our patients within the eight boroughs. In NW London there are 10 acute and specialist hospital trusts, 423 GP practices, two community trusts and two mental-health trusts.

The NHS in NW London

Hospitals in NW London

8 London boroughs
2 million people
£3.4 billion annual health budget
More than **400** GP practices and **1100** GPs
8 clinical commissioning groups
10 acute and specialist hospital trusts
2 mental-health trusts
2 community-health trusts

The rich diversity of NW London, with its hundreds of different communities and wide range of people, makes delivering healthcare a demanding challenge. Every single employee of the NHS understands this and is committed to meeting the challenge. It is what the NHS was created to do – to care for its patients, no matter how complex or difficult that might be.

This means delivering more care in surroundings which are better for patients – for example in community facilities, GP surgeries, and in the home. It means making sure that centres of excellence, such as the hospitals in NW London, have access 24 hours a day, seven days a week, to the best doctors, equipment and back-up.

To provide services of the highest quality across this diverse part of London, we need to have the right resources. We need a high-quality workforce of expert, well-trained colleagues, the latest equipment and technology, backed by world-class research and education, and the best possible surroundings in which to work.

If you live in NW London, it means providing care for you across the many organisations that are involved in that care, so you always know what is happening, have full access to the best advice when and where you need it, and if things do not go as planned you know you can quickly get the very best back-up.

These might seem obvious and entirely understandable requirements for a health service, given the importance to the NHS of caring for so many people across so many boroughs. But it is easy to lose sight of just how complex and challenging the health needs of an area can be, and just how challenging it can be to meet these needs.

Increasingly, many different factors in NW London are making it very difficult for us to look after our patients in this way – which may include you. The next part of this document explains why.

2. The challenges facing the NHS in NW London

There are a number of challenges facing the NHS as a whole and those of us who deliver health services in NW London.

Many of the challenges are part of the nature of a thriving, bustling, successful city. Some of them apply only to certain communities and areas, others are the same as those faced by major cities the world over.

Population challenges

- A growing population. NW London is a very densely populated area, and over the next 10 years the number of people living here is expected to increase from just under 1.9 million to 2 million. The sheer number of people needing care, 'from cradle to grave', represents a major challenge for the NHS.

- A population with different life expectancy. NW London varies hugely from place to place in economic terms, with very poor and very wealthy households often living side by side. And health varies with wealth: the poorer you are, the more likely you are to suffer ill health. Within NW London, there is a 17-year difference in the life expectancy of those living in the most deprived wards, compared with those in the wealthiest wards. These differences can be caused by many things, such as living conditions, diet, levels of smoking and drinking, access to sport and leisure facilities, and even language barriers. Better healthcare cannot overcome all these things but it can make a major difference to them, and is known to reduce inequalities between people.

- An ageing population. In NW London the good news is that life expectancy is improving and so people are living longer. Ten years ago, life expectancy in NW London was 77 years for men and 82 years for women. Today, it is about three years longer. For the NHS, this increases the pressure on services because older people are more likely to develop long-term health conditions such as diabetes, heart disease, breathing difficulties and dementia.

- A population with modern lifestyles. Poor diet and lack of exercise are the hallmarks of a typical, western lifestyle. They lead to increased rates of obesity and diabetes and, in NW London, we are treating more and more of these conditions. Similarly, smoking is the UK's single greatest cause of preventable illness and early death, and alcohol abuse (which is increasing in NW London) is leading to increasing rates of death from liver disease and other conditions.

Clinical challenges

- It is difficult for people to get to see a GP when they need to and too many people end up in A&E. 75% of people say they manage to see their GP when they need to but this means that one in four patients in NW London feels it takes too long. The same number feel they are not treated with care and concern by their GP. These satisfaction rates are below the national average.

- At the same time, NW London has more A&E departments per person than other parts of the country and more people than average use A&E services. This is partly because people who cannot access primary care (such as GP services) often end up going to hospital instead. But providing healthcare through A&E is more expensive, and lacks the kind of co-ordinated care that a GP can provide because, for example, they know the patient's family and their health history. Many GPs offer good-quality care, but for too many patients that care is not available when they need it.

- More people are now living with long-term medical conditions, such as diabetes, heart disease, and respiratory problems such as asthma, which are creating particular problems in NW London. One complication of diabetes for example is reduced blood flow to the legs. If not treated early, this can lead to amputation. When people are managed by GPs with specialised clinics, supported by a diabetic nurse, amputation is much less likely to happen. But not everyone in NW London has access to such a service. The 'integrated care pilot' we describe in section 4 has already improved outcomes for diabetics, but NW London still needs local specialist services to improve treatments.

- Too many elderly people end up in hospital when, with appropriate care outside hospital, they could be treated in the community and looked after at home. There are good reasons for caring for people outside hospital, because elderly people are at risk of developing further conditions in hospital. Equally, at the end of people's lives, the NHS needs to do more to support them to die at home if this is what they want. In NW London, only 18% of people die at home compared with a national average of 23%, even though 54% of patients say they would prefer to die at home.

- As shown by the reorganisation of stroke services in London (see section 4), there is clear evidence that in emergency cases, having senior hospital staff on hand means a better outcome for the patient. In other words, people suffer fewer complications and are less likely to die when there is a senior doctor there to care for them when they arrive seriously ill. Statistics show that in London as a whole, people who are admitted to hospital as an emergency case at the weekend are 10% more likely to die than people who are admitted during the week. At present, the number of senior doctors available drops by more than half at many London hospitals during the weekend. Solving this issue could save 130 lives in NW London every year.

- The number of women who need maternity services is increasing and pregnancies are becoming more complicated. The rate of maternal deaths in London has doubled in the last five years, reaching twice the rate in the rest of the UK. Many of these deaths could have been prevented. Babies born outside of normal working hours are also at a higher risk of dying. This is associated with a lack of access to senior staff at these times, and maternity units cannot meet recommended midwife staffing

levels. We also do not have enough nurses to care for sick babies in NW London (we have the highest vacancy rate in London) and we do not have enough senior doctors to provide round-the-clock care for children in hospital.

- These issues won't be solved simply by training and hiring more doctors. Those doctors also need experience of dealing with complications regularly, so they can provide the best specialist care. If they do not see enough patients, they lose their skills and cannot provide such high-quality care. If they are spread across many hospitals, doctors will not get that experience.

NHS buildings and facilities challenges

- You might think having lots of big hospitals would help if a population has many health problems, but this is actually not the case, and NW London proves the point. The fact that there are a lot of big hospitals here causes more problems than solutions. With 50% more building space per hospital bed in NW London than in the rest of the country, it means:

> we spend much more on hospital maintenance and running costs than in many other places and this means we have less money to spend on services such as GPs than in other parts of the country;
> two-thirds of hospitals in NW London would ideally need significant investment and refurbishment to meet modern standards. The 'backlog' maintenance bill to correct just the very worst issues is around £53 million; and
> there are so many big expensive NHS buildings in NW London that even with this level of spending on maintenance, NHS buildings in NW London are generally not in a good condition.

- The best way to treat a population with lots of increasing health demands is actually to spend more money on services outside hospitals – and the more money spent in the community, the better the overall health of the population becomes.

- Equally, some health services in NW London are delivered from very modern, up-to-date facilities which have the latest technology. Clearly it would be a poor decision not to make the most of these buildings, especially at a time when the NHS cannot afford to find and buy new land and build new hospitals.

Financial challenges

- Not surprisingly, looking after such a large population with so many health needs costs a lot of money and the NHS currently spends approximately £3.6 billion a year in NW London – some 24% of all NHS spending in London. But as we all know, the world, the UK and London are facing particularly difficult economic times right now. Although the Government has promised to protect health budgets, the amount of money available to the NHS in real terms is likely to increase only very slightly in the years up to 2015.

- In other words, keeping up with new technology and better treatments and managing the health needs of a population that is getting older means that the NHS needs to find an extra £20 billion a year by 2015. In NW London we estimated that by 2014/2015 we would need an extra £1 billion a year. However, we already know that there isn't anywhere near this amount of money available. We have to find savings of at least 4% a year – something which has never been done by the NHS before – by becoming more productive, by changing the way we deliver services and by doing what we can to reduce demand for services. Unless things change, we predict that most of the hospitals in NW London will end up in financial difficulties.

- It would be wrong to say the NHS, and these proposed changes, are driven mainly by the need to save money. We are actually first and foremost driven by the challenge of delivering high-quality care. But money is an important consideration.

3. What will happen if we do nothing?

Even with all the challenges facing the NHS, why is there a need for such drastic change?

Surely the extra money should just be found, more doctors and nurses recruited, buildings repaired and more community facilities built? Then what is now pretty good, would become very good. If only it were that easy. Unfortunately, the situation facing the NHS in NW London is a lot worse than this, and needs more drastic solutions. The fact is, if nothing is done within the next few years, some major things will start going very badly wrong with the NHS in NW London:

- Inequalities would continue and perhaps get worse. Currently people in some parts of NW London die on average 17 years earlier than those in nearby areas. This is neither fair nor reasonable and we need to try to reduce those differences.

- People would continue to die unnecessarily. A recent study showed patients treated at weekends and evenings in London hospitals – when fewer senior doctors are available – stand a higher chance of dying than if they are admitted during the week. We need a system that allows all of our hospitals to benefit from having senior, expert consultants on-site at all times.

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

- Existing hospital trusts would be under severe financial pressure, which means they could literally run out of money. And while the NHS can cope with some financial losses, this is obviously far from ideal and the deeper 'into the red' that trusts go, the more difficult it is to keep services running, to keep staff and maintain morale, and to provide high-quality patient care. As there is a limit to the money available, some of the hospitals in NW London would simply have to stop providing services. Crucially, this would happen in a disorganised way – meaning a worse effect on patients and staff.

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

While this may sound alarming, it is worth noting that many clinicians working for the NHS in NW London feel that we have not explained in strong enough terms what would happen if we did nothing. Though services are mostly providing good standards of care at the moment, they cannot do so for much longer and it will be patients, and the clinicians who treat them and care for them, who will be the first to feel the consequences.

1

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

2

What comments, if any, do you have on any of the issues raised in sections 1, 2 or 3 of this consultation document?

4. So what is the answer?

Those of us leading the NHS in NW London – its leading GPs, hospital doctors, nurses, pharmacists and others – do not believe that things should just be allowed to deteriorate.

We do not believe that allowing unplanned cuts to services is the best way to manage the NHS either now, or in the future. It would be highly irresponsible not to act in these circumstances.

So, we have developed a vision for how we want health services to be developed and improved. Importantly, we have involved patient groups and representatives in developing this vision. In this consultation we want to find out what you think.

We have based this vision of care on improvements and innovations which are already being made in many parts of NW London and the rest of the country. This is important because it means the changes are tried or tested ways of delivering healthcare – we already know that they work, that they improve care and that they can be delivered.

Example **Stroke services**

London has made giant strides in tackling one of the biggest killers – stroke – over the last few years. Just three years ago, stroke care was spread across the city, with all 31 acute hospitals trying to deliver it.

Now, a dedicated network of eight hyper-acute stroke units provide the immediate, specialist care that stroke patients need – in NW London these include Northwick Park Hospital and Charing Cross Hospital – and another 24 stroke support units around London provide ongoing care once a patient is stabilised.

This is estimated to have prevented around 400 deaths in London and 100 in NW London every year since the changes were made and proves an important principle – that hospital care for certain conditions is much better when centralised at a specific, limited number of specialist sites.

There was of course some opposition to this change when it was suggested as it meant that some hospitals 'lost' services. However, it is now clear that it is much more important that an ill patient gets to the best place which has the right, expert consultants and surgeons, even if it means driving straight past their nearest hospital.

Example **Integrated care pilot**

A major frustration of patients with long-term conditions is that their care is not well managed across different NHS organisations. So an integrated care pilot (ICP) was set up in Westminster, Kensington and Chelsea, Hammersmith and Fulham, and in parts of Ealing and Hounslow to look into this, concentrating on people aged over 75, or with diabetes.

The ICP makes sure hospitals, community-care services, social care and local authorities all work as a team, so patients receive co-ordinated care across different services. It has proved so successful that it has won national awards for its pioneering work.

The ICP shows what can be done outside hospitals, particularly when the various health and social care teams in a community pull together for the benefit of the patient. It is now being expanded to include all boroughs in NW London and to include more conditions.

The GP practices taking part in the pilot have so far reduced emergency admissions to hospital for elderly people by 7% and have created 20,000 individual care plans for their patients.

5. Our vision for healthcare in NW London

So we can make sure that health services do not deteriorate severely in the future, we have a vision that in NW London you will have:

- the support you need to take better care of yourself;
- a better understanding of where, when and how you can be treated;
- the tools and support you need to better manage your own medical conditions;
- easy access to primary care providers, such as GPs, 24 hours a day, seven days a week; by phone, email or in person – when you need to be seen urgently
- fast and well-co-ordinated access to specialists, community and social care providers, (this access will be managed by GPs); and
- properly maintained and up-to-date hospital facilities with highly trained specialists available all the time.

There are three major principles that sum up our vision for the NHS in NW London. They are:

- localising routine medical care (delivering as much care as possible, as soon as possible, in convenient places which are easy to access);
- centralising the most specialist services (bringing more services together on a number of specific sites); and
- integrating care between primary, secondary and social care providers (making sure all parts of the NHS and social services work more closely together).

Our vision of care

Three main principles form our vision for care	
1	**Localising** Localising routine medical services means better access closer to home and improved patient experience
2	**Centralising** Centralising most specialist services means better clinical outcomes and safer services for patients
3	**Integrated** Where possible, care should be integrated between primary and secondary care, with involvement from social care, to give patients a co-ordinated service

3

Please say how important you think it is that we should aim to make sure that you and everyone else in NW London will have each of the following:

a) The support you need to take better care of yourself

b) A better understanding of where, when and how you can be treated

c) The tools and support you need to better manage your own medical conditions

d) Easy access to primary care providers, such as GPs, 24 hours a day, seven days a week; by phone, email or in person – when you need to be seen urgently

e) Fast and well-co-ordinated access to specialists, community and social care providers (this access will be managed by GPs)

f) Properly maintained and up-to-date hospital facilities with highly trained specialists available all the time

6. World-class healthcare outside of hospital

The vision for care outside of hospital developed by the NHS and particularly our local GP leaders is based on the principles of localisation and integration (see section 5).

Care outside hospital includes all those services provided in community settings such as in your home by community nurses, at your GP's surgery and in health centres. It also includes all the ways that you can look after yourself better.

This means delivering as much care as possible which is local to you at a convenient time – so either in your home or at your GP's surgery, for example, or even in your local hospital. By offering a much wider range of high-quality services within the community, we can make sure people have easier and earlier access to care.

Your GP practice will be at the heart of delivering an integrated service, using a range of providers. With more co-ordinated primary health and social care services, your GP practice will co-ordinate care across all services and have overall responsibility for your health. GPs and other primary-care professionals will be able to pick up on health issues at an earlier stage, and provide treatment that prevents patients ending up in hospital. This kind of planned care avoids the need for emergency and urgent care at a later stage. This approach, with different providers delivering care in an integrated package, will help people get better more quickly so they can get on with their lives.

To make sure that the quality of care improves, every care provider will have to keep to high standards of care. The new clinical commissioning groups, the organisations that are being led by GPs to plan healthcare services, will work with partners including health and well-being boards to make sure the standards are kept to.

The leaders of all the eight clinical commissioning groups in NW London have made the same commitment to change how primary and community care is delivered, based on four main quality standards.

Quality standards for care outside hospital (please see note below)

Individual Empowerment and 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 and 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 and Multi-Disciplinary Care Delivery	Individuals using community health and care will experience co-ordinated, 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 and 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.

Note: Plain English Campaign's Crystal Mark does not apply to these standards as they were agreed by the leaders of the eight clinical commissioning groups in NW London before this consultation document was written.

Delivering this vision will:

- improve access to GPs and to other services so patients can be seen more quickly and at a time that is convenient to them;
- mean more people can take control of their own health conditions;
- help carers to support those with health and social care needs;
- mean that healthcare providers and patients will be able to access information about patients' health, so reducing possible errors and avoiding patients having to give the same information many times;
- deliver co-ordinated care plans for people, preventing deterioration in health and reducing admissions to hospital; and
- reduce complications and poor outcomes for people with long-term conditions by providing more specialist services in the community.

4a

How far do you support or oppose the standards that have been agreed for care outside hospital?

7. Making hospitals centres of excellence

Our vision for hospital care is based on centralising services – that is, bringing more services together on fewer sites to create a greater level of expertise so that we can provide better care and save more lives.

It has been shown that having more expertise and more senior doctors available in hospitals improves the outcome for patients. As shown in section 4, we know that this approach works, based on what has been done to centralise heart-attack care, major arterial surgery, stroke care and trauma care in London. Other countries around the world have used exactly the same approach successfully.

In NW London however, as explained in section 2, not enough services have been centralised, leaving some hospitals with stretched senior medical cover and not enough expertise – particularly at the weekends and at night. Across NW London, the quality of hospital care differs too much. It sometimes meets high standards, but quite often it does not and this can, in the worst cases, lead to unnecessary deaths.

Clinicians have looked closely at this and at the latest research and evidence and believe it is clear that by centralising certain services, patients will have better outcomes. This may mean reducing recovery time, preventing relapse or the need to go back to hospital or, in the most extreme cases, saving lives.

Naturally, people may be concerned about travel times. It is important that we can still provide emergency care close to, or at, the scene of an accident. However, once someone is being treated by an ambulance crew, the time it takes to get to hospital is much less important. These days so much more care can be provided at the scene of accidents, actually within ambulances, or in the community. And, of course, ambulances do not station themselves at hospitals, but at more spread-out locations to provide the best cover for a certain area.

Outcomes for patients improve much more if they are taken to the right place for treatment even if this is not the place nearest to where they were taken ill. This is already happening in some situations and is getting excellent results. For example, in a major accident that happened anywhere in NW London, the ambulance crew would stabilise the patient and then take the patient straight to the best hospital to treat their injuries, even if it meant driving past several hospitals on the way.

The big difference that centralising services makes is that it means we can provide access to senior doctors and lots of back-up services 24 hours a day, seven days a week. Travel times need to be within an acceptable limit, but are not as critical as they used to be

in deciding exactly where services such as emergency care should be located.

Centralising services onto fewer, more specialist sites also has important benefits for training clinicians. Academic and training institutions, such as medical specialties, work best when they are located closer together. Sharing ideas, innovations, new technology and new techniques becomes much easier. This is why the most successful health education and research institutions all over the world, as in London, are often 'clustered' together around a well-known campus or area.

NW London has some excellent centres of academic and medical institutions already – such as the Academic Health Science Centre, covering Imperial College and Imperial College Hospital Trust in West London, and the specialist services in Chelsea and Westminster Hospital which cover heart, lung and cancer services. Making sure we build on this excellence is important to us. We want to make sure we not only have a current, highly skilled workforce which is able to deliver the best services, but that we can protect that workforce for future generations.

To make sure that the quality of care is improved, every provider will have to meet high clinical standards of care. The local GP commissioners will monitor this. All hospitals in NW London will have to meet these standards, which we have agreed.

Quality standards for hospital care (please see note 1 below)

Emergency Surgery and A&E	**Access to senior and specialist skills**	• All emergency admissions to be seen and assessed by a relevant consultant within 12 hours of the decision to admit or within 14 hours of the time of arrival at the hospital • Acute medicine inpatients should be seen twice daily by a relevant consultant • When on-take for emergency / acute medicine and surgery, a consultant and their team are to be completely freed from any other clinical duties / elective commitments that would prevent them from being immediately available • Any surgery conducted at night should meet NCEPOD (National Confidential Enquiry into Patient Outcome and Death) requirements and be under the direct supervision of a consultant surgeon • All hospitals admitting emergency general surgery patients should have access to an emergency theatre immediately and aspire to have an appropriately trained consultant surgeon on site within 30 minutes at any time of the day or night • The Critical Care Unit should have dedicated medical cover present in the facility 24 hours per day, seven days per week
	Access to diagnostics and multi-professional teams	• All hospitals admitting medical and surgical emergencies should have access to all key diagnostic services (e.g. interventional radiology) in a timely manner 24 hours a day, seven days a week, to support decision making • Prompt screening of all complex needs inpatients should take place by a multi-professional team which has access to pharmacy, psychiatric liaison services and therapy services (including physiotherapy and occupational therapy, seven days a week with an overnight rota for respiratory physiotherapy) • Single call access for mental health referrals should be available 24/7 with an aspired maximum response time of 30 minutes
	Processes	• The majority of emergency general surgery should be done on planned emergency lists on the day that the surgery was originally planned and any surgery delays should be clearly recorded • On a site without 24/7 emergency general surgery cover, patients must be transferred, following a clear management process, to an Emergency Surgery site if a surgical emergency is suspected without delay

Maternity	• Women with complex medical conditions must be offered assessment by a consultant obstetrician • Units with more than 6000 births a year should provide 168 hours of consultant presence (24/7) • Units with between 2500 and 6000 births a year or classed as high risk should provide 98 hours a week of consultant presence (please see note 2 below) • Units with up to 2500 births a year are strongly recommended to have 40 hours of consultant obstetric presence but should conduct a risk assessment exercise to determine their individual requirements • Outside the recommended minimum 40 hours of consultant obstetrician presence, the consultant will conduct a physical ward round as appropriate at least twice a day during Saturdays, Sundays and bank holidays, with a physical round every evening, reviewing midwifery-led cases following referral • All women's care should be co-ordinated by a named midwife throughout pregnancy, birth and the postnatal period. Where specialist care is needed this should be facilitated by her named midwife. Clinical responsibility for women with complex care needs should remain with the specialist, but these women should still receive midwife-co-ordinated care • Consultant-delivered obstetric services should include a co-located midwife-led unit to provide best care and choice for women and babies. Women should be able to choose the option of an out of hospital pathway (home birth and standalone midwife-led unit) if appropriate • Obstetric units will need support from different services, including onsite access to emergency surgery (some have argued this can be provided by emergency gynaecological surgery cover), interventional radiology, and critical care, in addition to support from an onsite neonatal inpatient unit but not necessarily paediatrics • There must be 24-hour availability in obstetric units of a clinical worker fully trained in neonatal resuscitation and stabilisation of a new born baby for immediate advice and urgent attendance • Midwifery staffing levels are calculated and implemented according to birth setting and case mix categories to provide a one-to-one midwife-to-woman standard ratio during active labour with immediate effect • There must be access to emergency theatre when required
Paediatrics	• All paediatric inpatient admissions to be seen and assessed by a relevant consultant within 12 hours of the decision to admit or within 14 hours of the time of arrival at the hospital • When on-take for emergency and acute paediatric medicine and surgery, a consultant and their team are to be completely freed from any other clinical duties or elective commitments that would prevent them from being immediately available • All inpatient paediatric services units need to have paediatric consultant availability within 30 minutes • Paediatric inpatients should be seen twice daily by a paediatric consultant • Paediatric Assessment Units (PAUs) should have clearly defined responsibilities, with clear pathways, and should be appropriately staffed to deliver high quality care as locally as possible

Note 1: Plain English Campaign's Crystal Mark does not apply to these standards as they were agreed by our clinical leaders before this consultation document was written.

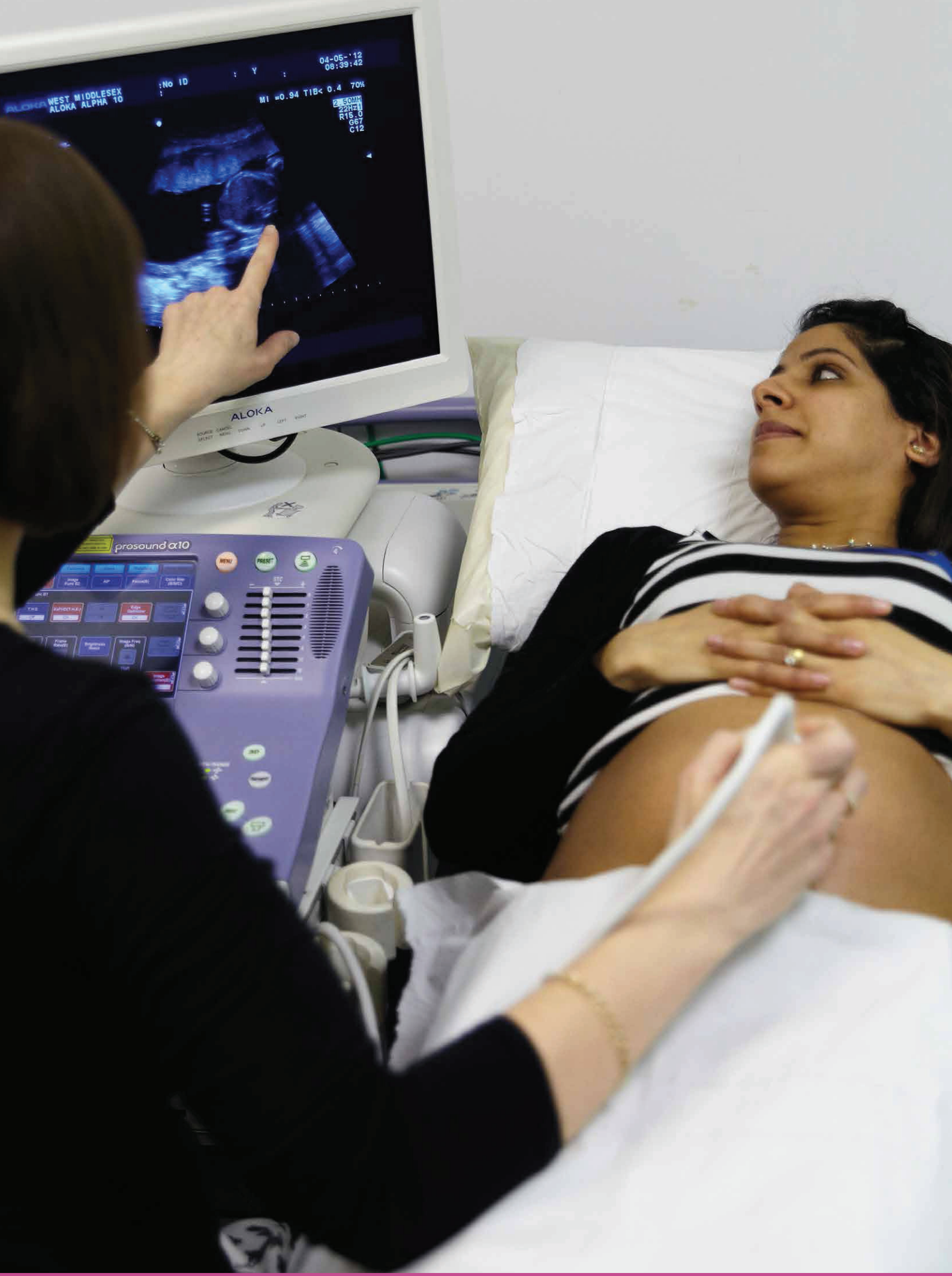
Note 2: Royal College guidance says that units with over 5000 births a year should provide 168 hours of consultant presence. Over time local maternity units in NW London will move to meet this standard.

Delivering this vision will:

- save lives by providing better access to more senior doctors for more of the time;
- mean that people will be treated more quickly by more senior doctors, leading to fewer complications; and
- allow doctors to develop their specialist skills, so they can provide the best possible specialist care.

4b

How far do you support or oppose the standards that have been agreed for care in hospital?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8. What will our vision mean for you?

A main part of this vision is that all the different parts of the NHS system will work together much more closely and effectively – whether they are hospitals, GP practices, community providers, or local authorities providing social services.

It will mean all these organisations, their leaders and workforces working across boundaries and without barriers, and as a result, patients in NW London all receiving better care.

In short, the vision will mean:

- you can be supported to take better care of yourself, lead a healthier lifestyle, understand where and when you can get treatment if you have a problem, understand different treatment options and better manage your own conditions with the support of healthcare professionals if you prefer;
- you can easily see a GP or community-care provider 24 hours a day, seven days a week by phone, email, or face-to-face in local, convenient facilities;
- you will be able to see a specialist or receive support from community or social care services if necessary (this will be organised quickly and GPs will be responsible for co-ordinating your healthcare); and
- if you need to go into hospital, it will be a properly maintained and up-to-date hospital where you receive care from highly trained specialists, available seven days a week, who have the specific skills needed to treat you.

The following stories show how care will improve for typical NW London patients before and after the proposed changes are put in place.

5

Do you agree or disagree that some services which are currently delivered in hospital could be delivered more locally?

6

How far do you support or oppose the idea of bringing more healthcare services together on fewer sites?

7

What further comments, if any, do you have on any of the issues raised in sections 4, 5, 6, 7 or 8 of this consultation document? (For example, if you disagree with our proposals, why is that?)

Easy access to high-quality care

Melanie is 36. She is a working mother with a young daughter who has a fever.

Now
- Melanie rings her GP but cannot get through, and takes Maya to A&E.
- The traffic is heavy and after a stressful journey they finally arrive. Maya is quickly assessed but not classed as high risk.
- After three hours they finally see a doctor who diagnoses that Maya is teething.

Future
- Melanie rings 111 and is given advice and an appointment for that evening at a local practice with extended hours, or a primary care centre by GP's out-of-hours service.

Simpler planned care pathways

Maria is 48. She has made an urgent appointment with her GP after bleeding vaginally for the last two days.

Now
- Maria sees her GP, who is not sure of the best treatment options and refers her to an outpatient clinic.
- Maria has an appointment and is scheduled for a follow-up appointment which takes several weeks to arrange.
- The results are not sent to her GP.

Future
- Maria sees her GP who books her for a one-stop assessment and diagnosis on-site.
- Two hours later the GP checks on the results and phones a consultant for a specialist opinion and together they agree on an appropriate procedure.

Quick responses to urgent health problems

Archie is 80. A family member has taken him to the doctor as he is in some pain and having difficulty passing urine.

Now
- The GP has diagnosed Archie as having a urinary tract infection. He is given a course of oral antibiotics and sent home.
- The next day his son visits and finds Archie in a confused state. Unsure what to do, he takes Archie to A&E.
- The strange surroundings make Archie more confused and he is admitted.
- Three weeks later, Archie is still in hospital and his mental state has deteriorated.

Future
- The GP has left a contact number for the rapid response service, following his appointment.
- Archie's son visits and finds Archie in a confused state and rings the rapid response helpline.
- A GP, social worker and physiotherapist from the rapid response team arrive and assess Archie at home, authorising a seven-day package of care to stabilise him at home.

Co-ordinated care for people with a long-term condition

Sameera is 45. She sees her GP complaining of shortness of breath and tightness in her chest.

Now
- After visiting her GP, Sameera is diagnosed with chronic obstructive pulmonary disorder, is put on an inhaler and given a stronger dose of drugs.
- Sameera continues to struggle at home with her condition and after a series of complications is admitted to A&E.

Future
- Sameera's GP thinks she needs an integrated care plan and he raises this at a case conference with a specialist chest doctor.
- They identify that Sameera needs advice on how to use her inhaler properly, rather than a stronger dose of drugs.

Less time spent in hospital

David is 80. He has recently fallen, fractured his hip and been admitted to hospital.

Now
- Following treatment, David's hip is mending well so the duty doctor reviews his case and says he is fit to leave following a physiotherapist's review.
- The review happens on a Friday and physiotherapists are not available until Monday, leaving David in hospital over the weekend.
- Social care takes three weeks to organise a package of care for when David leaves hospital.

Future
- When David is admitted to hospital his history is available to staff.
- His health and social care co-ordinator is told and plans to discharge him begin immediately.
- The next steps are recorded in a clear care plan and everything is in place for when the time comes for David to leave hospital.

9. Delivering the vision

If we are to deliver this new vision for health services across NW London, a lot needs to be done, and major changes need to be made to the way the NHS currently works.

Of course this will not be easy, nor will it be very popular among certain groups of people or communities. People understandably get very attached to local hospitals, whether they live nearby, have been treated there, or work there.

But that does not mean it is wrong to change services – healthcare is constantly changing, as are the ways it is delivered, where it is delivered from, and who delivers it. So while people feel strongly about local health services, this does not mean it is wrong to change the services. But it does mean we should make these changes thoughtfully, carefully, and by consulting patients – and many of you reading this document – first.

Changes, above all, must lead to improvements in the quality of care and so it is important that GPs, hospital clinicians, nurses, community service staff and others lead the way in how these changes are designed and put in place. Clinicians need to work with patients and patient groups and senior managers to make sure that proposals are good for patients as well as being realistic.

Delivering this vision will also significantly improve the finances of the NHS in NW London. It will take at least three years to deliver this vision and lots of work has been done to make sure the NHS can afford it. Delivering the vision for care outside hospitals will cost up to £120 million. On top of this, it is estimated that it will cost between £60 million and £90 million to run new and old services at the same time while changes are made. However, once made, the changes will mean that hospitals in NW London will be in a much improved financial position than if we do nothing. The pre-consultation business case (volume 1, chapter 6) available on our website at www.healthiernorthwestlondon.nhs.uk contains more detail on this financial analysis.

In the rest of this document, we describe:

- which services will be delivered where;
- how we will deliver the vision for services outside hospital;
- what services will be delivered in which type of hospital;
- how many hospitals we believe we need in NW London;
- the process we have used to recommend where these hospitals will be; and
- three different options for where these hospitals should be.


Angie Waddell

10. Where will care be provided in future under the proposals?

We have looked at the way in which we deliver healthcare, particularly the settings where we can deliver it, and have identified eight different settings for care.

Home – some services can be provided in people's homes, for example through nursing care or telephone support services.

GP practice – GP practices can provide lots of services other than GP appointments, such as immunisations, screening, blood tests and therapy services.

Care network – there are some services that can be provided by GP practices but we need practices to group together so there are enough patients to make it cost-effective to provide the skilled workforce and specialist equipment needed. This includes some diagnostic tests (such as ECGs) and therapies, and services for some long-term conditions. Grouping practices together can also mean urgent cases can be seen within four hours.

Health centre – sometimes a building is needed to provide 'networked' GP services such as therapy, rehabilitation or specialist imaging equipment.

Local hospital – this type of hospital provides all the most common things people need hospitals for, such as less severe injuries and less severe urgent care, non-life threatening illnesses, care for most long-term conditions such as diabetes and asthma, and diagnostic services. It basically provides the kinds of services that most people going to hospital in NW London currently go there for.

Major hospital – this is the closest to what is currently known as an 'acute' or district general hospital, and provides most types of care, right up to highly complex and urgent services. Major hospitals also provide care for children and maternity services, since these both sometimes need complex emergency services. In these proposals these hospitals will have more senior clinicians and specialist services than now – they will have investment so that they can be better than our current 'acute' hospitals. If patients at a local hospital suddenly need more urgent or complex care, they will be transferred by ambulance to these major hospitals. Major hospitals will also provide local hospital services.

Elective hospital – this hospital is where you go if you need an operation which is not urgent, so it could be

planned (or 'elected') by you or your doctor to happen when necessary. These hospitals cover things like hip replacements and cataract operations. They are particularly good places to be treated because they are not disrupted by emergency cases which have to be dealt with before less urgent ones, and can more easily be kept clean and free from hospital infections.

Specialist hospital – this is where clinicians have specialised in treating certain conditions, for example cancer or heart conditions or lung diseases. So you only tend to go to these places if you have a condition which needs really specialist care, perhaps because your condition is particularly life-threatening or complex.

The names of these eight settings of care and the services associated with them have been determined by clinicians and commissioners in NW London. However, we recognise there is a confusing array of different titles in use across London and nationally. The Department of Health is currently undertaking a piece of work on urgent and emergency care to support a more consistent approach across the country. Once the work is published, we will make sure that our proposals are aligned with the Department's recommendations.

8

We have described the proposals to deliver different forms of care in different settings. How far do you support or oppose these proposals?

9

What further comments, if any, do you have on any of the issues raised in sections 9 or 10 of this consultation document? (For example, do you have any concerns about arranging care in this way, or about the way we propose to classify hospitals? Can you suggest a better way of delivering care?)

Home

- GP, community and social care services
- Patient rings 111 for advice
- Response within four hours

GP practice

- GP consultations
- Management of long-term conditions
- Health promotion and preventative services

Care network

- Multi-disciplinary care
- Diagnostic and therapy services

Health centre

- GP, therapy and rehabilitation and diagnostic services
- Specialist GP services

Local hospital

- Urgent care centres
- Outpatients and diagnostics
- Further services including
  – specialist clinics
  – outpatient rehabilitation

Major hospital

- A&E, urgent care centres and trauma care
- Emergency surgery and intensive care
- Obstetrics and midwifery unit
- Inpatient paediatrics

Elective hospital

- Elective surgery and medicine
- Outpatients and diagnostics
- High-dependency care

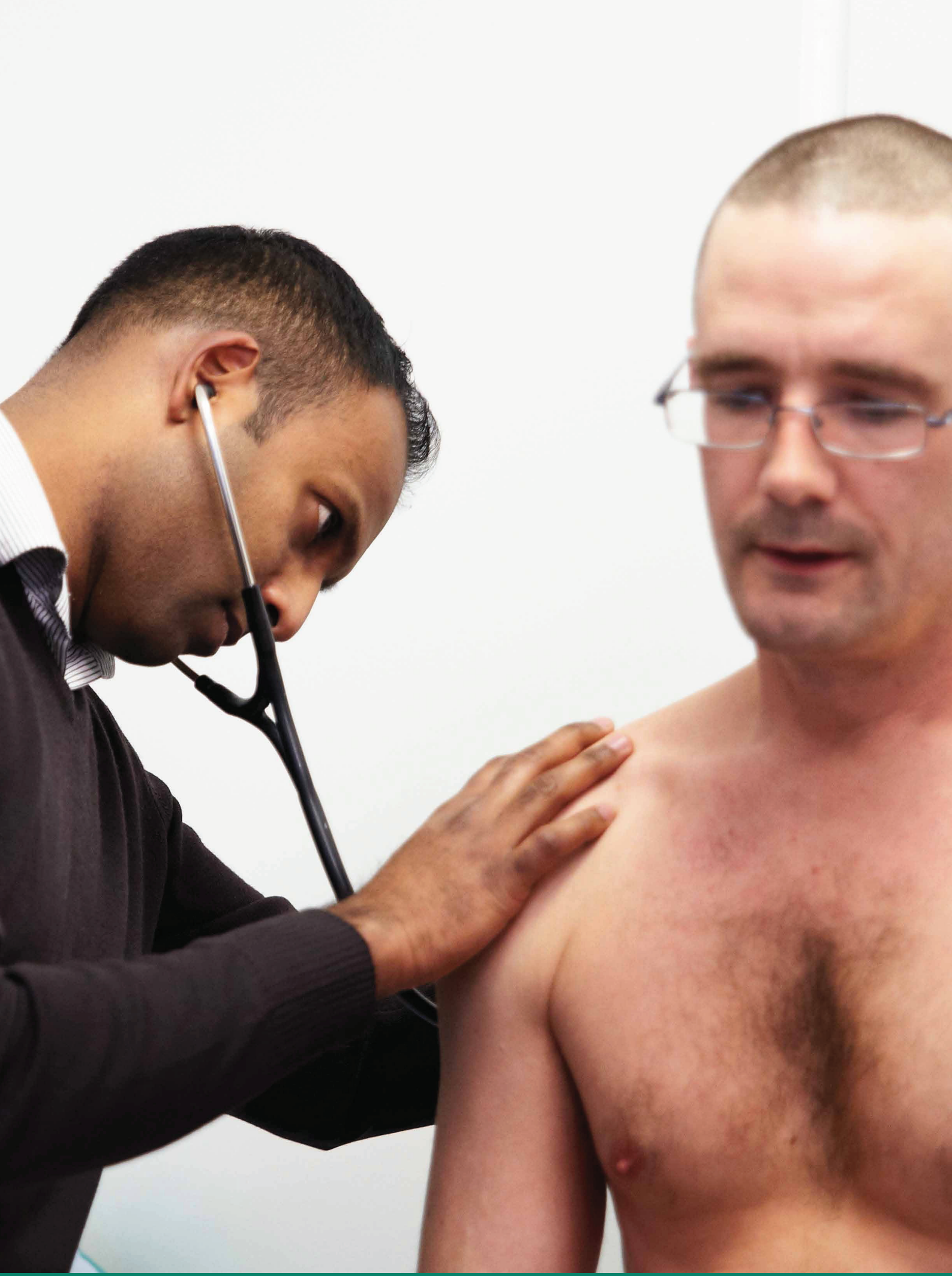
Specialist hospital

- Highly specialised care such as cardiothoracics and cancer

11. Proposals for delivering care outside hospitals

To deliver the vision for care outside hospitals, GP practices will work together to serve their patients, making the best use of their skills and resources to improve access and quality.

Networks of GP practices will work with other health and social care providers to deliver co-ordinated services to the local community, improving care planning and local services and information and communication standards. We have developed plans showing where services will be provided.



Within the home, GP surgeries, networks and health centres, we will deliver:

- **easy access to high-quality care**, with longer opening hours for GPs, and urgent care centres open 24 hours a day, seven days a week (these centres will see many of the people who would currently go to A&E);
- **simpler planned care pathways** (the different stages of NHS care you may go through), with specialists available to give advice, more clinics in the community for common health issues and patients able to have simple operations without needing to go to hospital;
- **quick responses to urgent health problems**, by setting up services in each borough to prevent 16,000 patients from having to go to hospital each year;
- **co-ordinated care for people with a long-term condition**, by setting up 38 multi-disciplinary health and social care teams covering the whole of NW London (this will mean people with a long-term condition will have a personal care plan); and
- **less time spent in hospital** because care providers will know when someone is in hospital and will make sure services are in place for them to leave hospital as soon as they can.

Up to £120 million will be invested in these services over the next three years, paid for out of savings made from working differently, to make sure that we can care for people outside hospital. We have promised that services will be in place before changes are made to hospital-based services.

There will need to be between 750 and 900 extra staff to run these new services. Many of these staff are already working in NW London, although they may have to work differently in the future. The full pre-consultation business case (volume 2, chapter 7) on our website, www.healthiernorthwestlondon.nhs.uk sets out the plans for developing the workforce in more detail. There will also need to be an extra 130 to 140 beds in the community.

GP leaders in NW London have agreed detailed plans for every borough to cover these new services. Because the people who live in each borough are different, services in each borough will be different. You can find more details of each borough plan for health services outside hospital on our website at www.healthiernorthwestlondon.nhs.uk

10

How far do you support or oppose our plans to improve the range of services we deliver outside hospital?

11

What further comments, if any, do you have on any of the issues raised in section 11 of this consultation document? (For example, what comments do you have on our plans to improve the range of services we deliver outside hospital?)

Investment in services outside hospital

Theme	From…	To…	Quality	Reduction in hospital activity	Investment (see note below)
A Easy access to high-quality care	• 9 urgent care centres (various opening hours) • 7 A&E departments • 2 limited A&E departments • Significant difference in GP practice opening times	• 9 urgent care centres (24 hours a day, 7 days a week) • 5 A&E departments • Extended GP opening hours for every patient	• More reliable emergency care • Better access to GP practices	• 100,000 hospital stays (14%) • Gross £12m to £15m	• 30 to 35 extra staff • £5m to £7m
B Simpler planned care pathways	• Most patients get access to specialist opinions through outpatient departments • Difference in referrals by GPs to outpatients • Most minor procedures only available in hospitals	• Access to specialist opinion by phone for GPs while with patient • Clinics in community for common specialties • Referrals within clear guidelines and reviewed by other GPs • Patients able to quickly have minor elective procedures without going to hospital	• Patients able to access a greater range of services through their GP • Less waiting times • More convenience	• 600,000 outpatient appointments (22%) • Gross £83m to £95m • 10,000 hospital stays (14%) • Gross £20m to £24m	• 205 to 235 extra staff • £59m to £65m
C Quick responses to urgent health problems	• Rapid response service in Brent avoiding around 1,000 admissions each year	• Rapid response service across all of NW London avoiding 16,000 hospital admissions each year	• Patients avoid unnecessary hospital visits	• 29,000 avoided emergency admissions (10%) • 391 acute beds • Gross £47m to £54m	• 275 to 320 extra staff • 130 to 140 community beds • £29m to £34m
D Co-ordinated care for people with a long-term condition	• Care networks have been piloted for integrated care for diabetes and the elderly for a population of 500,000	• Around 38 multi-disciplinary groups across NW London, covering 1.9 million people with care plans for all long-term conditions and elderly and case conferences for complicated cases	• 17,000 more diabetics • 200 fewer amputations • 880 fewer deaths	• 19,000 avoided emergency admissions (7%) • Gross £33m to £39m	• 255 to 300 extra staff • £27m to £32m
E Less time spent in hospital	• Many patients stay in hospital longer than necessary and leave without good support	• Care providers will know when a patient is in hospital and will help them into planned, supportive care outside hospital	• Better recovery with support when the patient leaves hospital	• Activity-reduction included under D (above)	• Included in trust cost improvement programmes

Source: Commissioning Service Plan, 1st December 2011, QIPP plans 15th December 2011, QIPP revision, Healthcare for London; HES; CCG input and expert interviews; NHS DSU; CCG finance teams;

Note: Not all out-of-hospital investment figures are listed. Total investment includes staffing, equipment and other services, including services provided by charitable or voluntary organisations.

Total investment £120m to £138m

12. Our recommendations for local hospitals across NW London

Most care that is currently delivered in hospitals will still be delivered locally in a local hospital, under changes proposed by 'Shaping a healthier future'.

The local hospitals in our plans will have specialist staff (who may also work in a major hospital) and specialist equipment and will be open 24 hours a day, seven days a week to see people with urgent health problems. Specialist staff will work with GPs and other community clinicians to deliver personalised healthcare. GP services, community services and social care will be based in these local hospitals, bringing services together around your needs.

Local hospitals will also be part of the local community. This means local patients, patient groups, the voluntary sector, the local council including the health and well-being board, and local clinicians will be involved in developing and running them. They will offer services based on what is needed locally, so these might be different in each local hospital.

The local hospital will also act as a 'home' for local clinicians – a place for education and training, for continuing professional development, as a centre for research and for clinicians and other professionals to come together to review and improve patient care.

Local hospitals will offer slightly different services depending on the health needs of the different local communities across NW London, but these services will include, for example, the following:

- **Quicker and more co-ordinated healthcare**. The local hospital will provide specialist care for people with long-term conditions. Patients and carers will be able to come together in self-care and support groups, either at the local hospital or closer to home. Some GP practices, community services and social services may be based in the local hospital, and will make sure care is co-ordinated for individual patients.

- **Access to specialist skills**. In some cases, patients may need specialist appointments. Many of these appointments will be available in local hospitals, including for people who are going to have, or have had, an operation. Some patients, for example, those with Parkinson's disease or children who need insulin for diabetes, need a lifetime of specialist care, much of which will be available at the local hospital. Also, some local hospitals will be able to provide treatments such as medical oncology, renal dialysis and simple surgery.

- **Tests**. Clinicians sometimes need tests so they can find out what is wrong with a patient or understand whether a treatment is working. Tests such as x-ray, ultrasound, endoscopy or MRI scans will be available in some local hospitals.

- **Bringing services together**. The local hospital will bring services together for patients. This could include assessments, transport to and from home and pain-management services. This will make it easier for patients to get to services and for clinicians to find out what is wrong with the patient and treat them.

- **Better nursing, therapy and rehabilitation services**. Local hospitals will offer better nursing, therapy, rehabilitation and community services such as physiotherapy, well-baby clinics, chiropody and wound clinics. This will include appointments with specialists. It might also include beds for patients who are at risk of deteriorating, and beds for patients who have been to a major hospital but who no longer need specialist care and can be cared for nearer to their home.

Urgent care centres

Local hospitals will have an urgent care centre, open 24 hours a day, seven days a week. Urgent care centres specialise in treating patients with urgent illnesses and injuries and conditions that can be seen and treated without the patient having to stay in hospital.

Clinicians in urgent care centres will also be skilled in stabilising patients who need to be transferred to more specialist A&E centres. There will be special processes to make sure these transfers happen quickly and some urgent care centres may also have beds where patients can be admitted if their problem can be dealt with locally.

NW London has led the way with some of the most successful urgent care centres in London. The centres are staffed by GPs and nurse practitioners. Many of these urgent care centres are inside A&E departments and are already treating a wide range of patients. People who go there get a very high quality of care. Patient satisfaction is high and waiting times are low. Today, there are different 'models' of urgent care centres in NW London and the proposed changes would encourage higher standards of urgent care centres across the area. For example, urgent care centres in NW London currently have different opening times and treat different problems. This can be confusing for patients and we will make sure that, in future, all urgent care centres in NW London are open 24 hours a day, seven days a week and all have the same level of services.

We want all urgent care centres in NW London to:

- see and treat patients within four hours of them arriving;

- be led by primary-care clinicians such as GPs;

- be linked with other services such as the new non-emergency phone number for the NHS (111); and

- have access to tests and specialist clinicians.

The kinds of health problems all urgent care centres would be able to treat include:

- illnesses and injuries not likely to need a stay in hospital;

- x-rays and other tests;

- minor fractures (breaks);

- stitching wounds;

- draining abscesses that don't need a general anaesthetic; and

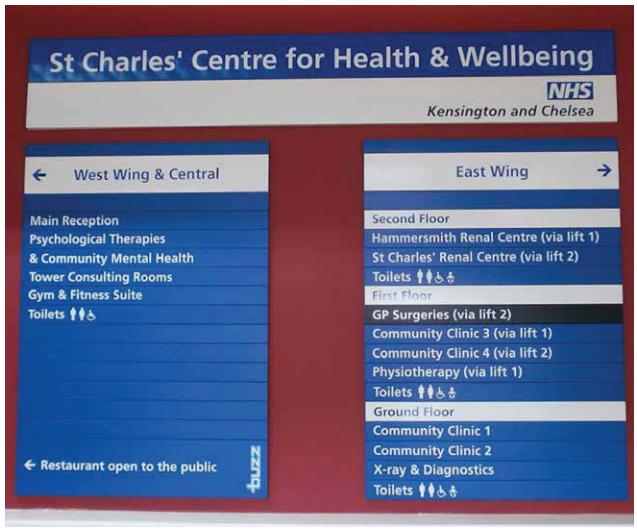
- minor ear, nose, throat and eye infections.

Urgent care centres will see people and children of any age.

It is important to note that urgent care centres do not treat problems such as major burns, head injuries, strokes, sickle-cell crisis, severe shortness of breath, heart failure, overdoses and self-harm. All these problems can be a sign of serious conditions that may need to be treated in a major hospital.

The best example in London of a local hospital is Queen Mary's Hospital in Roehampton, North East Wandsworth, which is described in the pre-consultation business case (volume 2, chapter 8) on our website at www.healthiernorthwestlondon.nhs.uk. St Charles' Centre for Health and Wellbeing in Ladbroke Grove in NW London also provides many local hospital services, including an urgent care centre. The patients who use these services rate them very highly and they are an important part of the local community.

The kinds of services we want to see provided in local hospitals are currently delivered at all nine acute hospitals in North West London (Charing Cross Hospital, Chelsea and Westminster Hospital, Central Middlesex Hospital, Ealing Hospital, Hammersmith Hospital, Hillingdon Hospital, Northwick Park Hospital, St Mary's Hospital and West Middlesex Hospital). Our proposals would see all these hospitals continuing to provide local hospital services, including an urgent care centre and outpatient and diagnostic services.



12

Do you agree or disagree that local hospital services such as urgent care centres (those open 24 hours a day, seven days a week) and outpatient appointments should continue to be provided at the nine acute hospitals in North West London that currently do so?

13

How far do you agree or disagree with our plans for urgent care centres?

14

What further comments, if any, do you have on any of the issues raised in section 12 of this consultation document? (For example, if you disagree with our proposals, what would you do differently?)

13. Elective hospitals using our high-quality buildings

If our proposals are agreed, elective hospitals would carry out operations on patients in NW London which are described as 'elective' rather than 'urgent' – such as hip replacements, and cataract operations.

In an elective hospital, treatment is not disrupted by emergency cases – which can take priority over less urgent ones at other types of hospital – and, partly because of this, they can more easily be kept clean and free from hospital infections.

Elective hospitals can be located within, or independently of, major hospitals as they do not rely on any of the back-up services of a major hospital. We are proposing that we should use any high-quality buildings that have spare space to house our elective hospitals. This would particularly include the buildings at West Middlesex Hospital and Central Middlesex Hospital, which have been built especially to deliver high-quality elective care.

Major hospitals would still continue to provide elective services and patients would still be able to choose where they had their operation.

15

How far do you support or oppose our recommendation that we should use our high quality hospital buildings with spare space as elective hospitals?

16

What further comments, if any, do you have on any of the issues raised in section 13 of this consultation document?

14. Five major hospitals for NW London

In developing a vision for hospital services, we focused on different areas: emergency surgery, A&E, maternity (pregnancy and birth), and paediatrics (children).

Doctors often need these specialised areas to be based in the same hospital to treat certain conditions.

Under our proposals, major hospitals would provide a full range of high-quality clinical services for patients with urgent or complicated needs (or both). They will have investment to equip and staff an A&E department (open 24 hours a day, seven days a week) with urgent surgery and medicine and a 'level 3' intensive care unit. Major hospitals would usually also provide consultant-led maternity services and radiology services. They may also have complicated surgery, a hyper-acute stroke unit (HASU), inpatient paediatrics (children), a heart attack centre and a major trauma centre.

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

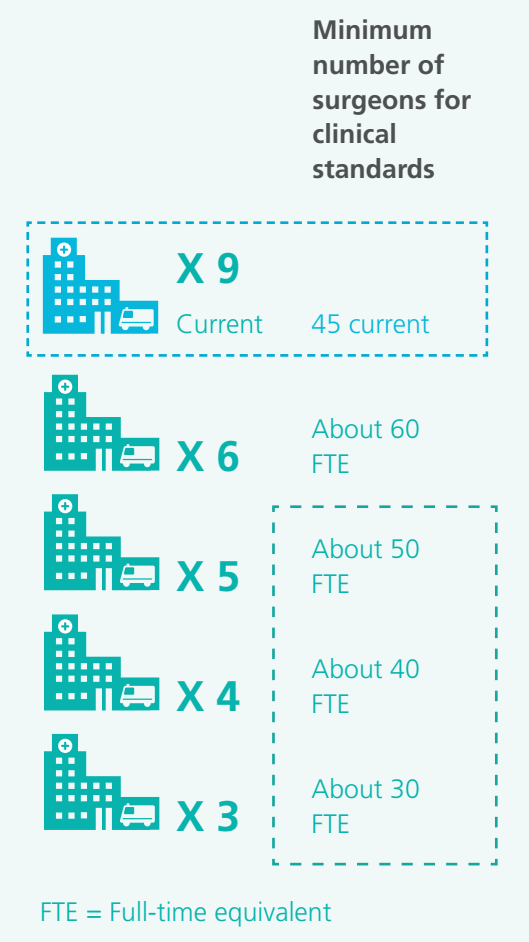
We looked at how many major hospitals we would need in NW London to deliver the highest-quality care. We used a set of 'hurdle criteria' (a series of tests) to help us decide. To pass these tests, we looked at how many major hospitals would be needed to:

- deliver the clinical standards shown in section 7;
- deliver them within a realistic time without affecting the high quality of services; and
- be financially affordable.

We looked at all the evidence and agreed the ideal number of major hospitals would be five. This is for the following reasons.

- Having six or more major hospitals would solve some of the problems we face in NW London as shown in section 2. But there would still be too many hospitals because we would not be able to recruit enough clinicians to provide services safely enough for six or more hospitals. We cannot solve this problem by hiring more clinicians because clinicians need experience of dealing regularly with complications to keep up their expertise – and there are not enough cases of certain complicated conditions to do this in NW London.

- A good example of this is the number of surgeons needed to provide the highest quality of emergency surgery. We know that having senior surgeons available at night and at the weekends means better health outcomes for patients. Today, there are only 45 surgeons working in NW London, but we would need at least 60 surgeons to meet the clinical standards at six hospitals.

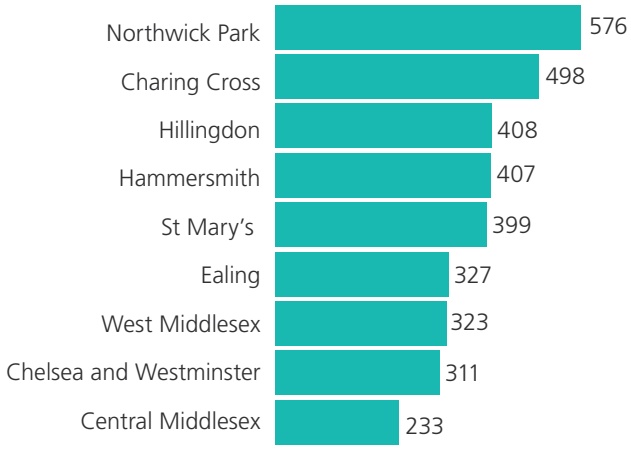


- To begin with, some clinicians recommended that we should have four or fewer major hospitals but it was agreed that this would not be enough. This is because we would have to build much bigger hospitals and move lots of services which would be high risk, difficult to deliver, and expensive. For example, if there were only three major hospitals in NW London, we would need to build hospitals that are twice the size of the ones we have now.

Number of beds needed for each major hospital if there are five or fewer hospitals in the area

Three major hospitals	**About 800 to 1000**
Four major hospitals	**About 600 to 700**
Five major hospitals	**About 500 to 600**

Current number of beds



We agreed that all A&E departments would need a maternity service as part of back-up services. And we agreed that maternity services need the back-up of a major or specialist hospital and so should not be put in other types of care settings (for example, local hospitals). We propose that all major hospitals will have a consultant-led maternity unit.

To give women in NW London more choice about where they give birth, the new major hospitals would also have a midwife-led maternity unit. We are not suggesting that we have any midwife-led units in NW London that are not within major hospitals. You can see the explanation for this in the pre-consultation business case (volume 2, chapter 8) which you can find on our website www.healthiernorthwestlondon.nhs.uk. All maternity services will work to support women who choose to have their baby at home.

Maternity services also need a paediatric (children's) service to provide support for new babies. So we propose that all major hospitals in NW London in future will have an inpatient paediatric service, unless there are enough specialist maternity services to support a paediatric consultant rota. The only hospital where this is possible in NW London currently is at Queen Charlotte's and Chelsea Hospital at Hammersmith Hospital. We propose that we should keep the consultant-led maternity unit at Queen Charlotte's and Chelsea Hospital. This means there would be six consultant-led maternity units in NW London if Hammersmith Hospital were not classed as a major hospital.

17

How far do you support or oppose the recommendation that there should be five major hospitals in North West London?

18

How far do you support or oppose the recommendation that all major hospitals should have inpatient paediatric (children's) units?

19

How far do you support or oppose the recommendation that all major hospitals in North West London should have consultant-led maternity units, with an extra consultant-led maternity unit at Queen Charlotte's and Chelsea Hospital if Hammersmith Hospital is not a major hospital?

20

What further comments, if any, do you have on any of the issues raised in section 14 of this consultation document? (For example, if you oppose the recommendations, how many major hospitals do you think there should be in North West London? Why do you think that?)

15. Where should the major hospitals be located?

We recommended that NW London should have five major hospitals and then carried out an in-depth evaluation to look at where these major hospitals should be.

Patients and clinicians told us that being able to access services easily was very important. So, to help them think about where to put the major hospitals, we looked at:

- ambulance journeys;
- car journeys at peak traffic hours and non-peak hours; and
- public transport at peak hours.

These were categorised by 'lower super output area' (similar to postcode areas). We looked at how long it would take people living in each area to get to a hospital if their nearest hospital for a particular service were to change. It was important to look at how long it would take people on average and also what the longest journeys might be.

After looking at the evaluation, we proposed that Hillingdon Hospital and Northwick Park Hospital should be major hospitals, due mainly to their location. If either of these hospitals were not to provide more complicated healthcare, people in surrounding areas would have to travel much further to get to the next hospital providing those kinds of services. To put it another way, both Hillingdon and Northwick Park are the furthest distance away from any other possible major hospital site in NW London.

For example, people would have to travel up to 34 minutes by ambulance to get to their nearest hospital if Hillingdon Hospital no longer provided some services. This is much further than for people living near the other hospitals in NW London.

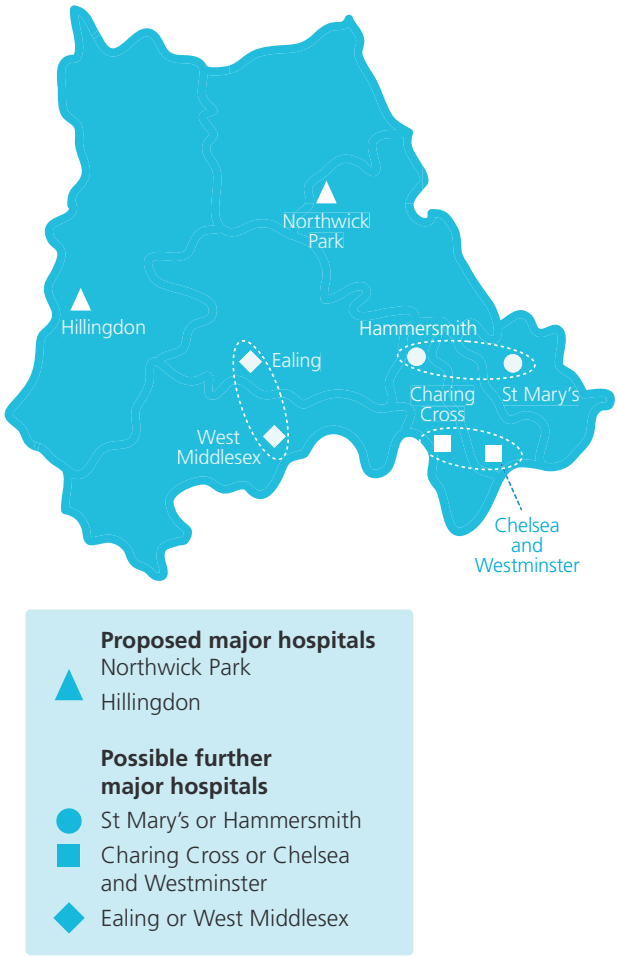
This means that two of the five major hospitals would be at Hillingdon Hospital and Northwick Park Hospital.

You can find more information on this analysis in our pre-consultation business case (volume 3, chapter 12) on our website at www.healthiernorthwestlondon.nhs.uk

There is not as much difference in travel times for people living near other hospitals in NW London. However, we wanted to make sure that the other three major hospitals were spread evenly across NW London. This is to make it easy for people to get to them. We looked at where people are likely to go if their nearest hospital did not provide some services, and proposed a choice of:

- a major hospital at either Ealing Hospital or West Middlesex Hospital;
- a major hospital at either Charing Cross Hospital or Chelsea and Westminster Hospital; and
- a major hospital at either Hammersmith Hospital or St Mary's Hospital.

This map shows these possible choices.



As an example, we would expect most patients who go to Ealing Hospital would go to West Middlesex Hospital (although they could of course choose to go to any other hospital) if some services were no longer provided at Ealing. And most patients who go to West Middlesex Hospital now would go to Ealing Hospital if some services were no longer provided at West Middlesex Hospital. We have based this on information on travel times provided by Transport for London. As a further test, we also looked at what would happen if both hospitals no longer provided some services and this showed that the time to get to the next nearest hospital would increase significantly. Assessing the choice between Charing Cross Hospital and Chelsea and Westminster Hospital and between St Mary's Hospital and Hammersmith Hospital gave similar results.

You can find more details on all the travel-time analysis in the pre-consultation business case (volume 3, chapter 12) on our website at www.healthiernorthwestlondon.nhs.uk

During the consultation, we will do further work on the effect of the proposals on travel and on plans for dealing with any travel issues (for example, access to public transport for people with a disability).

There are eight possible combinations of hospitals where there is a major hospital at:

- Hillingdon Hospital;
- Northwick Park Hospital;
- either Ealing Hospital or West Middlesex Hospital;
- either Charing Cross Hospital or Chelsea and Westminster Hospital; and
- either Hammersmith Hospital or St Mary's Hospital.

The next section looks at these options in more detail.

	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7	Option 8
St Mary's	Local hospital	Local hospital	Local hospital	Local hospital	Major hospital	Major hospital	Major hospital	Major hospital
Hammersmith	Major hospital and specialist hospital	Major hospital and specialist hospital	Major hospital and specialist hospital	Major hospital and specialist hospital	Specialist hospital	Specialist hospital	Specialist hospital	Specialist hospital
Charing Cross	Local hospital	Major hospital	Local hospital	Major hospital	Local hospital	Major hospital	Local hospital	Major hospital
Chelsea and Westminster	Major hospital	Local hospital	Major hospital	Local hospital	Major hospital	Local hospital	Major hospital	Local hospital
West Middlesex	Major hospital	Major hospital	Local hospital and elective hospital	Local hospital and elective hospital	Major hospital	Major hospital	Local hospital and elective hospital	Local hospital and elective hospital
Ealing	Local hospital	Local hospital	Major hospital	Major hospital	Local hospital	Local hospital	Major hospital	Major hospital
Central Middlesex	Local hospital and elective hospital	Local hospital and elective hospital	Local hospital and elective hospital	Local hospital and elective hospital	Local hospital and elective hospital	Local hospital and elective hospital	Local hospital and elective hospital	Local hospital and elective hospital
Northwick Park	Major hospital	Major hospital	Major hospital	Major hospital	Major hospital	Major hospital	Major hospital	Major hospital
Hillingdon	Major hospital	Major hospital	Major hospital	Major hospital	Major hospital	Major hospital	Major hospital	Major hospital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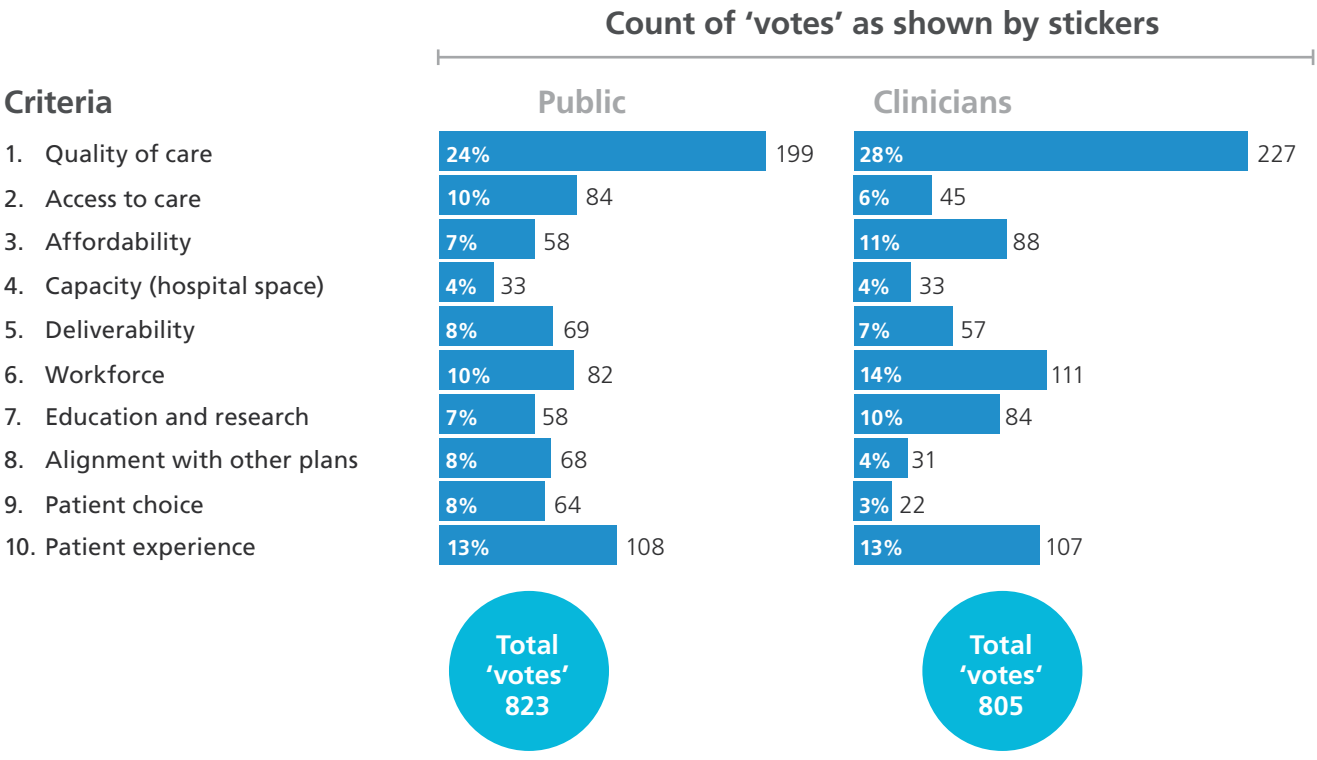
16. Which options are practical?

We asked the public and a wide range of clinicians what criteria (or measures) we should use to review the options and assess which were practical.

For example, at a public event in February 2012, 200 representatives of public and patient groups and clinicians ranked the most important criteria for them as follows.



From this work, we used the following criteria to review the options and assess which were practical.

Criteria	Sub criteria
1. Quality of care	• Clinical quality • Patient experience
2. Access to care	• Distance and time to access services • Patient choice
3. Value for money	• Capital cost to system • Transition costs • Viable Trusts and sites • Surplus for acute sector • Net present value
4. Deliverability	• Workforce • Expected time to deliver • Alignment with other plans
5. Research and education	• Disruption • Support current and developing research and education

To review how practical each option was using this criteria, we then asked a number of questions as follows.

- **Clinical quality** – Which options would provide better clinical quality in future using clinical surveys and measures?
- **Patient experience** – Which options would provide a better experience for patients using patient experience surveys and looking at the quality of the buildings and facilities?
- **Distance and time to access services** – Would any options keep to a minimum the increase in the average or total time it takes people to get to hospital by ambulance, car (at off-peak and peak times) and public transport?
- **Patient choice** – Which options would give people in NW London the greatest choice of hospitals for emergency care, maternity care and planned care across the greatest number of trusts?
- **Capital cost to the system** – Which options would have the lowest capital costs (cost of buildings and equipment)?
- **Transition costs** – Which options would have the lowest cost of transferring services between hospitals?
- **Viable trusts and sites** – Which options would have the lowest yearly subsidy and the fewest hospitals and trusts with a financial surplus of less than 1% (the lowest acceptable level of financial surplus allowed for trusts in the NHS)?
- **Surplus for acute sector** – Which options would give the largest financial surplus across all hospitals, to make sure that the proposed changes are affordable?
- **Net present value** – Which options would give the largest net present value (overall financial benefit) over the next 20 years?
- **Workforce** – Which options would provide the best workplace for staff (using staff satisfaction surveys)?
- **Expected time to deliver** – How long would it take to deliver the proposed changes in each option? A shorter delivery time means that benefits can be delivered earlier.
- **Fitting in with other strategies** – How well would each option fit with what is happening, or may happen, nationally or in London?
- **Disruption** – Which options best fit with current research and education to minimise disruption in these areas?
- **Support current and developing research and education delivery** – Which options would best support what is happening in research and education?

You can find all the information and analysis we used to answer these questions in the pre- consultation business case (volume 3, chapter 14) on our website at www.healthiernorthwestlondon.nhs.uk

Once we had answered these questions, we looked at the overall evaluation, which is shown in the table overleaf.

Summary of evaluation

	1	2	3	4	5	6	7	8
	• West Middlesex • Hammersmith • Chelsea and Westminster • Northwick Park • Hillingdon	• West Middlesex • Hammersmith • Charing Cross • Northwick Park • Hillingdon	• Ealing • Hammersmith • Chelsea and Westminster • Northwick Park • Hillingdon	• Ealing • Hammersmith • Charing Cross • Northwick Park • Hillingdon	• West Middlesex • St Mary's • Chelsea and Westminster • Northwick Park • Hillingdon	• West Middlesex • St Mary's • Charing Cross • Northwick Park • Hillingdon	• Ealing • St Mary's • Chelsea and Westminster • Northwick Park • Hillingdon	• Ealing • St Mary's • Charing Cross • Northwick Park • Hillingdon
Quality of care								
Clinical quality	++	++	++	++	++	++	++	++
Patient experience	++	+	+	–	++	+	+	–
Access								
Distance and time to access services	–	–	–	–	–	–	–	–
Patient choice	+	–	+	–	++	+	++	+
Affordability and value for money								
Capital cost to the system	– –	– –	– –	– –	+	+	+	+
Transition costs	– –	– –	– –	– –	–	–	–	–
Viable trusts and sites	+	+	– –	– –	+	+	– –	– –
Surplus for acute sector	+	+	–	– –	+	–	–	– –
Net present value	–	–	– –	– –	++	+	+	–
Deliverability								
Workforce	+	–	+	+	+	–	+	+
Expected time to deliver	–	–	– –	– –	+	+	– –	– –
Fitting in with other strategies	–	–	– –	– –	+	+	–	–
Research and education								
Disruption	–	–	–	–	+	+	+	+
Support current and developing research and education delivery	–	–	–	–	+	+	+	+

Our preferred viable option
Other viable options
Options we have evaluated as not being viable

++ High evaluation
– – Low evaluation

You can find the detailed evaluation in our pre-consultation business case (volume 3, chapter 14) on our website at www.healthiernorthwestlondon.nhs.uk.

This showed that three options (option 5, option 6 and option 7) were practical. The other options were not practical because they were assessed poorly against a number of criteria or because they did not show value for money (or both). We assessed option 5 as being much more practical than the other options and so this became the preferred option following this exercise. In the next section we describe the three most practical options in more detail and explain why option 5 is the preferred option.

21

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

22

Please say how important you think each of these criteria (measures) should be in choosing which hospitals should be major hospitals, rating their importance on a scale where 10 means 'absolutely vital' and 0 means 'not important at all'. (We have given more details on the criteria in the list on page 53).

Hammersmith Hospital

As we have assessed options 1 to 4 as not practical, this means we do not propose Hammersmith Hospital as a major hospital in any of the consultation options. Today, Hammersmith Hospital provides a wide range of specialist services, a very limited A&E service and maternity services. Under all the options for consultation, Hammersmith Hospital will keep all of its specialist services and its maternity unit. The only proposed change is to the A&E department, which would become an urgent care centre, and the non-specialist services that support this.

The reasons that we are not proposing Hammersmith Hospital as a major hospital are as follows.

- **Significant extra cost**. Hammersmith Hospital doesn't provide important services such as emergency general surgery and orthopaedics at the moment, and significant capital spending (spending on buildings and equipment) would be needed to provide these services at Hammersmith Hospital.

- **Complicated to deliver**. A major hospital at Hammersmith Hospital rather than St Mary's Hospital would mean moving a large number of services from St Mary's Hospital, including the major trauma centre and paediatric services, which would be a challenge.

- **Allows an extra maternity unit**. The maternity unit at Queen Charlotte's and Chelsea Hospital would continue to be provided under options where Hammersmith Hospital is not a major hospital (the specialist services at the Hammersmith Hospital means that the Hammersmith Hospital can provide the senior clinicians and back-up needed to run a safe maternity unit even if Hammersmith Hospital were not a major

hospital), giving an extra maternity unit in NW London.

- **Better support for research and education**. Most medical research in NW London is currently carried out at Hammersmith Hospital, with some research at St Mary's Hospital and Chelsea and Westminster Hospital. If Hammersmith Hospital becomes a specialist hospital and St Mary's Hospital becomes a major hospital, current research arrangements can continue at both those sites.

Central Middlesex Hospital

We have not proposed Central Middlesex Hospital as a major hospital in any of the consultation options. We have recommended that Central Middlesex Hospital should not be a major hospital but an elective hospital with local hospital services. This is because it is already providing these services, its major A&E services are already under pressure (A&E emergency round-the-clock care had to be suspended in late 2011 because not enough senior emergency care doctors were available on-site), essential services for a major hospital – emergency surgery, paediatrics and maternity – are not provided on-site and patients could access these major emergency care services elsewhere in other nearby hospitals.

23

What further comments, if any, do you have on any of the issues raised in sections 15 or 16 of this consultation document? (For example, please tell us if you think there are any criteria that we have missed and which should also be taken into account in choosing which hospitals should be major hospitals).

17. The three options for major hospitals

In this section, we describe the three options for major hospitals. We also explain why there is a preferred option.

To make consultation easier, we have renumbered the options.

- Option 5 has become option A
- Option 6 has become option B
- Option 7 has become option C

All our options for consultation will mean that quality of care will improve outside and in hospitals.

- **Improved care outside hospital**. Under all options, improved quality of healthcare outside hospitals will support people to lead healthier lifestyles, improve access to services, allow people to take control of their own health and mean care is more co-ordinated.

- **Improved quality of care in hospitals**. Under all options, reducing the number of hospitals providing some services will mean there will be more specialist and experienced doctors available for more of the time, and that they will be able to build and maintain the skills and expertise they need to deliver high-quality care. There will also be more back-up for services.

All options will mean that some patients would have to travel a little longer for some aspects of their care, but on average no more than 6 minutes longer. As described in section 7, clinicians agree it is more important that patients are taken to the right place for treatment by the right clinicians even if they need to travel further.

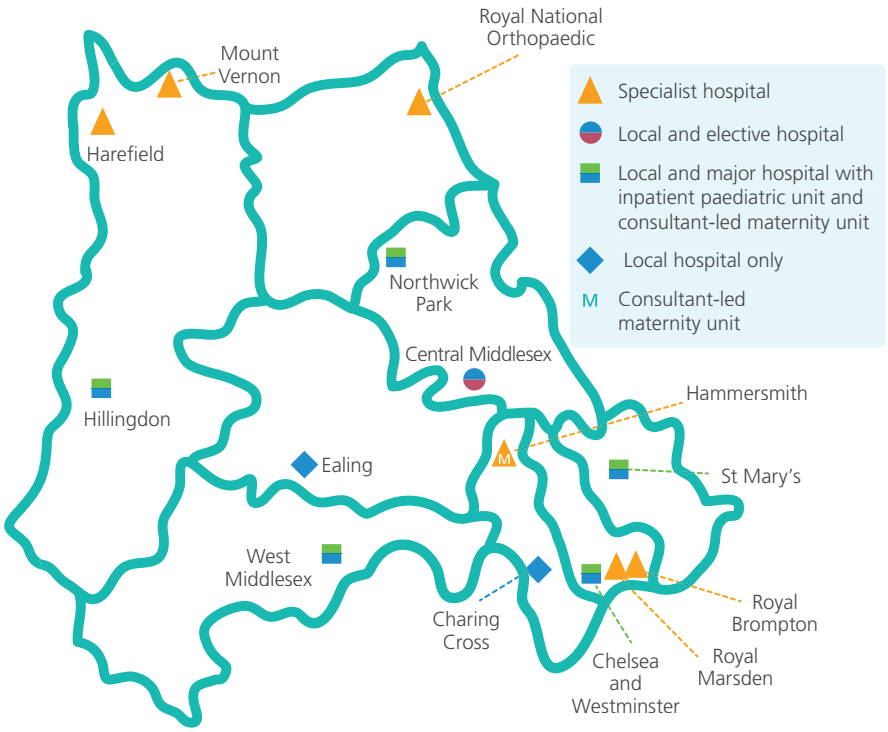
Option A (preferred option)

This option is the preferred option. It has Chelsea and Westminster Hospital, Hillingdon Hospital, Northwick Park Hospital, St Mary's Hospital and West Middlesex Hospital as major hospitals. It has Central Middlesex Hospital as a local and elective hospital and Hammersmith Hospital as a specialist hospital. Ealing Hospital and Charing Cross Hospital are proposed as local hospitals.

Some services will no longer be available in some hospitals and instead will be provided at neighbouring hospitals where there would be more senior, experienced staff available and extra back-up in case of problems. Some specialist services will also need to move where hospitals become local hospitals. We have outlined the services provided at each site before and after the proposed changes in the table on page 59.

Under this option, around 91% of services would not be affected by the proposed changes. The proportion of services that would be affected under this option is

Option A (preferred option)



relatively low, with 22% of inpatient cases, 14% of A&E cases and 5% of outpatient cases likely to move. Similarly, it is estimated that 81% of the workforce would not be affected by the changes, with most of those affected needing to move location to provide services either within a neighbouring hospital or within the community.

We believe this option would deliver the greatest benefits for NW London for the following reasons.

- **Good use of buildings**. Chelsea and Westminster Hospital and West Middlesex Hospital both consist of very recently built buildings, with space that is suitable for both current and future requirements. Given what we have already said about the need to manage and maintain NHS buildings in NW London, and the difficulty of building new ones, this is a major factor.

- **Value for money**. This option would need relatively limited amounts of capital spending (on buildings and equipment) and it would leave NW London with a predicted overall financial surplus greater than 2%. Only one trust (one hospital) is predicted to have a deficit in this option. We predict this option will provide the best return on investment of all the options. It means the NHS in North West London would be in a much better financial position than if nothing were to change.

- **Easy to deliver**. This option corresponds most closely with services already being delivered at each hospital, and with other changes taking place outside the 'Shaping a healthier future' programme. So, the scale of the change needed would be smallest under this option.

- **Supports research and education**. Most important medical research in NW London is currently carried out at Hammersmith Hospital, St Mary's Hospital and Chelsea and Westminster Hospital. Under this option, Hammersmith Hospital becomes a specialist hospital and St Mary's Hospital becomes a major hospital, which would mean current research arrangements can continue at both those sites.

Option A

		Local hospital		Major hospital								Elective hospital		Other	
		Urgent care centre	Outpatients and diagnostics	A&E (24 hours a day, 7 days a week)	Emergency surgery	Non-elective medicine	Non-elective surgery	Complex elective medicine	Complex elective surgery	ICU level 3	Inpatient paedatrics	Obstetrics and maternity unit	Non-complex elective surgery or medicine (or both)	High Depend-ency	Heart attack	HASU
● Charing Cross	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔						✔
	Future	✔	✔													
Chelsea and Westminster	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
	Future	✔	✔	✔	✔	✔	✔	✔	✔	✔	S	✔				
● Ealing	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
	Future	✔	✔													
St Mary's	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
	Future	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				✔
West Middlesex	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
	Future	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
● Central Middlesex	*Current*	✔	✔			✔	✔		✔	✔			✔	✔		
	Future	✔	✔										✔	✔		
Hammersmith (incl. Queen Charlotte's)	*Current*	✔	✔	L	S	S	S	✔	S	✔		✔			✔	
	Future	✔	✔		S	S	S	S	S	S		✔	S	S	✔	
Hillingdon	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
	Future	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
Northwick Park	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				✔
	Future	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				✔

KEY

● Site specifically affected by option

✔ Service on-site

S Specialist service on-site

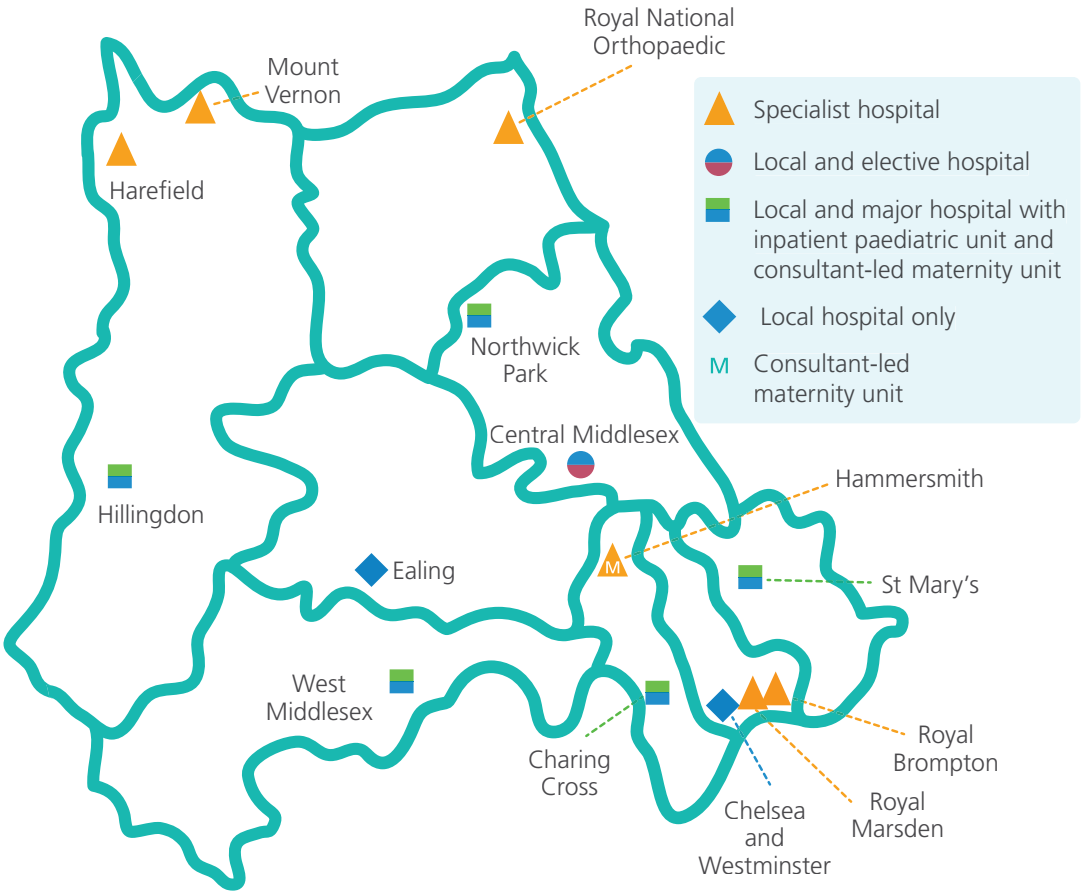
L Limited service on-site

Option B

This option has Charing Cross Hospital, Hillingdon Hospital, Northwick Park Hospital, St Mary's Hospital and West Middlesex Hospital as major hospitals. It has Central Middlesex Hospital as a local and elective hospital, and Hammersmith Hospital as a specialist hospital. Ealing Hospital and Chelsea and Westminster Hospital would be local hospitals.

Some services will no longer be available in some hospitals and instead will be provided at neighbouring hospitals where there would be more senior, experienced staff available and extra back-up in case of problems. Some specialist services will also need to move where hospitals become local hospitals. We have outlined the services provided at each site before and after the proposed changes in the table opposite.

Under this option, around 87% of services would not be affected by the proposed changes. The proportion of services that would be affected under this option is relatively low, with 25% of inpatient cases, 17% of A&E cases and 9% of outpatient cases likely to move. Similarly, it is estimated that 79% of the workforce would not be affected by the changes, with most of those affected needing to move location to provide services either within a neighbouring hospital or within the community.



Option B

		Local hospital		Major hospital								Elective hospital		Other	
		Urgent care centre	Outpatients and diagnostics	A&E (24 hours a day, 7 days a week)	Emergency surgery	Non-elective medicine	Non-elective surgery	Complex elective medicine	Complex elective surgery	ICU level 3	Inpatient paedatrics	Obstetrics and maternity unit	Non-complex elective surgery or medicine (or both)	High Depend-ency	Heart attack	HASU
Charing Cross	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔						✔
	Future	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				✔
● Chelsea and Westminster	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
	Future	✔	✔													
● Ealing	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
	Future	✔	✔													
St Mary's	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
	Future	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
West Middlesex	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
	Future	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
● Central Middlesex	*Current*	✔	✔			✔	✔		✔	✔			✔	✔		
	Future	✔	✔										✔	✔		
Hammersmith (incl. Queen Charlotte's)	*Current*	✔	✔	L	S	S	S	✔	S	✔		✔			✔	
	Future	✔	✔		S	S	S	S	S	S		✔	S	S	✔	
Hillingdon	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
	Future	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
Northwick Park	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				✔
	Future	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				✔

KEY

● Site specifically affected by option

✔ Service on-site

S Specialist service on-site

L Limited service on-site

This option would deliver benefits for NW London.

- **Good use of some buildings**. This option has West Middlesex Hospital as a major hospital, which would be a good use of high-quality buildings but does not include a major hospital at Chelsea and Westminster Hospital, which also has high-quality buildings.

- **Value for money**. This option would need relatively limited amounts of capital spending (on buildings and equipment). Two trusts (two hospitals) would continue to have a predicted deficit in this option and the predicted overall financial surplus would be less than 2% across NW London. This option is predicted to provide a positive return on investment, although less than for option A. It means the NHS in NW London would be in a better financial position than if nothing changes.

- **Fairly easy to deliver**. This option corresponds reasonably well with services already being delivered at each hospital, and with other changes taking place outside the 'Shaping a healthier future' programme. However, the maternity and paediatric units at Chelsea and Westminster Hospital would have to be moved elsewhere under this option.

- **Supports research and education**. Most important medical research in NW London is currently carried out at Hammersmith Hospital, St Mary's Hospital and Chelsea and Westminster Hospital. Under this option, Hammersmith Hospital becomes a specialist hospital and St Mary's Hospital a major hospital, which would mean current research arrangements can continue at both those sites.

Option B gives fewer benefits than option A, because it would:

- **be more difficult to deliver** – Chelsea and Westminster Hospital has a large obstetric unit, and if it were not chosen as a major hospital, these beds would need to be moved elsewhere;

- **be a poor use of buildings** – it would not make the best use of the high-quality buildings at Chelsea and Westminster Hospital;

- **give worse value for money** – it would be more expensive to put in place than option A and would result in a lower financial surplus across NW London;

- **leave two trusts (two hospitals) in deficit** – two trusts (two hospitals) would still lose money compared with option A; and

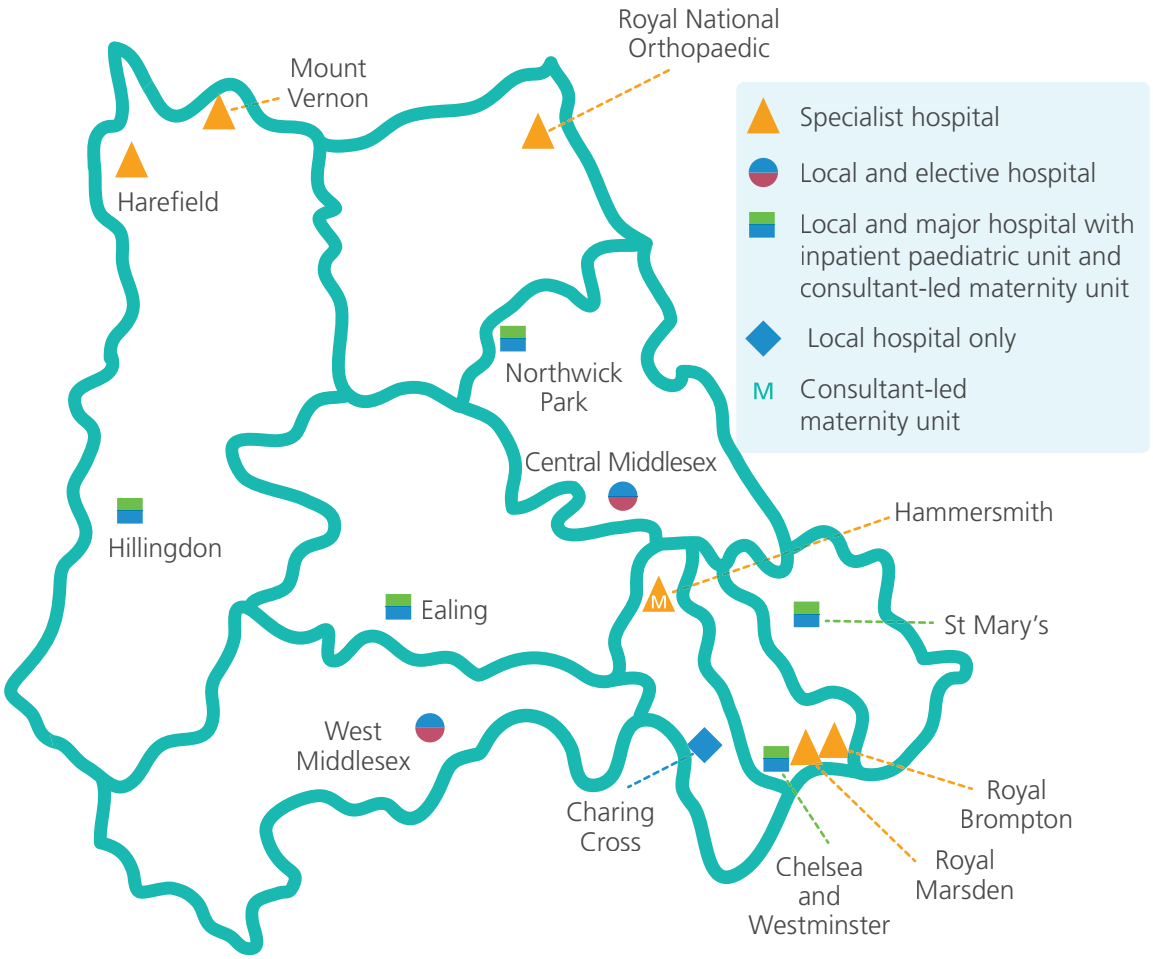
- **reduce patient choice** – including Charing Cross Hospital rather than Chelsea and Westminster Hospital would mean only four trusts running major hospitals, rather than five.

Option C

This option has Chelsea and Westminster Hospital, Ealing Hospital (with the stroke unit at West Middlesex Hospital moved to Ealing Hospital), Hillingdon Hospital, Northwick Park Hospital and St Mary's Hospital as the major hospitals. It has Central Middlesex Hospital and West Middlesex Hospital as a local and elective hospital and Hammersmith Hospital as a specialist hospital. Charing Cross Hospital is proposed as a local hospital.

Some services will no longer be available in some hospitals and instead will be provided at neighbouring hospitals where there would be more senior, experienced staff available and extra back-up in case of problems. Some specialist services will also need to move where hospitals become local hospitals. We have outlined the services provided at each site before and after the proposed changes in the table opposite.

Under this option, around 91% of services would not be affected by the changes. The proportion of services that would be affected under this option is relatively low, with 18% of inpatient cases, 15% of A&E cases and 5% of outpatient cases likely to move. Similarly, it is estimated that 81% of staff would not be affected by the changes, with most of those affected needing to move location to provide services either within a neighbouring hospital or within the community.



Option C

		Local hospital		Major hospital									Elective hospital		Other	
		Urgent care centre	Outpatients and diagnostics	24/7 A&E (24 hours a day, 7 days a week) A&E	Emergency surgery	Non-elective medicine	Non-elective surgery	Complex elective medicine	Complex elective surgery	ICU level 3	Inpatient paedatrics	Obstetrics and maternity unit	Non-complex elective surgery or medicine (or both)	High Depend-ency	Heart attack	HASU
● Charing Cross	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔						✔
	Future	✔	✔													
Chelsea and Westminster	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
	Future	✔	✔	✔	✔	✔	✔	✔	✔	✔	S	✔				
Ealing	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
	Future	✔	✔	✔	✔	✔	✔	✔		✔	✔	✔				
St Mary's	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
	Future	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				✔
● West Middlesex	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
	Future	✔	✔										✔	✔		
● Central Middlesex	*Current*	✔	✔			✔	✔		✔	✔			✔	✔		
	Future	✔	✔										✔	✔		
Hammersmith (incl. Queen Charlotte's)	*Current*	✔	✔	L	S	S	S	✔	S	✔		✔			✔	
	Future	✔	✔		S	S	S	S	S	S		✔	S	S	✔	
Hillingdon	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
	Future	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
Northwick Park	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				✔
	Future	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				✔

KEY

● Site specifically affected by option

✔ Service on-site

S Specialist service on-site

L Limited service on-site

This option would deliver benefits for NW London.

- **Good use of some buildings**. This option has Chelsea and Westminster Hospital as a major hospital, which would be a good use of high-quality buildings but does not include a major hospital at West Middlesex Hospital, which also has high-quality buildings.

- **Value for money**. This option would need more capital spending on buildings and equipment than option A. We predict that two trusts (three hospitals) would have a deficit in this option and the predicted financial surplus would be less than 2% across NW London. So, this option would provide a positive return on investment, but less than for option A. It means the NHS in NW London would be in a better financial position than if nothing changes, under this option.

- **Supports research and education**. Most important medical research in NW London is currently carried out at Hammersmith Hospital, St Mary's Hospital and Chelsea and Westminster Hospital. Under this option, Hammersmith Hospital becomes a specialist hospital and St Mary's Hospital a major hospital, which would mean current research arrangements can continue at both those sites.

Option C is not as good an option as option A, because it would:

- **give worse value for money** – it would not save as much money, and is predicted to be the least financially secure of the options;

- **be a poor use of buildings** – it would not make the best use of the high-quality buildings at West Middlesex Hospital;

- **leave two trusts (three hospitals) in deficit** – two trusts (three hospitals) would still lose money compared with option A; and

- **be more difficult to deliver** – the stroke unit at West Middlesex Hospital would need to be moved as it would not be able to provide this service safely without major hospital back-up.

We have carefully considered whether there should be a 'preferred option' for consultation, since the three options – A, B and C – are all practical. However, because the Joint Committee of Primary Care Trusts, which is leading this consultation, believes that option A delivers the greatest benefits for NW London, it would be misleading not to say so.

Having said that, this is a consultation aimed at gathering people's views. So we are putting all three options forward and inviting your views on which option will have the most benefits.

As part of the consultation, we would encourage healthcare providers, including from the independent and voluntary sectors, to make proposals for new and innovative ways of delivering services. We will make sure that information is available so that anyone who is interested in making proposals is able to do so, and we will fully and fairly consider any responses.

Thinking about the proposals put forward in sections 16 and 17, please say how far you support or oppose each of the three proposed options for the location of major hospitals in North West London. (You can support more than one of the options if you want.) Please explain why you support or oppose each option.

24

24a. Option A (the preferred option):
Major hospitals – Chelsea and Westminster Hospital, Hillingdon Hospital, Northwick Park Hospital, St Mary's Hospital and West Middlesex Hospital.
Elective and local hospital – Central Middlesex Hospital.
Local hospitals – Charing Cross Hospital, Ealing Hospital.
Specialist hospital (with maternity unit) – Hammersmith Hospital

24b. Why is this your answer?

25

25a. Option B:
Major hospitals – Charing Cross Hospital, Hillingdon Hospital, Northwick Park Hospital, St Mary's Hospital and West Middlesex Hospital.
Elective and local hospital – Central Middlesex Hospital.
Local hospitals – Chelsea and Westminster Hospital, Ealing Hospital.
Specialist hospital (with maternity unit) – Hammersmith Hospital.

25b. Why is this your answer?

26

26a. Option C:
Major hospitals – Chelsea and Westminster Hospital, Ealing Hospital (with the stroke unit at West Middlesex Hospital moved to Ealing Hospital), Hillingdon Hospital, Northwick Park Hospital and St Mary's Hospital.
Elective and local Hospital – Central Middlesex Hospital and West Middlesex Hospital.
Local hospitals – Charing Cross Hospital.
Specialist hospital (with maternity unit) – Hammersmith Hospital.

26b. Why is this your answer?

27

27a. All the options above include the recommendation that Central Middlesex Hospital should be an elective and local hospital. How far do you support or oppose the recommendation that Central Middlesex Hospital should be an elective and local hospital?

27b. Why is this your answer?

28

28a. All the options above include the recommendation that Hillingdon Hospital should be a major hospital. How far do you support or oppose the recommendation that Hillingdon Hospital should be a major hospital?

28b. Why is this your answer?

29

29a. All the options above include the recommendation that Northwick Park Hospital should be a major hospital. How far do you support or oppose the recommendation that Northwick Park Hospital should be a major hospital?

29b. Why is this your answer?

30

30a. All the options above include the recommendation that Hammersmith Hospital should be a specialist hospital. There would continue to be a maternity unit at Hammersmith. How far do you support or oppose the recommendation that Hammersmith Hospital should be a specialist hospital with a maternity unit?

30b. Why is this your answer?

31

Are there any other options we should consider when making our decisions? If so, please give your reasons for suggesting these.

18. Proposals for changes to specialist services

Specialist hospitals already provide high-quality services in NW London and cover the local population (and many other parts of London too) very well.

So specialist hospitals will stay largely as they are.

However, as part of this consultation, we are recommending two particular changes to specialist services, as well as changes to specialist services where hospitals become local hospitals.

1. Moving the hyper-acute stroke unit (HASU) from Charing Cross Hospital to St Mary's Hospital under options where Charing Cross Hospital is not a major hospital.

If Charing Cross Hospital were to become a local hospital, we could not maintain a hyper-acute stroke unit (HASU) there. The HASU would need to move to a major hospital close to the Charing Cross Hospital site. The stroke and major trauma consultation in 2009 showed a preference for putting HASUs on the same site as major trauma centres, as they need similar back-up and support. As there is now a major trauma centre at St Mary's Hospital, we propose to move the HASU from Charing Cross Hospital to St Mary's Hospital in option A and option C, where Charing Cross Hospital is a local hospital.

2. Moving services from the Western Eye Hospital to St Mary's Hospital

The Western Eye Hospital is the specialist ophthalmology hospital in NW London and part of Imperial Healthcare NHS Trust. It is the only hospital to offer a 24-hour emergency eye-care service in NW London for ambulance and walk-in cases. The service uses a minor surgical theatre, a triage system, inpatient beds and theatres. The Western Eye Hospital also offers outpatients, inpatients and day-care surgery.

The hospital is located on its own just off Marylebone Road. As part of Imperial's strategy, they would like to move these services to one of their other hospital sites and, so that people can understand all the changes being proposed in NW London, we have included this proposal in this consultation.

Separating Western Eye Hospital services from the main hospital services at St Mary's Hospital creates service and financial waste. By combining services, Imperial will be able to offer an integrated ophthalmologic service for urgent and non-urgent patient needs. There will be one place for all ophthalmologic emergencies, reducing the need for transferring patients and allowing clinicians to work more economically and effectively.

Imperial have looked at the option of moving services to each of its other sites (St Mary's Hospital, Charing Cross Hospital and Hammersmith Hospital). It thinks that

the best option is to move the Western Eye Hospital to St Mary's Hospital as this would:

- have little effect on patient access compared with the current site;
- improve clinical performance because of combining services and putting them with major trauma and paediatrics at St Mary's Hospital; and
- be the better long-term option (clinically and financially) for Imperial.

Imperial estimates the net costs of moving to St Marys would be between £5 million and £15 million, with the lower amount being more likely as part of broader site redevelopment at St Mary's.

You can find more details in our pre-consultation business case (Appendix K) on our website at www.healthiernorthwestlondon.nhs.uk

32

32a. Do you agree or disagree that the hyper-acute stroke unit, which was designated to Charing Cross following the stroke and major trauma consultation, should move to be with the major trauma unit at St Mary's?

32b. Why is this your answer?

33

33a. Do you agree or disagree that the Western Eye Hospital should be relocated with the major hospital at St Mary's?

33b.Why is this your answer?

19. Making this work for patients

We have worked long and hard, with patient representative groups and others, to make sure that the 'Shaping a healthier future' programme as it is put in place over the next few years in NW London should benefit patients, not have a negative effect on them.

But because there is understandable concern about some areas of change to NHS services, we want, in particular, to highlight the following.

- We are investing in developing bigger, better specialist teams in major hospitals and in community services.

- We are investing to increase services outside hospital and have plans for new facilities to deliver these services.

- The main parts of the proposed changes have all been delivered before, in this country and around the world, and so are known to be a successful way to reorganise health services to prepare for future demands.

- Most patients using NW London hospitals' emergency services are already using minor injuries units or urgent care centres – they are not actually using, or needing to use, major A&E departments. So moving the major A&E departments away from some locations would not affect many of the patients using these same hospital sites already.

- It will take longer for some people to get to some services, or visit relatives. But the benefits of better, specialised care at these hospitals, and from more care being delivered closer to home, far outweigh the inconvenience of these increased journeys. Those using the NHS have consistently said in surveys that they would rather travel further to receive better care – and would want the same for their families.

- Many health services provided in the community – such as GP services and mental-health services – are already being improved and would need a relatively modest investment of time and money to cope with the extra services that would switch from being provided in hospitals at the moment to being provided by facilities closer to home, such as in improved GP surgeries, new health centres, and new community facilities. We have promised that we will not make changes to hospitals until any alternative services that are necessary are in place.

- To find out whether our proposals might unfairly disadvantage some communities, we have done an independent equalities impact review which looked at how

the proposed changes would affect people such as young children, ethnic communities, women and the elderly. This review showed that in most cases these groups would not be unfairly disadvantaged. We are developing an action plan to tackle any potential disadvantages that have been reported. You can see the full report for this review on our website at www.healthiernorthwestlondon.nhs.uk

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Is there anything else you want to say about the consultation or the issues it covers? If you want to explain any of your answers, or you feel the questions have not given you the chance to give your views fully, or if you think there are options we have not considered that we should have done, please say so here.


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16
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20. Next steps

We are keen to continue the discussion with patients, the public, and those who may be affected by the proposed changes to health services in NW London.

There is a recognised process for doing this as, by law, the NHS has to consult patients and the public on any major change to local health services. Government guidance on this says we must:

"1. Consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of the policy.

2. Be clear about what the proposals are, who may be affected, what questions are being asked and the timescale for responses.

3. Ensure that the consultation is clear, concise and widely accessible.

4. Give feedback regarding the responses received and how the consultation process influenced the policy.

5. Monitor the effectiveness of the consultation, including through the use of a designated consultation co-ordinator.

6. Ensure the consultation follows better regulation best practice, including carrying out a Regulatory Impact Assessment if appropriate."

So, through a large-scale consultation running for 14 weeks from 2 July to 8 October, we are asking people for their opinions on these options for change, making sure we involve patients and the public more widely. (We have added an extra two weeks to the minimum consultation time because it is taking place over the summer.)

There will be focus groups, roadshows, events in hospitals, and other events around all eight NW London boroughs (and the three outside NW London who may be affected by the changes), to make sure we involve as many people and communities as possible, including some who are sometimes referred to as 'seldom heard' groups. The aim is to explain, to listen, and to receive views from as many people as possible.

We will then spend some time assessing people's views, before making a further report, in early 2013. The Joint Committee of Primary Care Trusts will then make the final decision on changes to services. The Joint Health Overview and Scrutiny Committee, which is made up of representatives from each of the local authorities in NW London, will closely check our consultation and proposed plans.

If the changes are agreed they will take at least three years to put in place. Work to develop services that can be provided in the home, GP surgeries and health centres has already started and only once these services are in place will changes to hospitals be made.

Glossary

A&E – accident & emergency is a service available 24 hours a day, seven days a week where people receive treatment for medical and surgical emergencies that are likely to need admission to hospital. This includes severe pneumonia, diabetic coma, bleeding from the gut, complicated fractures that need surgery, and other serious illnesses.

Acute care – acute care refers to short-term treatment, usually in a hospital, for patients with any kind of illness or injury.

Acute trust – NHS acute trusts manage hospitals. Some are regional or national centres for specialist care, others are attached to universities and help to train health professionals. Some acute trusts also provide community services.

Bundle – a combination of relevant 'packages of care' for a patient. For example, a bundle for a patient with diabetes could include podiatry, dietetics, diabetes nursing and ophthalmology.

Cardiothoracic – is the field of medicine involved in surgical treatment of diseases affecting organs inside the thorax (the chest) – generally treatment of conditions of the heart (heart disease) and lungs (lung disease).

Cardiovascular – this refers to the heart and blood vessels. Cardiovascular diseases affect the function of the cardiovascular system, which carries nutrients and oxygen to the tissues of the body while removing carbon dioxide and other wastes from them.

CCG – clinical commissioning group. These are the health commissioning organisations which will replace primary care trusts (PCTs) in April 2013. CCGs are led by GPs and represent a group of GP practices in a certain area. They are currently shadowing the PCTs and will be responsible for commissioning healthcare services in both community and hospital settings from April 2013 onwards.

Care outside hospital – care that takes place outside of hospital, in a community setting. This could be a patient's home, community bed or community health centre.

Centralise – a principle of the 'Shaping a healthier future' programme, which is about bringing more services together on a number of specific sites to create a greater level of expertise.

Complex elective medicine or surgery – a planned operation or medical care where the patient may need to be in a high-dependency unit while recovering from the operation, either because the operation is complex or because they have other health problems.

Continuity of care – an integrated care project that has been launched in Hammersmith and Fulham. The project aims to improve outcomes for patients at minimal costs and reduce treatment or stays in hospital.

COPD – chronic obstructive pulmonary disease. COPD is a lung disease which causes difficulty or discomfort in breathing.

CQC – Care Quality Commission – this is an organisation funded by the Government to

check all hospitals in England to make sure they are meeting government standards, and to share their findings with the public.

Deficit – when spending is greater than income.

Elective hospital – this is where patients go if they need an operation which is not urgent and so can be planned.

Emergency surgery – surgery that is not planned and which is needed for urgent conditions. This includes surgery for appendicitis, perforated or obstructed bowel, and gallbladder infections. It is also known as non-elective surgery.

Financial surplus – when income is greater than spending.

Foundation trust (FT) – NHS Foundation Trusts are not-for-profit corporations. They are part of the NHS yet they have greater freedom to decide their own plans and the way services are run. Foundation trusts have members and a council of governors. The aim is that eventually all NHS trusts will be FTs.

GP network or cluster – a smaller group of GP practices within a borough or CCG area (see CCG above).

HealthWatch – these are new organisations which will replace LINks (see below) as part of the restructure of the NHS. Their role is to make sure patients are involved in developing and changing NHS services and to provide support to local people. There will be a national HealthWatch to oversee the local HealthWatch and provide advice as an independent part of the CQC (see above).

Health centre or 'hub' – a setting for care outside hospital which will be adapted from existing community sites to provide other services locally, serving as a support 'hub' to local healthcare teams. The services offered will vary depending on local needs and will range from bases for multidisciplinary teams to 'one-stop' centres for GP services, diagnostics and outpatient appointments.

Heart attack centre – a centre which treats people who have had a heart attack.

Health and well-being board (HWB) – part of the NHS restructure, the aim of these boards is to encourage joint working between the NHS and local authorities across health and social care. HWBs are expected to be up and running in April 2013.

High-dependency unit – treats conditions that need intensive nursing support, such as people who are ill with pneumonia or who have had major surgery.

Hyper-acute stroke unit (HASU) – hospital wards that specialise in treating people who are having a stroke.

Integrated care pilot (ICP) – a joint venture led by commissioners and providers of primary, community, acute, social and mental-health care for people aged 75 and over with diabetes. The aim is to offer integrated care to improve the outcome for patients and reduce unnecessary stays in hospital.

Inpatient – a patient who is admitted to a hospital, usually for 24 hours, for treatment or an operation.

Inpatient paediatrics – these units treat sick children who require a stay in hospital.

Integrate – a principle of this programme which refers to creating more co-ordinated care for the patient, making sure all parts of the NHS and social services work more closely and effectively together.

Interdependency – where some clinical services need other clinical services to be based on the same site for particular types of care to be successfully and fully delivered together.

Interventional radiology – uses minimally invasive image-guided procedures to diagnose and treat diseases in nearly every organ system.

Intensive care – these units provide support for patients after complex surgery, or patients needing multiple organ support such as ventilation and dialysis.

Key performance indicator (KPI) – targets that are agreed between the provider and commissioner of each service, which performance can be tracked against.

Level 3, as in level 3 intensive care unit - ICUs are sections within a hospital that look after patients whose conditions are life-threatening and need constant, close monitoring and support from equipment and medication to keep normal body functions going. Level 3 ICU is for patients who need advanced respiratory support alone or basic respiratory support with the support of at least two organ systems. This level includes all patients with complex needs who need support for multi-organ failure.

LINks – local involvement networks. LINks are made up of individuals and community groups whose goal is to improve health and social care services. They are funded by local councils, although they are independent of the Government. In 2013 they will be replaced by HealthWatch (see above).

Local hospital – a type of hospital proposed in the changes. Local hospitals will include urgent care centres, which provide the services that three-quarters of people go to hospital for – such as everyday illnesses, minor injuries and long-term conditions such as diabetes or asthma.

Localise – a principle of this programme, which is to deliver as much care as possible in the most convenient locations, making sure people have earlier and easier access to treatment.

Major hospital – a type of hospital proposed in the changes. A major hospital will include full A&E, paediatrics and maternity services.

Maternal deaths – death of a women while pregnant or within 42 days of end of pregnancy, from any cause related to the pregnancy.

Maternity – relating to pregnancy, childbirth and immediately following childbirth.

Multi-disciplinary group (MDG) – sometimes referred to as a multidisciplinary team. These are groups of professionals from primary, community, social care and mental-health services who work together to plan a patient's care.

Neonatal – relating to newborn infants.

Non-complex elective surgery or medicine (or both) – this includes hernia repairs, knee replacements and planned gallbladder operations, usually as day cases.

Non-elective medicine – treatment for illnesses that is not planned, including severe pneumonia, flare-ups of inflammatory bowel disease, severe asthma attacks and worsening of COPD, needing admission to hospital.

Non-elective surgery – see emergency surgery

Obstetric – the care associated with giving birth.

Obstetrics and maternity unit – where babies are delivered and women with complex pregnancies, such as expectant mothers with diabetes or heart disease, or who are pregnant with triplets, are monitored.

Overview and Scrutiny Committee (OSC), Health OSC (HOSC) and Joint Health OSC (JHOSC) – the committee of the relevant local authority, or group of local authorities, made up of local councillors who are responsible for monitoring, and if necessary challenging,

programmes such as the 'Shaping a healthier future' programme. Parts of consultation, such as the length of the consultation period, have to be agreed by them.

Outpatient – a patient who attends an appointment to receive treatment without needing to be actually admitted to hospital, unlike an inpatient. Outpatient care can be provided by hospitals, GPs and community providers and is often used to follow up after treatment or to assess for further treatment.

Outpatients and diagnostics – for people who need specialist advice or investigation in hospital. This includes support for insulin-dependent diabetics or neurological conditions such as multiple sclerosis. It also includes minor surgery, ECGs, x-rays, ultrasounds, CT and MRI scans.

Package of care – a term used to describe a combination of services put together to meet a person's assessed healthcare needs. It outlines the care, services and equipment a person needs to live their life in a dignified way.

Patient pathway or journey – this is a term used to describe the care a patient receives from start to finish of a set timescale, in different stages. There can be integrated care pathways which include multi-disciplinary services for patient care (see MDG above).

Paediatric services – this refers to healthcare services for babies, children and adolescents.

Patient and public advisory group (PPAG) – there is a London-wide PPAG as well as a PPAG in NW London. Their role is to make sure the interests of patients and the public are represented in the NHS. Members usually include representatives of local LINks, hospital patient groups, local clinical commissioning groups, the London PPAG and NHS staff.

Primary care – services which are the main or first point of contact for the patient, provided by GPs, community providers and so on.

Primary care trust (PCT) – PCTs commission primary, community and secondary care from providers. To be replaced by CCGs (see above) in April 2013.

Quality, innovation, productivity and prevention (QIPP) – the Department of Health QIPP agenda aims to achieve up to £20 billion of efficiency savings by 2015 by making sure that each pound spent is used to bring maximum benefit and quality of care to patients.

Secondary care – hospital or specialist care that a patient is referred to by their GP or other primary care provider.

Specialist hospital – a hospital which provides specialist care for particular conditions, for example cancer or lung disease.

Stroke – a stroke is the sudden death of brain cells in a particular area due to inadequate blood flow.

Trauma, as in major trauma centre or trauma centre – these centres treat major trauma patients who have complex injuries – either one very serious injury or a number of injuries – which make managing these patients very challenging. They need expert care from a large number of different specialties to give them the best chance of survival and recovery.

Urgent care centre (UCC) – a centre that is open 24 hours a day, seven days a week. These centres will treat most illnesses and injuries that people have which are not likely to need treatment in hospital. This includes chest infections, asthma attacks, simple fractures, abdominal pain and infections of the ear, nose and throat.

Value for money (VFM) – a term often used to demonstrate the quality of a healthcare service balanced against the cost of delivering that service.

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Arabic:

هذه الوثيقة متاحة أيضاً بلغات أخرى وبالأحرف الطباعية الكبيرة وبطريقة سمعية عند الطلب.

Portuguese:

Este documento também está disponível em outros idiomas, em letra de imprensa de tamanho grande e em formato de áudio sob solicitação.

Bengali:

এই ডকুমেন্ট অন্য ভাষায়, বড় প্রিন্ট আকারে এবং অডিও টেপ আকারেও অনুরোধে পাওয়া যায়।

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یہ دستاویز درخواست کرنے پر دوسری زبانوں، بڑی چھپائی ، اور آڈیو طرز میں بھی دستیاب ہے۔

Farsi:

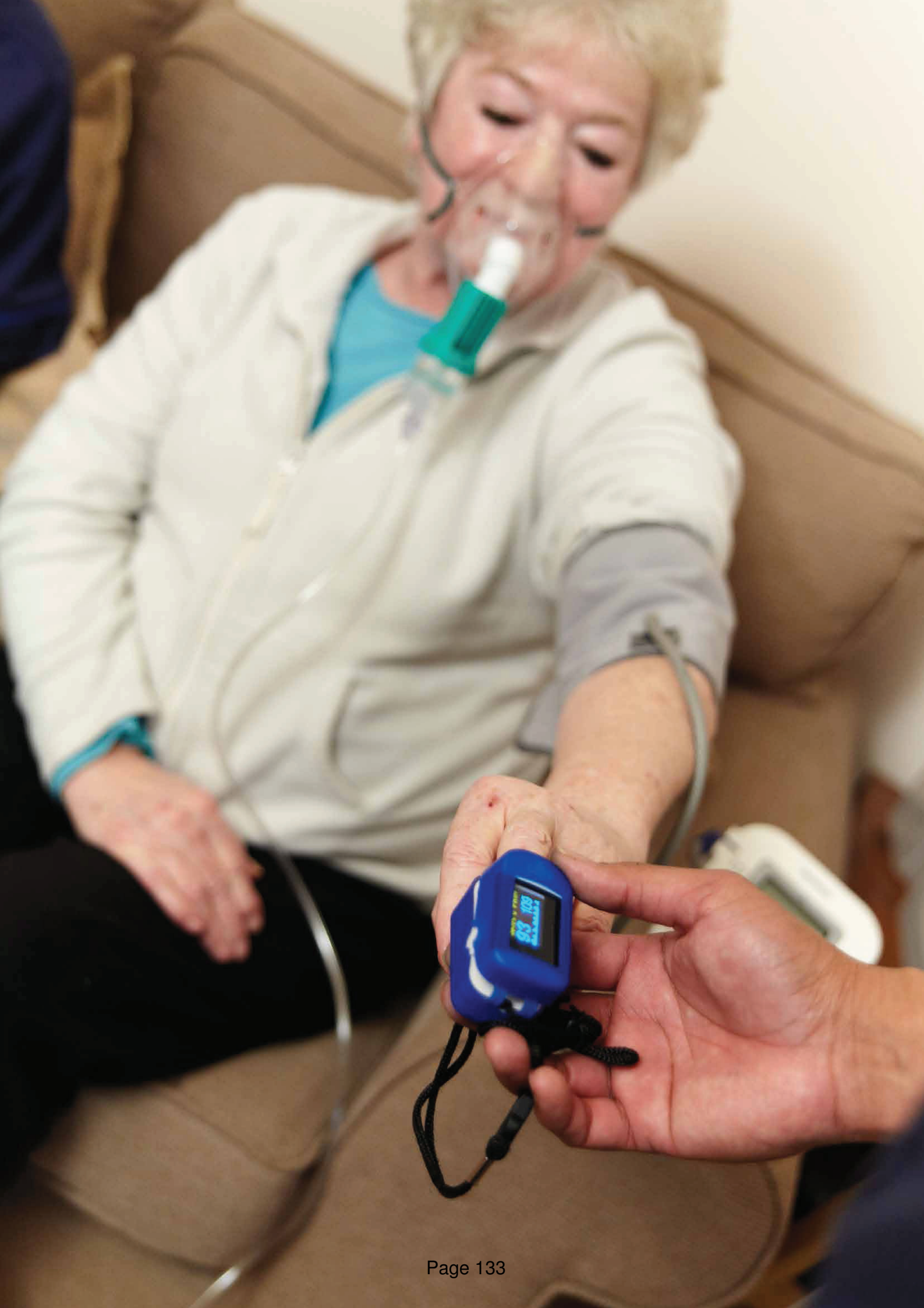
این اطلاعات در صورت نیاز به زبانهای دیگر، چاپ درشت و اشکال صوتی نیز موجود می باشند.

Punjabi:

ਇਹ ਪਰਚਾ ਹੋਰਨਾਂ ਬੋਲੀਆਂ, ਵੱਡੇ ਛਾਪੇ ਤੇ ਸੁਣਨ ਲਈ ਰਿਕੌਰਡ ਕੀਤਾ ਵੀ ਮਿਲ ਸਕਦਾ ਹੈ। ਇਹ ਤੁਸੀਂ ਆਖ ਕੇ ਲੈ ਸਕਦੇ ਹੋ।

Tamil:

வேண்டப்படும்போது இந்தப் பத்திரம் ஏனைய மொழிகளிலும் பெரிய எழுத்திலும் ஓடியோ வடிவத்திலும் கிடைக்கின்றது.



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London Borough of Hammersmith & Fulham

HOUSING HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE

DATE	TITLE	Wards
17 July 2012	Housing Strategy 2007-2014	All

SYNOPSIS

The seven year Housing Strategy sets out how the Council will meet the housing challenges facing the borough and how it will provide opportunity in terms of the housing and housing services provided currently and into the future.

CONTRIBUTORS

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RECOMMENDATION(S):

The Committee is asked to respond to the consultation.

CONTACT

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NEXT STEPS

N/A

London Borough of Hammersmith & Fulham

Housing Strategy 2007-2014

A Housing Ladder of Opportunity For All

CONTENTS

Foreword

Hammersmith & Fulham is a borough of opportunity. Its economy is growing, its town centres are being rejuvenated, and new businesses are setting up here at a fast rate. However, it is also a borough facing real challenges. Demand for housing is outstripping supply and too many people are being forced to leave the borough because they can no longer afford to live here due to high house prices. There are areas in the borough, concentrated on the larger social housing estates, with continuing high levels of deprivation and many local people who have great aspirations but believe that the ladder of opportunity at least in this borough has well and truly slipped away.

Our 7 year Housing Strategy is not only intended to set out how we will meet the housing challenges facing the borough head on but how we will provide opportunity at every turn in terms of the housing and housing services we provide now and into the future.

We will tackle lack of supply by increasing the housing developed in the borough. Our planning policies will seek to assist developers who share our aims to increase the supply of good quality housing that will help us meet the vision set out in this strategy. This will include maintaining a programme of development of affordable rented housing particularly to meet the demand for family housing. However we will not repeat the mistakes of the past by developing large concentrations of social rented housing in our most deprived areas. Working with developers and housing associations our aim is to build high quality mixed tenure developments.

We will promote homeownership. Owning your own home gives you a greater stake in your community, a greater stake in your own future prosperity and more choice. Building assets (particularly through home ownership) is central to advancing social mobility and an important foundation for personal security. Yet in Hammersmith & Fulham too many people are unable to get on the housing ladder; the first rung is way out of reach. We will make homeownership a viable option for more households in the borough and we set out here how we will do this through increased development of low cost homeownership housing and innovative low cost homeownership options that make homeownership affordable for the many and not the few.

We are determined to improve the quality of all housing services provided in the borough including housing management services both in the public and private sectors. Through the provision of high quality housing advice services our aim is to reduce levels of homelessness and provide high quality advice to those people on low to middle incomes looking to stay and buy in the borough. We will set tough targets for our housing management services to improve and increase satisfaction levels which have, over the last 3 years, fallen. We will expect all housing management services to go that bit further to effectively tackle crime and

anti social behaviour and increase levels of employment amongst social housing tenants.

The Housing Strategy also identifies our aspirations to set in place area regeneration programmes in the Shepherds Bush area, Hammersmith Centre and North Fulham, aimed at improving the social housing available in those areas, improving neighbourhoods, building communities and breaking down the “them and us” culture that can so easily develop when communities are segregated by tenure.

The approaches we use to make neighbourhoods and communities successful must empower individual households and neighbourhoods to help themselves. Therefore this strategy identifies how we will work with households living in more deprived neighbourhoods to take a step change to improvement through neighbourhood management initiatives and targeted employment and training schemes.

We have a clear mandate to deliver a borough of opportunity. We have a clear vision of what we want to achieve. With the help of our housing partners we are determined to deliver not only a borough of opportunity for all but thriving neighbourhoods and communities that people want to live in now and into the future.

I therefore commend this Strategy to Council housing staff and our housing partners who will help us deliver it and to tenants, leaseholders and residents who we will all work hard to serve into the future by delivering better homes, better housing services, successful neighbourhoods and opportunity for all.

Cllr Lucy Ivimy
Cabinet Member for Housing

1. Introduction

This Housing Strategy is an overarching policy document that sets out the strategic aims and objectives for housing related services across the entire spectrum of housing activity including; housing management both in the council and housing association sectors, housing advice services, allocation of social rented housing, private sector renewal and new development.

The updated Housing Strategy reflects the approach and direction for housing in Hammersmith & Fulham. It is intended to positively respond to the strategic housing direction set out in the recently published Government Green Paper "Homes for the Future", to requirements set out in Planning Policy Statement 3 and to the Mayor of London's Draft Housing Strategy within the context of local circumstances which dictate an approach to meeting housing demands that balances housing needs within the context of tackling economic and social polarization and securing prosperous, safe, thriving and sustainable neighbourhoods.

The Strategy draws together a broad range of activities and will inform and is aligned to other key Council strategies and plans including Planning Policy, Regeneration and Economic Development. Most of all however it is a keystone to the delivery of the objectives set out in the boroughs Community Strategy. In this respect the Strategy is geared towards the delivery of high quality, outcome focused and value for money housing and housing services that provide more opportunities for households to get on and help deliver successful neighbourhoods and communities where people want to and can live now and into the future.

2. Summary Analysis

Overview

Hammersmith & Fulham is a unique, diverse, vibrant, and popular borough to live and work in. Being on the outer edge of Inner and Central London it is well served by transport links and has significant cultural, leisure, business, and employment attractions.

According to the latest mid-year estimates from the Office for National Statistics (ONS) Hammersmith and Fulham's population was 169,729 people in 2009. This is virtually static when compared to the 2001 population estimate of 169,374. This represents a very small increase of 0.2% or 355 people, a lower rate of increase than those for both West London (3.4%) and London as a whole (5.9%).

Just over one in five residents are from non-white ethnic backgrounds, 5% were born in Ireland. There is also a well-established Polish community in the borough and a growing French community in the south of the borough. Some ninety different languages are spoken in local schools. London's place as a world city means that the borough will continue to be home for many diverse groups of people, of different nationality, ethnic origin, religion, and culture.

Residents in H&F have better general health compared to London as a whole, as 73% of all people reported good health. 7.2% of population aged 16-64 in H&F reported not to have good health. Over a quarter of older residents in the borough have reported the same; this compares to 23.3% in London.

The proportion of H&F working age population suffering from limiting long-term illness (11.6%) was lower compared to West London (12.0%) and London (12.4%). Conversely, a half of H&F older residents reported to suffer from LLTI; this compares to 48% in both West London and London as a whole.

The future population projections suggest that H&F's population will continue to but at a slower pace than West London and London as a whole. The currently projected increase in population between 2009-2018 is 2%, with a further projected increase between 2018 and 2033 ranges of 5%. This is the third slowest population growth rate in London.

There are 11,000 businesses in the borough and it is anticipated that employment levels will increase by 18% (29,000) by 2016. The borough has one of the highest percentages of employees working in the creative industries in London and there are future opportunities opening up to increase employment in this area of activity in the north of the borough as plans to develop a creative media hub are taken forward as part of the regeneration of W12. The Westfield shopping centre in Shepherds Bush also provides a range of job opportunities

for skilled and non skilled workers as may possible plans to improve convention, leisure and hotel facilities in the Earls Court and Olympia area.

In 2007 45% of all vacant posts were either in sales and customer services occupations or elementary occupations (e.g. hospital porters, postal workers, cleaners, labourers). 70% of working-age people in Hammersmith & Fulham are employed compared to 68.6% for London. An estimated 80,000 workers commute into the borough every day.

3. Housing Supply

It is unsurprising that there is a high demand for all forms of housing with the borough having the 4th highest house prices in the country. As at July 2010 the average price of a house in the Hammersmith & Fulham housing market was £495,000. This is significantly higher than both averages for London and England and is 12 times higher than the median borough income of £ 40,045 pa which is the 12th highest in London.

Therefore, property in Hammersmith & Fulham is prohibitively expensive and for the vast majority of people who live in the borough (93%), their income levels are beneath the level required for an entry level property in the area.

The vision of the H&F Community Strategy is to create a borough of opportunity for all. A key priority of this vision is to promote home ownership – to make home ownership more affordable for a greater number of residents. This will help address the current tenure imbalances and ensure that more local people stay in the borough and have a stake in the future. In particular, we will provide more home ownership opportunities for key workers, first time buyers and those on low to middle incomes.

The 2010 Housing needs assessment suggests that there are many households in Hammersmith and Fulham that fall into the " intermediate market" – households who do not meet the criteria for social housing but who can not afford market priced housing in the borough. Opportunities for finding affordable accommodation that meets the need their needs within Hammersmith and Fulham is currently limited and must be expanded.

.The demand for low cost homeownership housing is high with over 3000 households on the Council's HOMEBUY register. About 70% of the applicants live in the borough with the remainder working but not living in the borough. Our latest Housing Needs Assessment (2010) suggests 1,434 households per annum could require intermediate products or need to have their housing needs met through the private rented sector.

About 2% of the housing stock is intermediate housing and there is evidence that the overwhelming need in H&F is for more intermediate housing to meet the aspirations of local residents and workers for home ownership. 32% of the housing stock is already social rented housing, compared to 24% in London as whole.

H&F aims to build a minimum of 6150 additional dwellings over the next 10 years and 2,460 additional affordable dwellings. This represents a 37% increase above the Council's current London plan target of 450 dwellings. These targets are likely to be exceeded if the proposals for estate regeneration go ahead.

The Council 2010 strategic housing market assessment which has identified that housing need can be met from the existing annual supply of social rented housing. The Council is also committed to replacing any social rented stock lost through regeneration and therefore their will not be a net reduction in the number of affordable rented dwellings in the borough in future years.

Between 2001/2002 and 2009/10 approximately 4,520 additional dwellings have been completed in the borough of which 53% have been affordable housing units. Of the affordable units , 1256 (53%) were for social rent and the remainder 47% for intermediate housing

In addition the supply of social rented housing can be increased by targeting employment and HomeBuy services to existing council tenants and those in housing need. The Rehousing Opportunities Initiative is tackling under occupation and overcrowding and proposals for estate regeneration will provide opportunities for tackling under occupation and overcrowding and of reproviding housing more suitable for families.

Meeting the continuing demand for family size social rented housing presents challenges when considering the significant percentage of 1 bed accommodation in this tenure e.g. 40% of council stock and 51% of Shepherd's Bush Housing Association (RSL) social rented units are 1 bed. This situation exacerbates overcrowding in the borough, and also waiting times for family sized units as illustrated in Figure 1 below.

Figure 1: households between January 2007 and 13th March 2011 : Average (median) time from band start to Rehousing months

All households	**Band A**	**Band B**	**Band C**	**Band D**
1 bedroom	4.5	4.4	35.1	3.6
2 bedroom	4.3	9.3	50.5	39.3
3 bedroom	7.3	13.9	63.2	2.8
4+ bedroom	15.8	-	89.9	-
TOTAL	**6.0**	**5.8**	**50.2**	**3.6**

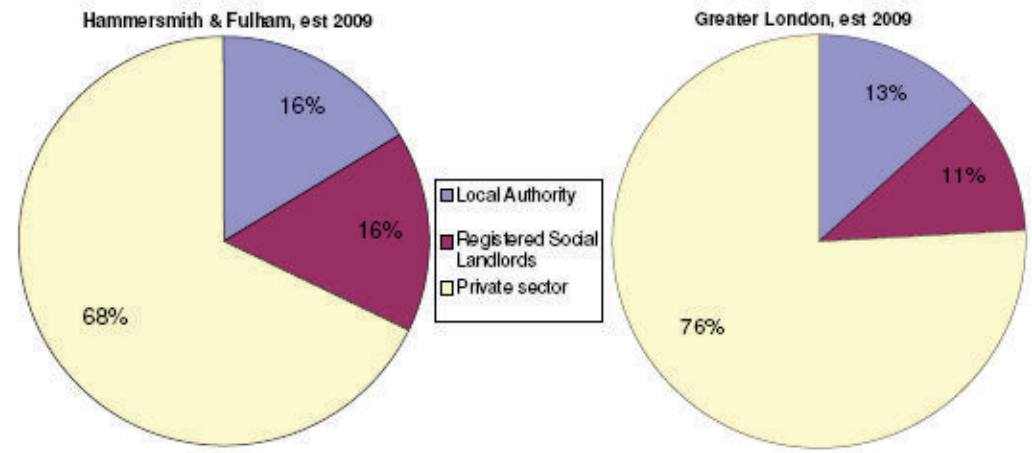
Source: Locata

Given Hammersmith & Fulham's current London Plan homes target of 450 additional units a year, and every with the aim to increase this to at least 615 additional homes pa, there is no way that the shortfall in affordable housing dwellings can be made up through new development in the borough alone. The challenges facing the Council therefore are how to balance demand against ensuring that our letting plans and new developments are sustainable, that social rented housing does not become a residualised form of tenure and that households successfully access housing that will become available outside of the borough.

The tenure and sustainability dynamics in Hammersmith & Fulham are not common to all London boroughs and are significantly different to those found in other boroughs in the West London Housing Corporation sub region.

There were 81,566 dwellings in April 2010 in Hammersmith & Fulham, some 4,500 more than in April 2001. Just over two thirds of housing stock or 55,741 dwellings in the borough are in the private sector while less than a third or 26,224 dwellings are from the public/RSL stock. This compares to 76% and 24% in London.

Figure 2. Tenure Mix Comparisons



Source: CLG HIP Data, 2009

Only 4 out of 10 households in the borough own their property compared to 6 out of 10 for London. There is a small intermediate housing sector accounting for less than 2% of the housing stock in the borough with few if any opportunities for those on low to middle incomes to access either shared ownership or affordable private rent accommodation[1]. The last Housing Need Survey showed that

[1] The London Requirement Study defined affordable private rented accommodation as accommodation with rents at or below the London lowest quartile.

although for every social rented unit that became available there were 3.8 households in housing need, it also showed that for every shared ownership unit that might come up for sale there were 107.9 households in housing need who could potentially afford some form of intermediate housing.

There are real challenges therefore in providing housing offers to younger households looking to stay in the borough and for family households on low to middle incomes looking to settle in the borough. The table below demonstrates the importance of low cost homeownership options in making accommodation affordable with the average key worker being able to purchase a new build flat if sold at 25% equity but not at full market price.

Figure 3.

Affordability by occupation

Occupation	Average Annual Income	Income as % of income required to purchase
Managers and senior officials	£51,099	59.4%
Professional occupations	£44,298	51.5%
Key workers	£34,751	40.4%
Nurses	£30,676	35.7%
Police officers	£46,213	53.7%
Social workers	£33,621	39.1%
Teaching Professionals	£37,764	43.9%
Prison service officers	£30,701	35.7%
Probation officers	£33,883	39.4%
Fire service officers	£33,087	38.5%
Town planners	£42,811	49.8%
Associate professional / technical occupations	£33,871	39.4%
Skilled trades occupations	£28,617	33.3%
Administrative and secretarial occupations	£20,954	24.4%
Personal service occupations	£16,062	18.7%
Customer service occupations	£17,578	20.4%
Sales occupations	£11,638	13.5%
Elementary occupations	£20,742	24.1%
Elementary administration	£12,068	14.0%

Source: Annual Survey of Hours and Earnings (ASHE) - 2009

Additionally, a recent independent study by the Housing Quality Network for Hammersmith & Fulham identified that households on incomes of between £50k to £60k would have difficulty in accessing new market housing larger than 2 bed accommodation and would be priced out of the market for 2 and 3 bedroom homes unless they brought with them equity or substantial savings.

From a recent 2010 survey of the Housing Register, 47% of main applicants stated that they or their partner was in some form of employment. At the same time, 7% of households on the housing register stated that they had annual incomes of £29k pa or more, and would be in a position to afford low cost home ownership products. The remaining 93% had incomes less than the £29k threshold, of which the vast majority had incomes of £19k per annum or less.

The housing register has not been validated since late 2005 and the Council is undertaking is currently undertaking an exercise to refresh the Housing Register, and these figures will be updated when the exercise has been completed.

There are also affordability issues that must be addressed in relation to service charge levels some of which are now as high as £2,000 for some new developments in London.

The Council and other social landlords must also consider whether the social housing they provide continues to be fit for purpose and what needs to be done to improve accommodation for all households.

In particular, they need to be mindful of the large expected increases in the population aged 65 or over in the next 20 years (at just over 20% increase). The largest increases will be among those aged 85 or over. With this, the expected numbers of older people with mobility problems and dementia will increase rapidly; and landlords will need to ensure that these needs are met and not exacerbated by housing conditions and availability.

At the same time with pressures on budgets across all service areas, and combined with increasing life expectancy, the Council will need to find alternative ways of keeping older people independent and in their own homes (should they choose to do so).

As part of the work to integrate social services with the local health services, the borough is considering the provision of nursing care in existing sheltered and extra care sheltered schemes to reduce the admission rate for nursing care and assist older people to remain independent through the provision of early care services designed to reduce the need for long term placements and hospital

3.1 Quality Housing Services

The Cave Review on social housing regulation, entitled " Every Tenant matters: A review of social housing regulation", was published in June 2007. It identified a number of disturbing trends in relation to housing management services delivered to social housing tenants:

- Nationally falling levels of satisfaction with housing management services with some housing management services still failing to get the basics right.
- A lack of tenant choice in who delivers housing services and indeed in some instances a failure to listen to what tenants and indeed leaseholders want.
- Nationally amongst social rented tenants a relatively ambivalent view of the advantages of continuing to be social housing tenants with 46% of Council Tenants and 45% of housing association tenants preferring to be owner occupiers and only 39% and 33% respectively preferring to remain with their current tenure.
- Nationally, a concern about how complaints or concerns raised by tenants are dealt with.

Cave has concluded that "What is common to each of these points is that they are symptoms of the failure of the social housing system to provide customer choice. The current regulatory arrangements have been only partially successful in remedying these defects".

For Hammersmith & Fulham there have been increases in levels of satisfaction locally and particularly with housing management services provided to council tenants where overall levels of satisfaction have increased from 65% in 2006 to 73% in 2010.

The steady increase in resident satisfaction can be attributed to the work undertaken to ensure residents views shape service delivery. The Tenant and Leaseholder Forums and Annual Conferences have sought to identify the key issues raised by residents, and to implement changes designed to improved service outcomes and the quality of front line delivery.

Figure 4.

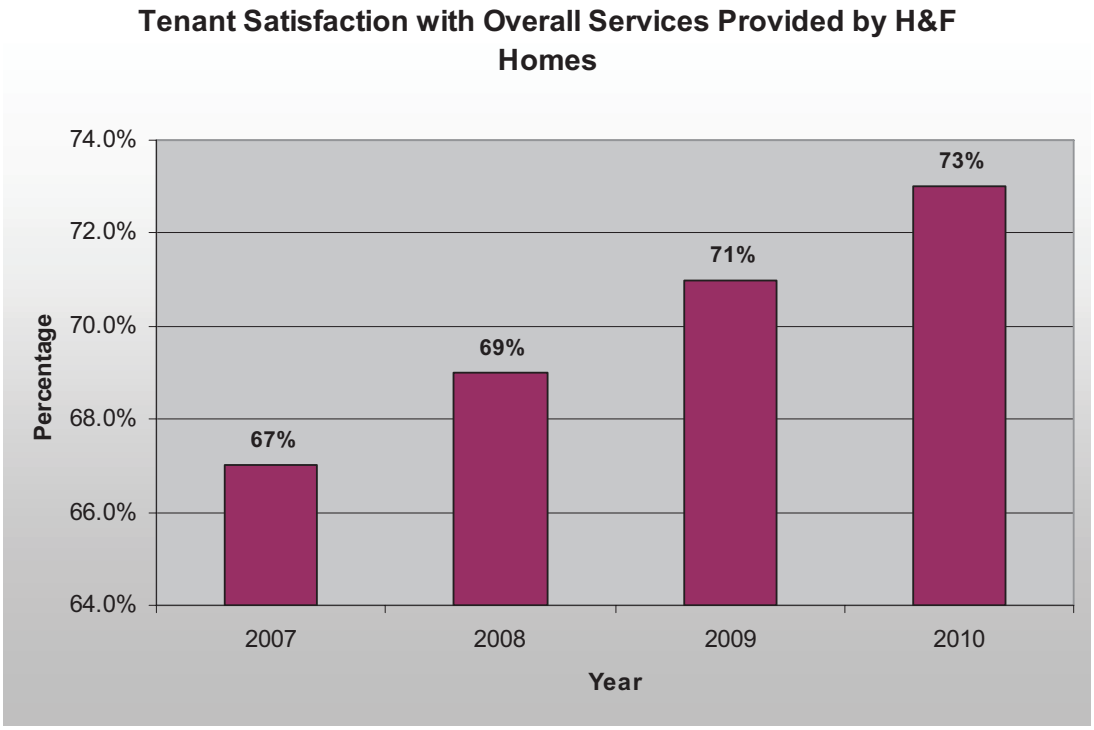
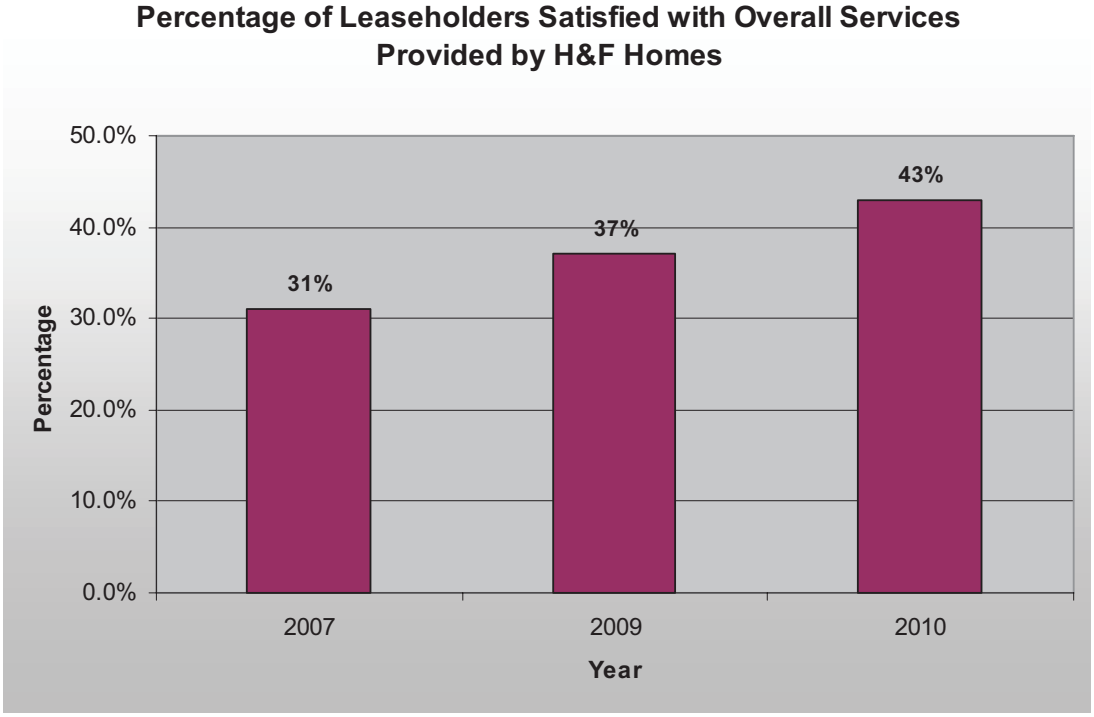


Figure 5.



Despite real improvements in most areas of housing management services locally and examples of excellent joint working between agencies residents wish to see further improvements in the repairs service, caretaking and tackling anti social behaviour.

Indeed recent surveys of Council social housing tenants and leaseholders have identified that anti social behaviour continues to be a concern with low levels of satisfaction as to how local services are responding to a range of ASB related issues.

Figure 6. Satisfaction Survey Results for Council Tenants 2010

To what extent are the following a problem in your neighbourhood.	
Dogs	36%
Litter	44%
Noisy Neighbours	27%
Young People Hanging around	39%
Racial and other Harassment	8.%
Graffiti and Vandalism	22%
Drugs	33%
Speeding Vehicles	31%
Car parking	34%

3.2 Housing related support services

The Hammersmith and Fulham housing related support programme aims to provide a timely service for the most vulnerable members in the community that prevents escalation of need and/or recourse to institutional services, and helps people develop the personal and practical skills and networks that enable them to live the life that they value and as independently as possible.

The Supporting People programme directly or indirectly contributes to all of the objectives of the Hammersmith and Fulham Community Strategy, most visibly in tackling crime and anti-social behaviour, setting the framework for a healthy borough, and delivering quality, value for money public services.

Beyond this, the programme contributed to many of Hammersmith and Fulham's Local Area Agreement Improvement Targets 2008-11 in a number of ways, including addressing offending, anti-social behaviour and related substance misuse; increasing employment amongst the vulnerable and long-term unemployed; and increasing the number of vulnerable people achieving independent living.

Housing related support services are:

- Available to vulnerable residents when needed, preventing an escalation of need and supporting individuals to develop their skills and move toward more independent living;
- Complementary to and integrated with each other, wider council programmes and specialist services across the community;
- Outcome-focused, with an emphasis on enabling the person to do things themselves and to work towards a more independent future.

The preventative nature of Supporting People services, and the variety of needs and client groups that they serve, places the programme at the intersection of a number of council departments and public bodies.

3.3 Social and Economic Polarisation

H&F is a polarised borough and has some of the most deprived neighbourhoods in the country and is ranked the 13th most deprived borough in London.

In 2010, the GLA published "Children in Poverty" report which shows the proportion of children living in families in receipt of out of work benefits or of tax credits where their reported income is less than 60% of median income. According to that measure, 36% of children in the borough were in poverty in 2008; this is the 10th highest level within London.

3.4 Worklessness

A key factor in contributing to the levels of deprivation in some of Hammersmith and Fulham's neighbourhoods is high concentrations of unemployment and worklessness. Despite the strength of H&F's economy, the borough has one of the lowest employment rates in the capital, with the 4th lowest employment rate for males. Furthermore, Hammersmith and Fulham also has the highest unemployment rate for working age people from ethnic minorities.

We know that unemployment pockets are concentrated on our housing estates, within certain BME communities, the homeless, lone parents and people with physical and mental disabilities. Improving employability of our more disadvantaged residents is vital to broadening the range of housing opportunities that are available to them.

Households in the social rented sector have the lowest average gross annual incomes (40% of borough average). Other household groups demonstrating below average incomes include lone parent households and those containing someone with a special need (annual incomes of just over 10k) and households from Black and minority ethnic (BME) groups (average annual income 15k).

It is estimated that up to 80% of homeless households in temporary accommodation are not working. The current unemployment rate in Hammersmith & Fulham is 2.8% but for households in social rented accommodation the rate (7%) is more than twice this. On a few council estates in the north of the borough the unemployment rate is closer to 10%. The percentage of lone parents who are not working in the borough is 61.4% compared with 60.1% for London and 50.2% for England and Wales. Additionally, profiling of local Council estates has identified high numbers of Incapacity Benefit claimants particularly identifying low level mental illness as a reason not for working.

This stark polarity and indeed the concentration of deprived households in particular neighbourhoods in the borough where there are also high concentrations of social rented housing has impacts on local services as for instance 50% of households choose to send their children not to local schools but to schools outside the borough.

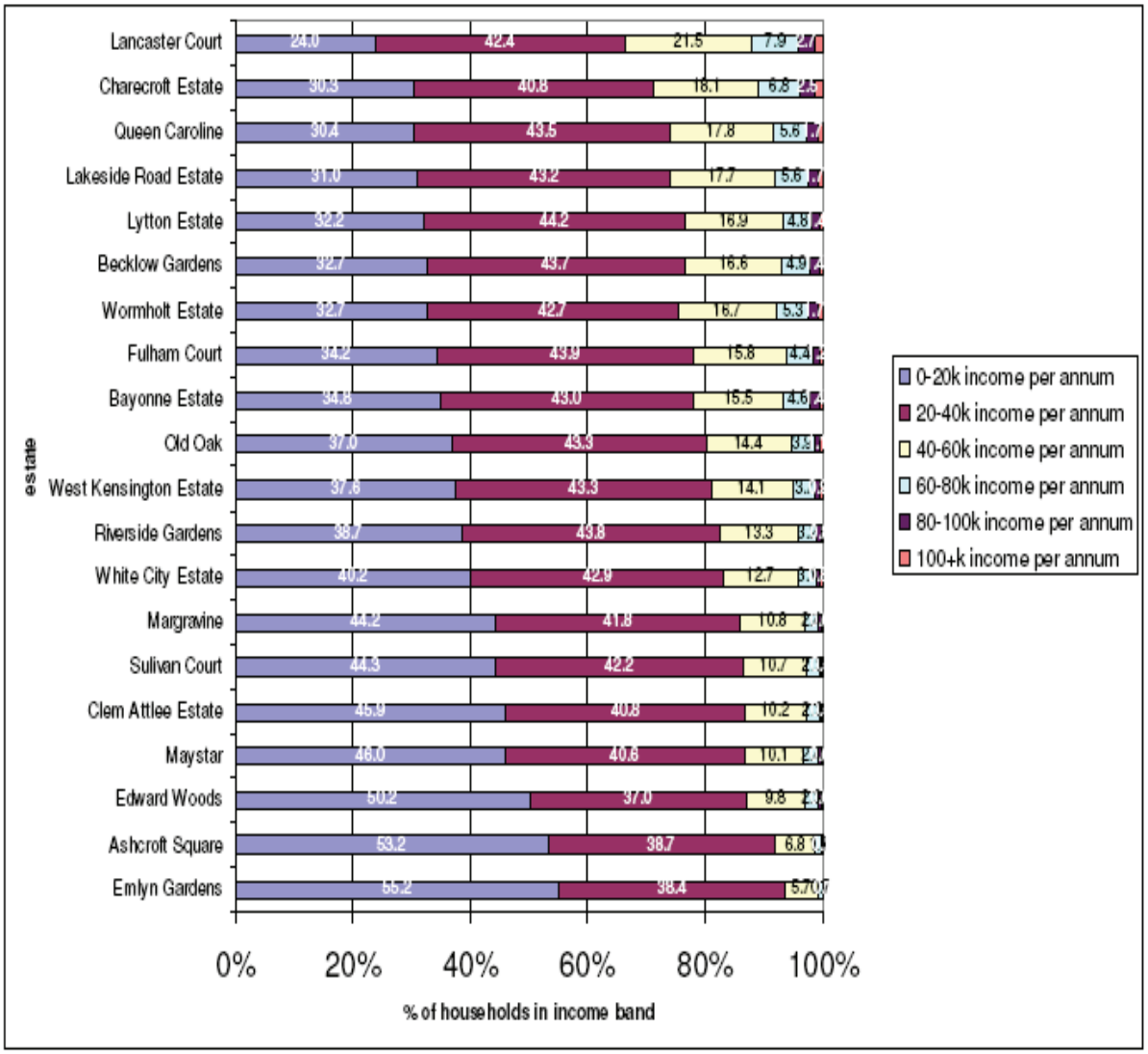
The borough is ranked as the 38th most deprived local authority area in the country and there are significant pockets of deprivation particularly in the north of the borough where crime, worse health, a poor environment and low aspirations blight people's lives. Seven (6.3%) of the borough's Super Output Areas (SOA[2]s)

[2] Super Output Areas are intended to identify distinct neighbourhoods within a borough. They consist of approximately 750 households.

are within the top 10% most deprived nationally. These five comprise major public sector estates: White City, Wormholt, Edward Woods, Clem Attlee and Charecroft. A further 21% of the borough's SOAs are in the 10-20% worst nationally (London 17%). Most of these areas are in the north of the borough but also extend down into parts of Hammersmith and north Fulham.

Figure 7.

Income distribution of households living in the largest 20 estates in the Borough



Source : CACI 2009 Paycheck data

As representative of the level of deprivation found in the social rented sector, John Hills in his influential study “Ends and Means: The Future Roles of Social Housing In England” also identified that between 1981 and 2006 the proportion of social tenant households in paid employment fell from 47% to 32%. Additionally he identified that employment rates of those living in social housing with particular disadvantages or with multiple disadvantages are substantially lower than those of people with similar disadvantages but living in other tenures.

However, in terms of resident aspirations half of households needing to move wish to stay in the borough with popular alternative locations being in the central and southern areas of Hammersmith & Fulham. The last Housing Market Assessment(2010) showed that there are high levels of aspiration for home ownership in the borough with 57% of households on the housing register interested in low cost home ownership products. 30% of all households in the borough live in the Private Rented Sector. A survey conducted by MORI for the GLA shows that 86% of all households in the sector wanted to own their own home.

- The relatively low levels of homeownership and higher levels of social and private renting in the borough which leads to a number of consequences that work against household, community and neighbourhood wellbeing: lack of mobility in and out of social rented housing, significant churn of households in the private rented sector, hot spot areas of deprivation where there are significant levels of social rented housing and high house prices putting market housing out of the reach of low to middle income first time buyers, key workers and families.
- Allocation and housing policies that have the potential to build in dependency, exacerbate levels of deprivation and build out opportunity. Social housing is now only available to those who are in very urgent need of housing and do not have the resources to resolve their own housing problems. Inevitably this means concentrating often vulnerable households who are often unemployed on social housing estates which further exacerbates levels of deprivation in those areas. Continuing to allocate accommodation solely in this way will only serve to further polarise communities in the borough and create unsustainable, isolated and low attaining neighbourhoods.
- In large part only those on higher incomes can afford to buy and privately rent in the borough. This leaves very few housing options available in the borough for low to middle income households. The borough is in danger of becoming further polarised than it already is with distinct ghettoes of rich and poor with very little in between. There is little doubt that if this trend continues there will be further residualisation of public services as those who have no choice continue to use them and those who can afford to look further afield and often outside the borough to educate their children, seek medical help and so forth.

- To find ways to reduce the high levels of deprivation on social housing estates and in social housing. Work more effectively to tackle the high levels of worklessness in the social housing sector and amongst homeless households in temporary accommodation. Tackle other negative outcomes found in social housing such as poorer health outcomes and higher levels of overcrowding.
- To provide the right kind of advice and assistance to very old people or people with very severe impairments or long term illnesses to ensure they are maximising take up of benefits, health and other support related services.

4. The Challenges

A number of key challenges exist in relation to increasing the borough's housing options:

Housing Supply

- We must recognise that Hammersmith & Fulham with its relatively low capacity compared to other London boroughs has not and cannot meet all the demand for housing being identified. To attempt to meet the demand for one type of accommodation, such as social rented housing or market housing, would merely exacerbate the economic and social polarisation evident in the borough.
- The need to increase the amount of new housing developed in the borough and release sites that have not been brought forward for development thus far due to restrictive planning policies or developer land banking.
- The failure in the past r to provide opportunities for households on low to middle incomes to progress up the housing ladder from private and social renting to homeownership given the very high house prices found locally and the flight of these households from the borough.
- To provide a wider range of housing options and opportunities both in the private and pubic housing sectors to those looking for and needing housing in and outside the borough.
- Recognising the planning requirements set out in the Access For All Supplementary Planning Document the need to be more responsive to the housing demands of disabled residents particularly for larger adapted or wheelchair accessible housing where there are identified needs which are unmet by existing or new supply.
- Inflexible housing funding regimes that fail to offer creative solutions to the borough's housing challenges. The social rented sector provides few opportunities for those looking to buy their homes to purchase given reductions in discounts. The shared ownership options developed with housing grants are unaffordable to many looking to move into homeownership

and is leading to the development of one and two bedroom properties only which does not meet the demand for low cost homeownership family housing.

Quality Housing and Services

- To look beyond the Decent Homes standard that will be delivered by 2011 and consider regeneration of social housing estates to provide energy efficient housing, high quality housing and public realms that meet rising resident demands and expectations. Levels of satisfaction with the housing management services and homes that the Council rents are falling. Often the public realm on Council estates is not well used or is indeed misused. The Council, working with tenants and leaseholders must make tough choices over the next 15 years as to whether to refurbish accommodation at great expense or to provide high quality new homes and public environments that better meet resident expectations and provide more mixed and sustainable communities and a better living environment.
- To improve energy efficiency through decent homes works in social housing and through energy efficiency initiatives in the private sector.
- For all social landlords working in the borough to deliver high quality value for money services to social tenants and leaseholders, and better respond to their demands and expectations. This is a key feature in making neighbourhoods better places to live and stay and in effectively addressing resident concerns.
- To demonstrate that housing management services and partner agencies including the police are effectively tackling crime and anti social behaviour providing reassurance to residents generally and those that live on the Councils social housing estates.
- The need to provide social tenants and leaseholders with more say in the running of the housing services they pay for and more choice in who provides those services.
- It is only recently that a comprehensive market testing programme has been put in place for services provided to council tenants and leaseholders. It could be seen that the Council has lagged behind other councils and social landlords in rigorously market testing its housing services to achieve optimum efficiency, quality and outcome.
- To continue and to better meet the housing and support needs of vulnerable people and households eligible for housing support services regardless of tenure and to provide high quality advice on a range of housing options including wheelchair accessible housing, adapted housing and opportunities to access housing built or adapted to lifetime home standards. The aim of the advice, management, support and care services is to allow residents to live successfully, independently and longer in their own homes and reduce the need for disabled people requiring care and support to be placed in care homes either in or outside of the Borough.

5. The Vision

Over the next seven years we want to do three things to improve housing, neighbourhoods and housing services in this borough:

Increase housing supply and deliver high quality housing and public spaces on new developments that meet resident expectations and complement existing neighbourhoods.

Work to bridge the social divide by increasing levels of employment, providing more homeownership opportunities for low to middle income households and deliver more mixed and sustainable communities.

Increase levels of satisfaction with social housing and all housing services, including advice and housing management services, delivered in the borough.

6. Our approach to delivery

Our approach to delivery will be innovative and creative. Working with the public and private sector we will seek the best solution to the housing challenges facing the borough and will be as flexible as possible in our housing and planning policies to deliver the outcomes we want to achieve. We will expect high standards and value for money in the services we deliver directly, we procure and our partners provide.

The Council recognises the part it must play in helping low to middle income households access housing be this low cost homeownership housing or low cost private and social rented housing. Our response to housing demands will be to provide a range of options to suit different lifestyles, circumstances and life stages both in the public and private housing sectors and in and outside of the borough.

In providing more housing options the Council will give greater choice to those looking for housing which builds in aspiration and opportunity including the opportunity to own for many more households.

We must be realistic in terms of who we can help given the limited supply of resources to meet housing demands. The specific housing needs of marginalised communities, including those with long term illnesses or disabilities, will be addressed by adopting measures that ensure our housing policies do not have any adverse impacts and provide access to the borough's 'housing ladder of opportunity'.

Whilst meeting our responsibilities to assist those in urgent housing need we must also have due regard to wider responsibilities to maintain and create thriving and successful communities.

By ensuring that the Council and its partner housing services, including the many housing associations working in the borough, provide good quality housing and excellent housing management services we will be in a better position to secure neighbourhoods where people want to live in and stay, now and into the future.

We will expect housing services to play their full part in delivering the Council's wider strategic objectives and for those services to go that extra mile. This includes housing services taking a tough line on anti social behaviour and crime and in services working pro actively with social tenants to get unemployed social tenants into work and helping deliver other borough objectives such as improving health.

We will seek local neighbourhood solutions to housing, environmental, health and socio economic problems, empowering local residents to make decisions that help improve their neighbourhoods. This will be facilitated by the Council through its Estate Improvement Projects which will combine physical and estate renewal with targeted and joined up initiatives to tackle local problems such as poor health, educational attainment, low levels of unemployment and crime.

Our aim is to deliver housing and neighbourhoods that are fit for the 21st Century and that better meet the aspirations, expectations and requirements of local residents. This will include taking forward major area and estate regeneration initiatives to improve social housing, build more housing for rent and low cost sale and to improve the public realm for all local communities.

Our determination to widen and strengthen our housing offer and to ensure that we build sustainable communities resonates with the policy objectives of London Councils, expressed in their document " Our vision for homes in London" (London Councils, January 2008). The vision is to make home ownership affordable, develop mixed and sustainable communities of which social housing is a part and tackle homelessness more effectively.

7. What we need to do

Attached to this Housing Strategy is a detailed Action Plan setting out what the Council is intending to do to deliver its Vision. In summary there are 9 areas the Council and its housing partners need to act to improve housing and housing services in the borough:

7.1 Increasing Housing Supply

I. Increase the new housing developed, providing quality homes on safe, mixed and sustainable new developments

We will increase the amount of housing developed in the borough from the current London Plan target of 450 to a minimum of 615 per annum over the next 10 years. This will be an increase of 37% We will aim to deliver 40% of all new housing as affordable. The Council will seek new social rented housing where this will enable the regeneration of existing estates and the provision of better accommodation (e.g. quality, dwelling size and conditions) for existing social rented tenants; and where it is possible to achieve a better mix of tenure and a more mixed and balanced community in the area. The Council's will ensure that there is no net loss of social rented accommodation in its two opportunity areas, Earls Court and White City should regeneration proposals proceed in these areas.

The Council will also take forward its ***"Hidden Homes "*** development programme in 2011 looking to develop housing for local residents on the smaller infill and redundant sites on council estates. The aim will be to develop a minimum of 150 new homes through this programme over the next 7 years.

We will improve and have better working relationships with developers that are focused on delivery of high quality housing and public realm. This will include meeting environmental sustainability, lifetime home and wheelchair standards as set out in the Access for All Supplementary Planning document, ensuring housing is safe and secure and developing safe and attractive public environments that are there for all to enjoy.

The Council will also produce comprehensive sustainability assessments for each new strategic development intended to inform tenure mix, size of units, the need for adapted and wheelchair accommodation and other key aspects that might be subject to Section 106 negotiations including; payments to support education, training and employment requirements and initiatives, new local facilities such as community and health centres, help to support local crime reduction initiatives and negotiating sustainable lettings plans.
We will negotiate tenure mixes and infrastructural requirements that lead to sustainable communities being developed that complement and enhance the neighbourhoods in which they are built and do not stand apart from them.

Supporting our plans to create a ladder of opportunity we will maximise low cost homeownership opportunities for social renters, families, first time buyers and key workers and maintain a programme of affordable rented housing particularly to meet the urgent need for family sized accommodation. In this

respect we will aim to develop 50% of all affordable rented housing and 10% of all intermediate housing as family housing (3 bed plus accommodation).

We will work with developers to build high quality housing which meets the expectations of future occupiers and which is in tune with and complements the local neighbourhood. We will look to keep service charges to a minimum and at opportunities to provide outside space which is either private to the occupier or alternatively communal space for the use of those occupying the new housing. By getting the quality right and building housing which people aspire to live in we will attract tenants and buyers who want to live in the housing developed now and into the future.

For existing homeowners we will look at how we can provide more opportunities and greater flexibility for such households to extend or adapt their current accommodation to better meet their needs at different life stages.

II. Offer more low cost homeownership housing that is affordable to those on low to middle incomes and encourage savings and equity stakes for social rented tenants

We will increase the amount of low cost homeownership housing in the borough for low to middle income working households so they can live, work and stay in the borough now and into the future. We will develop innovative low cost homeownership products that make this housing affordable to households on incomes between £19K and £60K.

Our aim will be to see at least a third of all new shared ownership housing sold at 25% equity so that it is more affordable to those on incomes below £30,000. We will also aim to negotiate lower rent on unsold equity on new developments. In all circumstances we will ensure that there is access to high quality financial advice so that those looking to purchase fully understand what they are taking on.

Making Low Cost Homeownership Affordable to More Residents

We want to work with the Government, Greater London Authority and Housing Corporation to tackle affordability issues with low cost homeownership housing. We will improve access to the intermediate housing sector for residents on lower incomes by offering innovative low cost home ownership solutions including:

- Development of smaller **discounted market sale** (DMS) housing for first time buyers and looking at opportunities to use DMS as one option to make standard shared ownership housing more affordable generally.
- Improve social homebuy for Council and Housing Association Tenants by offering **zero rent shared ownership** and looking to negotiate similar arrangements on new build schemes for low cost homeownership.
- **Tenant incentives** which will help low income households in social rented housing to purchase a home in the borough.
- Build in opportunity to the social rent offer through **slivers of equity** initiatives and targeted employment, training and savings initiatives.
- Looking at the viability of other ownership options such as **Community Land Trusts and Self Build Initiatives** particularly in the context of larger developments where deliverability of such options is potentially more feasible.

We will look to develop "Rent Plus" and "Tenant Repair Incentive" schemes for council tenants and encourage the development of such schemes by our partner housing associations. Rent plus schemes allow tenants to save above rent levels collected, and Tenant Repair Incentive schemes financially reward tenants for assuming responsibility for low level maintenance tasks.

Hammersmith & Fulham Credit Union

H&F Credit Union is sponsored by the Council, North Fulham New Deal for Communities and leading Housing Associations to directly tackle the financial exclusion evident in the borough's social rental sector (Over 80% of the financially excluded in England & Wales are social housing tenants).

A Credit Union is a not for profit financial cooperative/community bank that is owned and controlled by its members. It provides a savings and loan facility for individuals financially excluded from conventional forms of banking, and forced to borrow from unscrupulous Loan Sharks/doorstep lenders. As well as providing access to cheap and flexible loans it provides financial literacy and money management skills that lead to the stabilisation of household income and expenditure, in turn this provides options to realise other aspirations.

We will also seek to negotiate on every new development where viable "micro staircase" purchasing for social renters to enable eventual purchase under social homebuy. This will take forward work that the Council has undertaken with Genesis Housing Association to develop an "Inclusive Living Scheme" where such arrangements will be put in place on a large new development in the north of the borough.

Finally, the Council will investigate the feasibility of ownership initiatives, such as Community Land Trusts, which give social tenants and leaseholders more control over the management of the housing they occupy. In this respect the Council will follow closely the work now being undertaken by the North Fulham New Deal for Communities in putting in place "legacy arrangements" which may see established a local neighbourhood trust.

III. Maximise use of social housing assets to meet housing demands and requirements encouraging mobility around and from social housing and using land and housing assets more effectively.

Given that the demand for all forms of housing outstrips supply, the Council will actively promote mobility and housing opportunities in and outside of the borough. This will include providing tenant incentives for tenants to move out of social rented housing and into homeownership, increasing the number of mutual exchanges and promoting mobility to housing opportunities that may arise in West London and further afield particularly in the housing Growth Areas to the north, south and east of London.

The yearly trend for the number of households in temporary accommodation since March 2006 has been steadily decreasing. This follows the five year target to halve the number of households in TA by the end of 2010, the target for LB H&F was 915 households. As at March 2010 the figure in LB H&F was already down to 877 households in Temporary accommodation.

Further we will ensure we are maximising the use of affordable rented housing in the borough through development of Sustainable Allocation Plans intended to provide a fair and equitable way for residents to access housing. We will develop sustainable allocation plans for all new developments to ensure the right mix and balance of households are offered social housing so that schemes are not set up to fail. We will also put in place revised allocation agreements with all local housing associations and see that they are applied and regularly monitored.

We will look at the current stock mix and as part of the development of the Council's Housing Stock Investment Strategy. We will identify options to better match the stock, particularly in terms of bedroom number, to demand

and adapted properties to individuals with disabilities through our estate renewal proposals that we will develop.

The Investment Plan will also set out the resources needed to maintain and improve council housing stock and opportunities to maximise the use of a valuable asset base to better meet a range of housing and estate improvement demands through our limited disposals policy.

We will continue to offer incentives to private landlords to bring their empty properties back into use as low cost rented housing.

Hammersmith & Fulham's Empty Homes Initiative

The last Private Sector Stock Condition Survey in 2004 identified that 688 private sector houses in the borough had been empty for more than six months. Utilising all the available residential properties in the borough is a priority for the Council and action will be taken to bring a further 100 empty properties back into use by March 2008. The Council is also working with owners of vacant commercial premises to convert suitable units for residential use; this will be facilitated by a proactive and sympathetic planning process.

7.2 Securing Quality Housing and Services

IV. Take forward estate regeneration and Estate Improvement Projects to tackle deprivation, improve housing and the public realm, better meet needs and deliver more mixed and sustainable communities.

Working closely and in tandem with tenants, leaseholders and residents we want to put in place an ambitious Area and Estate Renewal programme aimed at improving council housing stock and the public realm and providing homes and environments that are fit and appropriate for 21st Century living. This will include looking to improve the quality of life in neighbourhoods with high levels of deprivation and poorer health outcomes, increasing the level of family housing available and looking to promote more mixed and sustainable communities in these areas.

The Councils objectives as it looks to take forward regeneration plans must be seen in the context of master planning to deliver successful neighbourhoods and communities through support of business and retail development, improvement of social and physical infrastructure to the benefit not only of Hammersmith & Fulham residents but to London as a whole.

Area Regeneration

We believe that there is a unique opportunity and much to be gained from working with a range of public and private sector partners to regenerate the more deprived areas of the borough. Our plans are ambitious and include:

1. **Shepherds Bush and White City** – develop one of the country's largest creative communities, see the successful opening of London's largest shopping centre whilst rejuvenating local business, aiming to deliver possibly 3,500 to 4,000 additional homes, and improve and regenerate the White City Estate.
2. **Fulham North** – improve the retail and business offer, build on the conference, hotel and leisure offer around Earls Court where there is 40 acres of development potential, address issues identified in the New Deal for Community area of high levels of social housing stock (48.7%) and concomitant deprivation issues through estate renewal, continued targeted intervention and promotion of homeownership, improve the public realm and deliver more housing.
3. **Hammersmith Town Centre** - improve the retail offer and further develop Hammersmith Town Centre as a key West London office hub. There are opportunities to more effectively use council owned land for housing, to improve the social housing offer and to increase housing and diversify tenure through development of intermediate housing given that 51% of the current housing stock in the area around the Town Centre is social rented.

We will involve social housing tenants and leaseholders from a very early stage in any Area Regeneration that might be taken forward and we will work closely with them to develop an "optimal" improved housing offer that will guarantee the development of affordable, high quality, accessible and energy efficient housing in a well designed public realm.

Our plans will be supported by development of a robust Housing Revenue Account Strategy ensuring that the Council has the resources to take forward its housing plans and to maintain its housing stock and estates into the future.

Finally through our Estate Improvement Projects, which we will pilot in 2011, we will pursue physical estate regeneration in tandem with a coordinated planning approach that provides a more integrated and cross sector response to tackling deprivation including poor health outcomes. The approach will set locally relevant short, medium and long term targets for improvement to tackle deprivation including increasing levels of educational attainment and

employment, improving health, tackling and reducing crime and anti social behavior and improving the public realm so it is safe and accessible for all local residents to use. It will also provide an estate based focus for the delivery of housing management services geared again to meeting local requirements.

V. Improve housing management services making them more responsive to tenant and leaseholder demands and in doing so increase levels of satisfaction with services.

If we are to achieve successful neighbourhoods and communities particularly in the more deprived areas of the borough, council and housing association management services need to be more responsive to the changing expectations and demands of all tenants and leaseholders.

We will work with social housing management services delivered to council and housing association tenants to ensure they are providing high quality value for money services to social tenants and leaseholders.

Social landlords will be asked to demonstrate how they are playing their part in positively and pro actively contributing to meeting wider borough objectives including; reducing crime and taking a tough zero tolerance stance against anti social behaviour, delivering a cleaner greener borough, increasing safety, improving accessibility to and use of public realm and increasing training and employment opportunities for tenants and their families.

The overall aim is to better understand what tenants and leaseholders want from housing management services and to deliver services that as far as possible meet these requirements in a cost effective and efficient way. The 2010 consultation with council tenants and leaseholder consultation provided a clear indication of resident priorities.

Residents' views about which services should be improved.

	Frequency	%
1. Repairs and Maintenance	670	32%
2. Caretaking	389	19%
3. Security and Anti Social Behaviour	224	11%
4. Lift Maintenance	58	3%
5. Gardening and Horticulture	14	2%

We will expect our Department for Housing and Regeneration and Registered Social Landlords with significant levels of stock in the borough to undertake as a minimum annual satisfaction surveys and have a customer feedback programme which details how tenants and leaseholders are asked their views of services provided.

Where there are lower levels of satisfaction either by area or household type (e.g. younger households, over crowded households, working households and BME households tend to have lower levels of satisfaction) we will expect more detailed surveys and focus groups to be undertaken aimed at improving the services offered.

Social landlords working in the borough will be asked to detail how services have changed as a result of the customer research they have undertaken. To help facilitate this process the Council will work with housing associations to put the Housing Management Sub Group of the Housing Association Forum more centre stage in promoting good practice in terms of customer research and housing management delivery. We will also work with social landlords to produce an annual progress report demonstrating what they have done collectively to improve services.

We will expect all social landlords and other housing services working in the borough to have in place and publicise service standards and to have complaints procedures which ensure that lessons are learnt, mistakes rectified to the satisfaction of the complainant and practices improved. Service standards and complaints procedures need to be demonstrably easy to understand and to use.

A New Deal for Council Leaseholders was launched in 2007 which has promoted clearer billing of costs and greater opportunities for leaseholders to participate and influence the housing management and repairs services they receive. The Council will continue to review leaseholder service charges and methods for improving services to leaseholders.

We and now provides a greater range of payment options for resident leaseholders to ensuring that the Council reduces the impact of any large bills they might receive for repair and refurbishment work, particularly in relation to decent homes work. We have also put in place arrangements which allow council leaseholders to request a review of high bills for major works (including decent homes works) with the Council.

We will also continue to seek better ways to help council leaseholders cope with bills for refurbishment work recognising that it is not only a major cost to low and middle income households but is a potential barrier to the Council carrying out improvements to estates and council blocks.

We will continue to monitor performance of Hammersmith & Fulham Homes against a set of key performance indicators, setting tough targets to move performance into the “top quartile” for London by 2012. We have also set efficiency targets for housing management and repairs services that will bring down costs and enable the Council to plan better for the future and to reinvest resources to improve services.

We will work with social landlords on multi landlord estates to establish management agreements that ensure services delivered are better co-ordinated.

It is the view of the Council that market testing is the only way to improve and demonstrate efficiency and to achieve optimal delivery of service in terms of quality and effectiveness. The Council will take forward the market testing programme that is in place for housing management and related services so that by 2012 all services provided by the Housing and Regeneration Department will have been market tested.

In the medium to long term the Council will also look at ways that it can promote, encourage and secure greater customer choice for its tenants and leaseholders through development of housing management markets increasing the number of potential providers of such services.

All social landlords have to recognise that the main priority for tenants and leaseholders living on many of the estates in the borough is crime and anti social behaviour. One of the main priorities for the Council over the next 3 years will be to tackle the problems tenants, leaseholders and residents face.

We will expect all social housing management services to work closely with the Council's Safer Communities Division and the Police so that there is a joined up and concerted effort to reduce and eliminate anti-social behaviour and crime and so that incidents of crime etc. perpetrated by those living on estates in private rented, leaseholder or owner occupied accommodation or just those coming on to estates are dealt with effectively.

We will expect all social landlords to sign up to the Housing Management Respect Standard and monitor progress in its application in reducing crime and anti-social behaviour on estates. We will expect all social landlords to work in partnership to provide swift and effective solutions to problems of anti-social behaviour and crime using a range of preventative and enforcement measures that are now at their disposal. Ultimately the approach we want to see taken is a zero tolerance approach to anti-social behaviour, with clear penalties leading to eviction where there are continued and significant incidents.

The Council's Community Safety Unit (CSU) has implemented a 11 point plan to improve the Borough's response to tackling to anti-social behaviour. The intention of the plan is to reassure all residents and particularly those living on social housing estates that the Council is taking a firm and determined line in reducing ASB and crime.

11 Point Plan to Tackle ASB and Crime

1. Identified the top 30 serious and persistent offending families for intensive enforcement action. This is an ongoing process monitored by the Cabinet leads for Crime and ASB and Housing.
2. Agreed at Cabinet for a CCTV Improvement Plan for nominated HF Homes Estates. Programme has begun and 5 completed. Next stage due to commence May 2011 whereby another 4 estates will have CCTV.
3. Employed a full time professional witness to enhance the fight against ASB.
4. To increase confidence in the response to tackling ASB developed an internal and external communications plan to publicise success in relation to Anti-Social Behaviour Orders, crack house closures, dispersal zones and ASB evictions.
5. Remodelled the Council's concierge service in line with realistic demands and requirements.
6. Provide ASB reduction services to at least one Registered Social Landlord.
7. Publicise activity with tenants and leaseholders of the Borough's estates.
8. Seconded one police officer into the CSU to improve intelligence and information sharing and the investigation of criminal behaviour.
9. Set ambitious performance indicators for all teams tackling ASB.
10. Implemented probationary and demoted tenancies.
11. Estate Warden Service remodelled and expanded to a Neighbourhood Warden Service covering the whole of the borough, not just estates.

On new developments we will also require developers and housing associations to outline how effective management services will be provided, how public spaces around new developments will be maintained for use by all, and where relevant what recreational facilities are provided for children and young people, thereby improving the quality of life and reducing potential anti-social behaviour. One key objective will be to minimise service charge levels through effective negotiation at the planning stage of new developments and in empowering tenants and owners in the management and upkeep of the housing they live in.

The current partnership working with the private rental sector will continue with an emphasis on landlord accreditation to promote good landlord practice, furthermore, the quality of the private rental stock will be improved by ongoing application of the Housing Health & Safety Rating System (HHSRS) and statutory inspection of Houses of Multiple Occupation.

VI. Provide high quality advice and assistance to those looking for housing in the private, social rented and low cost homeownership sectors.

We will continue to provide high quality housing advice services that signpost local residents looking for housing to a range of housing options in the private and where appropriate in the public sector. Our advice services will link with other services, such as children's services, supported housing, adult social care and money advice services, to ensure that the best possible advice and assistance is given to households either looking for housing or with housing problems and/or housing support needs. We will aim to ensure services are accessible for vulnerable adults and young people in the borough.

We will continue to work with households to identify housing opportunities in the private rented sector for those looking for housing ensuring that if ongoing support and advice services are needed that they are made available.

The Singles Homeless Project

A runner up in the Andy Ludlow Homelessness Awards in 2007 the Singles Homeless Project provides an integrated, holistic and outcome focused approach to tackling single homelessness in the borough. Through the Singles Homelessness Partnership, which includes local agencies, the police and the mental health trust, the Project ensures that people are not missed and are provided with timely help and assistance either through mediation and reconnection services or through the provision of good quality supported accommodation.

Successful outcomes include introduction of a single assessment process for single homeless which takes a holistic look at needs and requirements and identifies the right kind of options that meet the individual's needs.

In February 2007 the Council established the Hammersmith & Fulham Home Buy Team. The Home Buy Team is the advice agency linking households on low to middle incomes with homeownership opportunities. The Home Buy Team plays a vital role in identifying homeownership requirements and working to provide equity share opportunities to existing social housing tenants living in Council and Housing Association homes. It works to ensure that anyone wishing to buy can access independent financial advice to ensure that they can afford to purchase and cover the financial commitments entailed in being a home owner.

The Debt Advice Project (DAP)

DAP is a joint partnership between Hammersmith and Fulham Citizens Advice Bureau and Shepherds Bush Advice Centre (SBAC) and has been funded by Hammersmith & Fulham Council. Advice and casework in the field of Corporate Debt (Council Tax, rent arrears, & Housing Benefit) is provided as a way of holistically enabling the reasons for indebtedness to be explored, broker agreements for debts to be paid, and focus on income maximisation to potentially increase household income.

DAP intervention has resulted in a reduced number of eviction, committal, and recovery proceedings with the associated cost reductions, furthermore, it has enabled residents to gain better control of finances, be more economically active, and even access employment opportunities.

The Council also needs to work to optimise housing opportunities that are available outside the borough and to publicise these opportunities to households looking and needing to move. We will therefore set targets to increase the number of moves to housing opportunities outside the borough and provide dedicated resources that encourage mobility both within the councils own stock and beyond.

The Disabled Peoples Housing Service & Accessible Housing Register (AHR)

The Occupational Therapy & Adaptations Service within Adult Social Care provides a one stop shop for those residents requiring adaptations to properties to enable them to continue living in their homes. The service provides both occupational and technical support that can work across tenures providing advice and facilitating adaptations in the council, RSL and private sector. It continues to set tough targets to improve delivery times for adaptations for residents.

LBHF Re-housing Solutions Service incorporates Occupational Therapy assessment from point of application in order to fully identify the housing support needs of a disabled person i.e. whether it is accessible in terms of wheelchairs, steps etc.

As part of developing an Accessible Housing Register an access audit of all council stock and a large proportion of the other Registered Social Landlord Stock in the borough has taken place, residents awaiting for rehousing on medical needs have also been reviewed and allocated a mobility category. This is in order to utilise the housing resource more efficiently and match a particular unit with the housing needs of an applicant.

We will continue working with private sector landlords to improve management standards particularly through the licensing of Houses in

Multiple Occupation and ensure that vulnerable people living in private sector live in decent housing.

We will also continue to provide high quality advice and assistance to facilitate energy efficiency works in the private sector for vulnerable households. Given that the vast majority of the private housing stock is solid wall construction, we will concentrate on delivery of cost effective energy efficiency measures such as installation of efficient heating systems through gas central heating with a condensing boiler with adequate heating controls and loft insulation.

VII. Provide high quality flexible supported housing and housing support services that are targeted and outcome focused

Housing support services are provided to those people who either need relatively short term or intermittent help to get back on their feet or maintain a tenancy, such as single homeless people, ex offenders and some people with drug and alcohol problems or more permanent support such as that offered to older people, those with long term mental illness or those with a learning disability. The assistance provided is usually practical (e.g. assistance with form filling, checking to make sure someone is not experiencing difficulties, helping someone to find a job, teaching basic skills) and can involve organising other services and ensuring that they have access to the person who needs them. The services are often accommodation based or provided to people living in a particular type of housing (e.g. a council or housing association tenant).

We will continue to work with public and voluntary sector services to improve housing and support services that better meet the needs of vulnerable residents recognising that there are limited resources to pay for these services. We will ensure that the housing support services we provide are as far as possible tenure neutral (e.g. provided to social and private renters and owner occupiers), where practicable delivered to people in their homes, better targeted to those who need them and outcome focused in what they do in supporting vulnerable residents to live as independent lives as possible in their own homes and reach their full potential.

Launched in 2003, the supporting people programme aims to help vulnerable people with housing related support needs to achieve a better quality of life by enabling them to live more independently and improve their life chances.

In 2009-10, the average void rate for Supporting People Service units was 8%. 4,111 people accessed a Supporting People service, including 905 people who stopped accessing services. 368 (41%) users left short term services and 537 (59%) left longer term services.

81% of service users who have been supported moved on in a planned way from short term living arrangements, and of those who left longer term services 86% left because they no longer needed the service and 14% because they could no longer live independently.

Units of accommodation for special needs groups in LBH&F, 2009-10

Primary Client Group	Household Units Available
Frail Elderly	27
Offenders or People at risk of Offending	33
Older people with support needs	1,445
People with a Physical or Sensory Disability	234
People with Alcohol Problems	12
People with Learning Disabilities	22
People with Mental Health Problems	201
Refugees	31
Rough Sleeper	74
Single Homeless with Support Needs	180
Teenage Parents	8
Women at Risk of Domestic Violence	23
Young People at Risk	110
Young People Leaving Care	52
TOTAL	**2,452**

Source: LBHF Supporting People

Supported accommodation must be fit for purpose providing tenants with a safe, supportive and encouraging environment which promotes independence whilst providing a safe and warm place in which to live. Where housing management, support and accommodation services are failing to do this we will work with landlords to remodel services and accommodation. We work closely with sheltered housing tenants and services in the borough to reshape older peoples support services so that they are more flexibly and efficiently delivered and better targeted to those who need them. Where necessary we will also improve the quality of sheltered accommodation so it is more adaptable and suitable for changing needs and requirements.

We will support the development of new supported accommodation where there is an evidenced need for it in the public and in the private sectors. For frail elderly a number of existing supported schemes will be remodelled to provide better supported accommodation for young adults, young mothers and for those who are mentally ill.

In 2008 a review of the accommodation and support needs of community care groups was undertaken. This review lead to establishment of a 5 year programme for future development including change of use to existing support schemes that are no longer required or fit for purpose.

In addition, the innovations offered by Assistive Technology will be fully utilised as a means to promote independent living, prevent hospital admissions, and reduce delayed hospital discharges. We will build on the success of the Occupational Therapy Self Assessment initiative.

We will also consider what opportunities there might be to offer those requiring housing support services their own budget to purchase these services themselves rather than relying on a service contracted by the Council and will continue to support outreach services that work with the police and street warden services to move rough sleepers and street users off the street and into supported accommodation where this is required.

7.3 Tackling Economic and Social Polarisation

VIII. Put in place a Sustainable Allocations Plan and develop sustainable allocation plans for new developments.

We will reshape the social housing offer for borough residents so that social rented housing is no longer an end destination for households, but a launch pad providing a secure footing from which members of that household can seek employment, training and educational opportunities and gain a foot on the homeownership ladder.

Our intention therefore is to develop a balanced and fair Sustainable Allocation Plan that whilst prioritising those in housing need seeks to provide more preference for working households or persons in some form of training leading to work in this category. We will use economic regeneration funding to actively work with prospective tenants to provide work opportunities as described below. Changes to the Allocation Plan are not intended to have any adverse impacts on any equalities groups and there will be monitoring undertaken to ensure that this is the case.

Our plans are intended to deliver 40% of housing as affordable on new developments whilst recognising the need to rebalance tenure mixes in some parts of the borough and in some neighbourhoods to achieve more sustainable communities. Working with housing associations we will put in place sustainable letting plans for new developments that achieve a balance of working, transferring, housing register and homeless households to ensure that new communities are not set up to fail.

Starter Tenancies for New Council Tenants

Starter tenancies are a managed way to ensure that a new tenant fully respects the terms of their contract with a housing provider, the tenancy operates on the basis of a 1 year probationary period with an option to extend if necessary. A tenant's conduct in relation to payment of rent, behaviour while in the accommodation, and other elements will be monitored and a determination made after the probationary period whether tenancy is permanent. Starter Tenancies have been in successful operation since 2008

IX. Increase employment amongst social tenants and homeless people

Through targeted and outcome focused employment and training programmes, such as Notting Hill Housing Groups Construction Training Initiative, our aim is to reduce levels of unemployment amongst social housing tenants and homeless households. This includes working with social landlords, and suppliers to ensure they work with tenants to get them into employment and offer either directly or through contractors apprenticeship and employment opportunities.

The relative inequity in the job market for black and ethnic minority groups, disabled, and older people is an acknowledged problem, one which the council will address by encouraging targeted employment initiatives such as those presented below.

Employment & Regeneration Partnership

We have a comprehensive series of programmes and initiatives aimed at increasing employment and training opportunities for residents in the Borough, including the Apprentice Scheme, Future Jobs Fund, Volunteering and Oneplace with other wrap around services such as One place, which is based in Hammersmith Job centre Plus.

The Work Matters team, also works on specialized training and courses from its base at Workzone at Shepherds Bush library. All of the course and resources are aimed at helping residents gain value work experience and knowledge which will enable them to enter the workforce fully skilled. The Work Matters Team work with a number of different agencies which includes the Voluntary sector, Charities and other government agencies.

We will review our allocation polices to consider what incentives we can use to encourage those who are moving into social rented housing to secure employment or to enter training that leads to employment where this is appropriate. We will also aim to ensure that provision is made to provide targeted employment and training assistance for social housing tenants moving on to new developments.

We are also committed to working with other local Councils to investigate how we can provide a viable alternative to the Housing Benefit subsidy system that does not give some households perverse incentives to stay on benefits but provides assistance to households so they are not poverty trapped or caught by too a steep a tapering off of benefits.

We also wish to initiate a debate with other Councils and public agencies as to whether there should be a stronger link made between the housing offer being made to those with priority need for social housing and employment with employment in some cases being a requirement to access housing for some households.

8. Measuring our success

We will measure our success through 20 key delivery targets

Nos	Action	Date
1.	Our aim is to work toward increasing the level of homeownership in the borough to 50% from its current level of 43%.	2014
2.	Increase the total number of low cost ownership units in the borough to over 3,000	2014
3.	Deliver a 3 year affordable housing programme to deliver 1,,000 affordable housing units.	2011
4.	Deliver a minimum of 6,500 new units of housing over the next 10 years 40% of which will be affordable housing. .	2017
5.	Aim to build 50% of all affordable rented housing as 3 bed room plus accommodation and a minimum 10% of intermediate housing as 3 bedroom accommodation.	2017
6.	Develop at least a third of intermediate housing as affordable to households with a gross income of £30K or less (subject to annual review and uplift against RPI).	2011
7.	To help tackle overcrowding achieve a minimum of 300 moves of under occupying households in council rented stock by 2010 and maintain a level of annual moves after that of 150 per annum up to 2014.	2014
8.	Improve the energy efficiency rating (SAP rating – Standard Assessment Procedure[3]) for Council housing in the borough from 64 in March 2007 to 70 by March 2010 exceeding the London top quartile. To facilitate energy	2010

[3] The Standard Assessment Procedure (SAP) is adopted by Government as the UK methodology for calculating the energy performance of dwellings.

	efficiency and improvement works for 390 vulnerable people living in the private sector.	
9.	All new social housing developed in the borough will offer social tenants some form of equity stake or savings incentive scheme. All large social landlords will provide either directly or by affiliation savings and incentive schemes for their social housing tenants.	2014
10.	Reduce levels of deprivation and unemployment in the top five most deprived housing estates as measured through periodic deprivation surveys. For the borough a reduction in the proportion of working age residents in receipt of out of work benefits (Income Support, Incapacity Benefit and Jobseekers Allowance) by 2% from 14.1% to 12.1% of the working age population. Baseline = 17,500 residents –target reduce to 15,000 by 2012.	2020
11.	All social rented accommodation in the borough to be decent by 2011. For Council housing this will include delivering a complimentary programme of adaptations for disabled residents and improvements in sheltered housing that makes it more adaptable.	2011
12.	Estate regeneration and renewal plans will be in place by 2011 for council estates to secure high quality and adaptable accommodation and public realm for our council tenants and leaseholders into the future.	2011
13.	Reduce the number of homeless households in temporary accommodation by half by 2010 and aim to have no more than 900 households in temporary accommodation beyond this date.	2010
14.	Aim to have in place joint management protocols for all large multi social landlord estates and the offer of management services for all privately tenanted accommodation on those estates.	2009
15.	Hammersmith & Fulham Homes (HFH, the Council's ALMO) to achieve a 3 CPA rating or equivalent.	2009
16.	For the HFH and the 5 largest RSLs in the borough by stock size to aim to achieve overall satisfaction ratings of 70% for their housing management services. If this cannot be achieved improve satisfaction ratings by 5% from last Status Survey.	2014
17.	Implement 11 Point Plan to improve response to anti-social behaviour. This will include targeting the top 30 serious and persistent offending families for intensive enforcement action.	2009
18.	Facilitate the better use of borough housing stock by bringing back 700 empty private sector properties into residential use over the next 7 years to help meet demand from those moving on from supported housing, key workers and those threatened with homelessness.	2014
19.	The Council will aim to assist 950 local residents into private rented accommodation by 2010 and facilitate 250 lets per annum after that up to 2014.	2014
20.	Re-model supported accommodation for young adults and teenage parents in housing need. From April 2008 implement a 6 year supported housing plan for community care groups setting in place plans for remodelling of supported accommodation and new provision.	2014

9. Delivering the Strategy

The Director of Housing and Regeneration will have overall responsibility for the delivery of the Housing Strategy. Although the Council will be reliant on partners, such as local housing associations, to help deliver key actions. Individual Business Unit Managers within the Housing and Regeneration department have been identified as responsible for delivering individual projects and actions.

The Housing and Regeneration Department will be responsible for reviewing the Councils Housing Strategy and lead on the delivery of the Strategy through the strategic commissioning of housing services for the Council and through strong performance management. The objective is to commission services that are cost effective, efficient, market tested and of the highest possible quality. The team will also encourage, facilitate, enable and direct services in linking and joining up with other services and initiatives that promote community, neighbourhood, household and individual well being and help deliver the boroughs Community Strategy objectives.

Delivery of this strategy will be monitored through existing review and scrutiny structures and by regular and periodic liaison with providers, local community and stakeholder groups. To summarise delivery, review and scrutiny arrangements:

WHO?	**WHAT?**
Cabinet Member for Housing	Take an annual report and review on progress in delivering the Housing Strategy to the **Housing, Health and Adult Social Care Select Committee**.
Director of Housing and Regeneration	Report progress on delivery of the Strategy.. Chair an **Housing Strategy Review meeting** with local providers, groups and stakeholders to review delivery and emerging priorities.
Assistant Director Housing Strategy and Regeneration	The ADHSR will be responsible for ensuring that the Housing Strategy and related actions are aligned to delivery of Community Strategy. The ADHSR will also be ultimately responsible for negotiating and putting in place partnership arrangements with internal council partners (e.g. Children's Services and Environment Department), external partners (housing associations and voluntary sector groups) and the private sector to secure delivery of the Strategy.
Housing and Regeneration Business Unit Managers	Will be responsible for delivery of individual targets, projects and actions and for ensuring that the right level of consultation is undertaken in taking forward delivery and in providing feedback on positive and negative impacts of those actions and projects as required.

Housing Association Forum	Working with the HHSP will contribute to a report on delivery of the Housing Strategy and will provide the forum through which individual projects and actions can be taken forward.
Local Forums and Groups	The HHSP and relevant CSD Business Unit Managers will take regular reports on delivery to local consultative forums including but not exclusively: the Council Tenant and Leaseholder Borough Forum; BGOV consultative groups; HAFAD, Supporting People and Community Care consultative and provider groups; voluntary sector liaison groups and where relevant the local Crime and Disorder Partnership.
Resident Feedback	Undertake regular satisfaction and user surveys. The Strategy itself identifies the importance of capturing user and resident feedback on a regular basis and we will use this information to review housing and strategy delivery.

London Borough of Hammersmith & Fulham

HOUSING HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE

DATE	TITLE	Wards
17 July 2012	Task Group: Repairs & Maintenance	All

SYNOPSIS

The report sets out the proposed terms of reference and membership of the Task Group.

CONTRIBUTORS

Stephen Kirrage, Director of Asset Management & Property Services

Gary Vickers, Re-procurement Project Manager

RECOMMENDATION(S):

The Committee is asked to recommend to the Overview & Scrutiny Board the establishment of a Task Group: Repairs & Maintenance, with the attached terms of reference and membership.

Housing, Health and Adult Social Care Select Committee

Repairs & Maintenance Task & Finish Group Proposal

Title of Review	**Repairs & maintenance re-procurement**
Proposer	Councillor Lucy Ivimy
Sponsoring Committee	Housing, Health & Adult Social Care Select Committee
Prospective Membership (including co-optees)	Administration; Cllr. Lucy Ivimy & Cllr. Joe Carlebach Opposition: Cllr. Stephen Cowan
Outline Purpose & Terms of Reference	Cabinet of 21st May 2012 received and approved a report for the re-procurement of repairs and maintenance contracts within the timescales set out in the report. Within the timeframes set out, the Task & Finish Group has been set up to facilitate valuable Member insight, input, support and challenge in terms of the customer journey, appropriate measures of success/ Key Performance Indicators and the evaluation criteria for the Invitation to Tender.
Expected Timescale of review	July - September 2012 (estimated 3 or 4 meetings of Task & Finish Group plus virtual meetings as necessary) Early July – Officers to present an overview of the contract terms, customer journey and draft Key Performance Indicators Late July – Finalise feedback from meeting one August – Consideration and discussion of draft evaluation criteria for Invitation to Tender (by correspondence) Early September – Finalise feedback on evaluation criteria.

Key Officer's involved in the process	Director of Asset Management & Property Services – Stephen Kirrage Re-procurement Project Manager – Gary Vickery Commercial & Contracts Manager – Ian Watts
Expected outcomes	An iterative process between Members and Officers that will feed into the overall procurement process timeline, covering KPI's, the resident experience and the contractual and cost controls that will be put in place.
Risks	• The project is running to strict timelines to allow residents to benefit from improved service delivery arrangements at the earliest opportunity. To avoid risk of slippage papers and items for discussion will need to be provided in a timely fashion and Members will need to allow sufficient time in their busy diaries. • Scope creep – this is a major project to be delivered within a tightly defined timeframe. Inevitably tangential issues will arise, however it will be important to remain focussed on the task in hand • Travelling to meetings may be hindered by the Olympics

Repairs & Maintenance re-procurement High level key milestones	
Contract Notice & Pre-Qualification Questionnaires issued	Jun-12
Pre-Qualification Questionnaires evaluation and short-listing	Aug-12
Invitations to Tender issued	Oct-12
Invitations to Tender evaluation	Dec-12
Preferred bidders identified	Feb-13
Prepare & Issue Notice of Proposal to Leaseholders & consult	Mar-13
Request key Cabinet decision to award	Apr to Jun-13
Award contract	Jul-13
Mobilisation period	Jul to Oct-13
Go-live date	Oct-13

London Borough of Hammersmith & Fulham

HOUSING, HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE

DATE	TITLE	Wards
17 July 2012	Work Programme and Forward Plan	All Wards

SYNOPSIS

The draft work programme has been drawn up, in consultation with the Chairman, from items in the Forward Plan and from action arising from previous meetings of the Housing, Health and Adult Social Care Select Committee and its predecessor committees.

The committee is requested to consider the items within the proposed work programme set out at Appendix A to this report and suggest any amendments or additional topics to be included in the future.

Attached as Appendix B to this report is a copy of the Forward Plan items showing the decisions to be taken by the Executive at the Cabinet.

CONTRIBUTORS

Finance and Corporate Services

RECOMMENDATION(S):

That the committee considers and agrees its proposed work programme, subject to update at subsequent meetings of the committee.

CONTACT

Sue Perrin
020 8753 2094

NEXT STEPS

n/a

Appendix A

Housing, Health & Adult Social Care Select Committee

Draft Work Programme 2012/2013
17 July 2012
Central London Community Healthcare: NHS Foundation Trust Status Application Housing Strategy Imperial College Healthcare NHS Trust: Oral report Shaping a Healthier Future: NHS Public Consultation Task Group: Repairs and Maintenance Services
11 September 2012
Housing Benefits Update Housing Performance Indicators Imperial College Healthcare NHS Trust Shaping a Healthier Future: NHS Public Consultation Task Group: Repairs and Maintenance Services
14 November 2012
Housing Development Company Housing Investment Plan
22 January 2012
Revenue Budget and Council Tax 2013/2014
Other Items
Public Health Transition Plans Remodel of Adult Social Care Day Services Transition from Children's to Adult Social Care Unemployed people back to work/school leavers into work West London Mental Health Trust: Service Gaps

Appendix B

FORWARD PLAN OF KEY DECISIONS

Proposed to be made in the period July 2012 to October 2012

The following is a list of Key Decisions, as far as is known at this stage, which the Authority proposes to take in the period from July 2012 to October 2012.

KEY DECISIONS are those which are likely to result in one or more of the following:

- **Any expenditure or savings which are significant, regarding the Council's budget for the service function to which the decision relates in excess of £100,000;**
- **Anything affecting communities living or working in an area comprising of two or more wards in the borough;**
- **Anything significantly affecting communities within one ward (where practicable);**
- **Anything affecting the budget and policy framework set by the Council.**

The Forward Plan will be updated and published on the Council's website on a monthly basis. (New entries are highlighted in yellow).

NB: Key Decisions will generally be taken by the Executive at the Cabinet. The items on this Forward Plan are listed according to the date of the relevant decision-making meeting.

If you have any queries on this Forward Plan, please contact
***Katia Richardson** on 020 8753 2368 or by e-mail to katia.richardson@lbhf.gov.uk*

Consultation

Each report carries a brief summary explaining its purpose, shows when the decision is expected to be made, background documents used to prepare the report, and the member of the executive responsible. Every effort has been made to identify target groups for consultation in each case. Any person/organisation not listed who would like to be consulted, or who would like more information on the proposed decision, is encouraged to get in touch with the relevant Councillor and contact details are provided at the end of this document.

Reports

Reports will be available on the Council's website (www.lbhf.org.uk) a minimum of 5 working days before the relevant meeting.

Decisions

Decision to be Made by: (ie Council or Cabinet)	Date of Decision-Making Meeting and Reason	Proposed Key Decision	Lead Executive Councillor(s) and Wards Affected

All decisions taken by Cabinet may be implemented 5 working days after the relevant Cabinet meeting, unless called in by Councillors.

Making your Views Heard

You can comment on any of the items in this Forward Plan by contacting the officer shown in column 6. You can also submit a deputation to the Cabinet. Full details of how to do this (and the date by which a deputation must be submitted) are on the front sheet of each Cabinet agenda.

LONDON BOROUGH OF HAMMERSMITH & FULHAM: CABINET 2012/13

Leader (+ Regeneration, Asset Management and IT):	**Councillor Nicholas Botterill**
Deputy Leader (+ Residents Services):	**Councillor Greg Smith**
Cabinet Member for Children's Services:	**Councillor Helen Binmore**
Cabinet member for Communications:	**Councillor Mark Loveday**
Cabinet Member for Community Care:	**Councillor Marcus Ginn**
Cabinet Member for Housing:	**Councillor Andrew Johnson**
Cabinet Member for Transport and Technical Services:	**Councillor Victoria Brocklebank-Fowler**

Forward Plan No 122 (published 15 June 2012) - *updated 26 June 2012*

Where the title bears the suffix (Exempt), the report for this proposed decision is likely to be exempt and full details cannot be published.

New entries are highlighted in yellow.

* All these decisions may be called in by Councillors; If a decision is called in, it will not be capable of implementation until a final decision is made.

Decision to be Made by: (ie Council or Cabinet)	Date of Decision-Making Meeting and Reason	Proposed Key Decision	Lead Executive Councillor(s) and Wards Affected
July			
Cabinet	23 Jul 2012	**Outsourcing of the provision of a Meals Service for vulnerable adults** To request authority for the outsourcing of the Meals Service to a "cook on route" model. To notify of multi borough tendering arrangements. To request that authority to award the contract be delegated to Cabinet Member for Community Care in conjunction with the Executive Director of Adult Social Care.	Cabinet Member for Community Care
	Reason: Expenditure more than £100,000		Ward(s): All Wards

Decision to be Made by: (ie Council or Cabinet)	Date of Decision-Making Meeting and Reason	Proposed Key Decision	Lead Executive Councillor(s) and Wards Affected
Cabinet	23 Jul 2012	**Youth Provision Commissioning** Proposals for the commissioning of Youth Provision from 2013-2015	Cabinet Member for Children's Services
	Reason: Affects more than 1 ward		Ward(s): All Wards
Cabinet	23 Jul 2012	**Proposal for the introduction of graduated parking suspension charges boroughwide**	Deputy Leader (+Environment and Asset Management)
	Reason: Affects more than 1 ward	Residents often complain about the number of suspensions of parking suspensions, especially long-term suspensions, as it reduces the available parking spaces, thereby increasing parking stress, and arguably adding to congestion and pollution. As a result, officers propose introducing a graduated structure for suspensions fees to the following: • £40 per space per day for suspensions lasting between one and five days; • £60 per space per day for suspensions lasting between six and 42 days; • £80 per space per day for suspensions lasting for 43 days or more.	Ward(s): All Wards
Cabinet	23 Jul 2012	**Tri-Borough Corporate Services Programme: Funding request for "Develop" phase**	Leader of the Council (+Regeneration, Asset Management and IT)
	Reason: Affects more than 1 ward	Request for funding for resources required to deliver the "Develop" phase of the Tri-Borough Corporate Services programme.	Ward(s): All Wards
Cabinet	23 Jul 2012	**Procurement of the provision of an out of hospital stroke support service for London Borough of Hammersmith & Fulham and Royal Borough of Kensington and Chelsea and a stroke support and information service for London Borough of Hammersmith & Fulham** To request that authority to award the contract be delegated to Cabinet Member for Community Care in conjunction with the Executive Director of Adult Social Care. This service will be accessed by the residents of LB Hammersmith & Fulham and the RB Kensington & Chelsea. Hammersmith & Fulham are the lead procurement and contracting authority.	Cabinet Member for Community Care
	Reason: Expenditure more than £100,000		Ward(s): All Wards

Decision to be Made by: (ie Council or Cabinet)	**Date of Decision-Making Meeting and Reason**	**Proposed Key Decision**	**Lead Executive Councillor(s) and Wards Affected**
Cabinet	23 Jul 2012	**Asset Disposals 2012/2013** This report sets out the properties for which authority is sought for disposal as part of the Asset Disposal Programme for 2012/2013	Deputy Leader (+Environment and Asset Management), Cabinet Member for Children's Services, Cabinet Member for Housing
	Reason: Expenditure more than £100,000		Ward(s): Hammersmith Broadway; Sands End; Town
Cabinet	23 Jul 2012	**Earl's Court Regeneration Project** The Council has been exploring the benefits of including the West Kensington and Gibbs Green estates within the proposed comprehensive redevelopment of Earl's Court and Lillie Bridge depot.	Leader of the Council (+Regeneration, Asset Management and IT)
	Reason: Significant in 1 ward		Ward(s): North End
Cabinet	23 Jul 2012	**Troubled Families** In December 2011, the Government launched its programme to turn around the lives of the country's 120,000 most troubled families: those experiencing multiple problems and disadvantages such as unemployment, truancy and causing problems such as crime and anti-social behaviour at an annual estimated cost of £9 billion. The Government has estimated that there are 1720 troubled families in the Tri-borough at an estimated annual cost to the taxpayer of £150 million. The programme will run for three years funded by a combination of attachment fees and on a "payments by results" basis to incentivise local authorities and other partners to prioritise this work. This report updates Members on: •the work which has been undertaken in identifying the 1720 troubled families in the tri- borough according to the Government's criteria; •the work undertaken within services and partners on developing a proposal for implementing the Troubled Families Programme within Tri-Borough •the proposal for delivering the programme across the Tri- borough.	Cabinet Member for Children's Services
	Reason: Affects more than 1 ward		Ward(s): All Wards
September			
Cabinet	3 Sep 2012	**Riverside Studios, Crisp Road, London, W6** Re-development of Riverside Studios	Deputy Leader (+Environment and Asset Management)

Decision to be Made by: (ie Council or Cabinet)	**Date of Decision-Making Meeting and Reason**	**Proposed Key Decision**	**Lead Executive Councillor(s) and Wards Affected**
	Reason: Expenditure more than £100,000	Site.	Ward(s): Hammersmith Broadway
Cabinet	3 Sep 2012	**Looked After Children Social Care Report** Looked After Children Social Care report.	Cabinet Member for Children's Services
	Reason: Affects more than 1 ward		Ward(s): All Wards
Cabinet	3 Sep 2012	**Child Protection Social Care Report** Child Protection Social Care report.	Cabinet Member for Children's Services
	Reason: Affects more than 1 ward		Ward(s): All Wards
Cabinet	3 Sep 2012	**Local Safeguarding Children's Board (LSCB) Social Care Report** Local Safeguarding Children's Board (LSCB) Social Care report.	Cabinet Member for Children's Services
	Reason: Affects more than 1 ward		Ward(s): All Wards
Cabinet	3 Sep 2012	**Learning Disability Social Enterprise** Options Day Service and Rivercourt Short Breaks Services are currently in house provided services for People with Learning Disabilities. Staff, managers, parents and carers have been working together to develop a business case for a social enterprise company. A shadow board has been set up to plan the launch of the new social enterprise charity "Linking Hands" (working title). The governance involves H &F managers, staff, business people, parents and carers.	Cabinet Member for Community Care
	Reason: Affects more than 1 ward		Ward(s): All Wards
Cabinet	3 Sep 2012	**Economic development Priorities** This report sets out the economic development goals as detailed in the draft Economic Development Strategic Priorities 2012-2017 in order to facilitate long term planning, partnership work and initiatives aimed at increasing local economic growth. The report seeks endorsement for key background documents; Local Economic Assessment (draft), Procurement Code, Business Investment Code and Job &	Leader of the Council (+Regeneration, Asset Management and IT)
	Reason: Affects more than 1 ward		Ward(s): All Wards

Decision to be Made by: (ie Council or Cabinet)	Date of Decision-Making Meeting and Reason	Proposed Key Decision	Lead Executive Councillor(s) and Wards Affected
		Employment Code. In addition the report details related expenditure requirements.	
Cabinet	3 Sep 2012 Reason: Expenditure more than £100,000	**Hammersmith Town Hall - Smart Accommodation Programme - Phase 1** Tender acceptance report to appoint contractor to carry out remodelling works on 1st and 2nd floor offices at Hammersmith Town Hall to provide smart working, open plan accommodation to maximise occupancy.	Deputy Leader (+Environment and Asset Management) Ward(s): Hammersmith Broadway
Cabinet	3 Sep 2012 Reason: Affects more than 1 ward	**Tri-borough ICT strategy 2012-2015** The Vision for Tri-borough ICT - A Tri-borough ICT Strategy for 2012-2015	Leader of the Council (+Regeneration, Asset Management and IT) Ward(s): All Wards
Cabinet	3 Sep 2012 Reason: Significant in 1 ward	**Shepherds Bush Market - Land Assembly** Report setting out progress to date on land assembly to facilitate regeneration of the market and next steps.	Leader of the Council (+Regeneration, Asset Management and IT) Ward(s): Shepherds Bush Green
Cabinet Full Council	3 Sep 2012 24 Oct 2012 Reason: Expenditure more than £100,000	**Treasury Outturn Report** This report provides information on the Council's debt, borrowing and investment activity for the financial year ending 31st March 2012	Leader of the Council (+Regeneration, Asset Management and IT) Ward(s): All Wards
Cabinet	3 Sep 2012 Reason: Affects more than 1 ward	**Measured Term Contract for Boroughwide Cyclical Planned Maintenance to Council-owned Housing Properties 2012 – 2015** The term contract will include external and communal repairs and redecorations, plus works to communal services installations, to the borough's housing portfolio.	Cabinet Member for Housing Ward(s): All Wards
Cabinet	3 Sep 2012 Reason: Expenditure more than £100,000	**SmartWorking Stage D : Paperless Office Business Case** A detailed Business Case for SmartWorking Stage D : Phase B "Paperless Office"	Leader of the Council (+Regeneration, Asset Management and IT) Ward(s): All Wards

Decision to be Made by: (ie Council or Cabinet)	Date of Decision-Making Meeting and Reason	Proposed Key Decision	Lead Executive Councillor(s) and Wards Affected
Cabinet	3 Sep 2012 Reason: Expenditure more than £100,000	**Elevator Monitoring Unit Installation - Various Sites** The works consist of the supply and installation of elevator Monitoring Units and Auto Diallers to be fitted to each lift in providing automatic reporting of lift breakdowns and two communication between each lift car and operators at a manned call centre in dealing with lift entrapment.	Cabinet Member for Housing Ward(s): All Wards
Cabinet	3 Sep 2012 Reason: Affects more than 1 ward	**Approval to procure WiFi service** To procure WiFi on lampposts around the borough at key points.	Deputy Leader (+ Residents Services) Ward(s): All Wards
Cabinet	3 Sep 2012 Reason: Significant in 1 ward	**Earl's Court Regeneration Project** The further report will outline progress to date on the discussions on the key issues around the Earls Court Regeneration project.	Leader of the Council (+Regeneration, Asset Management and IT) Ward(s): North End
October			
Cabinet	15 Oct 2012 Reason: Expenditure more than £100,000	**Reprocurement of frameworki Social Care IT system** Confirmation of reprocurement of Frameworki social care system (or equivalent social care system) is requested for both Adult Social Care and Children's Services from January 2013.	Cabinet Member for Community Care, Cabinet Member for Children's Services Ward(s): All Wards
Cabinet	15 Oct 2012 Reason: Affects more than 1 ward	**Travel Assistance Policies** Travel Assistance Policy – Special education needs (SEN)	Cabinet Member for Children's Services Ward(s): All Wards
Cabinet	15 Oct 2012 Reason: Affects more than 1 ward	**Building a Housing Ladder of Opportunity** Seeks adoption as housing policy following public consultation for four housing documents: housing strategy; housing allocation scheme; tenancy strategy; and homelessness strategy	Cabinet Member for Housing Ward(s): All Wards