Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting

Hospital Boardroom
Chair: Juggy Pandit
Date: 24 July 2007
Time: 4:30pm

Agenda

1. GENERAL BUSINESS	**4.30pm**
1.1 Apologies for Absence	**JP**
1.2 Declaration of Interests	**JP**
1.3 Minutes of Previous Meeting held on 10 May 2007 (attached)	**JP**
1.4 Matters Arising (attached)	**JP**
1.5 Chairman's Report (attached)	**JP**
2. ITEMS FOR DISCUSSION/DECISION/APPROVAL	
2.1 Approval of new Proposed Trust Chairman (oral)	**ALL**
2.2 Proposed Constitutional Changes (attached)	**CM**
2.3 Annual Members Meeting (attached)	**JP/HL**
2.4 Draft Membership Development Strategy and Membership Report (attached)	**CM**
2.5 Draft Minutes from Membership Development and Communications Sub-Committee	**CM**
2.6 Patient and Public Involvement in Research (oral)	**DB**
2.7 Framework for London and Related Service Development (attached)	**HL**
3.1 Patient & Public Involvement and LINKs – K and C Early Adopter Project (attached)	**JP**
4. ANY OTHER BUSINESS	
5. DATE OF THE NEXT MEETING	

20th September 2007
8th November 2007

Members' Council Meeting, 24 July 2007

AGENDA ITEM NO.	1.4/Jul/07
PAPER	Matters Arising
AUTHOR	Julie Cooper, Foundation Trust Secretary
LEAD	Juggy Pandit, Chairman
EXECUTIVE SUMMARY	This paper lists matters arising from previous meeting(s) and the action taken/to be taken.
DECISION/ ACTION	The Members' Council is asked to note the matters arising and update where appropriate.

Matters Arising from Previous Meetings

Reference	Item	Action
1.3/May/07	REGISTER OF INTEREST Anyone who has not yet completed the register should do so.	ALL
1.4/May/07	MATTERS ARISING Minutes It was agreed to post an 'open' set of minutes on the Trust website from the Trust board within one week of approval. It was agreed that the open minutes would also be sent to relevant organisations. Vacancies 1. Action: JP to write to all Council Members who have missed three consecutive meetings and inform them that according to the constitution their office will be terminated, unless they justify their absence. 2. Action: JP to write a letter to all Council Members to discern if anyone is planning to step down and then review situation regarding succession planning.	JP/JC JP/JC JP/JC
2.2/May/07	APPOINTMENT OF NEW CHAIRMAN It was agreed to call a meeting of the Members' Council on 24 July.	JC
2.3/May/07	ANNUAL MEMBERS' MEETING 1. Action: Council Members to share suggestions around themes and speakers for the meeting 2. Action: Explore possibility of holding a crèche during the annual members meeting 3. Action: Membership and Communications Sub Committee to look further into venue and location for the Annual Members' Meeting	ALL SH MCSC
2.6/May/07	REPORT from the MEMBERSHIP AND COMMUNICATIONS SUB-COMMITTEE 1. Action: It was agreed that the sub-committee would bring back a prioritised work plan to guide the implementation of the Membership Development and Communications Strategy 2. Action: Membership and Communications Sub-Committee to meet more than 10 days in advance of the Members' Meeting.	MSCS MCSC
2.8/May/07	PATIENT BEDSIDE COMMUNICATION Action: HL agreed to discuss internally the suggestion that the cost of an incoming call should be on par with the cost of a call from a mobile phone	HL
2.9 /May/07	ANNUAL PATIENT SURVEY Action: Invite Council Members to undergo training to become mystery shoppers.	JC

Members' Council Meeting, 24 July 2007

AGENDA ITEM NO.	1.5/Jul/07
PAPER	Chairman's Report
AUTHOR	Juggy Pandit, Chairman
LEAD	Juggy Pandit, Chairman
SUMMARY	This report outlines key issues for the attention of the Members' Council.
DECISION/ ACTION	The Council is asked to note the report.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

MEMBERS' COUNCIL
CHAIRMAN'S REPORT

1.0 CHAIRMAN AND NED RECRUITMENT

The process for recruiting a new Trust Chairman has concluded. The Nominations Committee will now make its recommendation to the Council for approval later in the meeting. Recruitment for the Non-Executive Director (NED) has commenced and will take place over the summer. A recommendation will be made by the Nominations Committee for approval at the September Council meeting.

As you know, I will be leaving the Trust in October. I have thoroughly enjoyed my tenure at the Trust, and I am happy to have served as your Chairman in your first year. I am confident that the new Chairman will continue to make the Members' Council and the membership a priority.

2.0 TRUST PERFORMANCE

Monitor Praises Chelsea and Westminster

I am pleased to announce that Monitor, the Foundation Trust Regulator, has praised all staff whose hard work meant that Chelsea and Westminster was one of just five foundation trusts highlighted for balancing good financial and service performance in an end-of-year report by Monitor. The Trust will also be featured in both the Monitor Annual Report and the FT Network Report entitled: 'NHS Foundation Trusts: the story so far'.

PACS

PACS, the new digital radiology system, went live across the Trust on Saturday, June 30 and the transition went very smoothly.

30 MBE AWARD

I want to congratulate Jean Hunt, one of our Council Members as well as a long standing St Stephen's Volunteer, who has been awarded the MBE.

5.0 FRIENDS FUND STROKE UNIT REFURBISHMENT

Thank you to the Friends who raised more than £25,000 at a fundraising clay pigeon shoot last year to refurbish the Stroke Unit which was officially opened in June. A national audit of stroke services in 2006 placed the Trust in the top 10 nationally.

Juggy Pandit
Chairman
24 July 2007

Members' Council Meeting, 24 July 2007

AGENDA ITEM NO.	2.2/Jul/07
PAPER	Proposed Amendments to Constitution
AUTHOR	Julie Cooper, FT Secretary/Head of Corporate Governance
LEAD	Juggy Pandit, Chairman
SUMMARY	It is the responsibility of the Members' Council to review the trust constitution. This paper is divided into two sections. The first outlines some practical changes to the constitution regarding vacancies, terms of office and elections, which are necessary for the effective, efficient and economic running of the Foundation Trust. The second section outlines other possible changes to be made to the constitution, which have been proposed either by the trust or by individual members of the Members' Council.
DECISION/ ACTION	The Council is asked to discuss all of the proposed changes and make a recommendation on the changes to be made, which will then be submitted to Monitor for approval.

PROPOSED AMENDMENTS TO CONSTITUTION

1.0 Introduction

1.1 Many established foundation trusts are reviewing their constitutions, either, as a routine annual review or as a result of internal/external changes that affect their constitution.

1.2 Having now been a Foundation Trust for ten months, it has been identified that there are certain parts in the constitution which are not workable in practice and in some cases are very costly.

1.3 This paper is divided into two sections. The first outlines some practical changes to the constitution regarding vacancies, terms of office and elections, which are necessary for the effective, efficient and economic running of the Foundation Trust. The second section outlines other possible changes to be made to the constitution, which have been proposed either by the trust or by individual members of the Members' Council.

1.4 Monitor now requires all applicant trusts to prepare their constitutions on the basis of a model core constitution. The proposed changes in this document have been made with consideration of the model, as well as other foundation trust constitutions for reference.

2.0 Changes to Terms of Office, Vacancies and Elections

2.1 Terms of Office / Vacancies

2.1.1 Current Constitution Wording

Where a vacancy arises on the Members' Council for any reason other than expiry of term of office, the following provisions will apply.

Where the vacancy arises amongst the appointed Council Members, the Secretary shall request that the appointing organisation appoints a replacement to hold office for the remainder of the term of office.

Where the vacancy arises amongst the elected Council Members, the Members' Council shall be at liberty either:

to call an election within three months to fill the seat for the remainder of that term of office, or

to invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat until the next annual election, at which time the seat will fall vacant and subject to election for any unexpired period of the term of office.

2.1.2 The Issue

Under the current wording, we are bound to either take the candidate who polled the second highest number of votes or call an election within three months. Under either system, the person would still only then fill the seat for the remainder of that term of office. On average an election costs approximately £10,000, takes three months and requires an enormous time commitment to administer. This arrangement would therefore be inefficient and uneconomical to manage going forward.

2.1.3 Proposed Wording

Where a vacancy arises on the Members' Council for any reason other than expiry of term of office, the following provisions will apply.

Where the vacancy arises amongst the appointed Council Members, the Secretary shall request that the appointing organisation appoints a replacement to hold office and serve for a three year term.

Where the vacancy arises amongst the elected Council Members, the Members' Council shall be at liberty either:

to allow the seat to remain open until the next scheduled election or

to invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat and serve for a three-year term.

Two elections shall be scheduled each year, but shall only be executed at the request of the Members' Council.

2.2 Transition Schedule/ Elections

2.2.1. Current Constitutional Wording:

The transition schedule forms part of the terms of authorisation to provide guidance during the initial year of becoming a Foundation Trust. The constitution currently states the following for the three elected constituencies respectively:

Not less than one third of the initial staff, public and patient Council Members who polled the highest votes will serve a term of office ending at the conclusion of the annual members meeting in 2009; not less than one third of the initial staff, public, and patient Council Members who polled the next highest number of votes will serve a term of office ending at the conclusion of the annual members meeting in 2008; the remaining initial staff, public and patient Council Members will serve a term of office ending at the conclusion of the annual members meeting in 2007.

2.2.2 The Issue

The transition schedule only applies to the first cohort of Council Members. The schedule was included to ensure the Council was refreshed. The Members' Council is now functioning well, and due to natural turnover, eight people have stepped down already (see Annex I). Those people who step down are replaced according to the rules of the constitution, but would only serve for the remainder of that term. In addition, we have invested resources into running an induction and individual information sessions for Council Members and it does not make sense to lose people who have acquired knowledge and expertise and who are beginning to contribute to the council.

The transition schedule also includes guidance on the Board of Directors with regards appointments and remuneration, which have all now been completed.

The proposed changes below would allow newly appointed or elected members to serve a full three year term.

2.2.3 Proposed Changes:

It is proposed that the transition schedule should be removed from the constitution.

3.0 Other Proposed Amendments

3.1 Patient Council Members

3.1.1 Current Wording

Membership of the patients' constituency is open to individuals who:

are a patient when they apply for membership; or

are a carer when they apply for membership; and

who are not members of a public constituency or eligible to be members of any of the classes of the staff constituency. Not more than one carer may be registered as a member in relation to each patient, with the exception of both parents of children who are under 16 years of age.

3.1.2 The Issue

Patients or carers of patients who have been a patient of the trust in recent years may very well have a vested interest in the running of the Trust and should have the possibility to join the Trust, but are able to do so as they have been discharged from our care.

3.1.3 Proposed Changes

Membership of the patients' constituency is open to individuals who:

are or have been a patient of the hospital in the past three years; or

are or have been a carer for a patient of the hospital in the past three years; and

who are not members of a public constituency or eligible to be members of any of the classes of the staff constituency. Not more than one carer may be registered as a member in relation to each patient, with the exception of both parents of children who are under 16 years of age. (NO CHANGE TO THIS SECTION)

3.2 Terms of Office

3.2.1 Current Wording

elected Council Members:

Shall normally hold office for a period of three years commencing immediately after the annual members meeting at which their election is announced, and serve for a three year term;

3.2.2 The Issue

If the Members' Council is to hold one or two scheduled elections a year then the term of office for the person elected should commence once the results are announced. It would also make the most sense that this person then serve a three-year term.

3.2.3 Proposed Changes

elected Council Members:

Shall normally hold office for a period of three years commencing immediately after *poll results are formally announced;*

3.4 Substitution

Mervyn Maze proposes a motion to change the Constitution of the Foundation Trust to permit appointed Council Members (including Partnership Council, University Council, Local Authority Council, and PCT Council Members) to have a nominated alternate to sit in their stead in the event that the appointed member cannot be present; further, the alternate should be able to exercise the same rights as the appointed member at Members' Council meetings.

3.5 Standing Orders

The Model Constitution suggests the inclusion of standing orders for the Members Council for the practice and procedure of the Members' Council. We propose to draft the standing orders and approve at the September meeting. They will then be attached to the constitution.

3.6 Nomination of Candidates

The Model Election Rules, which are included in Annex 2 of the Constitution, stipulate that each candidate must nominate themselves on a single nomination paper. The trust had decided that it would be good practice to require that all interested candidates seek the support of two persons from within their constituency. This was done by way of a statement on the actual nomination form requiring the support of two trust members from within the same constituency. Having run two elections, this has proven difficult for candidates because we are not allowed to provide the names of members in their respective constituency. Many interested candidates have therefore not been able to run for election. We believe that we may be losing good candidates and propose to stop this practice. This change does not however require a change to the constitution, but we feel it does require agreement from the Members' Council.

If agreed, the form would state the following:

> **Nomination of candidates –** (1) Each candidate must nominate themselves on a single nomination paper.

Julie Cooper
FT Secretary/Head of Corporate Governance
July 2007

ANNEX I

According to the transition schedule, seven seats (2 staff, 2 public and 3 patient) would need to be terminated. Due to natural turnover, eight people have or will be stepping down in the first year. These people are listed below:

(1) Jean Hunt (patient) is stepping down
(1) Liz Thomas (patient) stepped down
(1) Sue Harris (staff) is stepping down
(2) James Alexander (public), Wendy Burrow – Office termination due to absence
(3) RClayton, KHand, SAngus previous council members who stepped down)
Total coming off = (8)

Members' Council Meeting, 24th July 2007

AGENDA ITEM NO.	2.3/Jul/07
PAPER	Annual Members' Meeting 2007 - Proposal
AUTHOR	Matt Akid, Head of Communications
LEAD	Heather Lawrence, Chief Executive
EXECUTIVE SUMMARY	This paper is an updated proposal for the annual members' meeting which builds on discussions at the Members' Council meeting held on 10 May.
DECISION/ ACTION	The Council is asked to agree this proposal for the annual members' meeting.

ANNUAL MEETING 2007 – PROPOSAL

1.0 Background

The annual meeting will be held this year on Thursday 20 September – a paper reviewing last year's meeting and presenting some options for this year's AGM was discussed at the Members' Council meeting on 10 May. This paper provides a further update on discussions and presents a proposal for the Members' Council to agree.

2.0 Statutory requirements

Our Foundation Trust constitution sets down the following requirements:

- The Board of Directors shall present to Foundation Trust members the annual report and accounts; report of the external financial auditor (included in the annual report and accounts); forward planning information for the next financial year (ie 2007/08)
- The Members' Council shall present to Foundation Trust members a report on steps taken to ensure that the membership of the Trust is representative of those eligible for membership of the public, patients and staff constituencies; progress on the membership strategy; results of Members' Council elections; announcement of any Non-executive Directors appointed.

Since the Foundation Trust came into existence in October 2006, the Trust must make its annual report and accounts for the first half of the year available as well – this year's report covers the full financial year 2006/07 and this will be made available on 20 September, together with full accounts for the two halves of the year.

3.0 Proposals for the meeting

Statutory presentations (5-10 mins max for each speaker):
1. Chairman
Introduce 'Choose Chelsea and Westminster' theme (carrying on from open day theme) – why it is important
2. Chief Executive
To include reference to the London strategy
3. Director of Finance
Presentation of accounts
4. Council Member (s)
To include membership strategy progress and as above.

Optional presentations (10-15 mins max for this part of the meeting):
Presentation(s) based on 'Choose Chelsea and Westminster' to focus on some of the areas of excellence highlighted in the annual report.
Suggestions include childrens' services as a topic. The Members Council are asked for their views.

Q&A
At least half of the meeting to be left for questions.

Fundraising campaign launch
Chelsea and Westminster Health Charity are launching a campaign for a new CT scanner. Initial discussions have been held with the Charity regarding the launch of this appeal and how this could fit in with the annual meeting.

4.0 Other issues

Time – start time 5.30pm. The Members' Council meeting is scheduled to start at 2pm.
Venue – the Restaurant, as it is the only venue big enough to accommodate the number of people who now attend the annual meeting.
Facilities – aids to communication and involvement are being investigated.

5.0 Other events in annual meeting week

The option of running events such as focus groups or educational seminars for Foundation Trust members during the week has been discussed. Suggestions include:

Maternity - morning or lunchtime groups to be family-friendly.
Paediatrics – morning or lunchtime groups to be family-friendly.
Diabetes – example of partnership with PCT, patient group are regular attenders.
Infection control – to address some of the general public's misconceptions about common issue such as infection control/hand hygiene.
PACS
Treatment Centre

The availability of Trust staff for events in the annual meeting week would need to be agreed if this proposal is approved by the Members' Council.

6.0 Timetable

In order to maximise the attendance of FT members and to ensure that the event is managed professionally, this year's mailing to all FT members (to include the 2nd FT membership newsletter) must include the annual meeting programme as a minimum.

The deadline for supplying text to the designers for the newsletter is Friday 27 July – this will ensure that FT members receive the mailing 3 weeks before the annual meeting. This means that this annual meeting proposal, including an agreed programme for the meeting, has been brought to the Members' Council meeting on 24 July for approval.

7.0 Agreement

The Members' Council is asked to agree this proposal for the annual meeting.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Members' Council Meeting, 24 July 2007

AGENDA ITEM NO.	2.4/Jul/07
PAPER	Draft Membership Development and Communications Strategy and Membership Report
AUTHOR	Julie Cooper, FT Secretary
LEAD	Juggy Pandit, Chairman
SUMMARY	This paper is an updated version of the original Membership Development and Communications Strategy which was submitted to Monitor with our Foundation Trust application.
DECISION/ ACTION	The Council is asked to discuss and agree to the updated paper which includes those objectives which have been deemed a priority for the next 12 months.

DRAFT

For approval by the Members' Council

Membership Development and Communication Strategy

July 2007

Content **Page**

1 Introduction

Building and maintaining a vibrant membership is essential for Chelsea and Westminster Hospital NHS Foundation Trust (Chelsea and Westminster) if it is to maximise the potential of Foundation Hospital Trust status. This document defines the membership community and describes how the trust will maintain an active membership and sets out a series of objectives to be undertaken to meet our Foundation Trust goals. Finally, it outlines how the trust will evaluate its success in implementing this strategy.

As a Foundation Hospital Trust, Chelsea and Westminster will be accountable to its membership community. The board of directors will be responsible for the day to day running and management of the trust, but members will play a key role in the governance of the organisation, primarily through the Members' Council.

The trust began building its membership in 2003 which now stands over 13,000 members. Over 200 people attended the trust's Annual General Meeting in September 2005 and close to 400 people attended in September 2006. The significant increase in the number of patients and members of the public attending these events is a sign of the level of enthusiasm to get involved. Our challenge is to harness this energy to improve service performance whilst continuing to grow our membership. It is reasonable to assume that we will loose around 5% of our membership per annum. To this end, the Trust will work in conjunction with the Membership Development and Communications Sub-Committee, to develop a range of membership recruitment materials including a recruitment leaflet, posters and display boards to be used at all key trust events to recruit new members.

1.1 Being a Foundation Trust

By becoming a Foundation Trust, we have become accountable to our membership. This means patients, local residents, members of staff and other healthcare stakeholders will have more influence on the way the hospital operates.

1.2 Being a Member

The principle behind the Foundation Trust model is one of openness where the business of the trust will be transparent and where the Members' Council has a key role in advising on and shaping its activities, in close dialogue with the public who join us as members. We will emphasise this aspect of membership as a way of harnessing the enthusiasm of patients, public and staff in helping Chelsea and Westminster to continually improve its services. Being a member has certain opportunities and members can:

- Elect representatives to serve on the Members' Council
- Stand for election to the Members' Council
- Apply to become a non-executive Director (subject to certain criteria) or the chair of the Foundation Trust

The Trust has an 'opt in' system for staff. The Trust will continue to encourage staff to join the trust via trust news and other key channels of communication with staff members. For trust events e.g. Open Day, AGM, we have developed new communication tools including posters, leaflets and staffed 'stalls' to ensure all staff are able to access information about membership.

2 Defining Our Membership Community

2.1 Representation

We would like the public membership to be representative of our geographical location and reflect the age, gender, ethnicity and socio-economic groups of our local population. It will be important to continue to recruit members to the Foundation Trust in order to reflect the changing population we serve.

The communities that will be represented in the membership are patients of the hospital and those residents within the local authority boundaries of The City of Westminster, The Royal Borough of Kensington and Chelsea, the Borough of Hammersmith and Fulham and the Borough of Wandsworth. This represents a population of 765,000 residents. The area is densely populated with a predominantly young and ethnically diverse population, while there are areas of extreme affluence there are also areas of deprivation in close proximity.

The 2001 census reported a total population for the North West London area of 1.85 million. The population has increased by 11% in the last ten years, making it one of the fastest growing in England. The area has a high proportion of 'young old' people (9.8%) and a population between the ages of 25-45 which constitutes 42% of the population; this is far in excess of the 30% national average.

The Index of Multiple Deprivation, 2000, published by the Department of the Environment, Transport and the Regions, shows that more than 10% of wards in Westminster, Kensington & Chelsea and Hammersmith & Fulham and Brent fall within the 10% most deprived wards in the country. Westminster also has a large population of 'rough sleepers'. The population of North West London is ethnically diverse, with approximately 35% of residents being from a minority ethnic background. Over 200 languages are spoken in the area. Nearly 30% of London's asylum seekers live in North West London.

The trust is committed to encouraging all qualifying individuals to become active members of Chelsea and Westminster. The trust has mapped local groups and continues to undertake outreach work to various local community groups, for example, Notting Hill Housing Association, Kensington & Chelsea Advocacy Alliance, BME Health Forum and Kensington & Chelsea Social Council.

The Trust has also has a post of Engagement and Partnership Coordinator. One of the post holders key roles is to work with the Members' Council to identify opportunities to engage with traditionally 'hard to reach' community groups. In addition, we are planning to work with our trust's Black and Minority Ethnic Group and Gay, Lesbian and Bisexual Group to harness their support for membership. We aim to ensure that the staff membership is representative of our workforce and we will continue to work to recruit members from all areas of our trust.

Using the Acorn analysis provided by Computershare, we intend to monitor the makeup of our membership on an ongoing basis and to compare it with the age, gender, ethnicity and socio-economic groups of our local population as outlined above. In this way, we will be able to take immediate action to focus our recruitment activities on any particular groups that prove to be under-represented within our membership.

3 Resources for Membership Development

The trust recognises the need to resource its membership functions adequately. We are also aware that new skills and services need to be provided. In examining what structures are needed to support a large and vibrant membership going forward, the trust has agreed that the management of elections will be outsourced. The trust also contracts out the management of the database.

The post of Foundation Trust (FT) Secretary is part of the Governance and Corporate Affairs Directorate. The FT Secretary has close links with the trust's existing Patient Affairs Department (Complaints, Patient and Public Involvement (PPI) and PALS) and the Equality and Diversity Manager, strengthening the trust's approach to user and public involvement.

3.1 Budget

A Foundation Trust budget has now been agreed for the financial year 07/08. A benchmarking exercise was undertaken to ensure value for money and that our expenditure was in line with other Foundation Trusts.

4.0 Membership and the Members' Council

4.1 Members' Council Training and Development

A corporate induction programme will be offered to all new Members of the Council and will form part of an ongoing programme of learning and development. The emphasis of the induction is on appraising new Council Members of their roles, particularly, how these relate to the board of directors and the membership at large, as well as assessing their training and development needs going forward.

5 Building the membership base

Chelsea and Westminster Hospital NHS Foundation Trust is a public benefit organisation; open to everyone able to use its services and willing to accept the responsibilities of membership, without gender, social, racial, political, or religious discrimination.

In conjunction with the Members' Council, the trust will deliver the objectives outlined below.

5.1 Objectives - Membership recruitment

- To provide a simple, accessible and publicised process for becoming a member.
- To take active steps to ensure the composition of membership reflects the diversity of the local communities in which we operate.
- To set and meet targets for increasing membership in each constituency as set out the annual plan.
- To maintain accurate and informative databases of members to meet regulatory requirements and to be a tool for developing membership.
- To agree a strategy for staff recruitment

6 Managing Active Membership

Our trust is a democratic organisation with elected members who actively participate in the governance structures as outlined in the introduction to this strategy.

6.1 Objectives

- To define active membership and ensure that interested members are encouraged and given ample opportunities to participate e.g. Open Day, Focus Groups, AGM, Consultations.
- To identify methods of increasing active membership.
- To monitor the composition of our active membership to gauge whether it is representative of our patients and local communities.
- To encourage more members to stand for election to the Members Council.
- To link with the trust's existing work and strategies on user and public involvement particularly working with existing user groups and representatives.

7 Communicating with Members

We will assist our members, elected representatives, managers and employees to contribute effectively to the development of the organisation.

We will maintain contact with our members through a bi-annual newsletter and the trust will formally report back on its performance at the annual members meeting and through its annual report which is available to members. Members can always stay abreast of the latest trust news by picking up a copy of our monthly newsletter or accessing the trust website at www.chelwest.nhs.uk.

7.1 Objectives

- To develop and maintain a membership communications strategy, to include evaluation of the methods of communication used.
- To ensure communications are used to stimulate active membership including encouraging new candidates to run for the Members' Council.
- To identify opportunities for and facilitate two-way communications between membership and Members' Council

8 Working in Partnership and Stakeholder Development

Chelsea and Westminster hospital will build a network of stakeholders and work with those organisations and individuals to deliver the highest quality service to the communities we serve.

Consultation and patient involvement is not just about asking for opinions, but about generating discussions and ideas and involving people in their communities. Consultation is based on principles of openness, integrity, mutual respect and transparency and should be upheld throughout the implementation of this strategy.

8.1 Objectives

- To identify good practice within other member organisations and share best practice

- To work in partnership with other organisations to increase membership e.g. PCTs

9 Evaluating Success and Active Membership

This membership development strategy, which was initially developed by the Trust, is now the property of the membership. The Members' Council and the Membership Development and Communications Sub-Committee will have a key role in monitoring the effectiveness of the strategy and ensuring that it remains a meaningful and relevant document as the membership of the trust grows and matures.

Specific tasks that will be undertaken to evaluate the success of the strategy are drawn from within the document. The Members' Council and the Trust Board will:

- Assess the composition of membership to ensure that it reflects the diversity of the local communities in which we operate.

- Evaluate the membership's response to different types of information and the methods of their delivery.

- Monitor electoral and democratic processes to ensure that they are fair and protected from undue influences, internal and external.

- Define the contribution membership has made to service development and improvement

- Identify areas in which the Members' Council have contributed to service development

- Audit if Members' Council feel they have had the opportunity to make a valuable contribution

Appendix 1 Achievements to Date

Task	Outcome
Communication strategy	• Communications Sub-Committee created with ToR • Membership Development and Communications Strategy is being reviewed and updated. • Action plan to be developed in conjunction with Membership Development and Communications Sub-Committee.
Meeting with trust membership staff	• Chairman holds regular surgeries for all Council Members
Website	• Foundation Trust website is regularly updated and members are invited to visit the site in the welcome letter
New recruitment materials	• Membership recruitment leaflet created • Membership recruitment posters developed for use at all key events • Welcome packs sent regularly to all new members • Background material on becoming an FT and the roles and responsibilities of the Members' Council are available
Membership Management	• External company contracted to manage membership database • New member welcome packs created with letter including membership card • First membership newsletter sent in April • All members invited to attend trust open day
Training and Development	• 85% of Council Members underwent a corporate induction programme

MEMBERSHIP REPORT – LATEST STATISTICS & RECRUITMENT TARGETS 2007-08

1.0 Membership Report

This report provides details of Chelsea and Westminster Hospital NHS Foundation Trust's past and planned Membership by constituency.

Membership size and movements

OVERALL MEMBERSHIP OVERVIEW	Last Year	Next Year (Estimate)
As at start (April 1st 2006)	10,740	13,287
New Members	5,162	2,809
Members leaving or changing constituency	-2,615	-1,958
TOTAL	**13,287**	**14,138**
PUBLIC MEMBERSHIP OVERVIEW	**Last Year**	**Next Year (Estimate)**
As at start (April 1st 2006)	3,500	6,982
New Members	4,192	837
Members leaving or changing constituency	-710	-698
TOTAL (at year end March 31)	**6,982**	**7,121**
PATIENT MEMBERSHIP	**Last Year**	**Next Year (Estimate)**
As at start (April 1st 2006)	6,536	5,898
New Members	969	1,769
Members leaving or changing constituency	-1,607	-1,179
TOTAL(at year end March 31)	**5,898**	**6,488**
STAFF MEMBERSHIP	**Last Year**	**Next Year (Estimate)**
As at start (April 1st 2006)	704	407
New Members	1	203
Members leaving or changing constituency	-298	-81
TOTAL(at year end March 31)	**407**	**529**

Analysis of current membership

PUBLIC CONSTITUENCY	Number of members	Percentage	Eligible membership
Black or black British	307	4.4%	68,025
Mixed	267	3.8%	29,013
Asian or Asian British	340	4.9%	49,221
Other	1,067	15.3%	20,150
White	4,272	61.2%	589,219
Unknown	729	10.4%	---
Overall total	6,982	100.0%	755,628

PUBLIC CONSTITUENCY	Number of members	Percentage	Eligible membership
0-16	11	0.2%	125,265
17-21	90	1.3%	41,156
22+	5,881	84.2%	771,257
Unknown	1,000	14.3%	---
Overall total	6,982	100.0%	937,678

PUBLIC CONSTITUENCY	Number of members	Percentage	Eligible membership
Male	2,897	41.5%	367,501
Female	4,085	58.5%	398,326
Unknown	0	0.0%	---
Overall total	6,982	100.0%	765,827

Members' Council Meeting, 24 July 2007

AGENDA ITEM NO.	2.7/Jul/07
PAPER	Framework for London and Related Service Developments
AUTHOR	Amit Khutti, Director of Strategy and Service Planning
LEAD	Heather Lawrence, Chief Executive
EXECUTIVE SUMMARY	At the June 7th Trust Board meeting, the Board approved a number of significant developments which will help deliver the Trust's corporate objectives for 2007/08. The areas for development are Paediatrics, Private Maternity and HIV/Gum. The key components of the business cases are outlined below.
DECISION/ ACTION	This paper is being brought to the Members' Council for information and to discuss any key issues that arise. Council Members are asked to express their views which will be considered as these developments move to fruition.

1.0 Introduction

At the June 7th Trust Board meeting, the Board approved a number of significant developments which will help deliver the Trust's corporate objectives for 2007/08. These developments are outlined below.

2.0 Strengthening the paediatrics service

The Board has agreed three proposals to strengthen the safety and quality of the Trust's paediatric service:

1/ Recruitment of a new paediatric consultant and additional middle grade doctors to ensure there is always a sufficiently senior medical presence on the paediatric wards and covering paediatric A&E. The current attending presence is fragmented, with different consultants conducting ward rounds during the week, and a lack of proper handover between consultants attending during the day and those attending in the evening and night. This proposal will provide much more continuity of care for patients.

2/ Recruitment of a lead consultant with particular experience in intensive care to head up the paediatric high dependency unit (HDU); increasing nurse staffing levels on HDU to recommended guidelines. The Trust believes this will help the HDU gain national accreditation in a similar fashion to the way the Trust's Neo-natal Intensive Care Unit (NICU) is accredited.

3/ Creation of an expanded unit within the current NICU to cater for short stay surgical babies up to 6 months old. This expansion will enable a greater volume of specialist paediatric surgery to be carried out at Chelsea and Westminster and strengthen the safety of the current surgical service.

The Trust's 2007/08 corporate objective around Clinical Governance and Safety is: "To maintain quality and efficiency and continuously improve patient outcomes and assure patient safety." The Board is clear that taking the steps above will improve patient outcomes and further assure patient safety in the paediatric service.

The Board has also approved proposals which support our 2007/08 corporate objective around innovation: "to be innovative with our clinical services and business models, using the new Foundation Trust freedoms".

3.0 Expansion of private maternity service

The Board has approved the expansion of the Trust's popular but small (6-bedded unit) private obstetric and maternity service. We cannot expand the service in its current form because as a Foundation Trust we are limited by the amount of income we can generate from private sources. The Board has therefore approved a new, innovative approach in which we intend to work closely with Chelsea and Westminster Health Charity which will establish a new company specifically to run the private maternity service. The Trust will charge this new company for the use of hospital facilities that it uses in providing the private maternity service. Any profit that the company makes would flow to the Charity, which in turn would use this profit for the benefit of NHS services at the Trust.

Expansion of private maternity is about investing to generate a surplus for the wider good of the Trust. Expansion of the NHS maternity service would not provide the additional income which an expanded private maternity service would generate. As a Foundation Trust we now have greater freedoms to re-invest our surpluses in improving NHS services, and this proposal is an important part of securing our future finances.

The intention is for refurbishment to take place around the existing private maternity unit to create more space for the larger unit. Staff who are likely to be affected because they work on the existing private maternity unit or are physically located in the area to be refurbished will be contacted to discuss how they might be affected.

3.0 Clinical Directorate of HIV and GUM - Innovative service offerings

The Board has approved four distinct proposals for the HIV and Genito-Urinary Medicine Directorate to develop collaborative models of service provision. These proposals are excellent examples of the type of innovation which will bring benefits to patients, improve the Trust's finances, and also help to strengthen the Trust's reputation.

The four proposals that the Directorate will be progressing are:

1/ Closer working between the Directorate and the Terence Higgins Trust (THT) on developing and delivering sexual health services in local communities. THT is a well-regarded charity which provides practical support, help, counselling and advice for anyone with or concerned about AIDS and HIV infection.

2/ Co-branding between the Trust and DrThom in respect of an Online Erectile Dysfunction Service which DrThom is about to launch. DrThom is the leading online medical service in the UK and is the only online medical service that is registered with the Healthcare Commission. DrThom provides postal testing and treatment for sexual and reproductive health and operates through the website www.drthom.com.
Piloting a national virtual HIV resistance clinic. This would build on the success of the Trust's existing Virtual Clinic in which HIV positive patients are referred by consultants in the Directorate to the Virtual Clinic for review of their treatment, care options and clinical trial options. The national virtual clinic would extend this service to other healthcare professionals involved in the treatment of individuals infected with HIV. This would allow centres without access to specialist resistance knowledge to maintain standards of patient care as required by new national guidelines from the British HIV Association.

Marketing and selling the Trust's 'E-Triage' product. 'E-Triage' was developed at Chelsea and Westminster and launched in 2006. It is a novel web-based Genito-Urinary Medicine (GUM) prioritisation system through which patients can access GUM appointments. A recent survey of Trust patients who had used the service found that 96% would recommend the site and 94% would use it again. The Board has agreed that the Directorate should work with Mikkom Ltd, who helped develop the product for the Trust, to sell 'E-Triage' to other NHS Trusts.

Members' Council Meeting, 24 July 2007

AGENDA ITEM NO.	3.1/Jul/07
PAPER	Patient and Public Involvement and Future Local Involvement Networks (LINKs)
AUTHOR	Amanda Harrington, Patient Affairs Manager Julie Cooper, Ft Secretary
LEAD	Juggy Pandit, Chairman
EXECUTIVE SUMMARY	This paper provides background information on the Government's plans for the future of patient and public involvement in health and social care. These plans include the establishment of Local Involvement Networks (LINks), for which we are an early adopter site.
DECISION/ ACTION	The Members' Council is asked to note the matters arising and update where appropriate.

1.0 Background

A Stronger local voice sets out the Government's plans for the future of patient and public involvement in health and social care. These plans include the establishment of Local Involvement Networks (LINks) which will replace patient forums. LINks will work with existing voluntary and community sector groups, as well as interested individuals to promote public and community influence in health and social care. The package of plans is designed to promote the importance of user and public involvement at all levels of the health and social care system, and to create a system which enables more people to become involved and have their voices heard.

2.0 Local Government and Public Involvement in Health Bill

This Bill provides for the establishment of LINks, but will also abolish Patients Forums and the Commission for Patient and Public Involvement in Health. It strengthens and updates the duties on health service bodies to consult the public. The Bill specifies that all NHS Bodies (including Foundation Trusts) must make arrangements to consult with users on:

- Planning of provision of services
- Development and consideration of significant proposals for changes in the way those services are provide
- Significant decisions to be made affecting the operation of those services.

A proposal for change is considered significant if implementation would have a substantial impact on the manner in which the services are delivered or the range of services available.

3.0 Time Line Update

It is currently anticipated that the Local Government and Public Involvement in Health Bill will receive Royal Assent in November 2007. This would mean that both PPI Forums and CPPIH will cease operating by the 31st March 2008.

LINks will be established from April 2008.

4.0 Local Involvement Networks (LINks)

It is envisioned that LINks will enable involvement for a greater number of people than the current system of PPI Forums. LINks will cover social care services as well as health and will be designed to reach out and include a wide range of existing local groups representing patients and the public and to provide a channel for local health and social care organisations to engage with those groups.

It will be the responsibility of local authorities to make arrangements for the establishment of LINks by contracting with a ‘host’ which will put in place arrangements to engage participants and form a LINk. Grants will be allocated by the DoH to Local Authorities to fund the establishment of LINks. LINks will be open to all interested parties; there will be no set membership.

Statutory functions of LINks will be:

- Promoting and supporting the involvement of local people in the commissioning, provision and scrutiny of local care services.

- Obtaining the views of people about their needs for and experiences of local care services and making these views known to people responsible for commissioning, providing, managing or scrutinising those services.

- Making reports and recommendations about how local care services could be improved to people responsible for commissioning, providing, managing or scrutinising those services.

LINks will have the following powers:

- Entering specified types of premises and viewing the services provided as well as collecting the views and experiences of users of that service.

- Requesting information and receiving a response within a specified timescale.

- Making reports and recommendations and receive a response within a specified timescale.

- Referring matters to the relevant O&S Committee and receiving a response.

In view of the wider membership of LINks it was considered impractical for every member to have a right to access and inspect facilities, therefore each LINk will have a specialist team who will receive the necessary training and checks to undertake this role.

There are nine early adopter projects managed by CPPIH established to support and inform the development of LINks. Kensington and Chelsea is an early adopter.

Whilst the focus of LINks is on all aspects of social and health care, it is likely they will establish a specialist group to focus on local acute Trusts.

5.0 Relationship between LINks and Foundation Trusts

In the Governments response to 'A Stronger Local Voice', December 2006, they suggest that it is likely that members of Foundation Trusts may wish to join local LINks or contribute to LINks research. They consider that Trusts will benefit from developing relationships with the LINks as a way of gathering information to be used to inform the development of their services.

As a service provider the Trust will have a duty to respond to the LINk with regard to any requests for information and dealing with reports or recommendations. This is the same as the duty that currently exists in relation to the PPI forums. The Act specifically states that the term 'service provider' relates to an NHS Foundation Trust.

6.0 NHS Foundation Trust Code of Governance

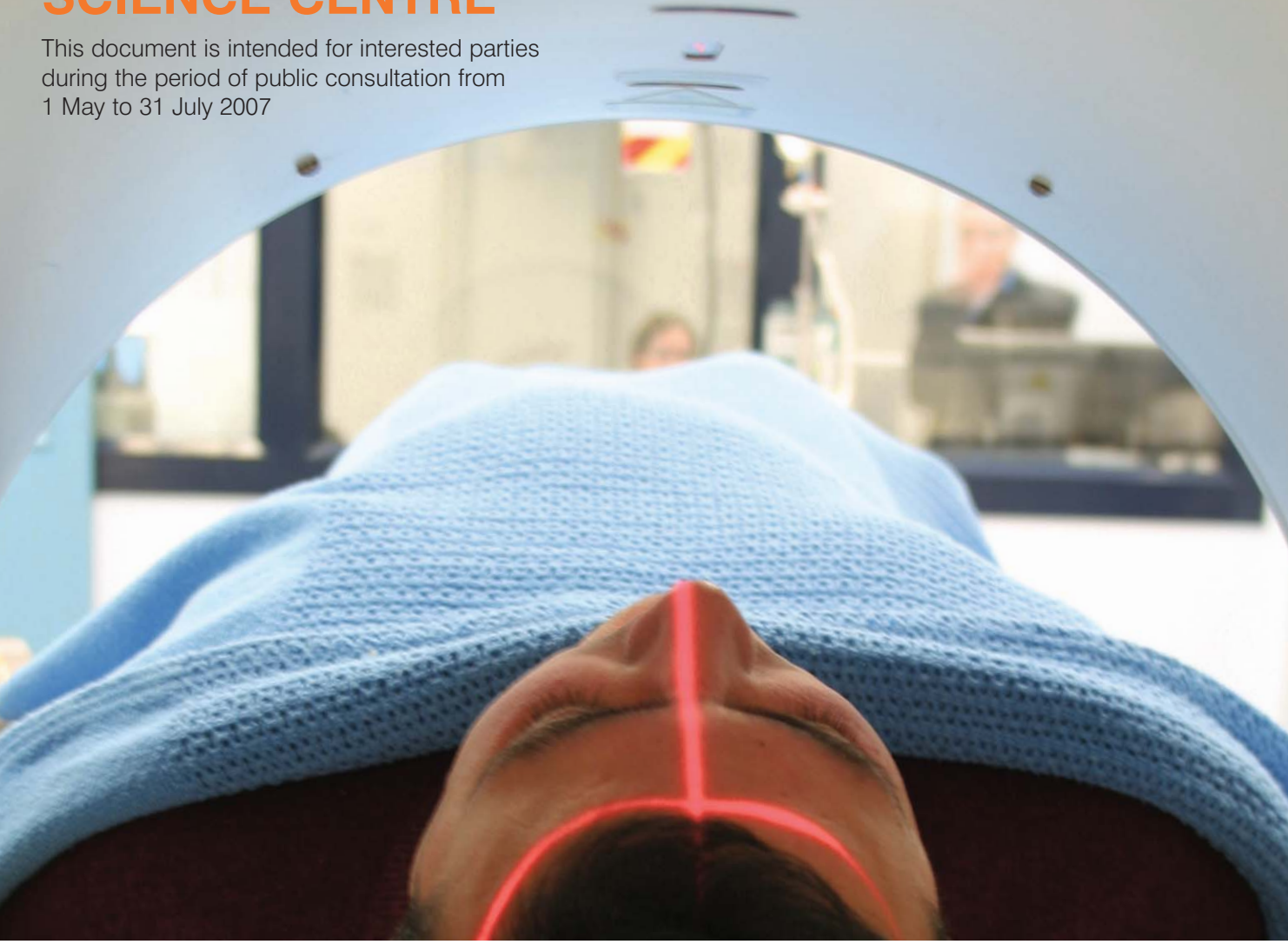
The Code of Governance states that, while recognising the complementary role of the Members Council, arrangements for consultation with members, patients and the local community lies with the board of directors.

A strategy document setting out a policy regarding consultation should include a description of the type of issues the Trust will consult on. There should be written clarification with regard to how the overlap between the Member's Council and other bodies such as the PPI Forum (LINks), overview and scrutiny committees will be managed.

A proposal to create the UK's first

ACADEMIC HEALTH SCIENCE CENTRE

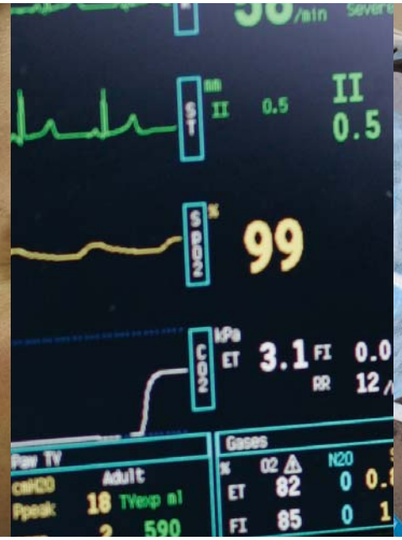
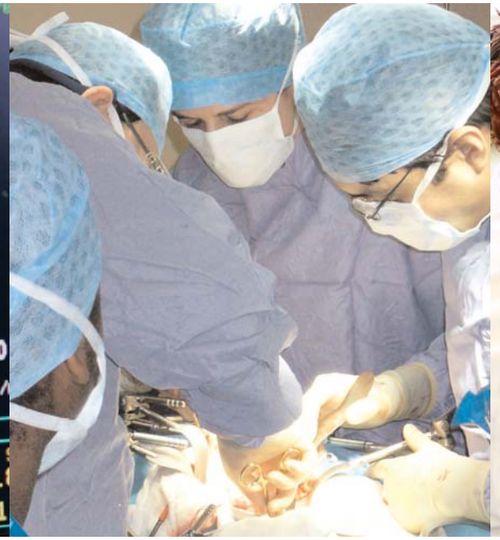
This document is intended for interested parties during the period of public consultation from 1 May to 31 July 2007

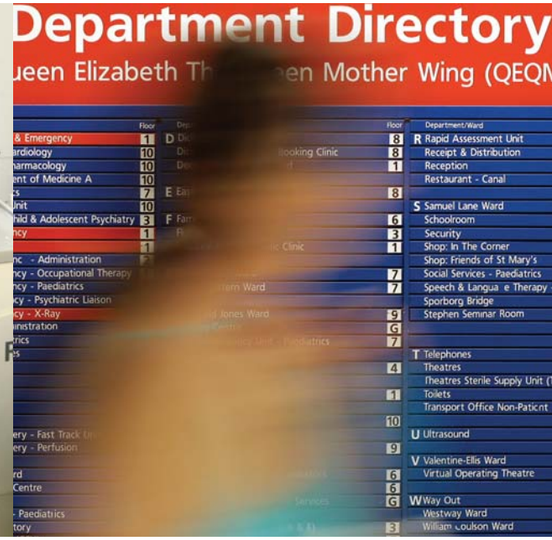


The Hammersmith Hospitals NHS Trust

Imperial College London

St Mary's NHS Trust

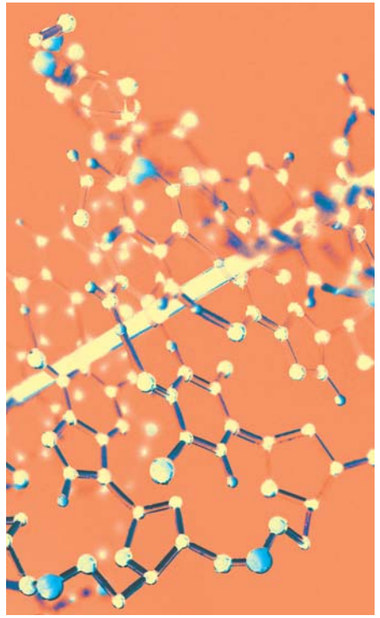




This consultation proposes the merger of Hammersmith Hospitals NHS Trust with St Mary's NHS Trust and integration with Imperial College London.

Contents

A pioneering healthcare partnership: Key points



- An Academic Health Science Centre (AHSC) brings together the delivery of healthcare services, teaching and research in a partnership whose purpose is to improve the health of its patients.
- Currently different managers are responsible for healthcare services, research and teaching. In future each specialty (for instance cancer or ear, nose and throat) will be led by one person responsible for ensuring his or her specialty meets challenging targets that compare with the best in the world, not just the best in this country.
- This document asks for your views on the creation of an AHSC which would be formed by the merger of Hammersmith Hospitals NHS Trust and St Mary's NHS Trust, and the integration of the Faculty of Medicine of Imperial College London (the partners).
- Please turn to page 34 to see how you can make your views known. All comments must be received by 31 July 2007.
- The three partners have a long and very successful record of co-operation and, since Autumn 2005, have been reviewing how best to meet future challenges and opportunities in healthcare. After careful consideration, the Trusts and the College concluded that a single organisation, with one shared mission, vision and unified governance is best suited to take advantage of the opportunities to improve healthcare in west London and the UK.

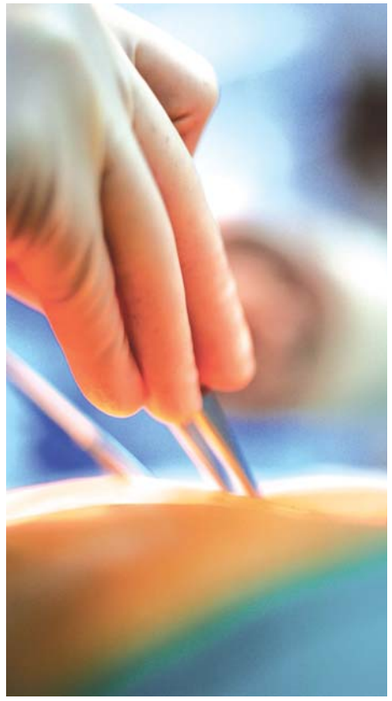
"We carry out some of the world's best biomedical research here in west London. We need to transfer that innovation to create the best hospitals and networks of care. We will be failing our patients if new treatments and techniques developed here are made available to patients around the world before helping local people."

Professor David Taube, Medical Director, Hammersmith Hospitals NHS Trust

- The partners believe that the creation of an AHSC, working in partnership with local, national and international organisations and professionals, will set a new standard for healthcare in the UK. It will provide patients in west London with access to a truly world-class healthcare service.
- Patients will receive healthcare from the world's best professionals, equipped with knowledge of the latest advances in treatment, using state-of-the-art equipment and technology.
- By working together, the most gifted researchers, academics and heathcare professionals will be able to focus on creating new inventions and developing them into life-saving treatments quicker than ever before - saving and improving the lives of local people before benefiting patients around the world.
- The new merged trust will continue to deliver and improve general, acute, and specialist services across a wide range of specialties.
- This consultation does not propose any service changes. Any future proposals for service change will require separate business cases and equality impact assessments and would be subject to the statutory consultation and scrutiny requirements.
- Subject to this consultation the two NHS Trusts will merge in October 2007. At the same time there will be executive integration with Imperial College through the appointment of a Board combining all three partners. The AHSC's management structure will look to integrate leadership positions across the NHS and university structures.

  Imperial College London would then sponsor an application for the AHSC to become an Academic Foundation Trust. This application would be subject to a separate consultation.
- The new Trust (and the proposed Foundation Trust) will be an NHS body and staff will have their employment rights protected.
- The Secretary of State for Health will welcome comments you make in response to this consultation on creating an AHSC, and will take them into account when making a decision whether to allow the partners to proceed.

A healthcare system for the 21st century: Summary



"The Patient and Public Involvement Fora welcome the commitment to full and meaningful consultation, and we encourage everyone to have their say."

Lynette Royle, Lead, Hammersmith Hospitals Trust PPI Forum and
Roy Oliver, Chairman, St Mary's Trust PPI Forum

Over many years both NHS Trusts and Imperial College have established an enviable record of success. The creation of an AHSC, bringing together the delivery of healthcare services, teaching and research in a partnership whose purpose is to improve the health of its patients, would build on this achievement and raise the standard of healthcare in the UK.

The idea of joining hospitals with medical education and research institutes is based on international health science centres that have become world leaders in patient care. The proposal aims to build on the best examples to provide local people with a centre of excellence for complex and specialist care of which the UK can be proud. Academic scrutiny will challenge conventional wisdom to determine the most effective use of staff, research and budgets to improve patient care and save lives. Innovation will become standard and new ways of working will bring dramatic improvements in patient safety and experience.

The Case for Change study of healthcare in London, conducted on behalf of NHS London, identified eight reasons why there needs to be change in London's healthcare.

1. The need to improve Londoners' health
2. The NHS is not meeting expectations
3. One city, but big inequalities in care
4. Hospital is not always the answer
5. The need for more specialised care
6. London should be at the cutting edge of medicine
7. Not using our workforce and buildings effectively
8. Making the best use of taxpayers' money

We support these findings and are keen to contribute to the development of the response to the challenges – *Framework for Action*. The AHSC concept is a key part of this vision.

The AHSC would support more care in the community as we develop closer links to primary care, encouraging health promotion and prevention. We will foster learning and the transfer of knowledge as an effective means to improve the health of the population both in the AHSC, and to other professionals in hospitals and primary care.

Patients will receive healthcare from the best staff, equipped with knowledge of the latest advances in treatment and technology. The west London community, along with patients from the rest of the UK, will have first-hand access to new life-saving treatments and cures, developed on their doorstep.

This proposal is not about building a new hospital (although we believe it will make it easier to invest in new buildings and facilities); it is about laying the foundations of a healthcare system fit for the 21st century that paves the way for providing services that are better, more innovative and more responsive to the needs of the community.

Stronger together: A letter from the Chairmen and Rector

"This proposal is about three organisations, wanting to work with the whole community to establish a world-class healthcare system.

Of course we want to create one of the world's best AHSCs, measured by both its research and clinical outcomes, but we also recognise that a world-class health service will become a reality only if we can build stronger partnerships with all healthcare professionals.

An AHSC Healthcare Network is being set up to work with the north west London healthcare community. The Chief Executives and Medical Directors of all north west London hospital trusts, mental health trusts and primary care trusts (PCTs) will be invited to join.

Working in the community

PCTs are doing excellent work meeting the needs of the community, involving schools, voluntary groups and 'hard to reach' groups (such as young men and women from minority ethnic communities, disabled people and people on low incomes). Everyone needs good, clear information to be able to make informed choices about their health. District nurses, therapists, pharmacists, dentists and GPs are in the ideal place to provide advice and treatment. We will support these professionals in the community and work to develop more initiatives with them as we recognise that most patients do not need hospital care and can be better cared for more locally.

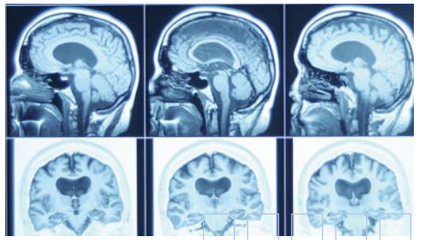
Emergencies and complex healthcare

Emergency or unplanned care is provided by a wide range of different services, including primary care, out-of-hours services, emergency mental health teams, ambulance services, NHS Direct and Accident and Emergency departments. We will work together to ensure patients receive fast, convenient, excellent care from the right person at the right time in the right place. If patients do need specialist treatment in a hospital then we need to ensure that support is available for them on discharge, through local health and social care organisations and social services. And for patients who have a rare condition that is not one in which the AHSC has particular specialism, we need to strengthen our links with other hospitals so that we are part of a network where additional skills and knowledge are readily available.

Working in partnership will deliver a stronger, seamless, more flexible service that is focussed on what patients need and want.

We are confident that, having read this document, you will share our belief that an AHSC offers the best opportunity to improve the health and lives of people in west London. We ask for your support for a concept that has already captured the imagination of many people, both in our organisations, and in health and local communities."

Sir Thomas Legg, Chairman of Hammersmith Hospitals NHS Trust
Baroness Joan Hanham, Chairman of St Mary's NHS Trust
Sir Richard Sykes, Rector of Imperial College London



Stroke

A stroke happens when the blood supply to a person's brain is cut off – a brain attack. It is the third most common cause of death in the UK and the single most common cause of severe disability.

Prompt recognition and treatment of stroke is essential if patients are to recover rapidly and effectively after a stroke. Access to the latest diagnostic scanning technology and treatment in a specialist stroke unit have been shown to improve outcomes substantially. And following discharge, patients need a programme of community based rehabilitation and monitoring of risk factors – such as high blood pressure and high blood cholesterol.

Compared to other hospitals in the UK, St Mary's and Hammersmith Hospitals have an excellent record of treating patients with stroke. If the two hospitals performed the same as the UK 'average' 40 more people would die from a stroke each year. But the performance is poor compared to other countries. In many parts of the world you are less likely to have a stroke, more likely to survive a stroke, you have less chance of becoming disabled following a stroke and you are likely to stay in hospital for a shorter time. We believe this is unacceptable.

By using the latest technology and working with local GPs and community clinical staff, the AHSC will develop pathways of care to provide its patients with a level of care that is equal or better than that found in the best hospitals in the world, not just for stroke, but for a range of conditions where the UK lags behind the rest of the world.

- *UK National Sentinel Stroke Audit from 2004*
- *Stroke Care in Organisation for Economic Co-operation and Development Countries, A comparison of treatment, costs and outcomes, Lynelle Moon, Pierre Moise, Stéphane Jacobzone and the ARD-Stroke Experts Group*

From first-class to world-class

Over many years Hammersmith NHS Trust and St Mary's NHS Trust have established a first-class reputation. Both hospitals are in the *Dr Foster Good Hospital Guide 2006* top three (three-year average) for quality of care and clinical performance.

The Trusts have some of the best outcomes and survival rates in the UK for a range of conditions, such as:

- Heart attacks and heart diseases;
- Kidney failure and transplantation;
- Cancers, including breast, prostate, stomach, lung and colon; and
- Viral liver infections and pneumonia.

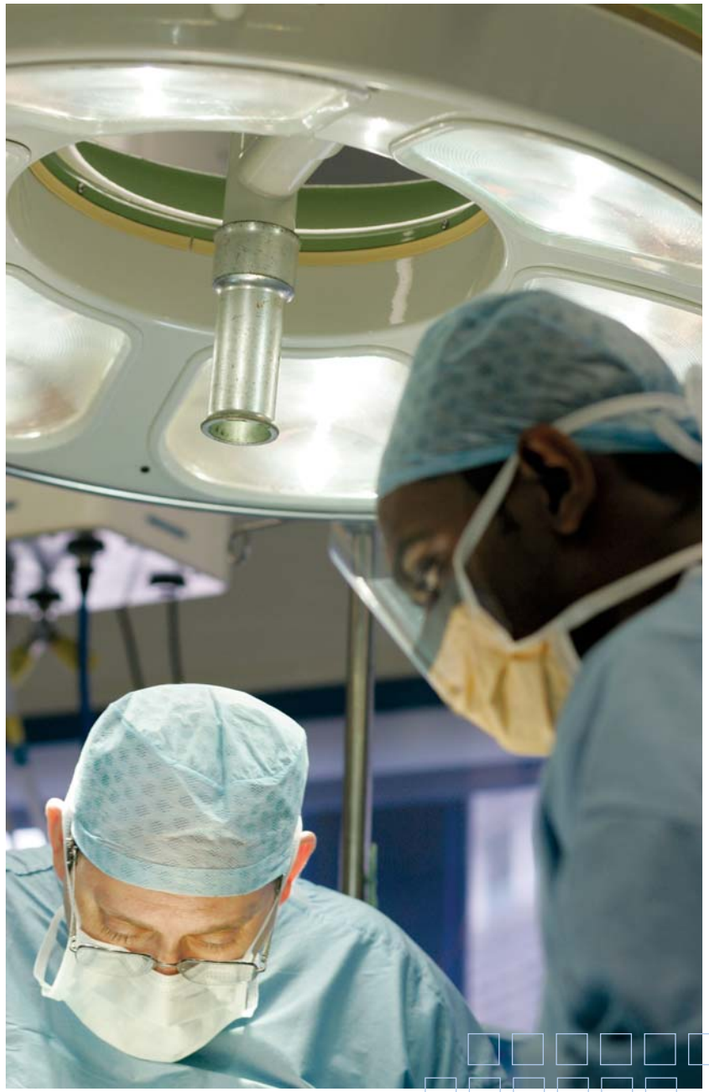
Imperial College London is one of Europe's largest medical research institutions. It has a world-class reputation, confirmed by the *Times Higher Education Supplement* 2006 World University Rankings, which placed the university fourth in the world for biomedicine and ninth in the world overall.

The partners have been able to achieve these reputations by employing the very latest thinking, technology and treatments. We wish to continue this outstanding record of success and unite our organisations to provide people in west London with a world-class service.

The three partners have produced some of the most innovative and useful medical research in the world. This includes the discovery and development of:

- the best combination of drugs for treating high blood pressure, preventing millions of strokes and heart attacks;
- a drug for treating hepatitis C that will save the NHS hundreds of millions of pounds;
- a ground breaking non-invasive treatment for women with the common gynaecological problem, uterine fibroids;
- an instrument that stops loss of blood during surgery – avoiding side-effects, the need for blood transfusions and death;
- a treatment for women with breast cancer that will save thousands of lives;
- a new drug that dramatically reduces rheumatoid disease activity and protects joints from further destruction, transforming the lives of hundreds of thousands of people;
- a new way of identifying the people most likely to develop type-2 diabetes; and
- particularly helping people around the world; a cheaper, faster and more accurate method of diagnosing tuberculosis and its multi-drug resistant strains; a new vaccine for polio; and a new treatment for malaria - all of which could save millions of lives;

The AHSC would encourage more effective innovation to be developed quicker, saving and improving the lives of local people before the knowledge is shared with others, benefiting patients around the world.



"Brilliant and innovative healthcare originates in a research-led hospital environment. I welcome the opportunity to work with clinical academics and healthcare professionals in this new AHSC to bring even greater benefits to patients."

Dr David Mitchell, Medical Director, St Mary's NHS Trust

A centre of excellence

In November 2005 the West London Renal and Transplant Centre opened its doors. The £40 million unit brought together specialist units from across the Hammersmith and St Mary's sites. As well as a rapid assessment unit, an acute dialysis unit, 92 renal beds, an intensive care unit and a high-dependency unit, the centre also provides satellite outpatient services at 11 other hospitals allowing patients to receive treatment close to their homes.

Since it opened the unit has performed 40% more transplants with 30% less mortality and improved skin graft survival compared to the original units. The amalgamation has allowed the development of several important clinical trials.

An AHSC would make successes like this easier and quicker to deliver, saving even more lives.

Who we are and what we do

St Mary's NHS Trust

St Mary's NHS Trust is St Mary's Hospital and the Western Eye Hospital.

- Budget of £287 million
- 500 beds
- 3,700 staff
- A&E cared for 111,000 adults and children
- cared for 270,000 outpatients
- delivered 4,500 babies
- provided 1,600 medical teaching placements

The Hammersmith Hospitals NHS Trust

Hammersmith Hospitals NHS Trust is Hammersmith Hospital, Charing Cross Hospital and Queen Charlotte's and Chelsea Hospital.

- Budget of £481 million
- 1,100 beds
- 5,900 staff
- A&E cared for 102,000 adults and children
- cared for over 350,000 outpatients
- delivered 4,800 babies
- provided 1,400 medical teaching placements

Imperial College London Faculty of Medicine

Imperial's Faculty of Medicine is based across six hospital campuses in west London and Imperial's main campus at South Kensington. The Faculty works closely with the college's other Faculties – Natural Sciences, Engineering, and the Business School.

- Faculty of Medicine research income of over £100 million (Imperial college overall budget £500 million)
- 1,900 Faculty staff, of whom 1200 are academic and research staff
- 1,900 undergraduates graduating with MBBS and BSc
- 750 Faculty of Medicine postgraduate and masters students
- 75% of Imperial's academic staff[1] work in top-graded 5* departments (the highest proportion of any university)
- researchers published over 1,000 research papers
- Capital investment in research infrastructure and buildings 2000/05, £102 million on the Hammersmith Campus and £26 million on the St Mary's Campus.

[1] Submitted to the 2001 Research Assessment Exercise

St Mary's Hospital


Imperial College London, South Kensington Campus


Hammersmith Hospital

Diabetes

There are over 2 million people with diabetes in the UK and up to another 750,000 people with diabetes who have the condition and don't know it.

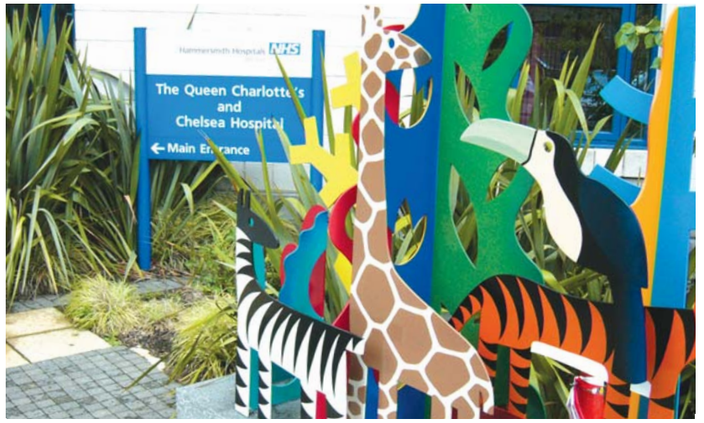
Both Hammersmith Hospitals and St Mary's have an excellent record of success in treating diabetes (particularly complex cases), which is particularly prevalent in west London.

The creation of an AHSC is an opportunity to better engage the local community in identifying methods to prevent, diagnose and treat diabetes; to encourage even greater cooperation and sharing of knowledge between the hospitals and for clinical research and trials to flourish in a centre of excellence.

National strategy, local delivery: Context

Since Autumn 2005, the Boards of St Mary's NHS Trust, the Hammersmith Hospitals NHS Trust (the Trusts) and Imperial College Council have been reviewing how best to meet the challenges and opportunities presented by the development of new drugs; technologies; techniques and treatments in medicine; patient expectations; NHS reforms, and global competition to attract the brightest and best doctors and clinical staff.

After careful consideration, the Trusts and the College concluded that a single organisation, with one shared mission, vision and unified governance is best suited to take advantage of the opportunities to improve healthcare in west London and the UK.



National strategy

The NHS is constantly changing to take advantage of developments in medicine and technology, and meet the expectations of the community.

The AHSC mission and vision supports the Department of Health's key targets to:

- improve the patient experience;
- reduce health inequalities; and
- achieve financial health.

The AHSC will become a beacon of good practice, leading the way in delivering the step-change required to bring the UK health service up to the standard of the best in the world.

"We now need to focus on efforts in transforming the whole system of care delivery." NHS Operating Framework 2007/08

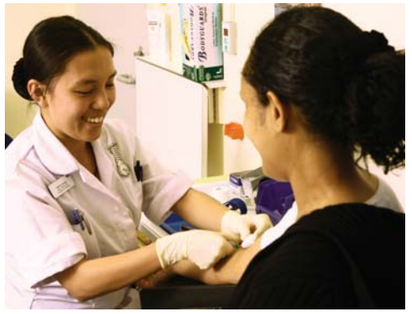
Local delivery

Until October 2007 the eight Primary Care Trusts in north west London are running a public discussion to help develop a 5 – 10 year strategy for how hospital, primary care and community NHS services should develop. We will take the opportunity to feed into this discussion about how an AHSC could contribute to a better, safer, more equitable healthcare service. For more information on the PCT-led public discussion go to **www.northwestlondon.nhs.uk**

Any resulting proposals for service changes would be the subject of separate consultation and scrutiny.

Nursing scheme moves antibiotic treatment into the community

Both Trusts are working with their local PCTs to help patients get back home quicker after a stay in hospital. If a patient is well enough to go home but still needs daily intravenous drugs, district nurses can now administer these at home, reducing the inconvenience to patients. We expect to work with a range of organisations to provide more services from home or in the community, safely and efficiently.



Bringing the best in the world to west London: Why change?


Charing Cross Hospital

The partners of the AHSC recognise the eight reasons why healthcare in London has to change, identified in *The Case for Change*, a recent study conducted by Professor Sir Ara Darzi on behalf of NHS London.
(For more information please visit www.healthcareforlondon.nhs.uk)

We believe that an AHSC would be best placed to tackle these challenges:

1 The need to improve Londoners' health

We need to tackle the lifestyle factors that put people at risk of poor health and focus on specific health challenges. London has a rich diversity of people with very different needs. London is home to 57% of England's cases of HIV and 25% of its adult drug users. One million Londoners have mental health problems and every hour one Londoner dies from a smoking related disease.

2 The NHS is not meeting expectations

There is much public support for the work of the NHS. Hammersmith NHS Trust and St Mary's NHS Trust are high performing trusts. However not all Londoners' expectations are being met, with 27% dissatisfied with the running of the NHS compared to 18% nationally[1]. Of course patients want the best clinical care available and the widest possible range of services, but they also tell us we need to work with other healthcare organisations to reduce delays in decision-making and minimise waiting times. Treatment should be in clean, safe, customer-friendly environments.

3 One city, but big inequalities in care

Patients want easier access to care, for instance in their local community; and clear, simple information to make smart choices – not just about healthcare when they are ill, but on how to stay healthy by making the right lifestyle choices.

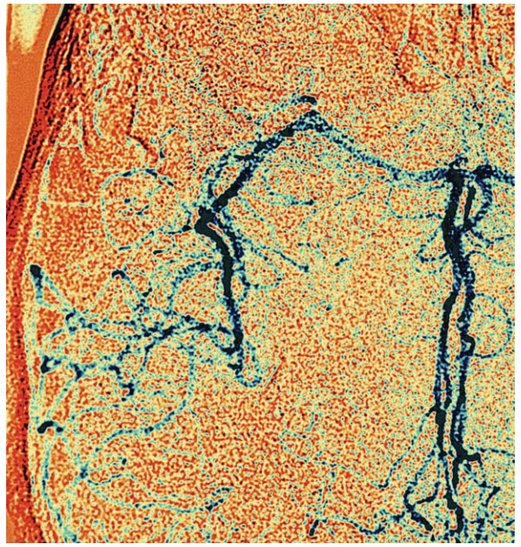
4 Hospital is not always the answer

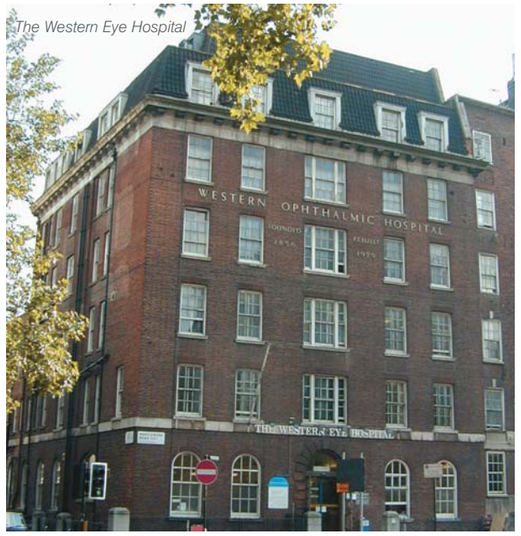
Medical advances mean that more care can be provided locally than ever before, for instance by GPs and specialist nurses. Many patients are admitted to hospital because no alternative is available. Patients need to have the confidence that they are receiving the best treatment available and we expect hospital consultants to share knowledge and transfer skills not only amongst themselves, but also with primary care professionals. We need to work with healthcare providers to ensure alternative care is made available.

5 The need for more specialised care

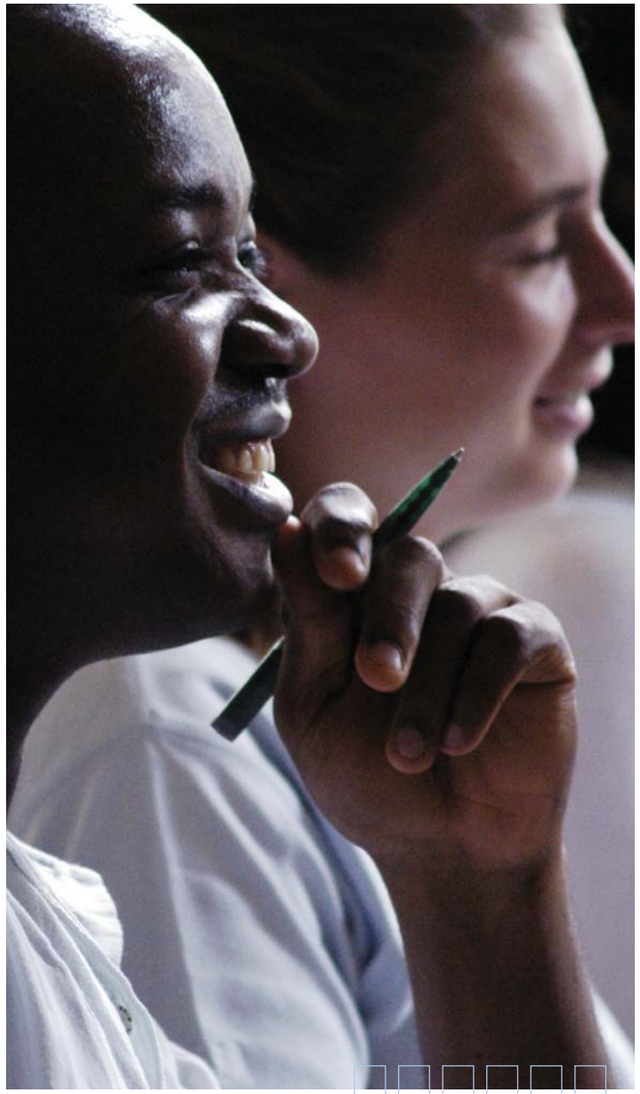
Increasingly we are required to harness the innovation and ever-expanding understanding in medicine. We need to ensure that we can develop, and take advantage of, exciting clinical and technical advances. There needs to be a concentration of expertise in centres of excellence with enough patients being treated by each specialty to ensure the service provides the best quality care.

[1] Ipsos MORI, London Residents' Attitudes to Local Health Services and Patient Choice, Dec 2006





The Western Eye Hospital



"London should be at the cutting edge of medicine. A new form of university/hospital partnership is needed to maintain the UK's academic institutions at the forefront of the global marketplace where they compete for grants, recognition and staff. Other large, developed cities have ensured the promotion of clinical excellence and the translation of research into practice by establishing one or more Academic Health Sciences Centres (AHSCs), combining world-class research with leading edge clinical services and education and training. AHSCs help to ensure that research breakthroughs lead to direct clinical benefits for patients. Cities such as Toronto and Boston already have AHSCs and London risks being left behind. AHSCs are a model of healthcare organisation London needs to explore."

The Case for Change, A first stage review published for Healthcare for London

6 London should be at the cutting edge of medicine

Countries around the world are all competing for limited research funding. The Government has recently changed the way it funds medical research and development. A few large centres of excellence that can prove they are providing world-class research that improves patient care will receive the greatest amounts of funding.

7 Not using our assets effectively

New legislation and ways of working are increasing demands on employers. We can, and should, reduce unnecessary duplication of effort. We need to make better use of staff expertise, buildings, beds and equipment in order to provide safe, efficient and responsive care for patients, and top quality training. For instance, 62% of those surveyed in the Ipsos MORI survey listed cleanliness of hospitals as needing attention and some cited cleanliness as a factor that would affect their choice of hospital.

8 Making the best use of taxpayers' money

We need to become more efficient. The NHS has received record levels of funding in recent years, but growth levels will reduce from 2008. We also face challenges to meet increasing patient choice and expectation, and the rising cost of care in a competitive NHS. Pay modernisation, inflation and the rising cost of drugs and treatments all mean that, although the Trusts have been very effective at increasing efficiency, we need to find savings of £30 million a year just to provide the same level of service.

What is an AHSC?

"I am investigating the role of carbon dioxide in the healing of chronic venous leg ulcers and would certainly welcome the continued opportunity to work with researchers at Imperial College and the MRC."

Dr John Fleming, Academic F2 Programme

An AHSC brings together the delivery of healthcare services, teaching and research in a partnership whose purpose is to improve the health of its patients.

Organisation

A Joint Steering Committee has been formed to manage the creation of an AHSC. The committee is chaired by an independent Chairman, Lord Tugendhat.

The AHSC can be created within existing NHS legal structures. Although the goal will be to become an Academic Foundation Trust (FT), the AHSC will need to operate as an NHS Trust until the second stage of the process - an FT application - can be made.

The FT application (under section 34 of the NHS Act 2006) will be sponsored by Imperial College London and will be the subject of a separate consultation and scrutiny. This application would be the first time an organisation other than an NHS Trust has bid to become a FT sponsor.

Foundation Trusts aim to bring about improved access to higher quality services for NHS patients, by devolving more power and responsibility to a local level.

Leadership

The leadership and management structure for the AHSC will be designed to ensure that it can meet its legal obligations and comply with established standards of corporate governance and ethics.

The benefits of an AHSC will be best realised through leadership of a single management team with a single lead role (combining the Chief Executive of the Trust with the Principal of the College's Faculty of Medicine). The lead position will be advertised through open competition.

There will only be one Board of Directors. The AHSC will be able to attract to its Board an influential and highly talented membership including a mix of individuals with clinical, managerial, academic and commercial skills and knowledge.

The chairman, chief executive, executive and non-executive directors will be appointed in accordance with the NHS Trusts (Membership and Procedure) Regulations 1990.

Vision

The vision of the AHSC is to be recognised internationally as:

- providing the highest quality healthcare to our community;
- a world leader in patient care, research, education and training;
- a place of discovery and innovation;
- a diverse community of the world's most talented people dedicated to the improvement of human health;
- a driving force in the local and national economies

"Improving the experience of patients will be paramount to the AHSC. The contribution of nurses, midwives and allied health professionals will be enhanced by bringing about changes in practice and ways of working that are based, not just on laboratory research, but on evidence from patients and a better understanding of their experiences. I am convinced that the culture of the AHSC will release the talents of staff of all disciplines to work with patients as effective teams and patients will be confident in the excellence of their bedside care."

Dr David Foster, Director of Nursing, Hammersmith Hospitals NHS Trust

Timeline

May - July 2007	Public consultation
August 2007	Secretary of State considers request for creation of an AHSC (submission includes comments from, and analysis of, the public consultation)
Oct 2007	Merger of trusts and integration of Imperial College to form AHSC subject to Secretary of State's decision and approval by Trust Boards
2008/09	FT application

Section 34 NHS Foundation Trust led by Imperial College

The future

The proposed merger of two of the best hospitals in the country with one of the best universities in the world heralds a new era for healthcare services in the UK. The three partners aim to create a new type of Foundation Trust; one that brings together the understanding of patient needs, the expectations of Primary Care Trusts, the expertise of clinicians and the enquiring nature of academics and researchers to develop a healthcare service that will revolutionise healthcare - re-establishing the UK as a world leader in clinical and research excellence.

The trust will work in partnership with grass roots organisations to meet the challenges of *The Case for Change*, sharing its knowledge to lead delivery of a new, sustainable healthcare network across London and the rest of the country.

We will achieve this by:

- ensuring the delivery of healthcare services, research, development and teaching are integrated;
- creating and using new knowledge to improve healthcare and clinical outcomes;
- sharing new knowledge among staff, students and trainees;
- working closely with primary care providers and commissioners of services to meet the diverse healthcare needs of the local community;
- ensuring public money and the organisation's resources are used effectively;
- working in partnership with patients, voluntary organisations, the local community, social services, and other health organisations;
- valuing the diversity of staff and investing in their development; engaging with staff, patients and the public, and listening to them as much as informing them, in a clear and honest way.

Services

The creation of an AHSC has the potential to bring many benefits to the health of our community.

The aim is to benefit every single patient using our services - and many that use other healthcare services in the community or in other parts of the country, not just to develop innovative treatments for a few with unusual or complex needs.

We want to make a difference for all our people, including service users, their relatives and carers, our staff and our other community partners.

We want to make a difference for someone coming into contact with the AHSC; whether it is for a routine check-up or a transplant, in an emergency or to visit a friend.

The AHSC aims to improve the very wide range of clinical, research and teaching services currently provided. Services across both Trusts will be integrated in a process led by clinical staff[1] with greater patient and community involvement. Proposals for service change will require separate business cases and equality impact assessments and will be subject to further public consultation and scrutiny at a future date – they DO NOT form part of this public consultation.

For the next 5 – 10 years the partners plan to:

- Ensure services that can be provided safely and efficiently in the community are encouraged and supported;
- Continue to improve outpatient and specialist services; and
- Investigate whether, by integrating some services currently provided on more than one site, we could provide better facilities, services, outcomes and efficiencies. Any service changes would be subject to the legally required consultation.

We will work with the PCTs and the Strategic Health Authority (SHA) on any future reconfiguration proposals to ensure that west London healthcare is the very best available.

Training the next generation of clinicians

The organisations are already leaders in the field of teaching. An AHSC will encourage the development of an extensive learning community that improves the way healthcare education can be delivered in a range of clinical settings.

[1] Throughout this document 'clinical staff' and 'clinical services' are taken to mean the broad range of healthcare professionals and services.

The focus on patients: Benefits

New baby scanner set to transform lives

A new state-of-the art baby scanner has begun taking never-before seen pictures that will significantly improve the life chances and care of premature babies. The scanner on the neonatal ward at Queen Charlotte's & Chelsea Hospital will enable doctors to take detailed images of the babies' lungs, heart and brain from 23 weeks. This will allow experts to understand how a premature child's body and brain develops – paving the way for quicker and better treatment of preterm babies in the future.

The precision of the £1 million scanner also allows researchers to understand the effect of new therapies at a much earlier age, speeding up the process of finding effective treatments to prevent brain damage.

Professor David Edwards, who is leading the research using the scanner, said: "This is a fantastic investment from Imperial College and the Medical Research Council. It's very tough being the parent of a premature baby. They come unexpectedly, without warning and parents are thrown into a maelstrom of high – tech medicine and machinery. They find it particularly tough not knowing what will happen in the future. It can be reassuring to know that a baby has a normal brain scan."

By becoming one organisation and enabling academics and clinicians to work side by side, the AHSC aims to put theory into practice quicker, more efficiently and more effectively than ever before.

"The creation of the UK's first, and long-overdue, Academic Health Science Centre with Imperial College at the helm, in partnership with two of the country's top hospitals, is a milestone in british medicine. The AHSC will ensure that new advances in medical diagnosis and treatment will be speedily exploited to benefit all patients."

Professor Myra McClure, Research & Development Director, Imperial College London, St Mary's Campus

Benefits for patients and carers

The majority of residents in north west London will rarely need to be treated in a hospital. We expect the AHSC to be a key partner in delivering healthcare in the community and ensuring issues such as methods of delivery, access, health inequalities and public health (for instance education, employment and housing) are as much a focus as biomedical research. We will work with healthcare, statutory and voluntary organisations to provide services which not only help treat illness but also support healthy people to remain so.

The AHSC will aim to provide a more seamless service for all patients, giving access to world-class services, quickly and easily, across all specialties and in clean, modern surroundings.

We want to maintain and develop local services dedicated to the patient – more convenient appointment times, better clinical outcomes, more choice and a greater range of specialists available to treat routine and complex conditions.

Where there are clinical services which are replicated across the existing trusts, a new merged trust with a consistent management approach will be better able to determine the most effective configuration of services and then consult on the proposals.

Bringing the very latest treatments and technologies to patients' bedsides

The AHSC will have the ability to commission and apply research in a coordinated way which will avoid duplication and ensure effective new treatments and techniques are introduced to clinical practice, safely and quickly.

At the AHSC, scientists and clinical staff will be working side by side to concentrate research on providing the most effective treatments for the care and safety of patients.

Providing a single focus for joint working

Organisational boundaries that currently inhibit or prevent closer working between related services will disappear. Working as a team will enable improvements in continuity of care, particularly for those who move between hospitals and other agencies such as social services.

Attracting the best clinicians, researchers and staff

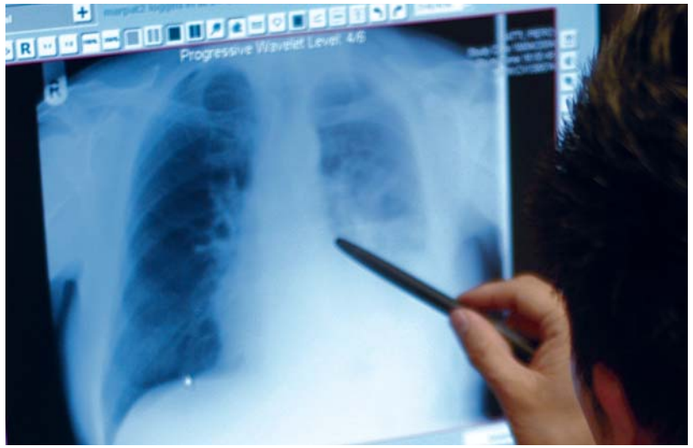
As the need for healthcare increases around the globe, the competition for the very best staff increases too. The partner organisations already employ many of the best clinicians, researchers and staff in their field who work to deliver excellent care to patients. The AHSC will enhance this by being a magnet for the very best staff, attracted by the reputation of the AHSC and the opportunity of working with the best thinkers, innovators and clinicians in the world.

Cardiovascular trials save lives

St Mary's and Imperial College cardiovascular teams, together with the University of Gothenburg have jointly coordinated a major European study designed to investigate ways of preventing heart attacks and strokes.

The study, involving over 19,000 patients, was stopped early due to the discovery of the overwhelming benefits of statins in the prevention of heart attacks and strokes, and of newer combinations of blood pressure lowering drugs.

The trial has resulted in major changes to international guidelines on the prevention of cardiovascular disease. The AHSC would be better able to lead more large-scale studies in the future.



Improving standards of clinical practice and care

By sharing expertise, best practice and the most up-to-date research in medicine and technology the AHSC will deliver higher standards of care across all its sites to all its patients. The concentration of clinical and academic expertise found in a teaching/research organisation combined with large numbers of patients and excellent clinical staff is a significant factor in delivering the best care outcomes.

If consultants see more patients with rare conditions they become more expert in these areas. A merger would ensure the greatest possible range of specialist services are kept close to people's homes, meaning that local patients wouldn't have to travel far to get the best quality care available.

A cleaner, safer, more attractive environment

To provide modern care, new buildings are needed, enabling the use of medical and information technology, access to large numbers of single rooms and more extensive critical care facilities. The new partnership will have greater opportunity to invest in new buildings and refurbish existing sites, providing a more pleasant environment that will be far more economical to run and maintain.

Benefits for partners and the local community

Patients, Primary Care Trusts, voluntary organisations, local authorities and anyone dealing with the AHSC will find that, rather than having to deal with different organisations with different work practices, it is far easier to work with a partnership with common values and priorities and a single – minded approach to collaborative working with the wider health community.

Generating wealth through economic development

The AHSC will stimulate local regeneration in and around the sites that it owns, not only to better utilise its estate, but also to improve public health in the community and improve the local environment. Through Imperial College's sponsorship, the AHSC will be able to attract inward investment from new partners which will be directed into improving clinical services. Evidence from similar schemes in the US and Europe suggests that the AHSC will attract investment, pharmaceutical and biotechnology companies and new jobs to the area, offering a welcome boost to the local economy.

The AHSC will strengthen London's worldwide reputation as a centre for the development of biosciences and healthcare and will aid collaboration between private enterprise and the higher education sector.

"The creation of an AHSC is a tremendous opportunity to improve the standard of healthcare for everyone in west London.

There is a divide which must be bridged between GPs who work in the community and consultants working in hospitals. Patients will benefit from district nurses, health visitors, GPs and all professionals sharing knowledge and raising standards of care and from information being properly managed.

Patients should not have to attend a hospital to get the results of a test that needs no follow up; and better use of technology will, for instance, allow us to monitor patients' conditions at home, or enable us to do one test in a health centre rather than an array of tests in a hospital.

However we must not let technology make us lose sight of the fact that patients are individuals who must be treated with care, respect and dignity."

Dr Stephen Jefferies,
GP, Professional Executive Chairman and Clinical Lead on the NW London Review

Benefits for academic and research activities

Imperial College's biomedical research is ranked amongst the top five in the world[1]. St Mary's and Hammersmith Trusts are both in the top three trusts in England for clinical performance, quality and safety[2]. Our aim is for the AHSC to be one of the world's top centres for both research and clinical performance.

A magnet for the world's best clinicians, academics and funds
Research and Development (R&D) is in a global competition to attract leading scientists, clinicians and funding. Increasingly funding bodies award grants to the most effective research teams, wherever they are in the world. A coordinated, well-funded, innovative, multi-professional research programme will ensure we are able to retain and attract world-class academics and clinical staff.

Ensuring patients benefit from the work of our exceptional research and development talent
We need to ensure we apply our innovation and ever-expanding understanding of medicine to the services we provide.

Creating an environment where clinicians and researchers work side by side to understand the needs of patients will mean we can align academic research with clinical requirements and ensure that our patients are the first to benefit from exciting advances in medicines and technology.

The AHSC will be committed to ensuring that the research undertaken is transferred to the broader health care system throughout west London and beyond in a fast, safe and effective manner.

Benefits for staff and students

Our staff will value being part of a world class team; learning and growing together and delivering the highest possible standards of patient safety and care supported by the latest research and being recognised for the unique contribution they make.

As well as being a world leader in research, the AHSC will offer staff the opportunity to work with the world's best clinicians and researchers and a wider range of career development, promotion and training opportunities in a larger, more diverse organisation. The people we employ will be critical to the success of the AHSC. As well as being a world leader in research, healthcare delivery and teaching, the AHSC will strive to be the employer of choice in its field, setting standards of employment and

people management which others strive to emulate - competitive in the local and international marketplace and responsive to the changing demands of healthcare.

During the consultation period staff will be invited to take part in a change management process to develop the vision and benefits of the AHSC and to design how it will work in practice.

New and innovative roles
The AHSC will attract investment and improve efficiency, releasing funds to put into frontline services and creating new and innovative roles.

Sharing best practice between disciplines and professions
The AHSC will provide staff and students

with experience in a broader range of clinical areas and roles with greater opportunities for joint working between health and academic professions.

Developing high quality education, training courses and qualifications
Partnership with Imperial College will enable the trusts to access educational research and development. The organisations will share their expertise and improve career development across all healthcare professions and management.

Best in class
The AHSC will provide a unique academic environment, fostering learning and the transfer of knowledge on effective means to improve the health of the population.

"The basic features of a hospital that patients demand – for instance no acquired infection, a clean environment, to be treated with respect and to be involved in decision-making go hand-in-hand with excellent medical care and excellent outcomes from their stay. The AHSC will be a model for providing both to the patient."

Lara Waywell, General Manager Surgery, Critical Care and Cardiovascular Sciences, St Mary's NHS Trust

Latest technology makes a difference to hundreds of women

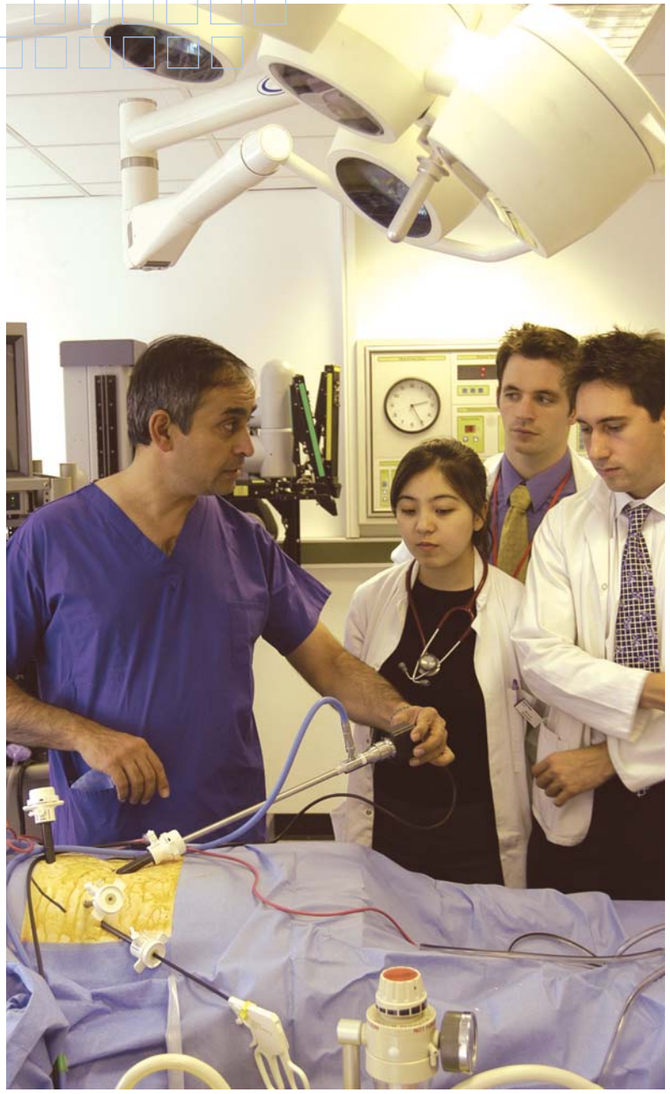
Uterine fibroids are a common, painful and life-damaging gynaecological condition for thousands of women in the UK. While previously patients were offered little choice but a full hysterectomy to treat the condition, St Mary's offers a unique and non-invasive treatment to eradicate the tumours.

Magnetic Resonance (MR) guided focussed ultrasound was first pioneered at St Mary's Hospital in 2001 and more than 300 women have benefited from the treatment, which requires no hospital stay or post-operative recovery time. The procedure is also more cost effective than a hysterectomy and does not impact on fertility.

In a world first, the treatment is now being trialled for bone and liver tumour patients, improving the quality of life for patients who previously would have faced chemotherapy or invasive surgery.

The AHSC would help clinicians and researchers to develop more, innovative treatments for a range of patients.

[1] *Times Higher Education Supplement* 2006 World University Rankings
[2] *Dr Foster Good Hospital Guide* (Dec 2006)



"An environment which supports the development of my talent and offers opportunities to train with experts gives me the best chance to further my career as a healthcare manager and contribute to improved patient care."

Ruth Dunlop, Head of Leadership and Management Development, Hammersmith Hospitals NHS Trust

Partners awarded Biomedical Research Centre status

In December 2006, Hammersmith and St Mary's, in partnership with Imperial College, were selected as one of the UK's 11 Biomedical Research Centres (BRC). If the AHSC goes ahead, the award guarantees the partners research funding of £19.5 million each year for the next five years, and makes the West London BRC the leading centre for the UK. The BRC funding would not be available to the Trusts individually and without it they would be facing substantial cuts to research programmes. BRCs will be leaders in translating scientific research into benefits for patients.

Finance

The following financial information reflects the three-year plans for the two NHS Trusts recently approved by the London SHA.

Assumptions

- For 2007/08 the Government assumes an improvement in all Trusts' financial efficiency of 2.5% (we will receive 2.5% less than before) but an extra 5% because of inflation.
- A loss of NHS Research and Development income which is partly mitigated by the awarding of Biomedical Research Status.
- Any deficits of the Trusts will be carried forward to the new Trust.
- Local cost pressures.

Current plans for savings include reduction in back office costs and expenditure on agency staff, reduction in expenditure on drugs, and savings made by reducing the length of time patients stay in hospital.

As part of the merger the Trusts will be reviewing these savings with an expectation that reductions in costs can be achieved through economies of scale that will allow investment in key patient services – for instance ensuring that the time between receiving a referral for a patient to the time the treatment starts is less than 18 weeks.

At the same time the Trusts will be investing in new equipment and building – this is estimated to be £116m over the next three years. The capital plans are mainly funded by internal resources and exclude any new capital investment, which will be subject to the development of business cases, or investment by Imperial College in its buildings.

INCOME (including efficiencies)				
2006/07 Estimated		2007/08	2008/09	2009/10
£Million		£M	£M	£M
490.0	Hammersmith Hospitals	472.1	468.5	473.0
289.4	St Mary's	292.2	296.9	303.4
779.4	**Total Income**	**764.3**	**765.4**	**776.4**

EXPENDITURE (including savings)				
2006/07 Estimated		2007/08	2008/09	2009/10
£Million		£M	£M	£M
485.4	Hammersmith Hospitals	469.7	466.1	470.6
282.3	St Mary's	291.2	295.9	302.4
767.7	**Total Expenditure**	**760.9**	**762.0**	**773.0**

SURPLUS (assuming savings are fully delivered – see below)				
£11.7 M	**Combined surplus for Trusts**	**£3.4M**	**£3.4M**	**£3.4M**
0	Costs and savings of merging	-£1.4	0.2	1.8
11.7	Surplus after merger costs and savings	2.0	3.6	5.2

SAVINGS

In the figures above, the Trusts are implementing (06/07), have identified the potential (07/08) or identified the requirement (08/09 and 09/10) to make the following savings (includes loss of income):

2006/07		2007/08	08/09	09/10
£Million		£M	£M	£M
24.0	Hammersmith Hospitals	22.0	19.8	23.2
12.8	St Mary's	9.2	13.2	10.8
36.8	**Total Income**	**31.2**	**33.0**	**34.0***

*This equates to 4.4% of combined turnover for 2009/10.

Imperial College London, Sir Alexander Fleming Building

"The unique clinical exposure I have received whilst researching cardiovascular sciences has allowed me to appreciate the impact of translating clinical science into practice, in order to benefit patients, and offer them the best that is available in modern healthcare.

I know a lot of students who are excited about the new merger which we hope will continue this tradition of excellence and which will serve to strengthen the ties between clinical research and medical practice."

Larisa Corda, Medical Student, Imperial College London

£75 m investment in a new Centre for Clinical Imaging

The new research facility on part of the grounds of Burlington Danes School is one of the world's largest industry-university collaborations. The venture by Imperial College, the Medical Research Council and GlaxoSmithKline builds on Hammersmith Hospitals' strong clinical trials reputation and will focus on cancer, strokes and neurological diseases such as Parkinson's, multiple sclerosis and psychiatric diseases.

The Centre will advance the latest technologies in Magnetic Resonance Imaging (MRI) and Positron Emission Tomography (PET) to look at real time chemical processes in human organs such as the brain, heart, and lungs, revealing the changes that medicines can make.

Imaging data can help speed up drug discovery by providing information about what is happening within the body.

Frequently asked questions

If this proposal for an AHSC is accepted, will it just clear the way for service change and cuts?

This consultation is not about cuts to services or jobs. The only jobs that will immediately be changed by this proposal are a small number of Board positions. If, and when, service changes, staff reorganisations, etc., are considered in the future they will be subject to appropriate discussion, proper consultation and scrutiny as required under NHS regulations.

Service change will happen even if the two Trusts do not merge as the NHS needs to continually improve, taking advantage of new opportunities and meeting the changing expectations of patients within a limited budget. Merging the organisations makes sense because we can plan services and the use of resources more effectively.

Are you going to close Accident and Emergency departments or Charing Cross Hospital?

There is no proposal in this consultation to change any services. There are currently no plans to close any A&E department, Charing Cross Hospital or any other site. In fact significant investment continues to be made at Charing Cross, with new mental health services; a new 72-hour day-and-stay surgery unit (Spring 2006, £3.5m); four new linear accelerators (£6.5m, Dec 2006); new research facilities; and a Maggie's Cancer support centre due to open in later in 2007, £2.5m.

Will I have to go anywhere different for my inpatient or outpatient treatment?

At present there are no plans to move any inpatient or outpatient treatments. In principle we aim to deliver more services in people's homes and the community but any service changes will be the subject of full and open discussions, and of formal consultation and scrutiny as required under NHS regulations.

Will the AHSC cost more to run than the existing organisations?

There are areas with the potential for providing better value for money and better patient care. Savings will be possible by reducing duplication of services, economies of scale (for instance increased buying power for services), sharing knowledge, and attracting funding and investment. Reconfiguration of services (which would be subject to separate consultation) would be more coordinated and effective if considered in one, rather than separate organisations and could provide substantial savings.

Why can't the benefits be realised by the existing Trusts working together with Imperial College?

Some of the benefits could be realised but there are many factors which make it difficult for the two organisations to work together – physical, legal, financial, administrative, professional, historic. For instance, the organisations are currently answerable to different parts of the Government.

Creating a partnership would remove or reduce many of these barriers. New treatments, ideas and technology could be introduced more quickly, efficiently and effectively.

Will the AHSC reduce waiting times and reduce journeys to hospital?

We will work with other health professionals to ensure many services are provided closer to people's homes, for instance in GP surgeries, health centres and by pharmacists. By coordinating our efforts we aim to reduce waiting times.

Will there be job losses if this proposal is accepted?

There will only be one Principal / Chief Executive and one Board. This will result in a reduction of Board positions. A more detailed consultation will take place with those board members who are affected by this. There are no plans for a reduction in other posts as a direct result of this merger. The Trust business plans will continue in place until a new plan is developed for 2008/09.

Will there be changes to the terms and conditions of employment for staff?

The new Trust will be an NHS body and staff will have their employment rights protected under the TUPE regulations. This means that staff will have a new NHS employer named on their contract, but they will have exactly the same terms and conditions of employment, pay, holidays, sick pay, pension and continuous service entitlement as they do now. The same staff side organisations will be recognised. In moving to a new organisation staff side representatives and staff will be involved fully in discussions, and the organisation will ensure all legal requirements are met.

Will the performance of the hospitals suffer whilst key staff are diverted to merger activities and how can you be sure the merger will be successful?

A programme team has been established whose aim is to deliver the merger. Finance and staff support have been set aside to ensure that front-line services are not affected.

A change management programme is already underway to keep staff informed, to involve them in creating the new organisation so that it best benefits patients, and to prepare staff for any merger.

The three organisations have worked closely together for many years. Joint projects (some of which have been illustrated this document) have been very successful and we believe a merger will be just as beneficial to patients. The merger has tremendous support from clinicians, managers and key healthcare and voluntary organisations.

How will the success of this proposal be measured?

By 2012 we aim to be one of the top five academic health science centres in the world for both clinical excellence and research.

About this consultation

What?

This consultation is gathering views on the proposal to create an Academic Health Science Centre (AHSC) by merging St Mary's NHS Trust and Hammersmith Hospitals NHS Trust to create a new NHS Trust, and forming a new organisation and integrating with Imperial College.

Who?

The consultation is being conducted by the partners. It offers everyone the chance to inform the proposal and the Secretary of State's decision to accept or reject it.

When?

The consultation period will run for twelve weeks from 1 May 2007 to 31 July 2007. During this period we will be asking staff, patients, students, researchers, partner organisations and the general public for their views on the proposal to create the AHSC.

How?

If you would like further information before you make your comments you can:

a) Contact the AHSC Office by:

- **Phone:** 020 8237 2018
- **Post:** AHSC, 2nd Floor, Education Centre, Charing Cross Hospital, Fulham Palace Road, London. W6 8RF
- **Email:** ahscprogrammeoffice@hhnt.nhs.uk

b) Contact the independent advisers:
Verve Communications[1], by

- **Post:** FREEPOST AHSC
- **Email:** ahsc@vervecommunications.co.uk
- **Freephone:** 0800 043 73 63

c) Attend one of the public meetings which will be held during the consultation period.

- 6 June 2007.
  The Irish Centre.
  (100m from Hammersmith Broadway). 6.30pm – 8pm
- 20 June 2007.
  Tuke Hall, Regent's College Conference Centre, Regent's Park.
  (5 mins from Baker St tube).
  6.30pm – 8pm

Please contact Verve Communications to register if you wish to attend one of these meetings (see b) so that we can accommodate everyone wanting to take part.

Dates, times and venues for other meetings will be listed on the AHSC website at www.ahsc.org.uk or you can telephone the AHSC office.

d) Visit the consultation website at www.ahsc.org.uk

[1] Verve Communications were selected using a competitive tender and an interview process which included independent representation from the local healthcare community. Verve has been contracted to independently assess the consultation process, give impartial advice to anyone wishing to make their views known, analyse the responses received and provide a report to be presented to the Secretary of State.

Have your say

We would like you to help us create world-class healthcare for west London, so we welcome your ideas, your concerns, your support and comments.

Whatever your job, age, sex, ethnicity, sexuality, faith or your current health, if you live in west London this proposal affects you.

You can make your views known by contacting the independent consultants:

- Using the form below or writing a letter to; FREEPOST AHSC
- **Freephone:** 0800 043 73 63
- **Email:** ahsc@vervecommunications.co.uk
- Completing the comments form on the consultation website www.ahsc.org.uk; or
- Attending one of the consultation meetings.

All comments should be returned by 31 July 2007.

Following an analysis of the consultation responses a decision will be taken by the Trust Boards on whether the Secretary of State for Health should be asked for permission to merge the Trusts and create an AHSC.

About you

To enable us to improve our services, and to better understand how we can meet your needs it would be helpful if you could tell us a little bit about yourself. Your comments will still be taken into account if you choose not to enter these details.

a) In what capacity are you responding to this questionnaire?

i) trust or college employee

- ☐ Hammersmith Hospitals NHS Trust
- ☐ Imperial College, London
- ☐ St Mary's NHS Trust

ii) ☐ individual

iii) ☐ representative of an organisation or business (go straight to question b)

☐ Male ☐ Female

☐ Under 18 ☐ 18 – 29 ☐ 30 – 49 ☐ 50 – 65 ☐ 65+

The first four characters of your home postcode ☐☐☐☐

Have you used Hammersmith Hospitals Trust or St Mary's Trust services in the last month? ☐ Yes ☐ No

Have you used Hammersmith Hospitals Trust or St Mary's Trust services in the last year? ☐ Yes ☐ No

Have you used other hospital or health services? ☐ Yes ☐ No

If so, which ones? _____

b) If you are responding on behalf of an organisation or business, please tell us:

- Your job title or role _____
- The name or nature of organisation _____

c) If you would like to sent a summary of the consultation results or be kept informed of further progress, please supply your email or postal address _____

Questions

1) Do you think the merger of Hammersmith Hospital NHS Trust and St Mary's NHS Trust and integration with Imperial College is a good idea? ☐ Yes ☐ No ☐ Don't Know

2) Please can you give your reason for the answer in question 1 _____

3) Do you think it is right to appoint a single management team to be responsible for the running of the Trusts and the Faculty of Medicine, Imperial College? ☐ Yes ☐ No ☐ Don't Know

4) What do you see as the benefits to you of an AHSC / what are your concerns? _____

5) Do you think it is right to want to create centres of excellence, like the renal centre, that bring together expertise and services on one site? ☐ Yes ☐ No ☐ Don't Know

Other comments

_____

_____

_____

Responses should be sent to: FREEPOST AHSC

The partners would like to thank all the staff and stakeholders who have generously assisted in the preparation of this document, including Westminster, and Hammersmith and Fulham Primary Care Trusts; the Overview and Scrutiny Committees of Kensington and Chelsea, Hammersmith and Fulham, and Westminster; the Patient and Public Involvement Fora of St Mary's Hospital, Hammersmith Hospitals, Westminster PCT, and Hammersmith and Fulham PCT; the St Mary's Paddington Charitable Trust and the Charitable Fund for Charing Cross, Hammersmith & Queen Charlotte's & Chelsea Hospitals; the Black and Minority Ethnic Health Forum and Voluntary Action Westminster.

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www.st-marys.nhs.uk

If you do not understand this document we can arrange an interpreter. Please call the number below to request this.

Në goftë se nuk e kuptoni këtë fletpalosje, ne mund t'ju sigurojmë përkthyes. Për ta kërkuar një gjë të tillë, ju lutemi telefononi në numrin e mëposhtëm.

Si vous avez des difficultés à comprendere ce livret, nous pouvons vous fournir un interprète. Veuillez appeler le numéro ci-dessous.

Se você não entender este folheto, podemos providenciar um interpréte. Favor telefonar para o número abaixo para solicitor este service.

Si no entiende este folleto podemos facilitarle el acceso a un interpréte. Para solicitor este servicio, llame por teléfono al número que aparece abajo.

Haddii aanad fahimin warqaddan la daabacay, waxanu diyaarin karnaa tarjume. Fadlan tilifoon u dir lambarka hoos ku qoran si aad tarjume u codsato.

Bu kitapçıkta yazılanları anlamıyorsanız sizing için bir çevirmen bulabiliriz. Çevirmen istemek için lütfen a_a_ıdaki numarayı arayınız.

إذا كنت لا تَفْهمُ هذه الوثيقةِ فيُمْكِنُنا أنْ نُرتّبَ لترجمتها. رجاءً إتّصل بالرقم الموجود اسفل هذا الطلب.

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This document can be provided on request in large print, on CD or tape, in Braille or in alternative languages. Please contact the AHSC Office for more information.

Phone: 020 8237 2018

Post: AHSC, 2nd Floor, Education Centre, Charing Cross Hospital, Fulham Palace Road, London. W6 8RF

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NHS London

Healthcare for London
A Framework for Action

The Case for Change

Introduction

1 This report makes a compelling case for why healthcare in London has to change. There are many excellent reports which consider how healthcare must develop in the future, both generally and in particular specialties.[1] This document does not seek to repeat those, but focuses instead on the specific challenges to improving healthcare in London. It is the first stage of a review being conducted by Professor Sir Ara Darzi on behalf of NHS London and will be followed by a *Framework for Action*, detailing the necessary response to these challenges.

[1] On general healthcare developments see, J Farrington-Douglas, *The Future Hospital: The progressive case for change*, IPPR January 2007. On particular specialties see the recent reports of the National Clinical Directors e.g. Professor Roger Boyle, *Mending Hearts and Brains*, DH, December 2006

Ongoing Change:

2 Why does healthcare in London need to change? After all, there have been considerable achievements in the last few years, most notably in reducing waiting lists and increasing survival rates for the big killers of cancer and coronary heart disease. These improvements were made possible by record increases in healthcare funding and the vision set out in *The NHS Plan*.[2] However, strategic documents setting out necessary changes specifically for London have been relatively neglected, most notably *Health Service in London – A Strategic Review*, the 1998 report by Lord Turnberg.[3]

3 Much of the Turnberg report continues to be relevant, with its emphasis on the rationalisation of major hospital services on the one hand, supported by the development of high quality community care on the other. Of its major recommendations only the suggestion that London does not need to reduce its acute inpatient beds has been proved obsolete by healthcare developments.[4] However, competing priorities meant that some of the most significant elements of the Turnberg report have never been implemented. In addition, the five previous Strategic Health Authorities (SHAs) that were established were simply not configured to lead the pan-London improvements envisaged. And whilst individual clinicians and managers have made improvements to services, this has often been on a piecemeal basis. There now needs to be a co-ordinated programme of change across London for eight reasons.

[2] *The NHS Plan*, Department of Health, 2000
[3] *Health Services in London – A Strategic Review* (Turnberg Report), 1998
[4] NHS Confederation, *Why we need fewer hospital beds*, May 2006

Reason 1

The need to improve Londoners' health

4 NHS London's key aim is to improve the health of all the capital's inhabitants. Improving health means focusing on London's specific health challenges and tackling the lifestyle factors that put people at risk.

5 In some health indicators London performs well. For instance, although it is a big killer, coronary heart disease mortality rates are lower in London than other parts of England.[5] However, London faces specific health challenges such as HIV, drug abuse and mental health. London has 57 per cent of England's cases of HIV. One in four adult drug users live in London. One million Londoners have had mental health problems.[6]

6 Londoners also need more help to adopt healthy lifestyles. Smoking is more prevalent in London than nationally. One Londoner dies every hour from a smoking related disease and smoking costs the NHS in London over £100 million a year.

7 London has higher rates of childhood obesity than the rest of England. Every year in London, obesity accounts for 4,000 deaths. London is far away from the "fully engaged" scenario envisaged by Sir Derek Wanless, where everything is done to prevent ill health.[7]

8 The second half of the key aim – for all the capital's inhabitants – means recognising that London's health services have to meet the needs of the capital's wonderfully diverse population. There might be 300 different languages spoken and 90 different ethnic groups in the capital, but there must be one NHS accessible to all Londoners.

[5] *National Centre for Health Outcomes Development Indicators*
[6] This and subsequent statistics in Reason 1 taken from London Healthcare Observatory, *Health and Healthcare in London – Key Facts*, September 2006, http://.healthcareforlondon.nhs.uk
[7] Sir Derek Wanless, Securing our Future Health: Taking a long-term view (The Wanless Report), April 2002

Reason 2

The NHS is not meeting Londoners' expectations

9 There is much public support for the work done by the NHS. However, not all Londoners' expectations are being met. 27 per cent are dissatisfied with the running of the NHS compared to 18 per cent nationally.[8]

10 A MORI survey of over 7,000 Londoners revealed that, despite recent reductions, further improvement in waiting times for operations, appointments and in accident and emergency (A&E) departments is a priority for people.[9]

11 62 per cent of those surveyed listed cleanliness of hospitals as an issue needing attention and some cited cleanliness as a factor that would affect their choice of hospital.

12 The survey also highlighted that those who felt they had choice in their healthcare were much more positive about the care they received. Thus 80 per cent of those who said they have at least a fair amount of choice felt their local NHS was providing them with a good service, compared to 54 per cent of those who said they have little or no choice.

13 The survey found Londoners gave their GP services a lower net satisfaction rating than people nationally. This corroborates the findings of the London "listening event" conducted as part of the *Your health, your care, your say* consultation, where people spoke of difficulty booking GP appointments in advance or being seen outside normal 9-5 working hours. They could also rarely speak to GPs directly by phone and tended to only get reactive, rather than proactive, care.[10]

[8] Ipsos MORI, *London Residents' Attitudes to Local Health Services and Patient Choice*, December 2006
[9] Ipsos MORI, *London Residents' Attitudes to Local Health Services and Patient Choice*, December 2006. The subsequent percentages are all from this survey.
[10] Report from London user group, *Your health, your care, your say*, 2005

Reason 3

One city, but big inequalities in care

14 Equity of care is a founding principle of the NHS, but the evidence suggests that Londoners are not experiencing equity either in terms of their health outcomes or in terms of the services they receive. Such inequity is not always visible, with London-wide data masking significant disparities.

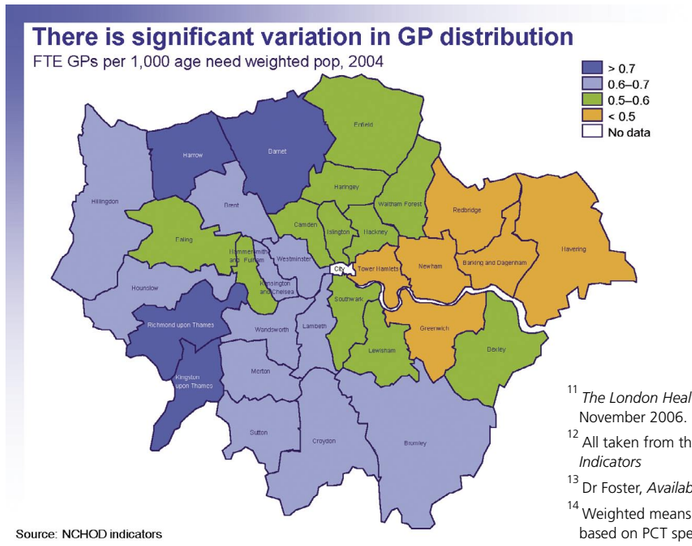
15 For instance, whilst overall life expectancy in London is similar to national levels, there are very significant differences within London. Just eight stops on the Jubilee line takes you from Westminster to Canning Town where life expectancy is seven years lower. This discrepancy means that raising life expectancy for the bottom half of London boroughs to the current London average would save 1,300 lives every year.[11]

16 Other examples of health inequality include:

- The infant mortality rate in Haringey (8.1 per 1000 births) is three times that of Richmond (2.7 per 1000 births).
- Hammersmith and Fulham has twice the proportion of smokers of Harrow (34.5 per cent compared to 17.5 per cent).
- Two thirds of children in Kensington and Chelsea consume three or more portions of fruit and vegetables a day, compared with one third in Barking and Dagenham.[12]
- Mental health inpatients are more than twice as likely to come from the 20% most deprived London electoral wards than the 20% least deprived.[13]

17 At the same time as there are big inequalities in outcomes, there is great disparity in health inputs, such as funding per person. Looking at the funding for the five old SHA areas it is noticeable that whilst North East London contains several deprived boroughs with some of the lowest life expectancies in England, in 2004/05 the average expenditure per weighted head of population was £1090, compared with the North West London figure of £1311.[14]

18 An inverse relationship also exists between health need and GP distribution. There are overall fewer GPs per head of weighted population in the east and north of London (where health need is greatest), compared to the south and west:



Source: NCHOD indicators

[11] *The London Health Inequalities Forecast*, London Health Observatory, November 2006.

[12] All taken from the *National Centre for Health Outcomes Development Indicators*

[13] Dr Foster, *Availability of Mental Health Services in London*, April 2005

[14] Weighted means adjusted to take account of health need. SHA data is based on PCT spend

Reason 4

The hospital is not always the answer

19 Medical advances mean that more care can be provided locally than ever before. For instance, modern surgery allows more procedures to be safely delivered as day cases, outside of major hospital settings. More outpatient appointments can take place in the community. In the US this has meant that whereas in 1981 90 per cent of outpatient appointments were in hospital, in 2003 the figure was 50 per cent with the other half being provided in physician offices (equivalent to GP practices) and polyclinics.[15] These developments mean that the vast majority of patients do not need hospital care.

20 The *Our health, our care, our say* White Paper presents a convincing argument that most people are best cared for by community services.[16] This is corroborated by medical studies such as one that demonstrates that people with chronic obstructive pulmonary disease greatly benefit from community pulmonary rehabilitation and one that shows that specialised, dedicated heart failure nurses in the community can improve health outcomes for patients with heart failure and reduce emergency admissions to hospital.[17]

21 Yet at the moment, community services are not providing a satisfactory alternative to hospital. Local urgent care is not good enough. Londoners are dissatisfied with the availability of GP services outside normal working hours.[18] They are using A&E departments for urgent care, and as a result London has proportionately almost twice as many A&E attendances as the East Midlands.[19]

22 In another example, many patients (especially older people) are admitted to hospital because no alternative is available. Lack of an alternative to admission seems particularly bad in London, which proportionately has over 50 per cent more admissions through A&E than the West Midlands.

23 Improvements in community services clearly need to happen, but this is made more challenging because of the existing configuration of services. GP practices in London are smaller than average for the rest of England – 54 per cent of GP practices in London have only one or two GPs, compared to 40 per cent nationally. This makes it harder for them to provide additional services in their practices such as basic blood tests and ultrasounds. Yet many cannot expand because of their buildings. A BMA survey found that almost 60 per cent of London GP practices felt their premises were not suitable for their present needs and this rose to 75% when asked about their future needs.[20]

24 Professional attitudes also act as a barrier to providing more community services. For historical reasons there has been a sharp divide in the UK between GPs who work in the community and consultants who work in hospitals – a separation which does not exist in other countries. Thus 65 per cent of doctors in the UK report problems due to care not being coordinated across sites/providers compared to 22 per cent in Germany and 39 per cent in Australia.[21] These barriers need to be overcome because most patients do not need hospital care and can be better cared for more locally.

[15] American Hospital Statistics; CSFB; AHA Trendwatch Chartbook; CMS, Office of the Actuary

[16] *Our health, our care, our say: a new direction for community services*, January 2006, Department of Health.

[17] Man et al., "Community Pulmonary Rehabilitation after hospitalisation for acute exacerbations of COPD," *BMJ* 2004:329;1209 and Blue et al., "Randomised controlled trial of specialist nurse intervention in heart failure," *BMJ*, Sep 2001;323:715-718

[18] Ipsos MORI, *London Residents' Attitudes to Local Health Services and Patient Choice*, December 2006

[19] This and subsequent figure from analysis of DH Hospital Activity Statistics 04/05

[20] BMA Health Policy and Economic Research Unit, *Survey of GP practice premises*, London 2006.

[21] *2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.*

Reason 5

The need for more specialised care

25 Whilst most people can be cared for by community services, the most seriously ill need more specialised care. For instance, a detailed review of stroke services found that dedicated stroke units saved lives.[22]

26 Dedicated stroke units provide rapid access to a CT scan to determine the cause of the stroke, immediate treatment with clot busting drugs (if appropriate to the type of stroke) and physiotherapy within a few days of the stroke. Delivering this high quality care requires specialist multidisciplinary teams and high quality equipment all available 24 hours a day, 7 days a week.

27 However, out of the thirty hospitals in London providing stroke services, only four treated over 90 per cent of stroke patients in a dedicated unit, and, whilst patients should receive a CT scan within three hours, only in seven hospitals were 90 per cent of patients getting a scan within a less-than-ideal 24 hours.[23]

28 Stroke care provides a salient lesson in how uncontrolled growth in service provision without proper consideration to the infra-structure and workforce needed can be dangerous for patients. What is needed is the planned development of specialist care. Achieving this requires the rationalisation and centralisation of more specialised services in fewer hospitals. There are three main reasons for this:

- **First**, specialist doctors, along with their specialised teams, need to see a large enough volume and variety of cases of a specific condition to hone their skills and develop and sustain expertise. There is evidence that specialist units performing a large number of cases achieve better results, particularly in more complex work.[24] Such concentration of care, with large numbers of patients, also creates centres of excellence that make it easier to train future specialist staff.

- **Second**, technology advances are driving more centralisation of specialist services. The most complex cases require a range of diagnostic equipment –MRIs, gamma cameras and even new methods such as Positron Emission Tomography (PET) scanners which can detect illness at a much earlier stage – all to be available in one place. To do this means locating high tech equipment in centres of expertise where trained staff can utilise them, and where there are enough cases to justify the technology's cost.

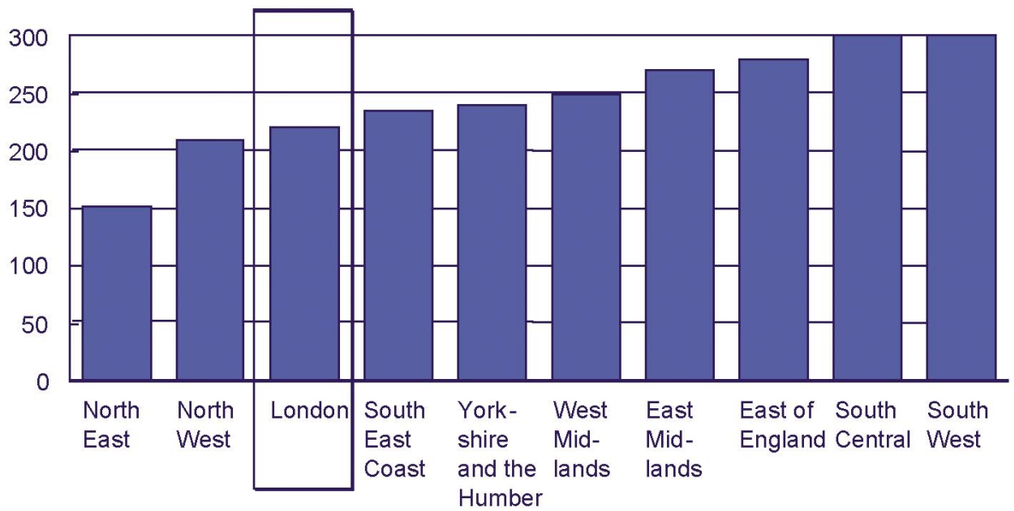
- **Third**, better working practices mean that staff are becoming centralised in fewer centres. Experienced staff are needed to manage the care of patients in hospital. The recent Healthcare Commission report into Northwick Park Hospital recommended that there be consultant presence on the maternity unit for 60 hours a week.[25] In addition, the European Working Time Directive (EWTD) is helping to ensure doctors are less likely to be tired when treating patients, by requiring them to work fewer hours. However, this does mean that more doctors are needed to maintain a 24 hours a day, 7 days a week, service. To achieve greater consultant presence in hospital and to comply with the EWTD will require the reorganisation of services. It will be harder for small hospitals to employ enough consultants to provide continuous cover for acute services.

29 In order to ensure sufficient volumes of work to maintain specialist staff expertise, to foster high tech facilities and to allow comprehensive consultant care, specialist services will need to cater for larger populations. Yet despite having the highest population density, London SHA has one of the smallest average catchment populations per hospital:

30 This means that hospitals in London are not able to take advantage of the advances in medical care as specialist staff and facilities are spread across too many sites.

London has relatively high number of general hospitals despite high population density

Population per general hospital, 000



Source: Hospital reconfiguration, IPPR Briefing, September 2006

[22] Intercollegiate Working Party for Stroke, *The National Clinical Guidelines for Stroke*, 2004 (2nd Edition) Royal College of Physicians, London

[23] *National Sentinel Stroke Audit* 2004

[24] Michael Soljak, "Volumes of Procedures and Outcomes of Treatment,", *BMJ* 2002;325:787-8 and Killeen SD, O'Sullivan MJ, Coffey JC, Kirwan WO, Redmond HP "Provider volume and outcomes for oncological procedures," *Br J Surg* 2005; 92(4):389-402.

[25] Healthcare Commission, *Investigation into Maternal Deaths at Northwick Park Hospital*, August 2006.

Reason 6

London should be at the cutting edge of medicine

31 London is the leading centre for health research in the UK. 50 per cent of the UK's biomedical research is carried out in the capital and 30 per cent of healthcare students are educated there.[26] However, the UK as a whole risks lagging behind its international competitors. The UK now spends half as much on research as a proportion of GDP compared to the United States.[27] At the same time, the number of commercial drug trials taking place in India and Russia is growing exponentially, whilst the trial numbers in the UK remain fairly static.

32 Changes to the way funding is allocated under the government's new research and development strategy *Best Research for Best Health* are also likely to mean that the share of research funding that London receives will decrease.[28]

33 Responding to these developments requires closer co-operation between hospitals and universities in London. A new form of university/hospital partnership is needed to maintain the UK's academic institutions at the forefront of the global marketplace where they compete for grants, recognition and staff.

34 Other large developed cities have ensured the promotion of clinical excellence and the translation of research into practice by establishing one or more Academic Health Sciences Centres (AHSCs), combining world-class research with leading edge clinical services and education and training. AHSCs help to ensure that research breakthroughs lead to direct clinical benefits for patients.

35 Cities such as Toronto and Boston already have AHSCs and London risks being left behind. AHSCs are a model of healthcare organisation London needs to explore – the recent announcement of three comprehensive and four specialist Biomedical Research Centres in London offers the first step in doing this.[29]

[26] London Higher, *Leading Health*, www.londonhigher.ac.uk

[27] HM Treasury (UK). NIH and US Government (US)

[28] *Best Research for Best Health*, DH, Jan 2006. Analysis of Funding of R&D in London, Dr Mark Lewis, Director of Clinical Governance and Research, NHS London (NWL) 15th January 2007

[29] Announcement of Biomedical Research Centres, http://www.nihr.ac.uk/programmes_biomedical_research_centres.aspx

Reason 7

Not using our workforce and buildings effectively

36 The NHS's staff are its greatest asset, but their abilities are not always fully utilised. For instance, productivity levels in London in terms of case mix adjusted Finished Consultant Episodes are noticeably lower than elsewhere in England. This means that doctors in a large acute hospital in London see 24 per cent fewer patients than their counterparts in comparable hospitals elsewhere in England. Nurses also see relatively fewer patients.[30]

37 Meanwhile, the NHS has never employed staff in a way that helps them to move easily between the hospital and community settings, as they will have to in future. There needs to be more support for staff to work flexibly to deliver the best care and not tie them to one institution. And there must be a greater emphasis on developing a culture that monitors and promotes improvements in the quality of the care that staff deliver.

38 Our buildings also need to be used more effectively. The NHS in London has a huge property portfolio of nearly 100 hospitals as well as hundreds of other sites for mental health and community provision. This equates to a total of 4-5 million square metres of facilities and this estate costs at least £0.7 billion (around 7 per cent of the total healthcare spend in London) simply to service.[31]

39 However, many of these facilities are under-utilised. The Bolingbroke Hospital in Wandsworth uses less than 50 per cent of its estate. Other sites are not fully utilised outside of the traditional working week.

40 Not only is our healthcare estate being used ineffectively, it is also ageing. Recent investment has led to the opening of impressive new healthcare facilities such as the Brent Emergency Care and Diagnostic Centre at Park Royal.

41 Yet much more needs to be done. Backlog maintenance – the figure used to determine how much investment is needed to bring hospital buildings up to an acceptable standard – for just the acute hospitals in London is over £800 million. Barnet and Chase Farm Hospitals NHS Trusts has backlog maintenance of £44 million whilst for The Hillingdon Hospital NHS Trust it is over £55 million.

42 Ageing facilities cause a multitude of problems such as being more difficult to access, not being designed with the latest medical techniques in mind and being harder to keep clean, leading to more infections such as MRSA.

[30] Analysis of DH HES statistics

[31] NW London SHA, *Pan London Estates Strategy,* June 2006.

Reason 8

Making the best use of taxpayer's money

43 Funding is not the major reason for change, but the NHS in London would be failing in its duty to its population if it did not make the best use of the money it has. Money wasted through inefficiency in one aspect of healthcare is money that could have been used to save lives elsewhere.

44 The unprecedented national growth in NHS funding that has occurred over the last five years will slow down from April 2008. In addition, an adjustment to the funding allocation will see most London PCTs getting significantly lower rates of increase to their funding than in the past whilst rising costs of staff, drugs and technology, and increasing expectations, will continue to exert pressure. The only way for future healthcare provision to be sustainable is changing to ensure care is provided in the most cost-effective way.

45 One of the major ways to achieve good value care would be to ensure people are not staying in hospital longer than they need to. For instance, in 2004/05 if all London hospitals had achieved the English average for lengths of stay this would have saved 800,000 bed days or over £200 million.[32]

46 Across London, achieving the average length of stay would free up over two thousand beds. This could be done by measures such as reducing the number of patients admitted the day before their operation.

[32] London Health Observatory

Conclusion:

The Need to Lead Change

47 These eight reasons for change provide a clear rationale as to why we cannot persist with the status quo in London. This is a compelling case but we need to understand that people have become used to their health service as it actually is, not how it might be in order to save more lives. The public remain very attached to services provided by their local district general hospital, especially A&E and maternity services, and can fiercely oppose changes.

48 People's first reaction when thinking of where money should be spent is their local hospital. Thus the MORI survey found that when asked a one-off question as to where the NHS should invest its money, 58 per cent of Londoners would choose existing hospitals as opposed to investing in more local services and fewer, larger, hospitals.[33]

49 Yet when the need for change is communicated clearly and when the evidence is presented, people can see the rationale for change. At the concluding event of the *Your health, your care, your say* consultation, 54 per cent of the thousand participants said they supported moving services closer to home even if this meant fewer services in hospital, compared to 29 per cent who opposed this proposal.[34]

50 In the past, the NHS has often been poor in communicating the case for change. There has been little attempt to demonstrate the high quality community services that will be developed or these services lack visibility when compared to the much-loved local hospital building.

51 Commissioners at all levels, from GPs as practice based commissioners through to commissioners of highly specialised services, need to make the case for change coherently. To do this they need to form effective partnerships with their clinical colleagues and with the local authorities who provide the social care, leisure services and so much more that is crucial to supporting the health of Londoners. They need to draw on research and evidence to quantify the impacts of spending and work with the public to decide which health services should be bought to meet their needs. They need to lead change.

52 Often the leadership of change is hampered by a lack of information. This document is the first phase in tackling this paucity of information and it will be followed by *The Framework for Action*, setting out the principles that the NHS in London should follow in responding to the challenges it faces.

53 *The Framework for Action* will be informed by contributions from leading clinicians in London, the UK and the world. It will use the best available evidence. It will take into consideration the perspectives of London councils, the voluntary sector and others. Most importantly, it will draw on the views of Londoners.

54 *The Framework for Action* will appear shortly and it is not intended to delay current change until it is published. Where developments need to happen because of the eight reasons for change outlined here, they must proceed.

[33] Ipsos MORI, *London Residents' Attitudes to Local Health Services and Patient Choice*, December 2006
[34] *Our health, our care, our say*, p.148