

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 | 2 |
| Foreword | 4 |
| Summary | 8 |
| 1 Describing the NHS in NW London | 12 |
| 2 The challenges facing the NHS in NW London | 14 |
| 3 What will happen if we do nothing? | 18 |
| 4 So what is the answer? | 20 |
| 5 Our vision for healthcare in NW London | 22 |
| 6 World-class healthcare outside of hospital | 24 |
| 7 Making hospitals centres of excellence | 26 |
| 8 What will our vision mean for you? | 30 |
| 9 Delivering the vision | 32 |
| 10 Where will care be provided in future under the proposals? | 34 |
| 11 Proposals for delivering care outside hospitals | 36 |
| 12 Our recommendations for local hospitals across NW London | 40 |
| 13 Elective hospitals using our high-quality buildings | 43 |
| 14 Five major hospitals for NW London | 44 |
| 15 Where should the major hospitals be located? | 48 |
| 16 Which options are practical? | 52 |
| 17 The three options for major hospitals | 57 |
| 18 Proposals for changes to specialist services | 69 |
| 19 Making this work for patients | 71 |
| 20 Next steps | 74 |
| Glossary | 76 |



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,
Southside,
105 Victoria Street,
London,
SW1E 6QT

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



consultation@nw.london.nhs.uk

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.

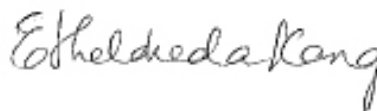
Our third commitment is that if patients need to see a specialist or receive support from community or social care services, this will be organised quickly and GPs will be responsible for co-ordinating their healthcare.

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

NHS Central London (Westminster) CCG Chair



Dr Mark Sweeney

NHS West London (Kensington and Chelsea, Queen's Park and Paddington) CCG Chair



Dr Mohini Parmar

NHS Ealing CCG Chair



Dr Tim Spicer

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.

A handwritten signature in black ink, appearing to read 'Mark Spencer'.

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.

A handwritten signature in black ink, appearing to read 'Jeff Zitron'.

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.

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.

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

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 |

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 | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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.

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

4b



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.

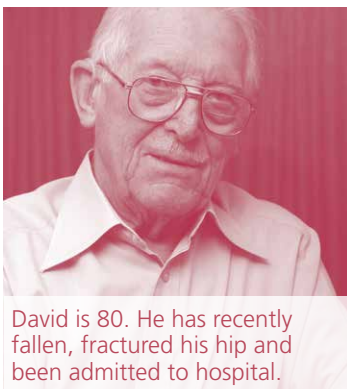
Now

- 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.



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  | <ul style="list-style-type: none"> 9 urgent care centres (various opening hours) 7 A&E departments 2 limited A&E departments Significant difference in GP practice opening times | <ul style="list-style-type: none"> 9 urgent care centres (24 hours a day, 7 days a week) 5 A&E departments Extended GP opening hours for every patient | <ul style="list-style-type: none"> More reliable emergency care Better access to GP practices | <ul style="list-style-type: none"> 100,000 hospital stays (14%) Gross £12m to £15m | <ul style="list-style-type: none"> 30 to 35 extra staff £5m to £7m |
| B Simpler planned care pathways  | <ul style="list-style-type: none"> Most patients get access to specialist opinions through outpatient departments Difference in referrals by GPs to outpatients Most minor procedures only available in hospitals | <ul style="list-style-type: none"> Access to specialist opinion by phone for GPs while with patient Clinics in community for common specialities Referrals within clear guidelines and reviewed by other GPs Patients able to quickly have minor elective procedures without going to hospital | <ul style="list-style-type: none"> Patients able to access a greater range of services through their GP Less waiting times More convenience | <ul style="list-style-type: none"> 600,000 outpatient appointments (22%) Gross £83m to £95m 10,000 hospital stays (14%) Gross £20m to £24m | <ul style="list-style-type: none"> 205 to 235 extra staff £59m to £65m |
| C Quick responses to urgent health problems  | <ul style="list-style-type: none"> Rapid response service in Brent avoiding around 1,000 admissions each year | <ul style="list-style-type: none"> Rapid response service across all of NW London avoiding 16,000 hospital admissions each year | <ul style="list-style-type: none"> Patients avoid unnecessary hospital visits | <ul style="list-style-type: none"> 29,000 avoided emergency admissions (10%) 391 acute beds Gross £47m to £54m | <ul style="list-style-type: none"> 275 to 320 extra staff 130 to 140 community beds £29m to £34m |
| D Co-ordinated care for people with a long-term condition  | <ul style="list-style-type: none"> Care networks have been piloted for integrated care for diabetes and the elderly for a population of 500,000 | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 17,000 more diabetics 200 fewer amputations 880 fewer deaths | <ul style="list-style-type: none"> 19,000 avoided emergency admissions (7%) Gross £33m to £39m | <ul style="list-style-type: none"> 255 to 300 extra staff £27m to £32m |
| E Less time spent in hospital  | <ul style="list-style-type: none"> Many patients stay in hospital longer than necessary and leave without good support | <ul style="list-style-type: none"> Care providers will know when a patient is in hospital and will help them into planned, supportive care outside hospital | <ul style="list-style-type: none"> Better recovery with support when the patient leaves hospital | <ul style="list-style-type: none"> Activity-reduction included under D (above) | <ul style="list-style-type: none"> Included in trust cost improvement programmes |

Total investment
 £120m to £138m

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.

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:

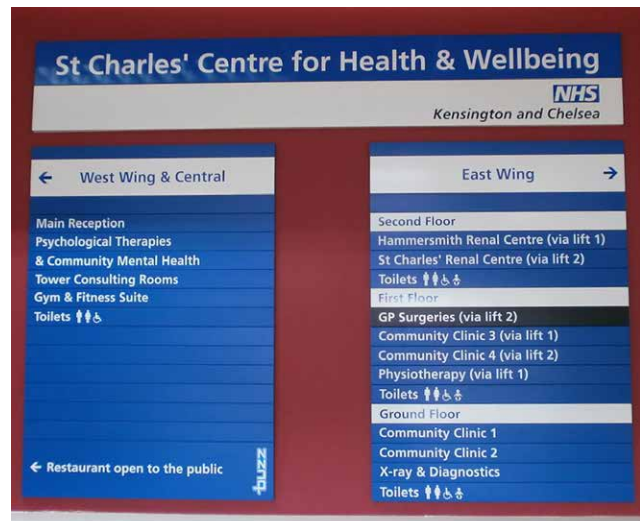
- illnesses and injuries not likely to need a stay in hospital;
- x-rays and other tests;
- minor fractures (breaks);
- stitching wounds;
- draining abscesses that don't need a general anaesthetic; and
- minor ear, nose, throat and eye infections.

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 Ladbrooke 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

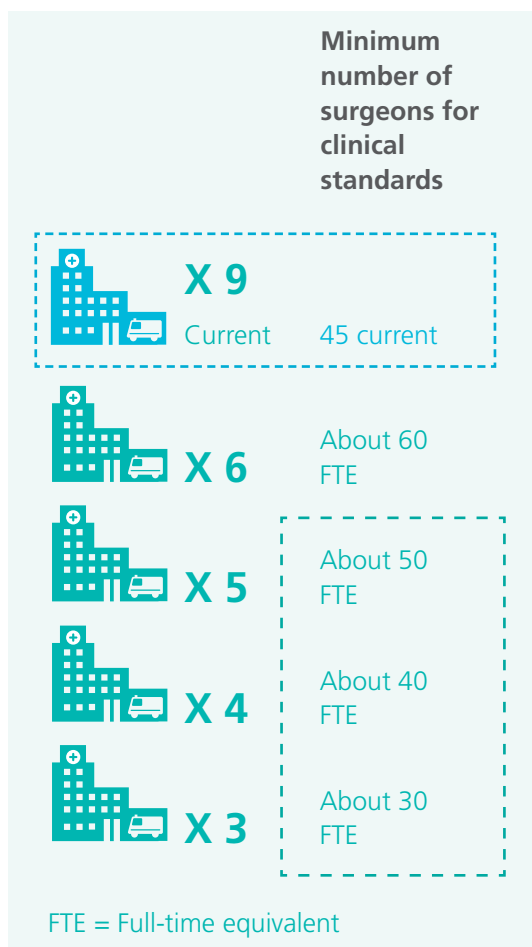
major hospitals would be needed to:

- 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.

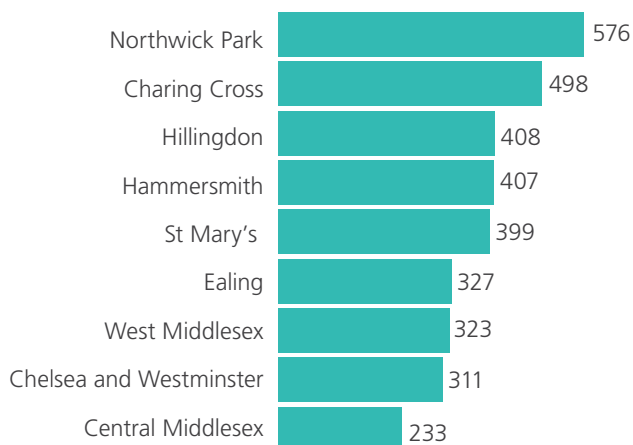


- To begin with, some clinicians recommended that we should have four or fewer major hospitals but it was agreed that this would not be enough. This is because we would have to build much bigger hospitals and move lots of services which would be high risk, difficult to deliver, and expensive. For example, 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.

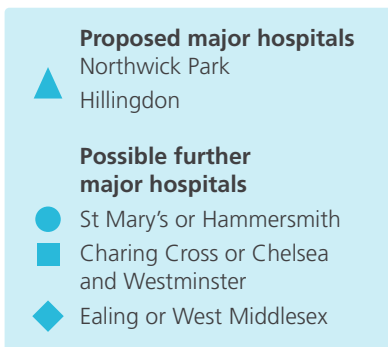
This means that two of the five major hospitals would be at Hillingdon Hospital and Northwick Park Hospital.

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

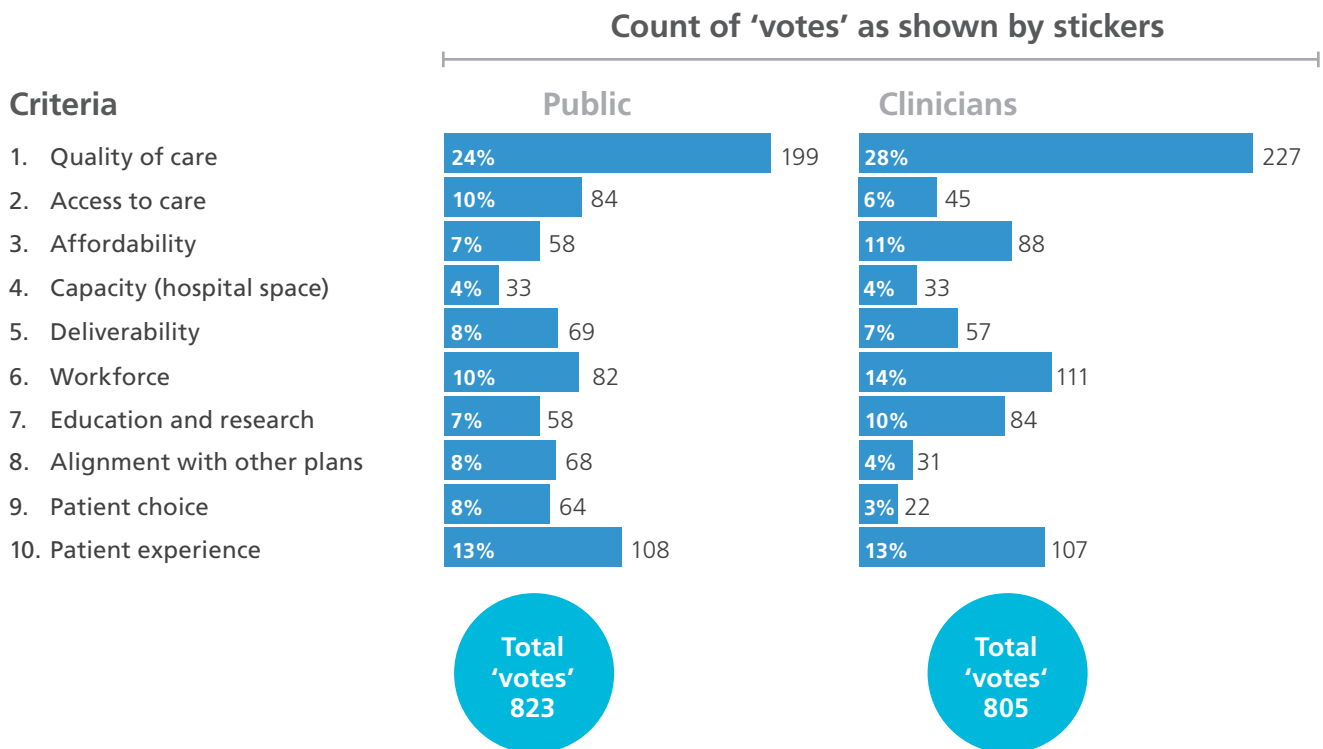
| | | | | | | | | | |
|-------------------------|--|--|--|--|--------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|
| St Mary's | Local hospital | Local hospital | Local hospital | Local hospital | Major hospital | Major hospital | Major hospital | Major hospital | 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 | Specialist hospital |
| Charing Cross | Local hospital | Major hospital | Local hospital | Major hospital | Local hospital | Major hospital | Local hospital | Major hospital | Major hospital |
| Chelsea and Westminster | Major hospital | Local hospital | Major hospital | Local hospital | Major hospital | Local hospital | Major hospital | Local 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 | Local hospital and elective hospital |
| Ealing | Local hospital | Local hospital | Major hospital | Major hospital | Local hospital | Local hospital | Major 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 | Local hospital and elective hospital |
| Northwick Park | Major hospital | 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 | Major hospital |



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 | <ul style="list-style-type: none"> Clinical quality Patient experience |
| 2. Access to care | <ul style="list-style-type: none"> Distance and time to access services Patient choice |
| 3. Value for money | <ul style="list-style-type: none"> Capital cost to system Transition costs Viable Trusts and sites Surplus for acute sector Net present value |
| 4. Deliverability | <ul style="list-style-type: none"> Workforce Expected time to deliver Alignment with other plans |
| 5. Research and education | <ul style="list-style-type: none"> 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 | West Middlesex Hammersmith Chelsea and Westminster Northwick Park Hillingdon | 2 | West Middlesex Hammersmith Charing Cross Northwick Park Hillingdon | 3 | Ealing Hammersmith Chelsea and Westminster Northwick Park Hillingdon | 4 | Ealing Hammersmith Charing Cross Northwick Park Hillingdon | 5 | West Middlesex St Mary's Chelsea and Westminster Northwick Park Hillingdon | 6 | West Middlesex St Mary's Charing Cross Northwick Park Hillingdon | 7 | Ealing St Mary's Chelsea and Westminster Northwick Park Hillingdon | 8 | 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.

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).

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.

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.

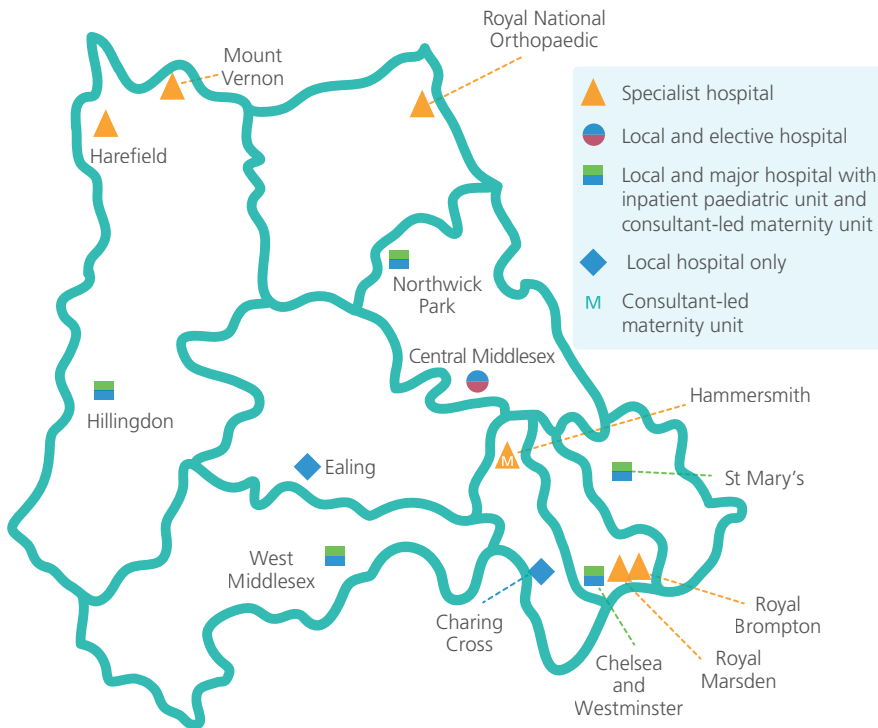
Option A (preferred option)

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 paediatrics | Obstetrics and maternity unit | Non-complex elective surgery or medicine (or both) | High Dependency | 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 Future | ✓ ✓ | L ✓ | S S | S S | 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

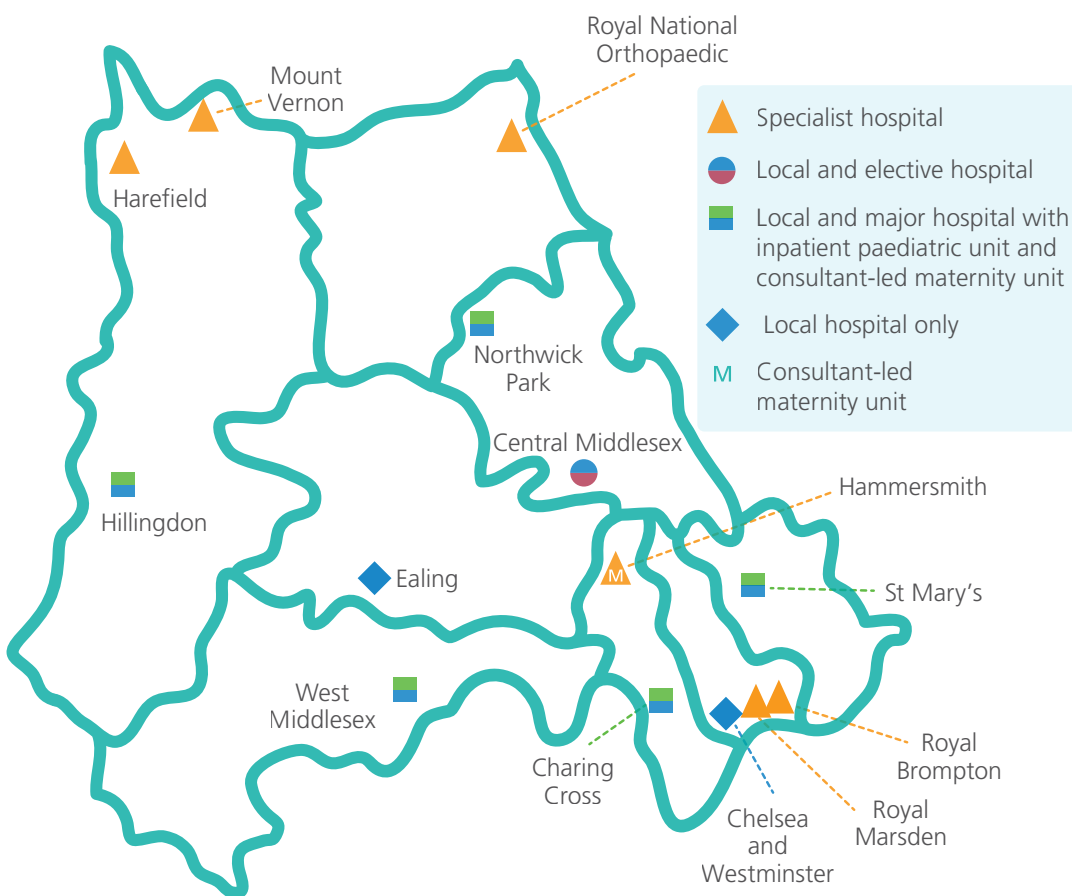
Option B

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 paediatrics | Obstetrics and maternity unit | Non-complex elective surgery or medicine (or both) | High Dependency | Heart attack |

| | | | | | | | | | | | | | | | |
|---------------------------------------|-------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| 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 Future | ✓ ✓ | ✓ ✓ | L S | S S | ✓ 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.
- **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 B gives fewer benefits than option A, because it would:



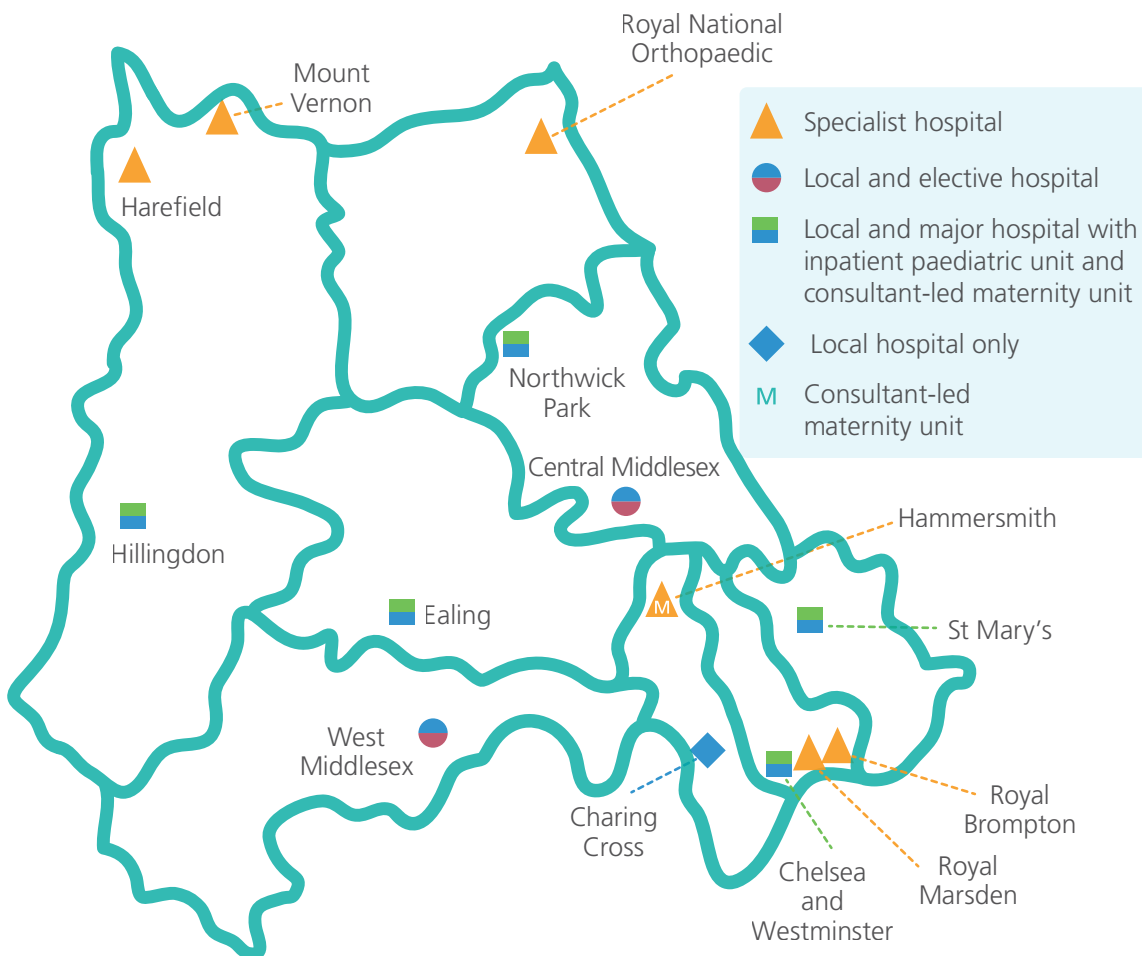
Option C

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 paediatrics | Obstetrics and maternity unit | Non-complex elective surgery or medicine (or both) | High Dependency | 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 Future | ✓ ✓ | L | 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

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?

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

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.



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 woman 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.

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.

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।

Polish:

Dokument ten jest na życzenie udostępniany także w innych wersjach językowych, dużym drukiem lub w formacie audio.

Somali:

Waxaa kale oo lagu heli karaa dokumentigaan luqado kale, daabacaad balaaran, iyo cajal duuban hadii la soo waydiisto.

Spanish:

Este documento también está disponible y puede solicitarse en otros idiomas, en letra grande y formato de audio

Chinese:

我們可應要求將這份文件翻譯成其他語文，及提供大字體和錄音版本。

Albanian:

Ky dokument është në dispozicion edhe në gjuhë të tjera, në format me shkronja të mëdha ose me kasetë, sipas kërkesës

Urdu:

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 வாடிவத்திலும் கிடைக்கின்றது.



0800 881 5209



consultation@nw.london.nhs.uk



t: 0800 881 5209
e: consultation@nw.london.nhs.uk
www.healthiernorthwestlondon.nhs.uk

