LAY MEMBER'S HEADLINE FEEDBACK FROM THE NHS WANDSWORTH PROFESSIONAL EXECUTIVE COMMITTEE (PEC) MEETING WITH THE MANAGEMENT TEAM ON 17 MARCH 2009

These headlines are for rapid briefing purposes about the lay/user issues arising in the meeting. It is not a full report from the meeting.

PEC and PCT Board papers are available on the NHS Wandsworth website: www.wandsworth.nhs.uk

The contents of this briefing note are for information only and are solely the responsibility of Andrew Craig, PEC Lay Member, including errors and omissions. They do not necessarily represent the views of the PEC or NHS Wandsworth.

NHS Wandsworth rebranding

The trading name of the Wandsworth Primary Care Trust has been rebranded to "NHS Wandsworth" from March. More details and the rationale for this are at www.wandsworth.nhs.uk/news/press_story.asp?id=489 The organisation hopes *"that by branding ourselves as NHS Wandsworth we will become more recognisable to the public and inspire more local people to access information and services to improve their health and well-being."*

Appointment of Ann Radmore as Chief Executive for South West London/Strengthening Commissioning

Ann Radmore has been appointed CEO for the South West London sector of the NHS, particularly to lead delivery on the strengthening commissioning objectives. See statement issued 24/3 at the end of this report with more details.

She will assume the role immediately for 2 days a week and fulfill her PCT job 3 days a week. This initiative is about improving the sector's overall performance not just that of individual PCTs as NHS London is performance managing local commissioners on a sector basis.

Items for Discussion

Externalisation of Provider Services

The PCT's provider services are required, following national policy, to become an independent employing organsiation. No national model is recommended and a number of options are being considered by staff, including a Community Foundation Trust (CFT). A firm position was anticipated by autumn this year. It should not be assumed that all 34 provider services will move into the same form or be part of the same organisation. There would be a "period of engagement", not a formal consultation because the change was deemed to be managerial and not a change in services, once the Board had considered a preferred model. There would be a short list at the April Board meeting. No staff had, as yet, exercised their right to request the formation of a social enterprise.

I expressed my concern that the Wandsworth public was largely unaware of the imminent change in the status of provider services. It was therefore essential that current users of provider services were asked for their views. How could staff say what was best for patients if patients were not asked what they wanted from potential new arrangements for providing care?

I believe there is much to be gained from vertical integration of community services with primary care (GP services) and social care (if employment issues can be sorted out). I would like to see the governance of an integrated provider be a social enterprise (such as a Community Interest Company or a Society of Benefit to the Community) . The owners would be both the people who worked for it and the patients who used its services.

An added complexity is the prospect of more people with long term conditions and elderly people holding individual health and care budgets (micro commissioning). Joining provider services with an existing Foundation Trust or NHS acute trust would be fatal for community services, the danger of asset stripping being only one risk. The road to CFT status is convoluted and would not produce any benefits that a social enterprise could not produce in much less time. Local GPs are already considering federations and this could be a step towards a community interest structure. The irony is that what could

emerge from all of this might resemble the former South West London community health services trust with the addition of GPs.

I stressed that the objective must be joined up care from the users' perspective. Being dogmatic about commissioning and separation from provider services must not have a perverse, fragmenting effect and divide providers to the detriment of individual patients.

As a result of the discussion the PEC agreed to add to the patient care criteria that any solution for provider services must, at its highest level, improve integration of patient care as a continuum.

Cancer Prevention Plan

The PEC had an initial presentation of the new Cancer Prevention Strategy covering 2009-11 which would be considered again in the summer in connection with an action plan. Over half of all cancers could be prevented. Areas covered in the strategy included: smoking, obesity, diet and physical activity, excessive alcohol intake, skin cancer, screening programmes and raising awareness of lifestyle factors contributing to cancer. This was an opportunity to think about commissioning for prevention. Coordination on a number of levels was crucial.

In discussion I said that explaining the risk of cancer to groups within the population and linking this to lifestyle factors was deceptively easy but in reality this was not very effective because other factors had overriding importance to individuals, especially in difficult economic times. Social marketing could be a productive way forward, but should not be seen as a panacea or a quick fix. Working with 3rd sector organisations and local government programmes, especially those engaged with younger people and particular communities, was essential.

A cancer prevention strategy was a perfect opportunity for co-creation of the approach with target communities and groups. The strategy would be incomplete until there was a clear process for engagement for each of the intervention areas with target groups so that we have user intelligence for commissioning. A community development approach is needed.

Healthcare for London Consultation on Services for Stroke and Major Trauma

The online consultation document is
www.wandsworth-pct.nhs.uk/about/HfL/default.asp
and questionnaire for completion by 8 May 2009 is
www.healthcareforlondon.nhs.uk

The consultation is part of Lord Darzi's ten year vision for the capital - 'Healthcare for London' - and looks at the location and coverage of potential sites for eight specialist stroke and four major trauma centres.

For stroke, the move needs to be towards the suburbs as that is where most of the strokes occur (compared with Inner London which has a greater concentration of major trauma – stabbings, shootings etc). The major gain in mortality is not via the Hyper Acute Stroke Units (HASUs) but in the more numerous dedicated stroke units to which patients would be transferred after scanning and thrombolysis if indicated. There will need to be more training of the London Ambulance Service and of the public about recognising strokes (see the current media campaign about "FAST").

The proposals for South West London are strong. St George's Hospital in Tooting is one of the proposed major trauma centres and one of the eight proposed specialist acute stroke units. It is also proposed that St George's would host a local stroke unit and a mini-stroke (TIA) centre. The implementation schedule will be decided by the joint committee of PCTs with differential dates across London, but SW London is well ahead of other areas in terms of when clinical services and the LAS will be ready to implement changed arrangements (probably mid – 2010).

I fully support the proposals, but pointed out that how they were presented could be mis-interpreted as discrimination against older people (80+) because the consultation document does not make it clear that this group will not benefit from thrombolysis in a HASU. Equally, there must not be a perverse effect of blocking up St George's with people who won't benefit from HASU intervention but should have stroke care elsewhere in a dedicated unit. I recommended a presentation covering this point to the Wandsworth Older People's Forum/Network during the consultation.

The PEC agreed it was necessary to make clear what the criteria are for going to a HASU or direct to a dedicated stroke unit, taking account of the age factor.

Items for Approval

Performance Report

I drew attention to the targets about childhood obesity in Wandsworth. As the cancer prevention strategy stated:

"A recent survey of school pupils' weight in Wandsworth has identified a local trend to increasing obesity during school years. The overall rate of obesity observed was nearly twice as high in Year 6 pupils compared to those in Reception and the overall rate of overweight pupils was 50% higher in Y6 than in Reception.The incidence of childhood obesity was highest for children in Reception year that live in Queenstown (26.3%) and lowest in Fairfield (3.8%). Obesity in Year 6 children was also highest in Queenstown (30%) but lowest in Thamesfield (4.3%)."

There was a clear relationship with deprived wards in these figures. Essentially between Year 1 and Year 6 there was a doubling of the number of obese primary aged children. The year on year change over just two years in year 6 was worrying enough, 20.5% (06-07) to 23.5% (07-08) , giving Wandsworth a much higher prevalence than London as a whole and considerably higher than the national average. I found it hard to accept that our target was more than 1 in 10 as obese in Year 1. This should not be accepted as "normal." On these figures, the primary age years were clearly obesogenic for a considerable number of our young people and their families. We needed to break this down by socio-demographics and ethnicity and by school environment/neighbourhood and consider interventions that might have a chance of success. The PCT as adopting the "Change4Life" programme. There was also an open procurement underway to see what the market might offer in terms of specific interventions for early years, school years as well as adults. It was unfortunate that the Local Area Agreement did not have both year 1 and year 6 in it, as only looking at year 6 was far too late in the process leading to morbidity.

The PEC considered that a local “stretch target” could be set for reducing childhood obesity. The targets were being evaluated for risk. Public health goals must not be in competition with achieving world class commissioning. PEC agreed that childhood obesity should be added to the list of topics for which special meetings with clinical input would be organised (obesity for September 09). Paul Robinson Wandsworth Council’s director of children’s services would be invited for that session.

Open Space

I had submitted a written question from a lay representative about reported healthcare developments – occupational health and a company offering dialysis services - in the new “Riverside Quarter” (reported in *Brightside* March issue, p 9). The PCT was not aware of any healthcare development in this area and would take the matter further to find out the source of the report.

Next Meeting of the NHS Wandsworth Board: Wednesday 1st April 2009, commencing at 09h30 in Room 123, **Wandsworth Town Hall**

Next Meeting of the PEC: 09h30 am on Tuesday, 21st April at Wimbledon Bridge House.

PEC and Board papers are available at www.wandsworth.nhs.uk For further information about Board meetings which are held in public contact Sandra Notridge on 020 8812 7740 or e-mail at sandra.notridge@wpct.nhs.uk

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23rd March 2009. Message from NHS Wandsworth Communications Department on Appointment of Ann Radmore as Chief Executive for South West London

Dear colleagues,

I am writing to let you know that last week I was appointed as Chief Executive for South West London. I will continue as Chief Executive of NHS Wandsworth but from now onwards I will dedicate two days a week to my new sector role.

In order to help me fulfil my duties at NHS Wandsworth, we will be advertising the new role of Director of Organisational Development to include additional responsibilities as Deputy Chief Executive. I will let you know as soon as we have successfully filled this important post. We were clear when designing this post that we need to bring in additional capacity to the management team rather than any of our existing executives take this additional role. We want to blend the PCT's current achievements from our vibrant and enthusiastic executive team with significant operational experience from outside the PCT.

My appointment follows the announcement in January 2009 by Ruth Carnall, Chief Executive of NHS London, that London would now enter a second phase of Strengthening Commissioning. Part of this phase is to secure strong consistent leadership, and a Chief Executive has now been appointed for all the sectors in London.

The role of sector Chief Executive will include:

- Delivering strategic change for South West London's Collaborative Commissioning Initiatives, which as you will remember include stroke, trauma, maternity and cancer.
- Setting up the South West London acute commissioning unit.
- Ruth Carnall will delegate responsibility to me for the delivery of acute performance across South West London, including the18 week and A&E targets, single sex accommodation and maternity services.
- Completing the strengthening commissioning programme, particularly stronger joint working between PCTs and with borough councils.

I know that with the support of the chair, Board and Professional Executive Committee will be able to successfully balance both roles. I hope to spend Tuesdays and Wednesdays at NHS Wandsworth, and the other days I will work in my role as sector Chief Executive and on London wide projects. I will continue to be based at Wimbledon Bridge House five days a week.

I am very pleased to begin this new and exciting role and I do not underestimate the challenges ahead. I look forward to continuing to work alongside the other four PCT Chief Executives, and with Sian Bates, Chair of Richmond & Twickenham PCT, who was appointed as chair for south west London, earlier this month.

Ann Radmore
Chief Executive, NHS Wandsworth and South West London