Overview & Scrutiny

Inner North East London Joint Health Overview and Scrutiny Committee

All Members of the Inner North East London Joint Health Overview and Scrutiny Committee are requested to attend the meeting of the Committee to be held as follows:

Thursday, 11th September, 2014,

7.00 pm
LB Newham, East Ham Town Hall, Barking Road, East Ham, London, E6 2RP

Gifty Edila
Corporate Director of Legal, Human Resources and Regulatory Services
Contact:
Jarlath O'Connell
☎ 020 8356 3309
✉ jarlath.oconnell@hackney.gov.uk

Members: **Cllr Ben Hayhurst, Cllr Ann Munn and Cllr Rosemary Sales**

Agenda

ALL MEETINGS ARE OPEN TO THE PUBLIC

Hackney

This page is intentionally left blank

Inner North East London
Joint Overview and Scrutiny Committee (INEL JHOSC)

Membership 2014-16

Borough	Members
Hackney	Cllr Ann Munn
	Cllr Ben Hayhurst
	Cllr Rosemary Sales
Newham	Cllr Dianne Walls OBE
	Cllr Winston Vaughan
	Cllr Anthony McAlmont
Tower Hamlets	Cllr Asma Begum
	Cllr David Edgar
	Cllr Mahbub Alam
City	Common Councilman Wendy Mead

The London Borough of Waltham Forest is also invited to attend when there are agenda items of interest, such as in regards to Barts Health NHS Trust.

This page is intentionally left blank

MINUTES OF A MEETING OF THE INNER NORTH EAST LONDON JOINT OVERVIEW AND SCRUTINY COMMITTEE FOR HEALTH

WEDNESDAY, 17TH FEBRUARY 2014 AT 7.00 PM
MULBERRY PLACE, LONDON

Members Present:	**Councillor Winston Vaughan (Chairman), Councillor Luke Akehurst (Vice Chairman), Councillor Ben Hayhurst, Councillor Ann Munn, Councillor Benzion Papier, Common Councilman Dhruv Patel, Councillor Terence Paul, Councillor Rachael Saunders and Councillor Ted Sparrowhawk**
Member Apologies:	**Councillor David Edgar and Common Councilman Wendy Mead**
Officers in Attendance:	**Luke Byron-Davies (Scrutiny Manager, LB Newham, Jarlath O'Connell (Overview and Scrutiny Officer, LB Hackney), Neal Hounsell (City of London Corporation), Tahir Alam (Strategy Policy and Performance Officer, LB Tower Hamlets), and Philippa Sewell (City of London Corporation)**
Also in Attendance:	**Nick Kennel (NHS England), Elizabeth Smith (Project Manager Clinical Support Unit, Moorfields Eye Hospital), John Pelly (Chief Executive, Moorfields Eye Hospital), Seaton Giles (CQC Compliance Manager (Newham and Waltham Forest)), Mark Graver (Head of Stakeholder Relations and Engagement, Barts Health), Kay Riley (Chief Nurse, Barts Health), Clare Dollery (Clinical Director of the Heart Hospital at UCL Hospitals, and Medical Director for Informatics and Governance, Barts Health), Pauline Farrell (Associate Director of Human Resources, Barts Health), and George Soutar (Healthwatch Newham)**

1 Welcome and Introductions

1.1 The Chair welcomed everyone to the meeting and advised of a change in the order of agenda items: item 8 London Cancer Project Update would now be taken as item 6.

2 Apologies for Absence

2.1 Apologies for absence were received from Councillor David Edgar and Common Councilman Wendy Mead. Apologies were also received from Dr Penny Bevan (Director of Public Health Hackney) and Sue Milner (Director of Public Health Newham).

3 Declarations of Interest

3.1 Councillor Ben Hayhurst declared a non-pecuniary interest in the London Cancer Project Update by virtue of knowing Nick Kennell (NHS England), and Councillor Winston Vaughan declared a non-pecuniary interest in the same item by virtue of being a member of the Association for Prostate Awareness.

4 Minutes of the previous meeting

4.1 The Committee gave consideration to the minutes of the meeting held on 20 November 2013.

RESOLVED – That the minutes of the meeting of the Committee held on 20 November 2013 be agreed as a correct record.

5 Actions and matters arising from the meeting on 20th November 2013

5.1 There were no matters arising.

6 London Cancer Project Update

6.1 The Chairman welcomed Nick Kennell from NHS England to the meeting, who gave a short presentation on the project to create integrated Cancer and Cardiovascular systems to provide local and specialist care.

6.2 Members were advised of the level of engagement to date and noted that a report on phase one engagement and an options appraisal report would be available later this month. The London Clinical Senate was undertaking an independent clinical assurance of the proposals, the outcome of which would inform commissioners' preferred recommendations. These would in turn be outlined in the initial business case to be published by early April.

6.3 With regards to the Major Trauma Centre, Mr Kennell outlined the key issues which had been identified from the clinically-led workshop held on 16th January, and reported that a programme of work was being arranged to address these and mitigate risks.

6.4 Phase two of the project, a series of engagement events and information, would follow the publication of the initial business case in April, after which planning for implementation and development of commissioner assurance, oversight frameworks and a decision-making business case could begin.

6.5 **Councillor Ben Hayhurst opened the questioning by asking whether NHS England could guarantee Cancer and Cardiovascular funding would not be reduced as a result of the consolidation of specialist centres?**

6.6 Mr Kennell responded that NHS England were unable to guarantee funding levels wouldn't be affected as the cost of delivering services would change, but

assured Members that the project was driven by clinical advantages not financial reasons.

6.7 **Councillor Terrance Paul queried when local residents would start to see the positive impact of consolidating services.**

6.8 Mr Kennell replied that the figure of 1800 lives being saved as a result of the changes was the potential figure; the next stage was to prepare a schedule of how the changes would be implemented. Councillor Paul followed up on this response, stating that Members wanted to know outcomes in terms of health, not the processes involved, and asked for a future presentation to address this.

6.9 **With regard to two cancer site being turned into one, Dhruv Patel asked whether proton beam therapy would be available at the UCL Cancer Institute.**

6.10 Mr Kennell advised that proton beam therapy was not part of the clinical appraisal as it was not core to service delivery and treatment.

6.11 In response to a follow up question from the Chairman regarding NICE guidance (National Institute for Health and Care Excellence), Mr Kennell reported that the guidance regarding prostate cancer was currently being revised, and that part of the London Clinical Senate review was to assess the impact of that change.

6.12 **Councillor Ann Munn asked when a report concerning Phase two of the project would come back to the INEL JHOSC, considering the Elections taking place in May.**

6.13 Mr Kennell confirmed that final decision making was anticipated for summer 2014, and Members agreed that a future presentation would be scheduled closer to the time.

7 Moorfields Eye Hospital

7.1 The Chair welcomed Project Manager Elizabeth Smith and Chief Executive John Pelly from the Moorfields Eye Hospital NHS Foundation Trust.

7.2 Mr Pelly advised Members that the document circulated with the agenda set out the reasons for the move and why the Kings Cross area had been chosen, as well as the engagement document used in a consultation exercise that concluded on 14th February.

7.3 Ms Smith reported that this initial consultation had lasted 12 weeks and had liaised with patients and Clinical Commissioning Groups (CCGs) via a questionnaire, drop-in sessions, open days and online communication and social media. She added that of the 59 responses received 87% were positive about the move.

7.4 **Councillor Luke Akehurst opened the questioning, asking whether Moorfields were considering changing their name?**

7.5 Mr Pelly responded that a new name was being considered to reflect the integrated clinical and research institute with UCL, but that "Moorfields" would still feature.

7.6 **Councillor Terrance Paul asked for more details concerning borrowings and funding for the new site.**

7.7 Mr Pelly replied that exact figures were unavailable as they would depend on the final choice of site (i.e. whether it was lease or freehold) but they were currently estimating that the project would cost in the region of £300million; £75million to be raised through charitable sources, £50-100million from UCL, £30million from Moorfields, and £60million borrowed from government sources.

7.8 **Councillor Ben Hayhurst queried where the majority of patients came from?**

7.9 Mr Pelly confirmed that referral figures for Newham, City & Hackney and Tower Hamlets had been circulated with the papers, and that the majority of patients were from neighbouring boroughs.

7.10 The Moorfields site on City Road saw 30% of the ophthalmology work in Central London as generally complex issues couldn't be treated at satellite sites. He reported that some presence would be retained at the City Road site, though exactly what was undecided, and that, after the move, Moorfields were looking to expand further in the East of London with regards to outpatient and surgical services.

7.11 **The Chairman asked for more details concerning the provision of parking at the new Kings Cross site.**

7.12 Mr Perry advised Members that the specific site was yet to be determined, though it was unlikely that a great deal of car parking capacity would be created. Instead transport links from Kings Cross St Pancras station would be facilitated (i.e. a shuttle bus) as well as car drop-off points.

7.13 **Councillor Terrance Paul enquired as to the footprint of the Moorfields site.**

7.14 Mr Pelly advised that the £300million estimate was just for City Road, which would be moving to a smaller site in Kings Cross. As such, satellite sites were also being invested in to ensure they could accommodate a greater number of patients once the move had occurred.

7.15 In a follow up question, Councillor Paul queried whether this had been included in the initial consultation document, as the existing quality of satellite services would affect consultation results.

7.16 Ms Smith advised that additional open days had been held at satellite sites to gather their views, and Mr Pelly confirmed that the initial consultation was just the beginning of a much more extensive engagement with patients and partner agencies.

7.17 **The Chairman questioned whether 87% of 59 respondents was enough to indicate a significant result?**

7.18 Ms Smith replied that 59 from 200 was an average level of feedback, though responses were still being received and some were sent in on behalf of multiple people. She confirmed that this initial consultation had lasted for 12 weeks but that they would continue to consult patients and partners throughout the project.

7.19 In response to a follow up question from Councillor Ted Sparrowhawk, Mr Pelly reported that the entire project was anticipated to take around 7 years.

7.20 The Chairman thanked the officers for attending, and noted that a further conversation would be needed concerning how extensive future consultations will need to be.

8 Care Quality Commission Report into Barts Health NHS Trust

8.1 The Chairman welcomed Seaton Giles from the Care Quality Commission (CQC), and Mark Graver, Kay Riley, Clare Dollery and Pauline Farrell from Barts Health NHS Trust

8.2 Mr Giles gave a short presentation on the inspection of Barts Health NHS Trust. He advised Members that since the appointment of Professor Sir Mike Richards as Chief Inspector of Hospitals new methodology for inspections had been adopted. All hospitals in the UK had been assessed against a number of key indicators which revealed Barts Health to be high risk. It was noted that as this was the first large inspection with the new methodology, no final rating had been given. These would be applied from inspections starting in April 2015.

8.3 The inspection asked five questions around eight key areas and an extensive consultation fed into the inspection plan. A large team undertook announced and unannounced visits, and was compiled from a broad range of people to ensure depth and breadth of information. Listening events were held for each named site and Quality Summits were held to discuss how to move forward.

8.4 Mr Giles briefly summarised three sites where areas for improvements had been found: Newham Hospital, Royal London and Whipps Cross. As well as areas for action, Mr Giles also highlighted the examples of good or outstanding practice for each.

8.5 Overall, Members noted that Barts Health provided very good services but there were issues that needed to be addressed. Mr Giles reported that it was early days for a combined Trust and the CQC recognised the scale of the challenges associated with reconciling different cultures and the additional financial pressure. He reported that there was a clear strategy and cohesive leadership, but also a lack of connection between the Executive Board and frontline staff.

8.6 Mr Giles advised Members that the Trust were now implementing the action plan, with Clinical Commissioning Groups and Trust Development Authority (TDA) monitoring ongoing performance. The CQC would maintain and ongoing

dialogue with the Trust, and there would also be follow up inspections in due course.

8.7 Chief Nurse at Barts Health was invited by the Chairman to respond. She replied that the Trust had welcomed the inspection, and that the robust and well-informed results had been beneficial. The outcome had been balanced and all of the issues raised were already known in some way to the Trust. There had been positive areas of work identified on every site, which had been a boost for staff morale and drew focus for further improvements.

8.8 Councillor Ben Hayhurst asked for the CQC to include a contents page for future reports of this size.

8.9 **Councillor Hayhurst asked for more detail concerning unannounced inspections, and queried how serious the problem was?**

8.10 Mr Giles responded that the Trust was informed in advance of the inspection as some of the data collection was carried out prior to the inspection itself, but that unannounced visits were less structured. The Trust were not informed of where exactly the inspection team would be visiting, nor how long they would stay, as this was decided by the feedback being received from staff and patients.

8.11 With regards to the issue of bullying, Mr Giles advised Members that this term was used in a broad sense and was indicative of staff feeling inhibited, unable to raise concerns, and that their concerns went unheard. In a follow up question Councillor Ann Munn questioned how staff were asked about bullying? Mr Giles replied that they weren't; it had been an issue raised by staff themselves.

8.12 **Councillor Luke Akehurst asked whether the inspection had determined how pervasive the problem was, i.e. was it institutional, a lack of positive management process, or lack of communication?**

8.13 Mr Giles responded that a range of factors had been identified. In addition to institutional problems, incidents of particular individuals undertaking bullying behaviour had also been reported.

8.14 **In a follow up question, Councillor Rachael Saunders asked whether instances of bullying were connected to the visibility of and confidence in senior leadership.**

8.15 Chief Nurse Ms Riley at Barts Health responded that the Trust was aware of the problem but hadn't appreciated the full scale of it. She advised Members that issues concerning visibility of leadership and trust in senior staff were unsurprising owing to the lack of stability of staff in the past. The Trust was looking to do more diagnostics and work was in place to ensure staff could speak freely in open meetings and in confidence. Ms Riley also reported that the Trust intended to look at and learn from other large organisations.

8.16 **Councillor Hayhurst returned to the issue of management visibility, and queried why initiatives started two years ago, such as First Friday, were still not well known.**

8.17 Ms Riley reported that Clinical Fridays, where senior maangement would visit and to review a range of issues and liaise with frontline staff, were an embedded and well-known practice. With regard to First Fridays, Clinical Advisory Groups (CAGs) had been given freedom to implement and organise them in the past, which had failed. Now the Trust were working with CAGs to ensure a more structured approach was in place.

8.18 **Councillor Terrance Paul asked whether a rating would be given for the Trust, either now or retrospectively.**

8.19 Mr Giles responded that the inspection was part of a pilot and that as the methodology was untested and still being refined the CQC would not be giving a rating for this inspection, either now or retrospectively. Instead the Commission would re-inspect during 2015 and give ratings for individual services and sites.

8.20 In response to a series of follow up questions from Councillor Paul, Mr Seaton advised Members that the report from this inspection was very detailed and readers could draw their own conclusions as to a final rating.

8.21 **With regard to impact on quality of care, Councillor Ben Hayhurst questioned whether use of bank and agency staff was being monitored and how it was being addressed?**

8.22 Ms Riley reported that there was a drive to reach 95% recruitment underway; Associate Director of Human Resources Ms Pauline Farrell added that current levels were at 90.5% but the Trust was aiming to reach 95% by June. Ms Farrell reported that the bank was generally made up of existing staff members but agency staff would not necessarily be familiar with processes, and their use was being reduced. The recruitment timescale had been reduced to eight weeks, and it was hoped this could be improved to six.

8.23 In a follow up question Councillor Hayhurst asked whether there were areas with more reliance on agency and bank staff. Ms Riley responded that there were pockets around specialist critical care which were difficult to recruit to nationally. At the request of Members, Barts Trust undertook to report back on the three departments with the highest number of agency staff for February and at the time of the next INEL JHOSC meeting.

8.24 **Councillor Rachael Saunders asked for more detail on the number of vacancies, and asked how the Trust were addressing ill-health as a result of unemployment in the local community?**

8.25 Ms Farrell advised Members that staff turnover was approximately 11-12% and that there were hundreds of vacancies each month. This was being addressed through the drive to 95% recruitment and by monitoring the number of offer letters and approvals for vacancies made each week against a target of 140 offers being made per month.

8.26 With regards to local employment Ms Farrell reported that a group had been set up which aimed to bring in local people and giving them access to work. Recruitment drives, apprenticeships and training and development pathways were in place to improve the health of the population through employment.

8.27 **Councillor Rachael Saunders asked a specific question around patients' meal times at Royal London, and Dhruv Patel queried why the food at Barts Hospital had been worse than elsewhere.**

8.28 Ms Riley responded that mealtimes were being protected at Royal London and visiting hours revised. She also reported that volunteers were being recruited currently to assist with mealtimes. With regards to Barts Hospital, Ms Riley advised that the Trust held several different catering contracts as a result of the merge, which would be addressed as they came up for renewal. A change in food provision on the wards at Barts had been implemented straight away, and Members noted that the Trust were about to re-audit the service.

8.29 **Councillor Terrance Paul returned to the issue of bullying, and asked what was being done to challenge the culture of senior managers and whether there would be any impact on their future employment.**

8.30 Ms Riley replied that the cultural issues were a hangover from the Legacy Trusts and had been compounded by the merge. Conversations were ongoing around challenging senior leadership and to diagnose problems, though it was assured that any individual bullies would be found and asked to leave.

8.31 With regards to the impact on future employment, Ms Farrell responded that a new appraisal process was being developed to link values and performance, which would highlight any issues and affect staff progression. She also advised Members that the Trust were looking to bringing in an external expert to advise on how to identify and resolve the reasons for staff feeling bullied or ill-treated.

8.32 **Dhruv Patel asked for a general update as to the financial turnaround, and queried whether there had been an impact as a result of recruitment?**

8.33 Ms Riley replied that the financial position had improved significantly as a result of income levels and other work streams, and reported that recruitment was being made to agreed establishments and as such had not created any issues.

8.34 **Councillor Ann Munn queried the level of consultant cover in relation to support and visibility of staff.**

8.35 Clinical Director of the Heart Hospital at UCL Hospitals and Medical Director for Informatics and Governance Clare Dollery reported that some departments had better cover and visibility than others, and this was currently being reviewed. She advised that it related to how people were organised rather than just staff numbers.

8.36 **In a follow up question, Councillor Hayhurst asked whether the bullying culture extended to junior doctors feeling inhibited to ask for additional support and to what extent was there monitoring of calls to on-duty consultants?**

8.37 Ms Dollery responded that there was no formal monitoring system of the number of calls. Support was expected and there would be more questions raised over junior doctors not asking for support. She advised Members that all

medical staff had 360 degree feedback which was looked at in detail before the staff member was revalidated.

8.38 The Chairman thanked the CQC and Barts Health Trust officers for attending and answering questions.

9 Any Other Business

9.1 There was no other business.

As this was the last meeting of the INEL JHOSC in its current format, the Chairman thanked Members for their contribution.

Duration of the meeting: 7.00 - 9.00 pm

Signed

……..

Chair of Committee

Contact:
Luke Byron-Davies
luke.byron-davies@newham.gov.uk

This page is intentionally left blank

Inner North East London Joint Health Overview and Scrutiny Committee 11 September 2014 **Removal of the Minimum Practice Income Guarantee (MPIG)**	Item No **6**

Outline

Due to the possible impacts of the removal of the Minimum Practice Income Guarantee (MPIG) to all of the INEL boroughs, members have requested to review this issue.

Further information is available at Appendix 1.

Action

The Committee is requested to give consideration to this issue and to offer a response if appropriate (either during or after the meeting).

This page is intentionally left blank

Removal of the Minimum Practice Income Guarantee (MPIG)

1 Background

1.1 There has been much recent media coverage and some parliamentary debate about changes to the Minimum Practice Income Guarantee (MPIG) which could potentially have a significant impact (defined nationally as more than an average reduction greater than £3 per weighted patient population over each of the seven year transition programme) on around 98 GP practices across the country. 34 of these are in London, which equates to around 2% of the total number of practices in the capital.

1.2 This paper provides some background information about the changes, along with an outline of the steps we have taken thus far to support practices as the MPIG will be slowly phased out.

1.3 GPs are independent contractors and their practices are independent businesses. The NHS has no jurisdiction in terms of a decision to remain in business or to close the practice essentially for commercial reasons - that remains the concern of an individual practice. GP income derives from a number of different sources external to NHS England (which would typically include Local Authority, CCG).

1.4 General practice is the bedrock of the NHS in London and is crucial to wider plans to transform healthcare in the capital. We are committed to supporting the capital's family doctors through these changes.

2 What is the MPIG?

2.1 The introduction of the General Medical Services (GMS) contract in 2004 presented a significant change to the way GPs are funded. It moved GP funding away from payment tariffs for each individual item of treatment to a new funding formula based on a wide range of patient, environmental, workload and workforce characteristics. Under the GMS contract, practices receive a share of a total amount of money allocated towards primary care in GMS practices – known as the 'global sum'. The global sum makes up the majority of the money a practice receives. This amount is calculated based on a formula relating to the characteristics of a practice's patients and the subsequent workload created - which are based on numbers of patients and key determinants of practice workload, such as patient age, health needs and the unavoidable costs of rural practice (not an issue in London). This is known as the Carr-Hill formula.

2.2 The national contract changes made in 2004 meant that a number of practices would face a drop in income. In order to smooth the transition between the old and the new contracts, the Minimum Practice Income Guarantee (MPIG) was introduced as a measure to protect the previous income levels of those who were liable to lose money under the new system. It has been in payment for 10 years.

2.3 Practices that gained under the transition to the new contract in 2004 did not receive MPIG.

3 Phasing out the MPIG

3.1 The MPIG was always intended to be a temporary measure or 'stop-gap' funding, which would give practices time to adjust their finances to the new system. It was never intended to be a permanent feature of GP contract income as it was anticipated that it would phase out over time naturally as GP incomes rose.

3.2 In 2006/07 NHS Employers and the GPC agreed that any future uplifts to the global sum should aim to reduce practice reliance on correction factor payments, to ensure a fairer allocation of resources across practices.

3.3 Two years ago, it was announced to GPs that MPIG would be phased out over a 7 year period. This change started in April 2014 - allowing time for practices to adjust to its gradual withdrawal.

3.4 The changes are part of a national policy to bring all practices into an equal financial position, which will ensure that all patients can expect the same high level of service from their GP wherever they live. At present, practices serving similar populations may be paid very different amounts of money per registered patient. In London's GMS practices based on 2012 list sizes, there was a significant range of funding per head of weighted capitation ranging from c£130 down to c£73 (after removal of the extreme outliers with very low lists). That is not equitable or sustainable.

3.5 There is a national review working group underway looking at the Car Hill formula with changes expected around deprivation factors, anticipated from April 2015. This is a major, complex piece of work and has already slipped from an expected operational date of April 2014. An explanation of the current construct of Carr Hill is available at the following site:

http://www.gpcwm.org.uk/wp-content/uploads/file/INVESTING%20IN%20GENERAL%20PRACTICE/Annex_D_Carr_Hill_resource_allocation_formula.pdf

4 Some other contractual issues

4.1 The culmination of a number of other contractual matters or changes is having a combined impact in some places in GP services. Aside from the MPIG removal, these other issues include:

- Changes in (Quality and Outcomes Framework (QOF) payments in 2013/14 resulting in an apparent drop in income last year
- Changes in QOF 2014/15 – retiring QOF indicators will be reinvested in global sum nationally not locally – (NHS England London Region said to be over target therefore the money will not be re-invested here)
- New 2014/15 DES schemes to be created as a result of changes in funding were not ready to start from April 1 2014 (they are now)
- An effective and on-going list maintenance programme is in place across London as part of the Quality, Innovation, Productivity and Prevention (QIPP) programme
- Reductions in all areas previously funded under the category 'discretionary funding' (e.g.
- locum payments through sickness)
- General trends in increasing workload/demand (although some of this may be funded through CCG developed local initiatives)
- Public health teams and Clinical Commissioning Groups putting the services, previously
- described as 'local enhanced services', out to tender or decommissioning them – reducing practice income and/or their ability to plan sensibly

4.2 However, related to the MPIG withdrawal, there are some issues where it could be argued that the Carr-Hill formula does not reflect the workload of London's GPs in some areas:

- Patients who attend the practice up to 12 times a year rather than for the 3.5 or 5.5 appointments per patient per year that are frequently used as a national benchmark figure
- Practices with a very high turnover and patients with no English or English as a second language which means generally booking double appointment slots

- Anecdotal reports of increased attendance of patients who are struggling to cope with the impact of national/Local Authority changes to benefits.

5 The Impact on London's GMS Practices

5.1 NHS England has chosen not to identify specific practices and the associated impact of these changes. Some practices have chosen to identify themselves through their efforts to lobby for change. That is their prerogative.

5.2 Amongst the 34 significant outliers in London 4 of these are in City & Hackney - but 2 of these have a list lower than 1000 weighted population.

5.3 It is not possible to find a generalization as to why the impact should be more significant in some areas rather than others. The construct of Carr Hill is very likely to have an impact in some places because of demographics, deprivation etc. It is important to remember that MPIG was introduced as a bridge between an old, fee for service contract to one funded on a capitation based system. Typically it was more difficult for practices to drive high income in a more deprived population under the construct of the old fee for service GP contract – and, in managing the succession of practices after April 2004 where the MPIG is not payable, it may have made the financial sustainability of succeeding practices more problematic although nationally procured practices must be offered an APMS contract.

6 Action so far

6.1 A small working group with the LMCs and the Office of London CCGs (as a first stage means of engaging with CCGs) has been convened to consider what support arrangements might be put in place to support the changes practices will need to make. There has been some analysis of the impact/spread across London. Two separate letters about MPIG have been sent to practices and two separate letters about the 2014/15 contract changes and the impact on each individual practice sent by Finance colleagues. Practices have been advised to:

- Calculate the likely impact on their practice (via Open Exeter)
- Assess the impact on their practice
- Think about the pace and scale of the reduction
- Commit to the need to plan for change
- Examine income and expenditure critically
- Consider future options for the practice
- Consider technological possibilities

6.2 The support offered to practices thus far is:

- offer of 1:1 conversations with practices with NHS England/LMC/CCG (CCG if so
- wishes) where impact greater than a £3 per weighted patient average year on year loss; 1:1 for others if requested (but no overt offer to meet)
- conduct an examination/review of income and expenditure including pensionable income
- understanding the exceptional workload directly attributed to the specific and unique demographics of the practice population that might be delivered in a different way
- discuss practical changes that might be made
- discuss future options for the practice, which might include merger of all/some functions, federations and networks, technological possibilities and retirement if so desired
- some limited organisational development input to plan delivery of changes.

6.3 Discussions with the LMCs did not make any promise of any further financial help from NHS England.

6.4 It is noted that in City & Hackney, c£8m CCG investment is made into local practices for delivery of a range of local services.

7 Moving forward - options

7.1 While the majority of practices in London will be better off financially in their global sum payments as a result of these changes, it is recognised that there is a small number (2%) which may be significantly affected. Having offered to meet with each of the 34 most affected practices to discuss their unique financial challenges and how they can be supported on a case by case basis, there has not been significant take up of this. **None of the City & Hackney practices have taken up the offer to meet with NHS England.**

7.2 In a number of instances, there may be special circumstances where the national funding formula may not be sufficiently sensitive to very local practice issues. For instance, the funding formula will not take into account certain factors, such as:

- Practices with a significant number of patients who attend the practice up to 12 times a year rather than the 3.5 or 5.5 appointments per patient per year that are frequently used as a national benchmark figure
- Practices with a very high turnover and significant numbers of patients who do not speak English

7.3 Additionally, there may be workload implications from increased attendance of patients who are struggling to cope with the impact of changes to the benefits systems.

7.4 There are a number of options for financial support being considered.

7.5 Internal discussions and dialogue with national colleagues continue and are expected to conclude during the course of week ending Friday 10 July.

8 Conclusion

8.1 NHS England has reflected on the needs and concerns of local practices that have been raised either by the practices themselves or as a consequence of their lobbying. There is some merit to an argument that Carr Hill may not adequately reflect the workload of some inner city practices where there are local population specific peculiarities. The London Region will shortly reach a view as to whether a short term financial support arrangement and on what terms, should be made available.

8.2 NHS England is also mindful that this does not and should not replace national primary care funding policy that is designed to ensure equitable funding in GMS practices across England.

Neil Roberts
Head of Primary Care
NHS England (London Region, North, Central & East)
7 July 2014

INNER NORTH EAST LONDON JOING OVERVIEW AND SCRUTINY COMMITTEE MEETING

11 SEPTEMBER 2014

Title:	Transforming Services, Changing Lives
Report Author: Neil Kennett-Brown, Programme Director	**Contact Details:** Tel: 020 3688 1222 E-mail: neil.kennett-brown@nelcsu.nhs.uk

Speakers:

Sam Everington – TSCL Primary Care Clinical Lead and Chair of Tower Hamlets Clinical Commissioning Group

Peter Morris – Chief Executive, Barts Health NHS Trust

Neil Kennett-Brown – TSCL Programme Director

Summary:

The Local Clinical Commissioning Groups (CCGs) of Tower Hamlets, Waltham Forest, Newham, Redbridge and Barking and Dagenham; plus NHS England, Bart's Health and other local providers, have established a clinical transformation programme called Transforming Services, Changing Lives (TSCL). It which will consider how services need to change to provide the best possible health and health care for local residents. **It does not, at this stage, outline any recommendations for change.**

A key element of the programme is to consider how best to ensure safe, effective and sustainable hospital services at Bart's Health hospitals, set in the context of local plans to further develop and improve primary, community and integrated care services.

The work of the programme, which was launched in February 2014, and is expected to run until autumn 2014, will develop a baseline assessment of the drivers for change in the local health economy and support further discussions about the scope, scale and pace of change needed.

Key milestones:

- **9 July:** Interim Case for Change published. Engagement commences to gather feedback to help to inform the final Case for Change and help us determine priorities for the future. This includes events for all Barts Health staff, attendance at public events and a series of patient focus groups.
- **Autumn**: Publication of final Case for Change.
- **After publication of Case for Change**: Explore and agree joint priorities to improve local services. If we think change is required we will work with the public and clinicians to consider a range of potential options to help improve healthcare services.

Recommendation(s)

The Joint Overview and Scrutiny Committee is recommended to:

(i) Provide comment and feedback based on their review of the Interim Case for Change. This will be used in the development of the final case for change, which is due to be published in October

(ii) Consider and confirm requirements and timings for future updates and presentations about the final Case for Change and any future work programmes

1. Background and Introduction

The five CCGs involved in Transforming Services, Changing Lives have a duty to promote a comprehensive health service for their populations of around 1.3 million people. Today, local NHS services face the very real challenge of providing care for a rapidly growing local population, whilst continuing to meet the health needs of some of the most deprived areas seen anywhere in the UK.

The health economy is never static. Change is happening all around the system. In the last year, since the establishment of CCGs, we have seen the introduction of NHS 111, the development of integrated care and soon the launch of personal health budgets. We need to respond to these changes to ensure that benefits are realised and unintended consequences are avoided.

However, we also know that some services simply need to improve to meet local needs. We need to address the areas where we are not so good. We know that the quality of care we provide is inconsistent. We need to work better with providers and with social care to address the challenges we face and decide how we can introduce new and different ways of providing care.

Collectively commissioners have agreed with providers to look at the challenges we face, to ensure we can continue to provide the care our patients need, at the best possible place for them. Organisation boundaries must not and cannot impede the commitment to deliver improvements at scale across the partnership.

We also need to make sure that any changes in the future happen safely and effectively.

In developing their case for change, clinicians will be guided by the principles of the Francis Report [1]to ensure delivering first class care for patients and local populations is the driver for change.

Local clinicians have been asked to use their own knowledge of national and international best practice to review the quality and performance of East London health services, highlight areas of good practice that should be maintained and developed, and set out if, why, and in what specialties they think there may be a case for change to ensure the very best care for local residents. They are not, at this stage, setting out any recommendations for change.

Their work has been published as an 'Interim Case for Change', which is available to view at www.transformingservices.org.uk.

[1] The Francis Inquiry report was published on 6 February 2013 and examined the causes of the failings in care at Mid Staffordshire NHS Foundation Trust between 2005-2009

2. Governance Arrangements

The governance arrangements for the programme have been established and include:

- Programme Board – tasked with providing the strategic oversight for the Programme. To reflect the external decision making requirements, the Programme Board reports to the relevant statutory bodies of CCGs, providers and the NHS England. CCGs ensure a clear link through to HWBBs. Additionally Waltham Forest, Tower Hamlets and Newham councils (the boroughs in which Barts Health hospitals are located) have been invited to sit on the Programme Board.

- Clinical Reference Group and Clinical Working Groups – these reflect the key clinical leadership role in exploring and shaping a Case for Change. CCGs, Barts Health, Homerton Hospital, community and mental health service providers and the London Ambulance service have nominated clinicians and other front-line staff to join clinical working groups. Links are also being established with academic partners. The clinical working groups focus on:
    - unplanned care (urgent and emergency care, acute medicine, non-elective surgery)
    - long-term conditions
    - elective surgery
    - maternity and newborn care
    - children and young people, and;
    - clinical support services

- A Public and Patient Reference Group – this group meets on a regular basis to provide ideas and feedback to clinicians leading the TSCL programme and support and advise on public engagement activities. Representatives have been invited from three broad groups:
    - local branches of Healthwatch
    - patient representatives from the CCGs involved in the programme
    - patient representatives from the providers involved in the programme

3. Engagement

Although TSCL does not, at this stage, set out any recommendations for change, the programme recognises the importance of engaging local stakeholders in our work at an early stage.

Since the programme was launched in February 2014, extensive engagement has taken place with stakeholders across Newham, Tower Hamlets, Waltham Forest, Redbridge, Barking and Dagenham, Hackney and City of London.

The current engagement period runs until 21 September, with feedback collected via online survey, post and at meetings and events. All feedback and requests for amendments to the final Case for Change are logged and reviewed for inclusion in the final document.

Engagement activity has included, but is not limited to:

- Information about the launch of the programme sent in February to key contacts including CCGs, providers, Local Authorities (including the Chief Executives, Health Scrutiny Committees, Health and Wellbeing Boards, Council Leader, Directors of Public Health and other services), Healthwatch, local MPs, London Assembly Members.
- Key stakeholders invited to attend large public events about the programme which took place on 4 April and 6 June 2014 at Stratford Town Hall.
- Formation of the TSCL Public and Patient Reference Group, including ongoing meetings and email updates.
- Press release about the interim Case for Change sent to local press outlets, local authorities, MPs and Assembly Members.
- A series of large staff engagement events at Barts Health
- Discussions with and presentations to Health and Wellbeing Boards and Overview and Scrutiny Committees
- Healthwatch Waltham Forest, Newham and Redbridge jointly hosted a large patient event on TSCL on 18 August, and are developing a report which will be fed in to the final case for change
- Wide clinical engagement programme to update clinicians, including GPs and doctors
- Presentations at CCG Governing Body meetings
- Public events, including attendance at open days and stands within hospitals

4. Appendix

Transforming Services, Changing Lives interim Case for Change

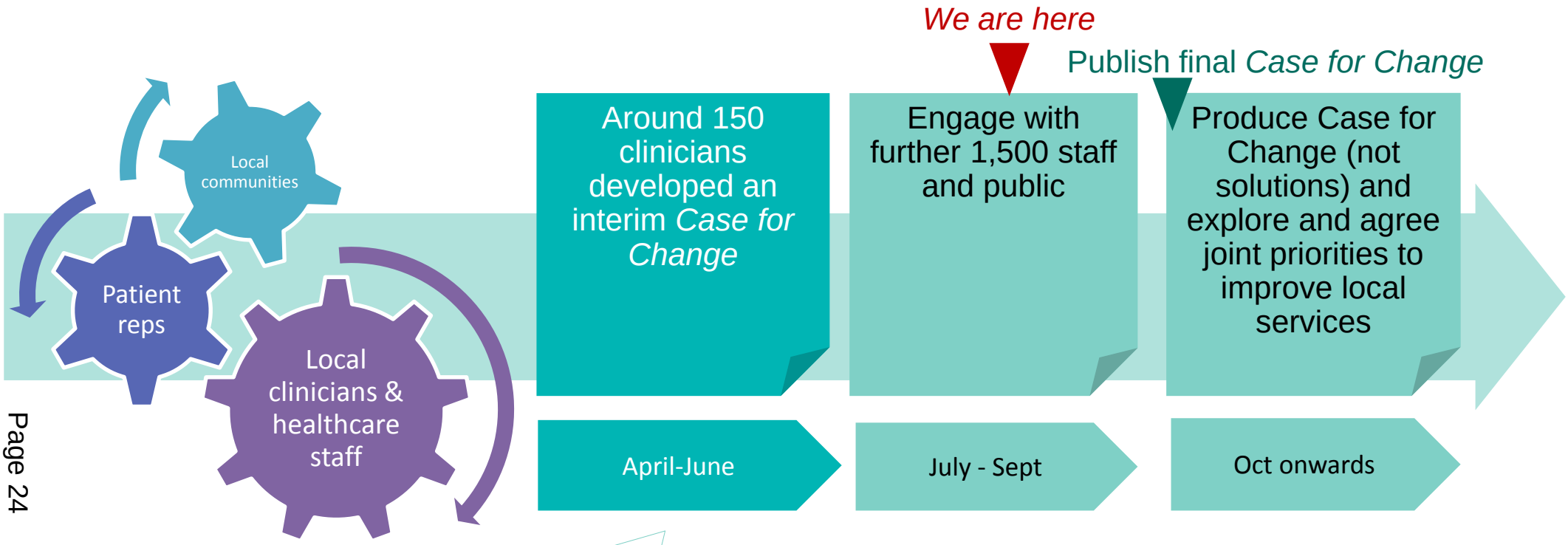
NEL Commissioning Support Unit

NHS

Transforming Services, Changing Lives

Interim *Case for Change*

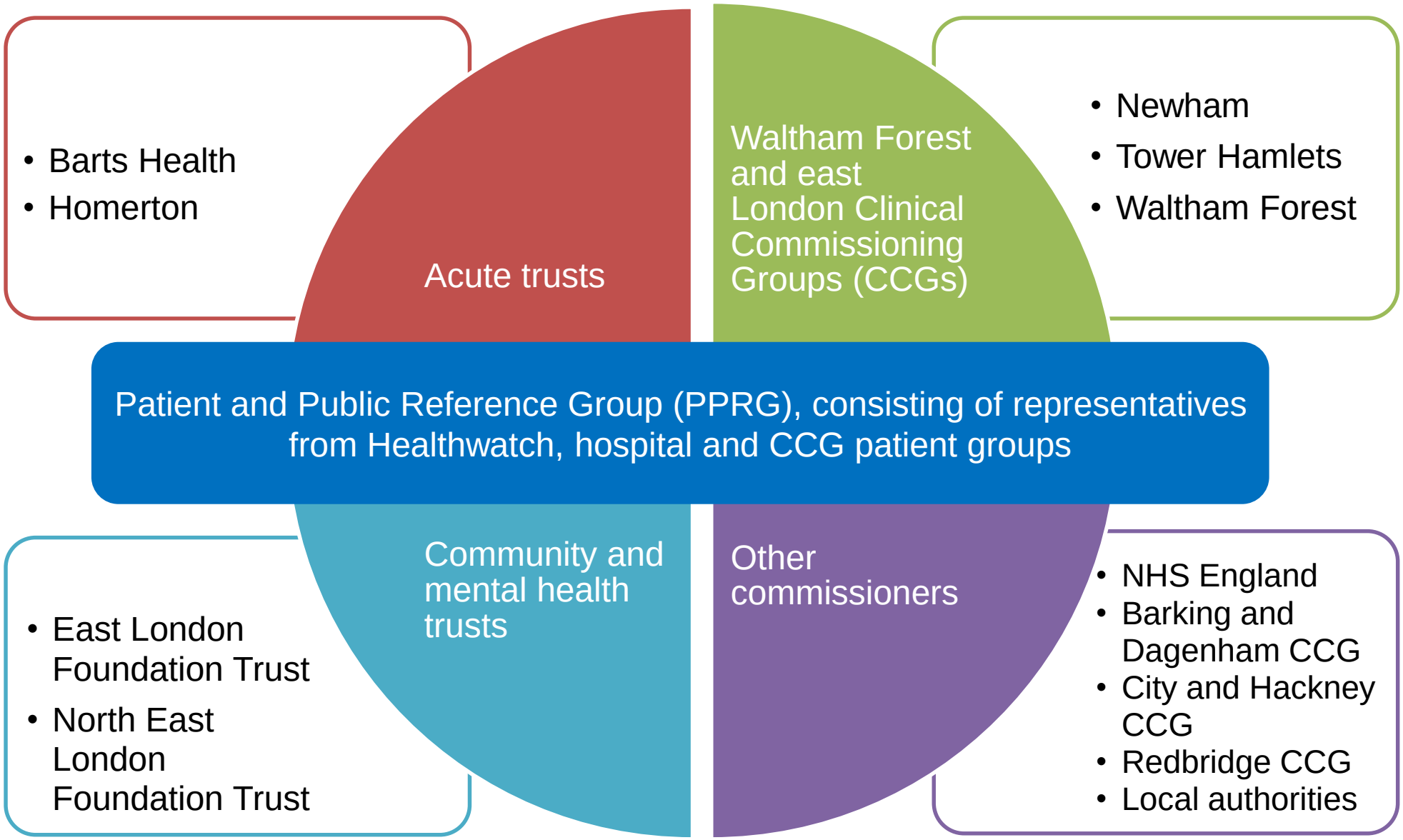
A journey to improve services for the whole community



The programme will:

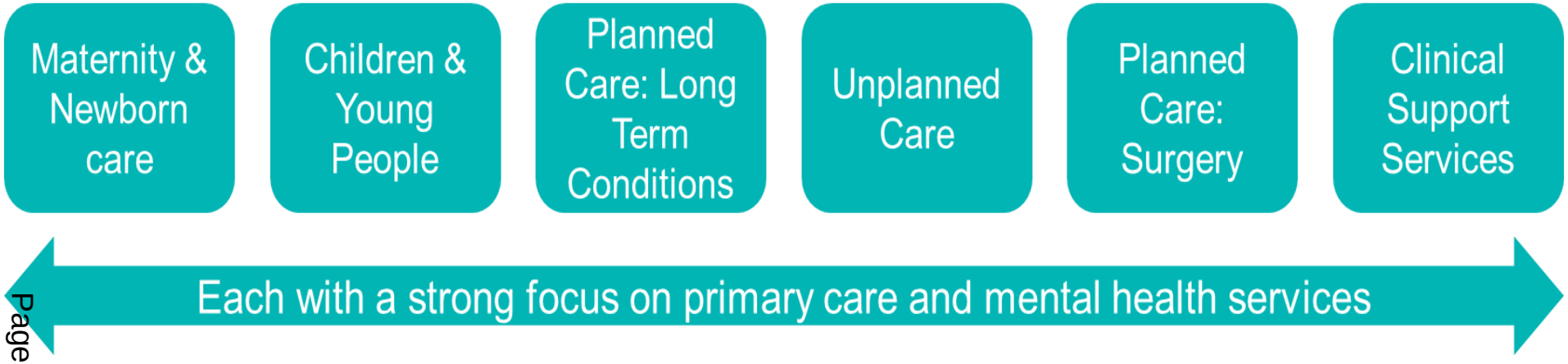
- describe the current state of services
- identify if change is needed to improve services for patients
- begin to develop a shared vision of how we can improve services

The organisations involved



How we worked

- Six Clinical Working Groups (CWGs)



- Clinical Reference Group (CRG) to consider overarching clinical and demographic issues
- A Patient and Public Reference Group
- The programme sits alongside other CCG initiatives including integrated care, mental health and primary care transformation

Inpatient bed sites

Homerton

General hospital (500 beds) with A&E/UCC (79,000 attendances), maternity (5,500 births) plus specialist care in obstetrics, neonatology, fetal medicine, fertility, bariatric surgery and neuro-rehabilitation

Whipps Cross

General hospital (589 beds) with A&E/UCC (112,000 attendances), maternity (4,980 births) plus some specialisms supporting the older population, including hyperbaric services

London Chest

Specialised heart attack centre and cardiovascular and respiratory centre (103 beds).

Newham University Hospital

General hospital (452 beds) with A&E/UCC (87,000 attendances), maternity (6,850 births) plus specialisms in fertility and diabetes

St Bartholomew's

Specialist centre for cancer, cardiovascular disease, fertility and endocrinology (250 beds). Minor injuries unit for non-emergency cases.

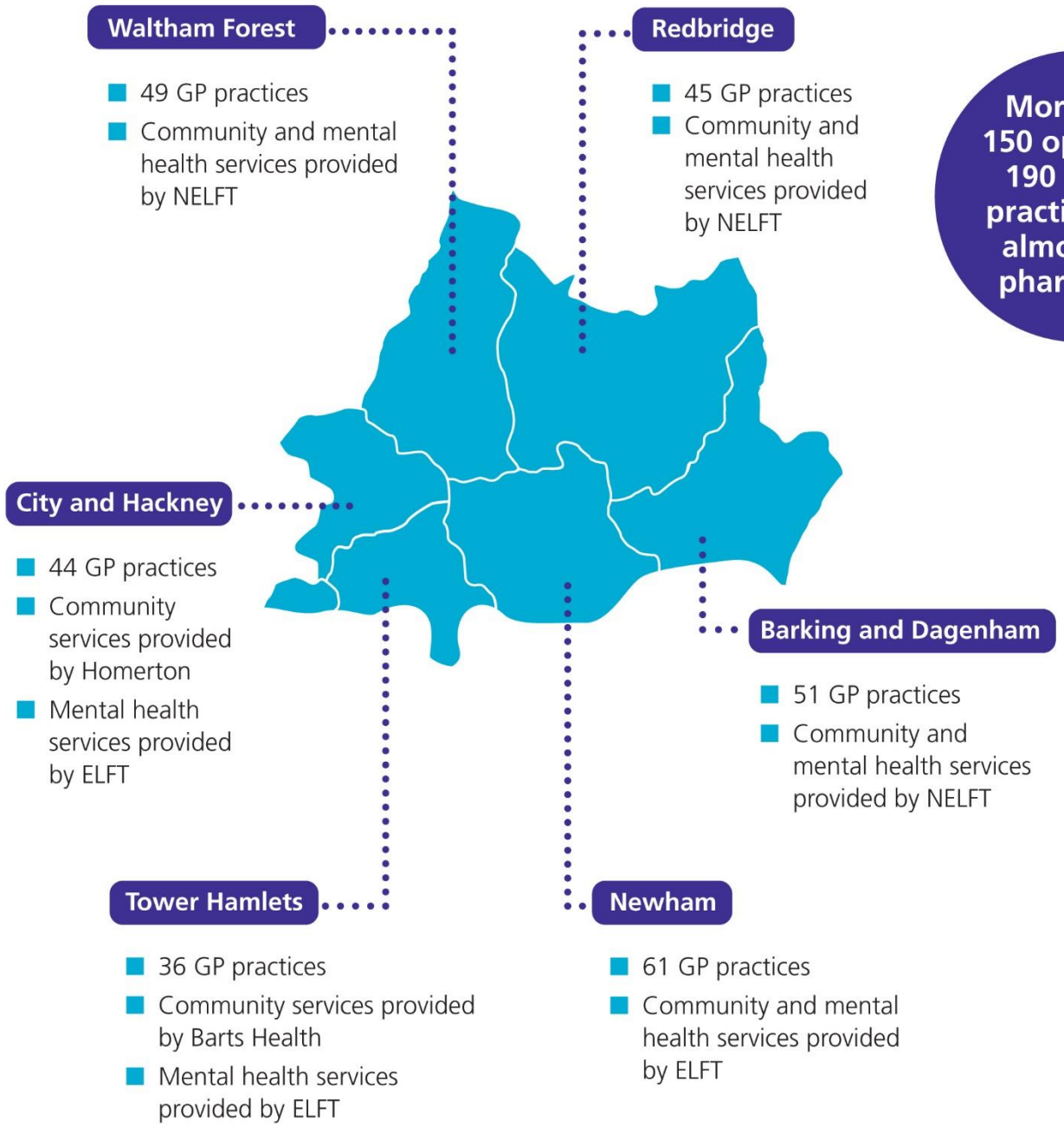
The Royal London

Teaching hospital (747 beds) with a full range of general acute services, A&E/UCC (101,000 attendances), maternity (5,500 births) plus specialist services including paediatrics, obstetrics, neonatal critical care, major trauma, hyper-acute stroke care, cancer, neurosurgery, dental hospital.

Mile End Hospital

Community hospital health centre providing a range of inpatient (64 beds) and outpatient services. These include family planning, termination of pregnancy and rehabilitation.

A range of primary, community and mental health services



- Varying degrees of single-handed practices (6-29%)
- Different models of mental health and community service provision

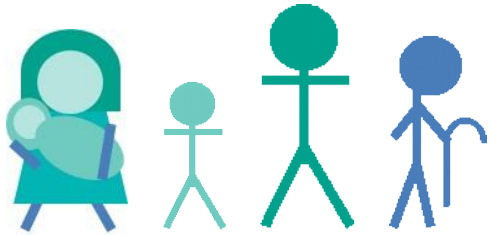
We are not making the best use of local health care services and resources

Emerging shared vision for the NHS in East London

1

The NHS working with an active local authority and voluntary sector to improve health, reduce health inequalities and prevent the need for health services

Improves health and **prevents** need for health services



People supported to manage their own health, self-care and use their NHS services appropriately. Back-up by high quality and responsive primary care services

2

Rare / dangerous / complex needs best treated by a specialist

When need arises, ensures **right care**, **right time**, **right place**

Acute episodes of care treated efficiently according to severity / urgency

Long term conditions which are actively managed with patients to reduce the need for unplanned care

Patients believe good health and care can be achieved by:

- Consistently high quality and efficient services
- Good patient experience and information
  - Individual, friendly, non-judgemental advice and services
  - Continuity of care
  - The right advice, results and service, in the right place, first time at the right time
- Supporting self management
  - Equal partners in care
  - Use of technology such as booking online
  - Good mental health support
  - Enough information and time to ask questions.

Staff believe good health can be achieved by:

- Consistently high quality and efficient services
  - Good transitions between and within organisations
  - Maximising technology opportunities
- Good patient experience and information
  - Effective IT systems
  - Workforce that is happy, engaged and flexible
- Supporting self management
  - Clear visibility of local services
  - Consistency in the pathways of care
  - Open and honest discussions about variability in health outcomes and measures.

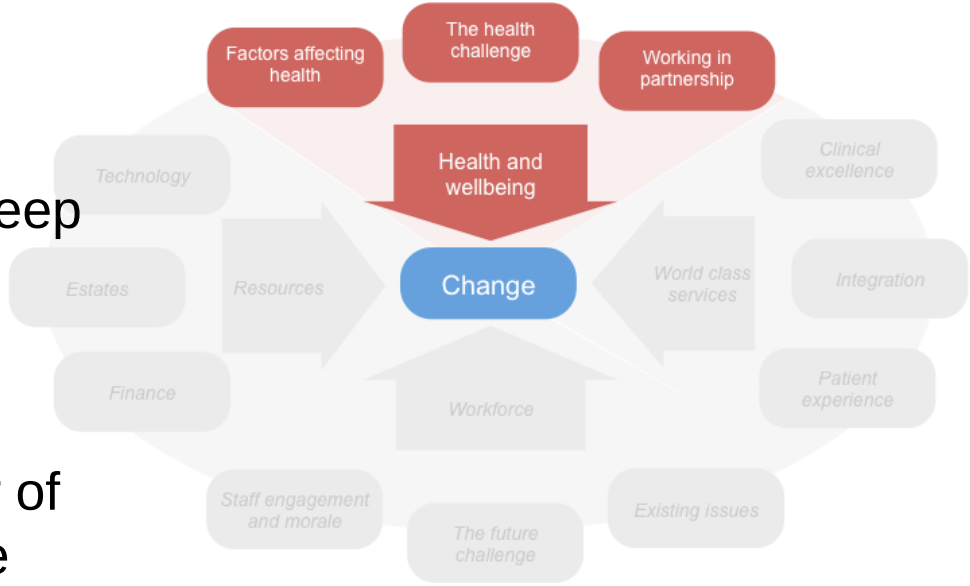
We have confusing and inconsistent models of care

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me." National Voices

Our work has identified a number of drivers for change …

Health of our population: Summary

There are some great examples of **innovative prevention and disease management** in the area, but more needs to be done if we are to keep people healthy and manage their conditions



i) **The health of our population could be improved.** We have higher than average mortality rates and high scores on a number of indicators of poor health. Key factors include high deprivation, rapid movement of population and a rich ethnic mix

ii) These challenges will not go away as the **population is growing** at a higher rate than anywhere else in the country – particularly in regeneration areas.

iii) **Everyone has a responsibility for good health**, the NHS, local councils, businesses, schools, and patients and the public

The health of our population could be improved

Note 1: Years of life at birth
Note 2: Directly age standardised rate of deaths per 100,000 population aged under 75, 2009-2011

	Note	Newham	Tower Hamlets	Waltham Forest	Redbridge	City & Hackney	England		
							Worst	Average	Best
Life expectancy (male)	1	77.5	76.7	79.0	79.9	77.7	73.8	78.9	83
Life expectancy (female)	1	82.0	81.9	83.1	83.8	82.3	79.3	82.9	86.4
Early deaths - heart disease & stroke	2	87.3	87.0	65.7	58.2	86.4	113.3	60.9	29.2
Early deaths - cancer	2	102.6	128.5	109.4	99.0	111.0	153.2	108.1	77.7

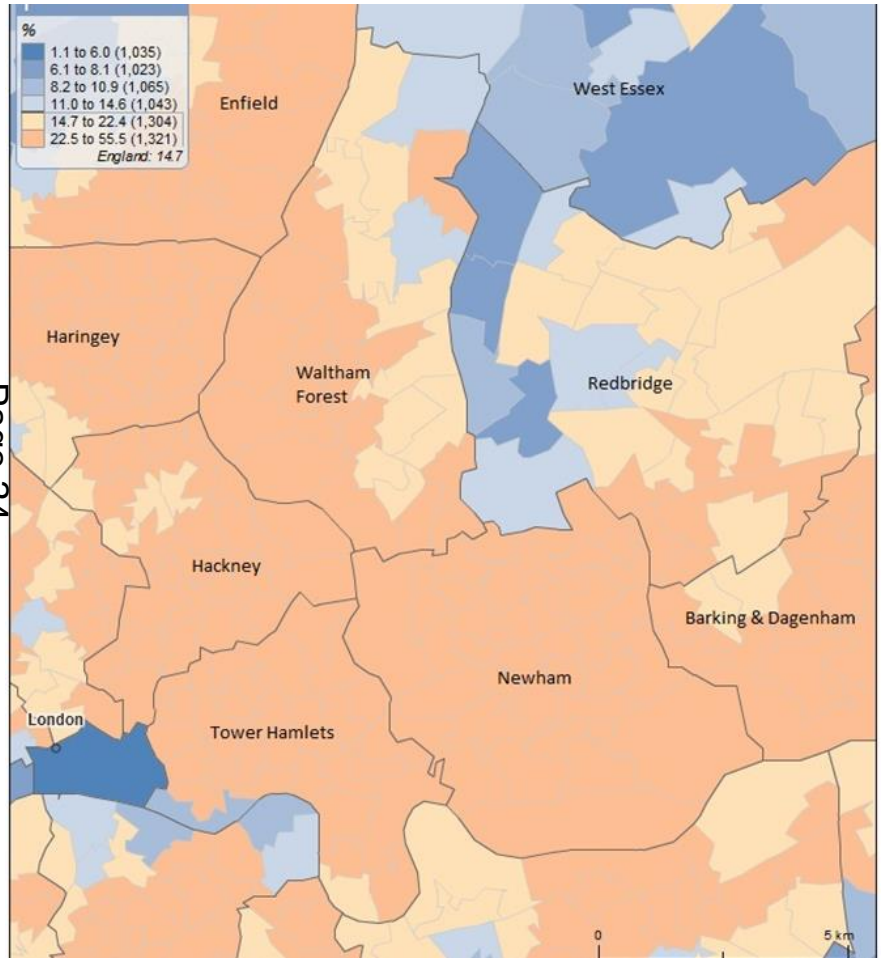
Significantly worse than the England average

Not significantly different from the England average

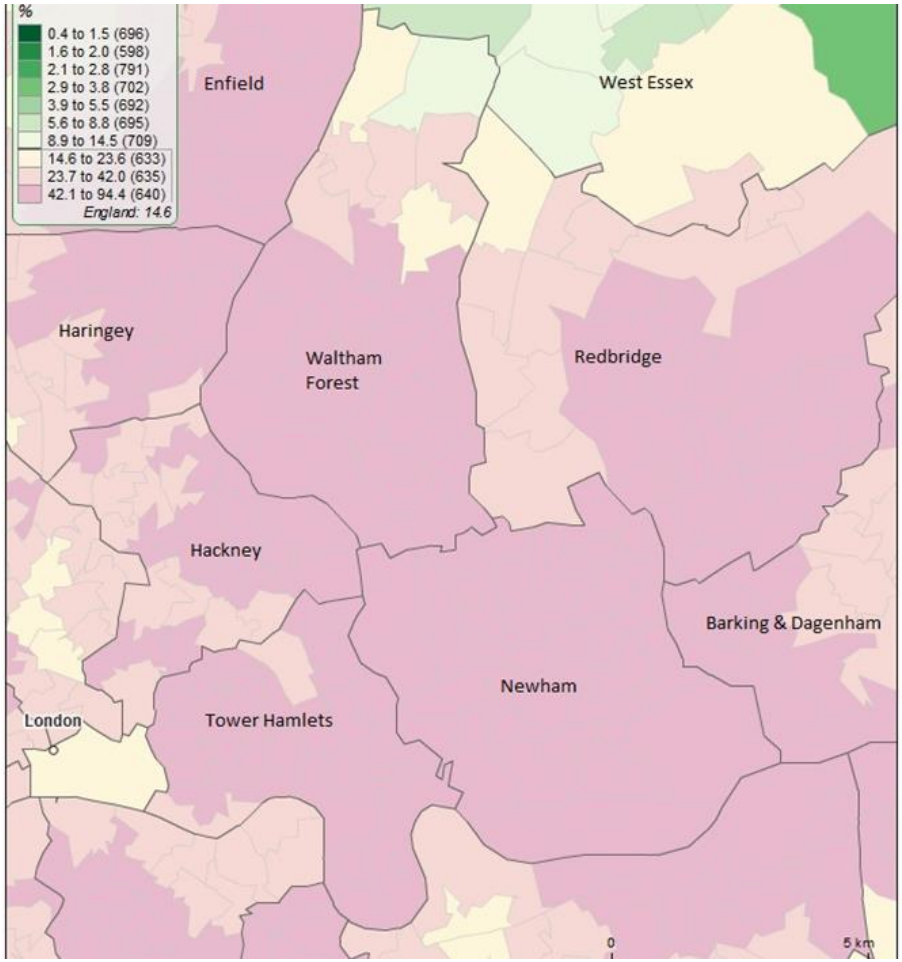
Significantly better than the England average

Key factors

- The map shows (in brown) where households are amongst the most deprived in England.

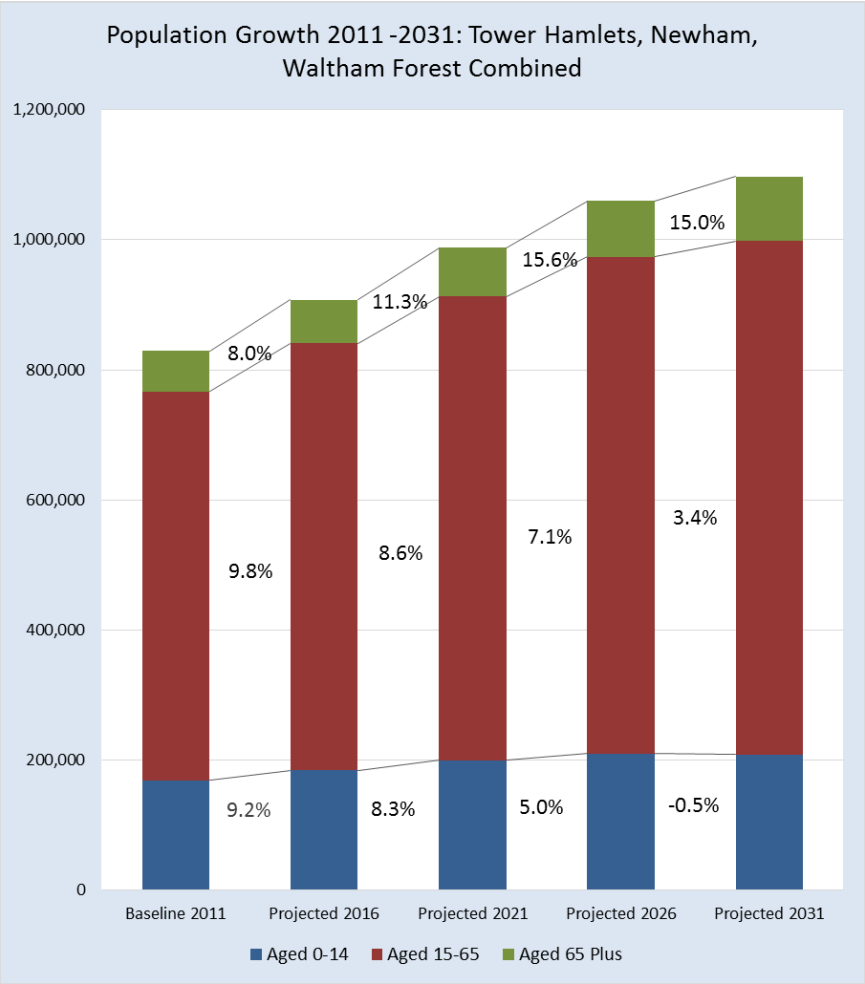


- The map shows (in pink) the areas where more than 42% of the population are from a black or minority ethnic group.

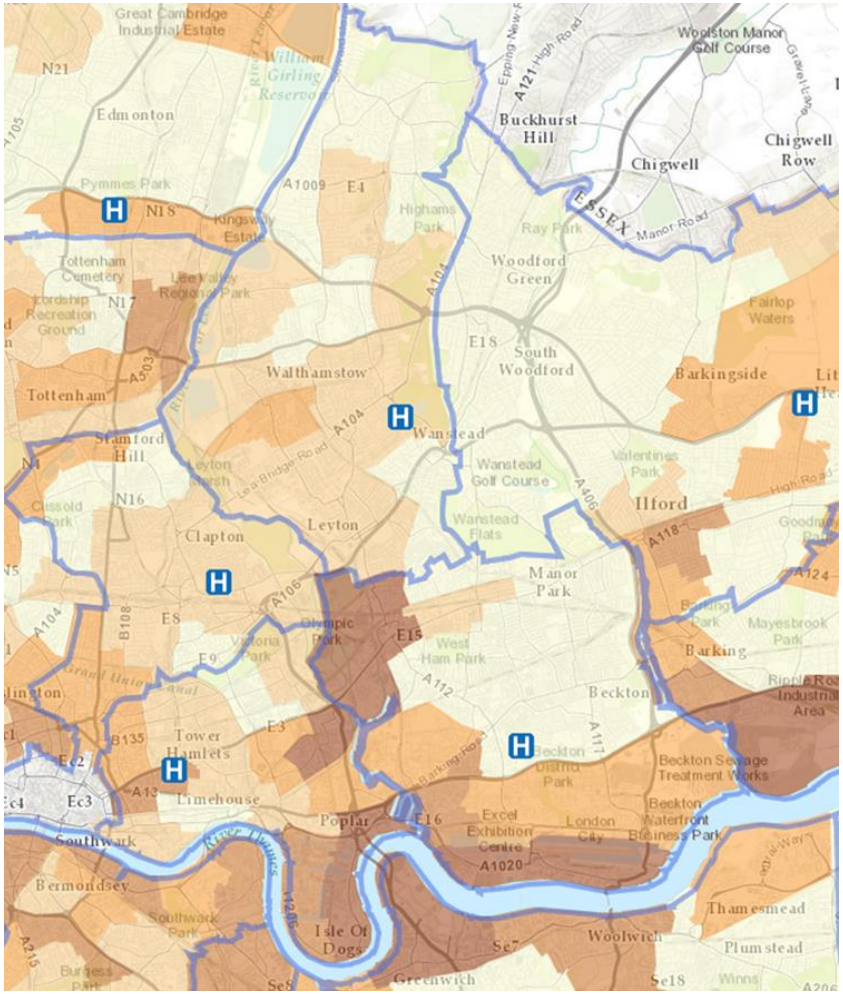


Population growth

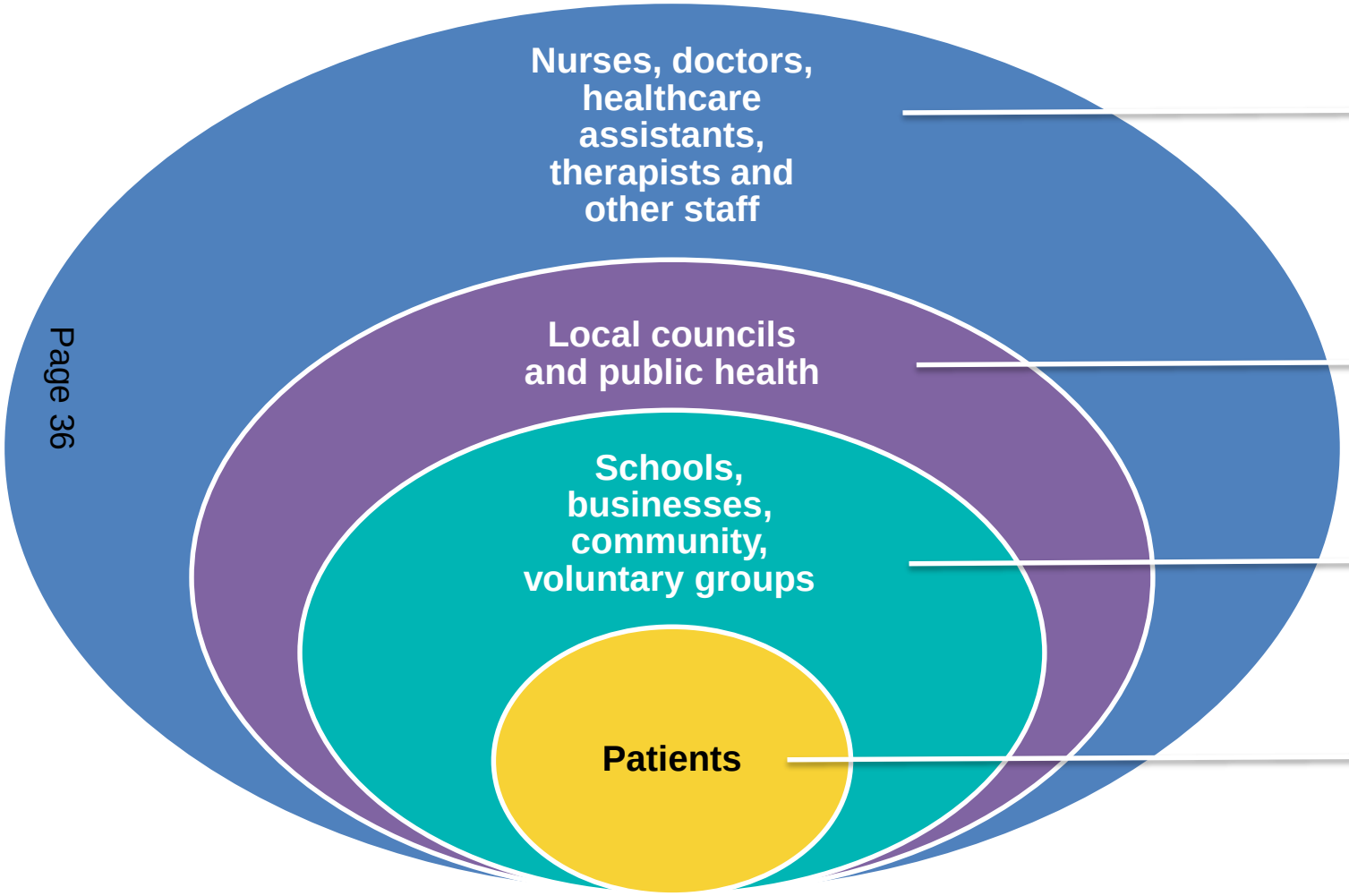
- The population of the three boroughs is set to grow by c270,000: a new London borough by 2031



- The map shows (in dark brown) the areas with most population growth



Good health, excellent disease management and a speedy recovery if you become ill is everyone's responsibility



Advice, early diagnosis and support to self-care

Housing, transport, health, environment, safety, education, quality of life

Health education, health promotion, support and early identification, mental health

Behaviour change & self-care

A world class service: Summary

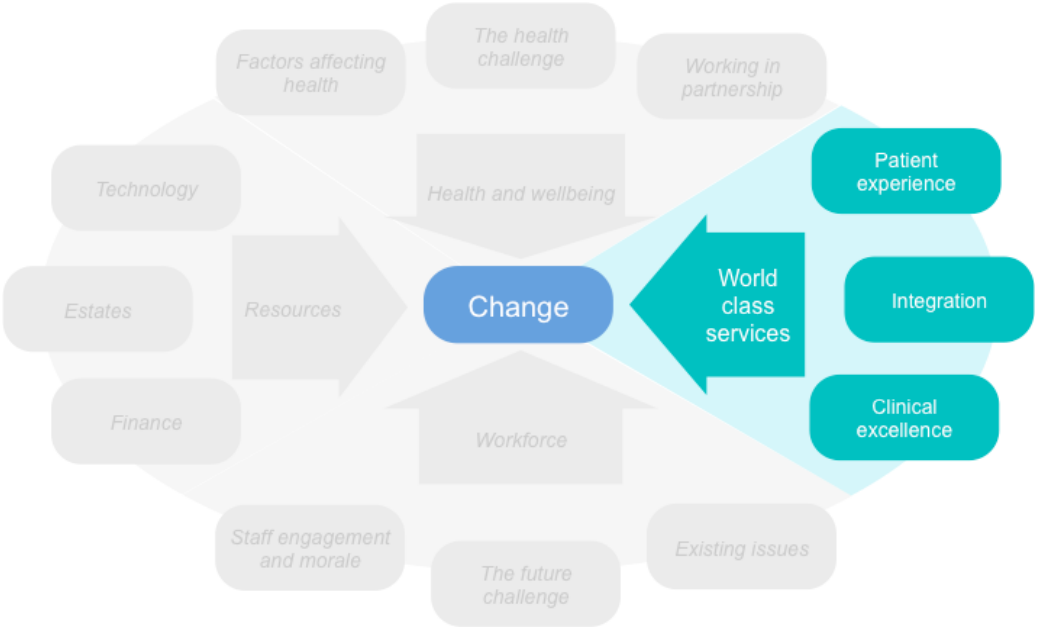
We have some world class services, but not every service is excellent all the time:

i) **Patient experience is often poor**

ii) Services are of differing quality depending on whether the patient is the focus of integrated, acute, primary, social and mental health care and:

- **where** they live
- **what** service they need
- what **time of the day or week** they need care

We also need to recognise the critical importance of **research** in developing new, cost effective solutions to improve patient safety and experience.



I would like to see someone take overall responsibility for my care…whether that is a GP, a nurse, a consultant…I just need some help pulling it all together

Our current workforce: Summary

Whilst there are examples of leading edge schemes to build a sustainable, flexible, professional workforce, there are **challenges in recruiting for specific posts** in both primary and secondary care, which reflects the national experience

There are additional issues in East London, in particular due to the **high cost of living** and variations in cost of living allowances. We need to work closely with local authorities as recruiting a local workforce is essential to delivering appropriate care.

We need to:

i) address the **current challenges** and workforce gaps

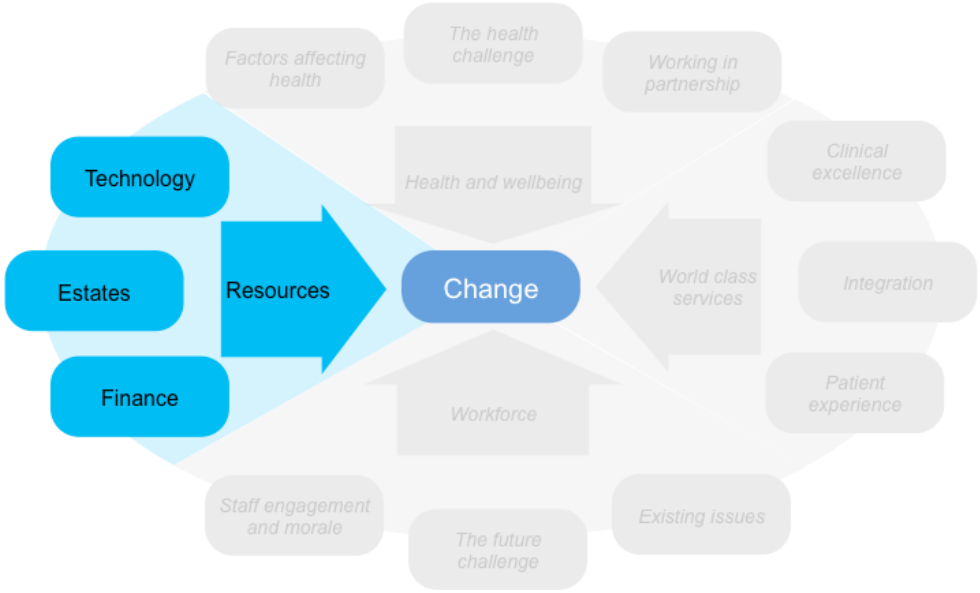
ii) ensuring our workforce have the skills needed to deliver the model of **care in the future**

iii) ensuring our **workforce is engaged, flexible and motivated** to be able to deliver high quality patient care and innovate to support continuous service improvements

iv) Recognise the importance of **clinical leadership**

Our resources: Summary

The NHS and local government are facing significant real terms reductions in funding. We need to work together to make better use of our resources to improve patient experiences, and invest in better care. We need to:



i) make more than £400m of **quality and productivity savings** over the next five years and get better at **preventing ill health**.

ii) **improve communication and information sharing** so patients can better care for themselves and do not have unnecessary appointments and tests

iii) make **more effective use of technology**

iv) make **better use of estates**

v) make **choices about the best way to spend resources**

There is not enough time and capacity, across all health and care services in East London, to deliver quality consultations for patients

What change is needed?

Next steps and priorities

Based on our findings, the key areas for change for our local NHS services are emerging as …

Realising this requires change system-wide change…

- A clear **understanding of any changes in demand**
- A single **shared vision** across the healthcare economy – this will require **choices** to be made about how and where the budget should be spent
- Supporting **self-care for patients** so that people are empowered to take responsibility for their own health, using their NHS services appropriately
- **Strong primary healthcare** services, where GPs and their teams are supported by the broader healthcare system to coordinate care on behalf of their patients
- A system which **promotes mental and physical health together**, and develops services based around the holistic needs of patients
- **Changes to the way that hospital services** are delivered to make the best use of resources and **ensure consistent high quality care 24/7**
- Supporting **collaborative and coordinated working** across the system
- A system which **supports and nurtures innovation** and removes barriers to improving care

Together we can achieve…

Great health and health outcomes for people in East London, such as:

People supported to manage their long term condition in the community

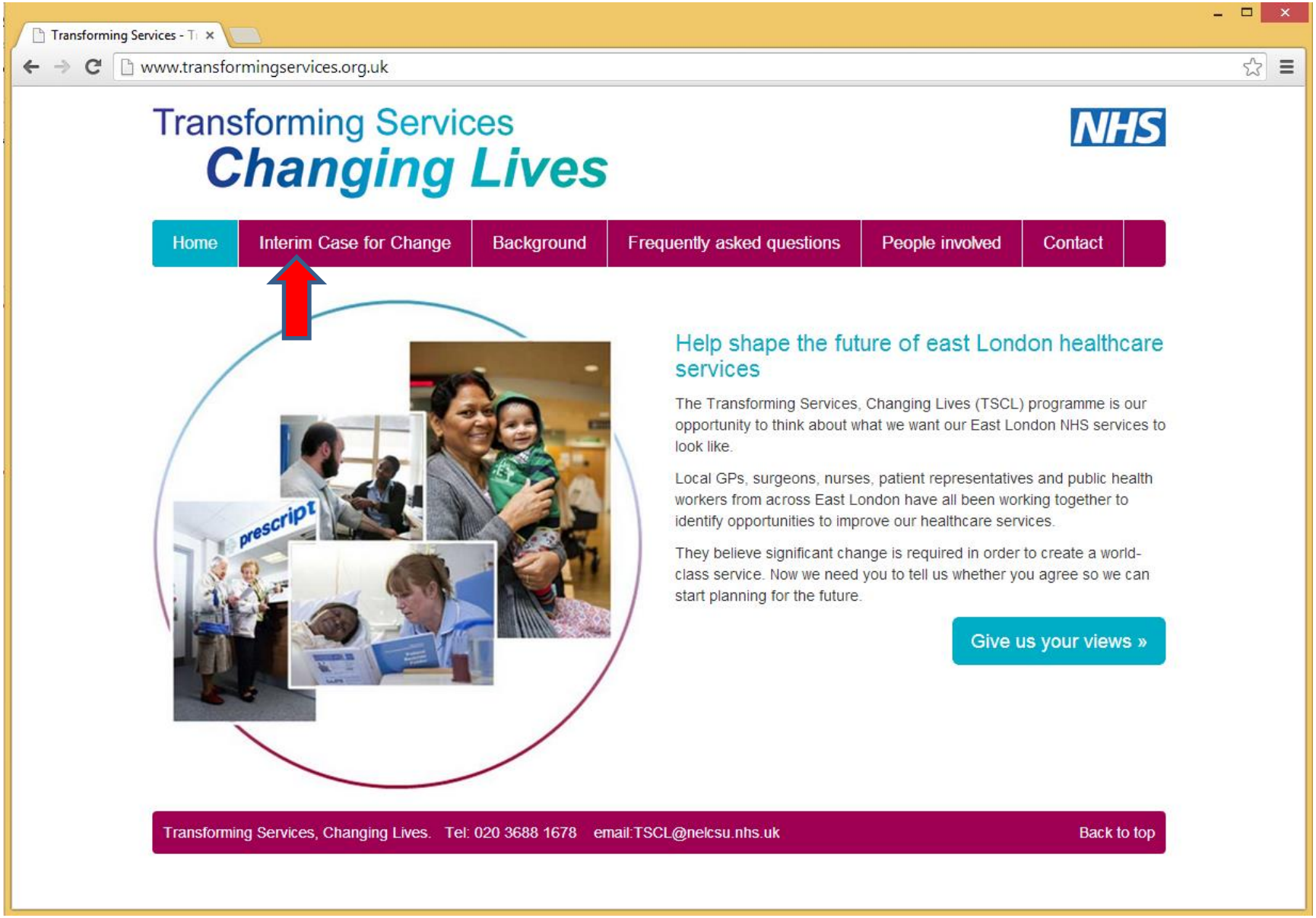
Patients reporting improvements in their quality of life as a result of health care interventions

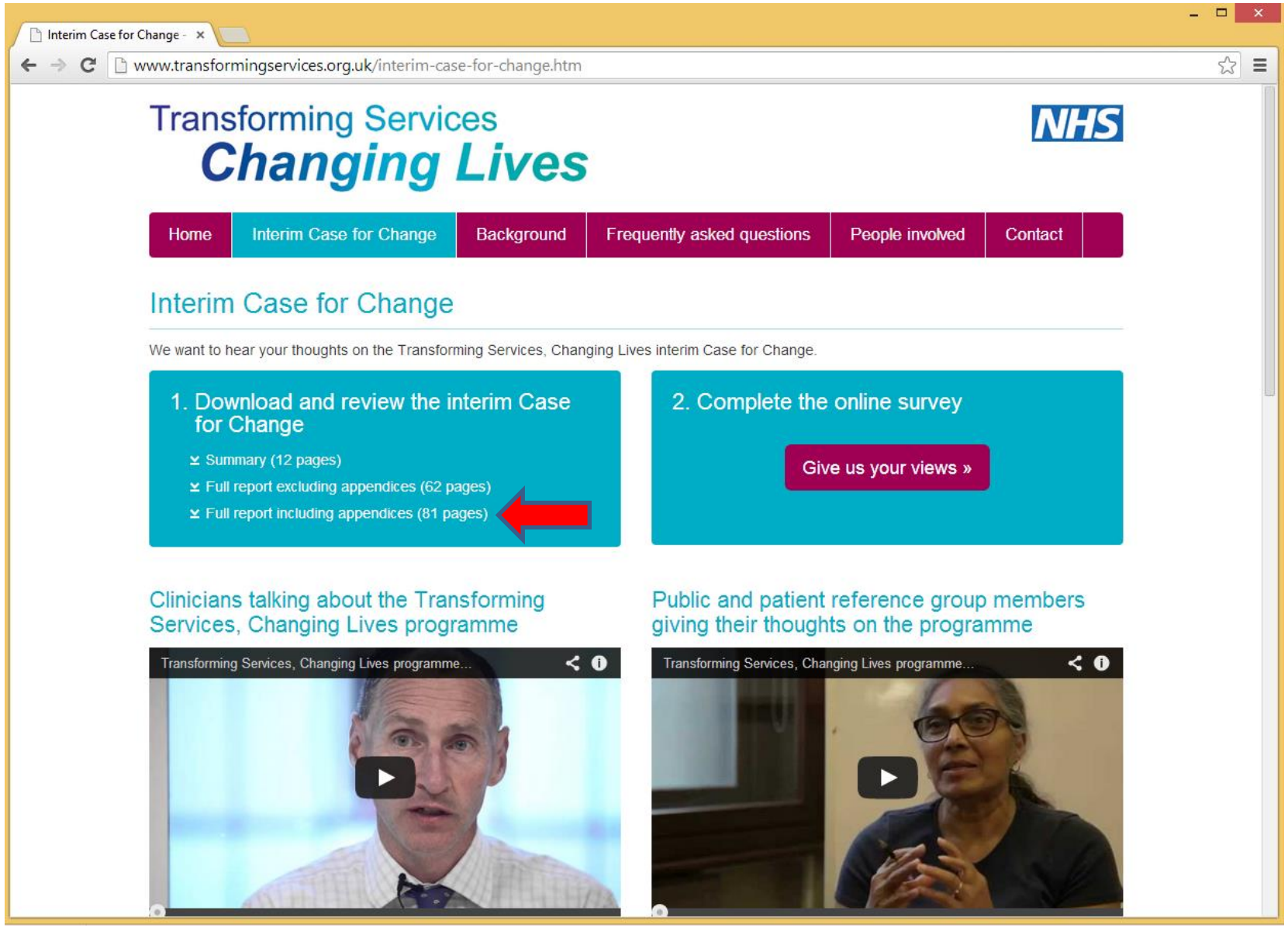
More people surviving life threatening events such as stroke, heart attack or major trauma

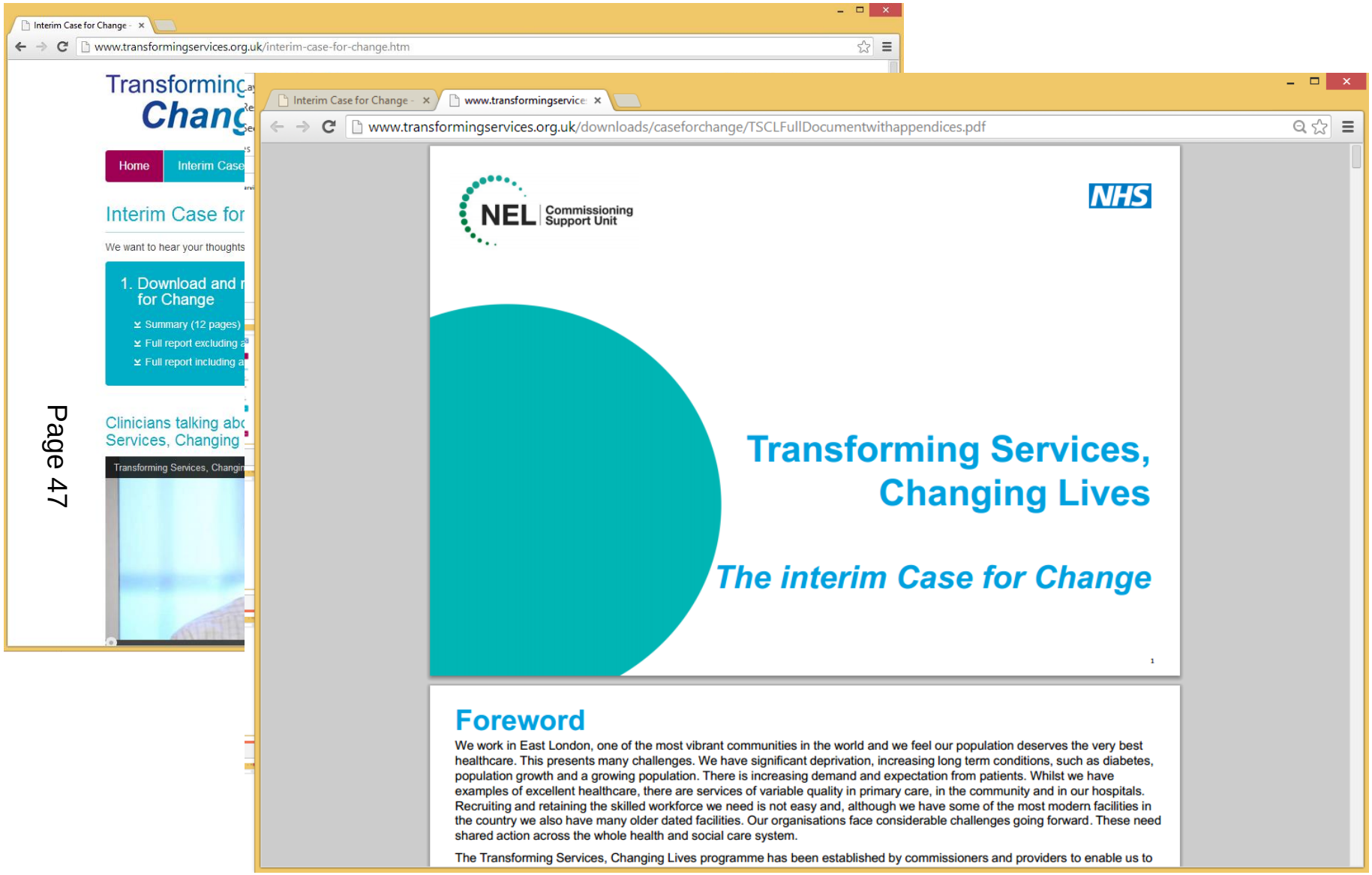
People supported to die at home where it is their choice to do so

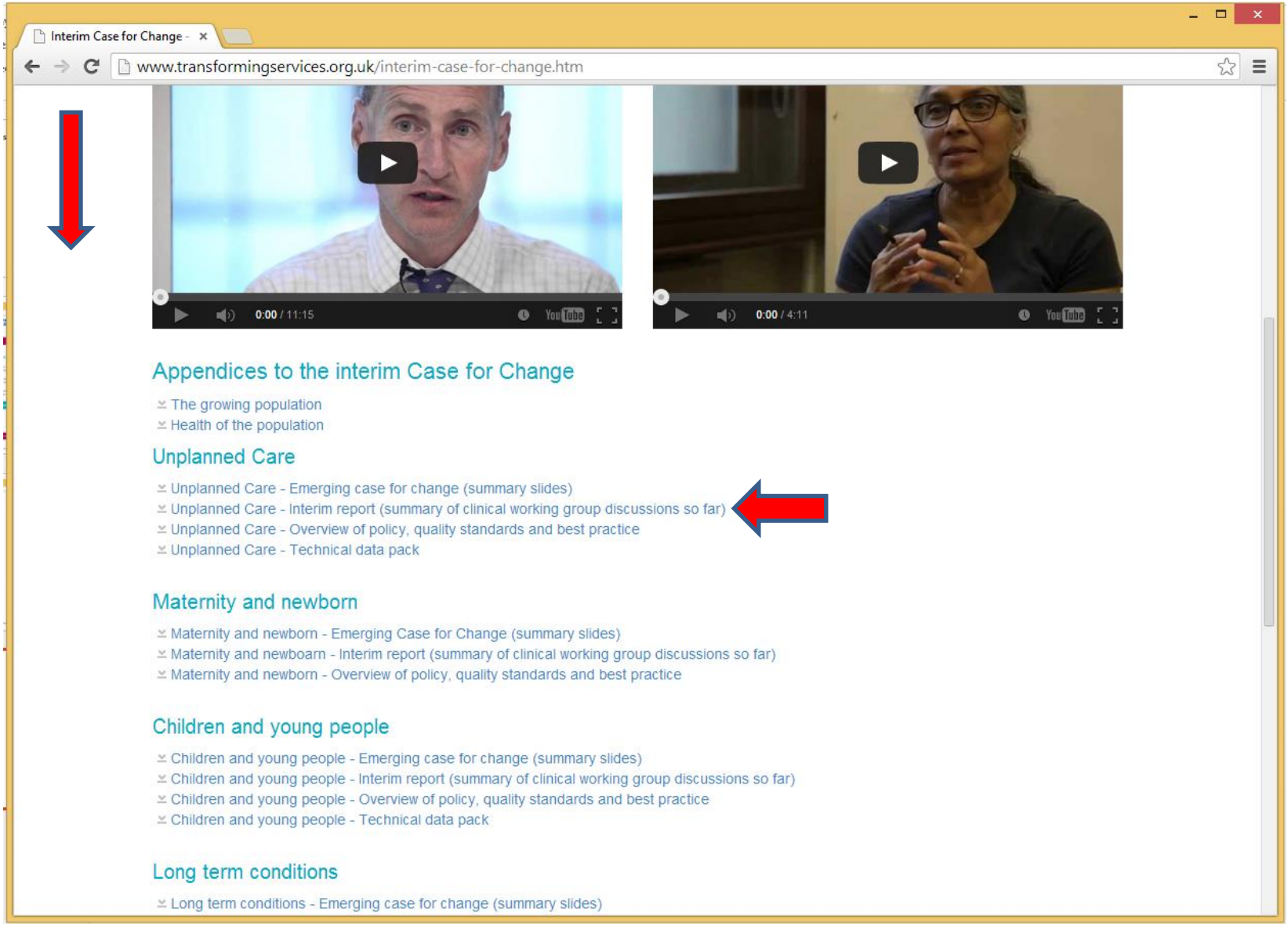
Patients reporting an excellent experience when accessing healthcare

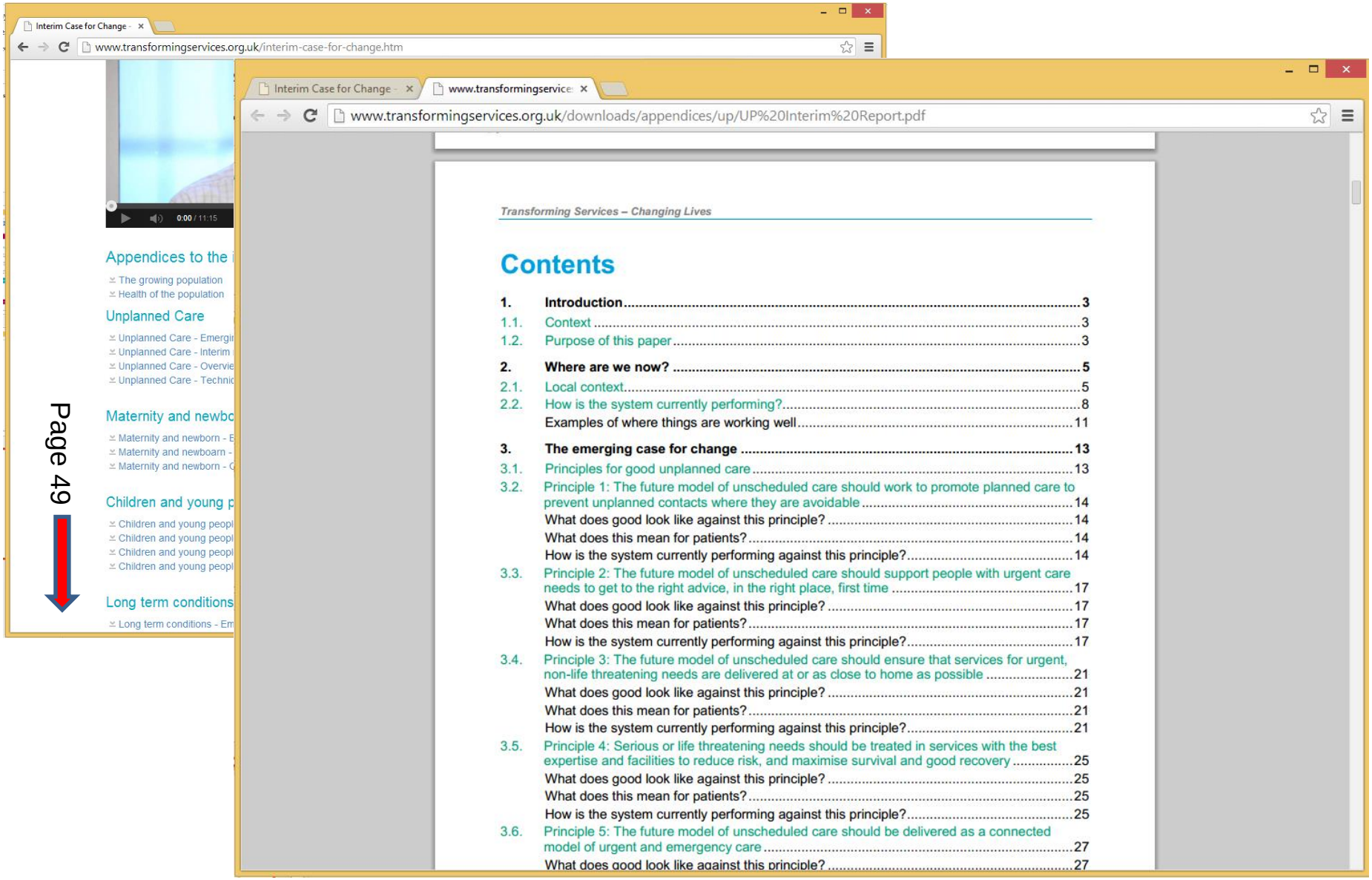
www.transformingservices.org.uk

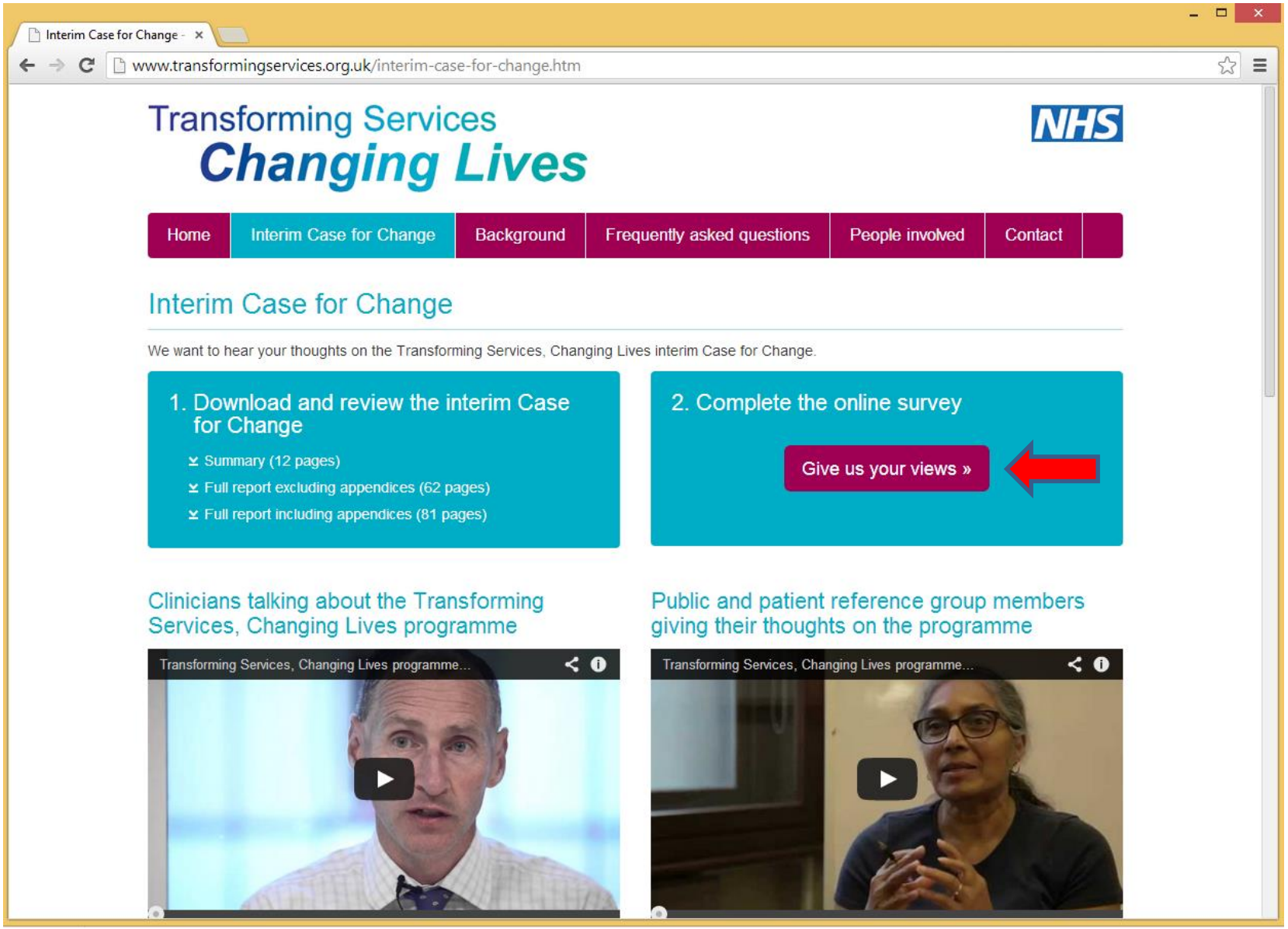

Transforming Services - T
www.transformingservices.org.uk
Transforming Services
Changing Lives
NHS
Home
Interim Case for Change
Background
Frequently asked questions
People involved
Contact
Help shape the future of east London healthcare services
The Transforming Services, Changing Lives (TSCL) programme is our opportunity to think about what we want our East London NHS services to look like.
Local GPs, surgeons, nurses, patient representatives and public health workers from across East London have all been working together to identify opportunities to improve our healthcare services.
They believe significant change is required in order to create a world-class service. Now we need you to tell us whether you agree so we can start planning for the future.
Give us your views »
Transforming Services, Changing Lives. Tel: 020 3688 1678 email:TSCL@nelcsu.nhs.uk
Back to top


Interim Case for Change
www.transformingservices.org.uk/interim-case-for-change.htm
Transforming Services
Changing Lives
NHS
Home
Interim Case for Change
Background
Frequently asked questions
People involved
Contact
Interim Case for Change
We want to hear your thoughts on the Transforming Services, Changing Lives interim Case for Change.
1. Download and review the interim Case for Change
Summary (12 pages)
Full report excluding appendices (62 pages)
Full report including appendices (81 pages)
2. Complete the online survey
Give us your views »
Clinicians talking about the Transforming Services, Changing Lives programme
Transforming Services, Changing Lives programme...
Public and patient reference group members giving their thoughts on the programme
Transforming Services, Changing Lives programme...


Interim Case for Change
www.transformingservices.org.uk/interim-case-for-change.htm
Home
Interim Case for
We want to hear your thoughts
1. Download and
for Change
Summary (12 pages)
Full report excluding
Full report including
Clinicians talking abo
Services, Changing
Transforming Services, Changin
www.transformingservices.org.uk/downloads/caseforchange/TSCLFullDocumentwithappendices.pdf
NEL Commissioning Support Unit
NHS
Transforming Services, Changing Lives
The interim Case for Change
1
Foreword
We work in East London, one of the most vibrant communities in the world and we feel our population deserves the very best healthcare. This presents many challenges. We have significant deprivation, increasing long term conditions, such as diabetes, population growth and a growing population. There is increasing demand and expectation from patients. Whilst we have examples of excellent healthcare, there are services of variable quality in primary care, in the community and in our hospitals. Recruiting and retaining the skilled workforce we need is not easy and, although we have some of the most modern facilities in the country we also have many older dated facilities. Our organisations face considerable challenges going forward. These need shared action across the whole health and social care system.
The Transforming Services, Changing Lives programme has been established by commissioners and providers to enable us to


Interim Case for Change
www.transformingservices.org.uk/interim-case-for-change.htm
0:00 / 11:15
0:00 / 4:11
Appendices to the interim Case for Change
The growing population
Health of the population
Unplanned Care
Unplanned Care - Emerging case for change (summary slides)
Unplanned Care - Interim report (summary of clinical working group discussions so far)
Unplanned Care - Overview of policy, quality standards and best practice
Unplanned Care - Technical data pack
Maternity and newborn
Maternity and newborn - Emerging Case for Change (summary slides)
Maternity and newboarn - Interim report (summary of clinical working group discussions so far)
Maternity and newborn - Overview of policy, quality standards and best practice
Children and young people
Children and young people - Emerging case for change (summary slides)
Children and young people - Interim report (summary of clinical working group discussions so far)
Children and young people - Overview of policy, quality standards and best practice
Children and young people - Technical data pack
Long term conditions
Long term conditions - Emerging case for change (summary slides)


Interim Case for Change -
www.transformingservices.org.uk/interim-case-for-change.htm
0:00 / 11:15
Appendices to the
The growing population
Health of the population
Unplanned Care
Unplanned Care - Emergi
Unplanned Care - Interim
Unplanned Care - Overvie
Unplanned Care - Technic
Maternity and newbo
Maternity and newborn - E
Maternity and newboarn -
Maternity and newborn - C
Children and young p
Children and young peopl
Children and young peopl
Children and young peopl
Children and young peopl
Long term conditions
Long term conditions - Em
Page 49
Interim Case for Change -
www.transformingservice
www.transformingservices.org.uk/downloads/appendices/up/UP%20Interim%20Report.pdf
Transforming Services – Changing Lives
Contents
1. Introduction ... 3
1.1. Context ... 3
1.2. Purpose of this paper ... 3
2. Where are we now? ... 5
2.1. Local context ... 5
2.2. How is the system currently performing? ... 8
Examples of where things are working well ... 11
3. The emerging case for change ... 13
3.1. Principles for good unplanned care ... 13
3.2. Principle 1: The future model of unscheduled care should work to promote planned care to prevent unplanned contacts where they are avoidable ... 14
What does good look like against this principle? ... 14
What does this mean for patients? ... 14
How is the system currently performing against this principle? ... 14
3.3. Principle 2: The future model of unscheduled care should support people with urgent care needs to get to the right advice, in the right place, first time ... 17
What does good look like against this principle? ... 17
What does this mean for patients? ... 17
How is the system currently performing against this principle? ... 17
3.4. Principle 3: The future model of unscheduled care should ensure that services for urgent, non-life threatening needs are delivered at or as close to home as possible ... 21
What does good look like against this principle? ... 21
What does this mean for patients? ... 21
How is the system currently performing against this principle? ... 21
3.5. Principle 4: Serious or life threatening needs should be treated in services with the best expertise and facilities to reduce risk, and maximise survival and good recovery ... 25
What does good look like against this principle? ... 25
What does this mean for patients? ... 25
How is the system currently performing against this principle? ... 25
3.6. Principle 5: The future model of unscheduled care should be delivered as a connected model of urgent and emergency care ... 27
What does good look like against this principle? ... 27


Interim Case for Change
www.transformingservices.org.uk/interim-case-for-change.htm
Transforming Services
Changing Lives
NHS
Home
Interim Case for Change
Background
Frequently asked questions
People involved
Contact
Interim Case for Change
We want to hear your thoughts on the Transforming Services, Changing Lives interim Case for Change.
1. Download and review the interim Case for Change
Summary (12 pages)
Full report excluding appendices (62 pages)
Full report including appendices (81 pages)
2. Complete the online survey
Give us your views »
Clinicians talking about the Transforming Services, Changing Lives programme
Transforming Services, Changing Lives programme...
Public and patient reference group members giving their thoughts on the programme
Transforming Services, Changing Lives programme...

To know more

If you would like to discuss any elements of this draft case for change, please contact our team on:

Tel: 020 3688 1678
Email: tscl@nelcsu.nhs.uk
www.transformingservices.org.uk

This page is intentionally left blank