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5th October 2012

Mr Jeff Zitron  
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Dear Jeff

**The Imperial AHSC response to Shaping a Healthier Future**

This is a response from the Imperial College Academic Health Science Centre and as such represents the shared views of Imperial College London and the Imperial College Healthcare NHS Trust.

As the Academic Health Science Centre (AHSC) in North West London (NWL), it is important that we propose and articulate a view encompassing all elements of our mission to provide excellence in patient care through combined excellence in healthcare, education and research. We welcome the opportunity to continue to partner with you in shaping the fundamental elements of Shaping a Healthier Future (SaHF) and in the delivery of these goals.

We have structured our response to address the core elements of SaHF and our tripartite mission before summarising with our conclusions which are to support option A, predicated on NHS confirmation to fund in full the education and research relocation/re-provision that is required by the College.

Yours sincerely



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## **The Imperial AHSC response to Shaping a Healthier Future**

### ***Introduction***

The core objective in reconfiguring healthcare in NWL is to build a world class patient care model, operating on multiple sites but working seamlessly as one entity developing a complementary set of core competencies to address the total portfolio of patient need. Operationally this implies both stronger integration between the settings of care, encompassing health and social care, and the integration of patient flows between these settings. To deliver this model sustainably we must all:

- (i) develop effective systems integrating the settings of care,
- (ii) educate and train the next generation of doctors and healthcare professionals in ways that encompass these new models of care, and
- (iii) encompass academic excellence by driving research, a core component of the NHS strategy, into all these settings of care, for the benefit of patients.

The AHSC, established to fulfil the tripartite mission of providing excellence in healthcare, education and research has an important and influential role to play in the delivery of these changes.

Built on localising where possible and centralising where necessary, SaHF looks to improve the quality in primary care and emergency services across NWL as a significant step on this journey. These are both ambitious and significant tasks which need to be tackled in a co-ordinated sequence and will require strong programme management to deliver, possibly beyond that seen to date in the NHS. Education should be seen as a critical part of this implementation process to deliver system sustainability supported by research that can be utilised appropriately to inform/refine these processes. A final consideration is that the realisation of our vision will be hampered unless we fundamentally address the currently unstructured patient flows. These substantially hinder rational planning, leading to inefficiencies in delivery of healthcare both for individuals, witnessed by the variations we see in quality and patient experience, as well as in the efficient use of resources. The effective completion of this journey in NWL will therefore need, in due course, to include elective care, cancer, tertiary/quaternary (specialist services), mental health and social care.

### ***Out of hospital services (OOH)***

The improvement in the quality of primary care is focused on the development of GP networks working closely with other providers of health and social care to keep people healthy and deliver co-ordinated patient care as required. This is a huge change programme involving a range of health/social care providers, multiple stakeholders and an ambitious three year delivery timetable. This will require further integration and co-ordination across care settings and the work of the NWL integrated care pilot (ICP) is an important plank in this development. Tackling long term conditions is the major focus of the ICP and as this is scaled there is enormous potential to enhance the links between service and academia. Areas include the development and testing of algorithms of care, implementation of protocol based therapies which are tested through rigorous research strategies, patient education and population care measures, and translational approaches to the management of

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long term conditions. IT is *the enabler* for sharing information across care settings and has been demonstrably critical for effective population health measures. Development of appropriate shared IT systems characterised by inter-operability and acceptable access protocols for all participants will be key to the success of all that SaHF is looking to achieve. This is best exemplified by the experience on Tayside where the embedding of effective information technology in clinical networks, eg. in areas such as diabetes, has led to demonstrable impact in terms of patient outcomes and the efficient delivery of healthcare.

We strongly support the necessity of such activities and as an AHSC will aim to participate with the clinical commissioning groups (CCGs) in the development of new rigorously tested models of care supported by best practice in both clinical service and IT. We recognise the difficulties of providing high quality sustainable primary care in challenging neighbourhoods but believe that this can start to be addressed by providing an attractive integrated academic working environment that, with the support of our GP training activities, will implement better society tailored models for health promotion and care delivery. Delivery of scaled services for the largest health and social care spend areas, ie. care of the elderly and multiple long term conditions, will require a delivery model that brings together resources and intellectual capital in different ways. We would look to utilise the AHSC's combined strength to work with the CCGs and other providers to develop such innovative delivery models, e.g. predictive tele-health solutions for active diabetes management and use of our BRC funded NWL Biobank and Population Health Laboratory projects. We therefore welcome the current discussion of alternative economic models, including capitation, as an active and shaping participant. Additionally the strengths in both fundamental and translational medical research of our internationally recognised Imperial School of Public Health can be engaged in the development and evaluation of innovative strategic approaches to the major healthcare issues facing society and we would like to support the evolving Health and Well Being Boards by offering the Imperial School of Public Health as an academic co-ordination hub for their public health/social care activities.

### ***Hospital services***

The AHSC continues to strongly support the principles of reconfiguration as articulated in the SaHF document and shown by the Trust's active participation to date. ICHT currently operates emergency services at three hospitals which collectively see over 300,000 emergency attendances per annum. Our services encompass hyper-acute stroke services, myocardial infarct services and major acute trauma services and we are fully cognisant of the benefits and necessity for the centralisation of services as an essential part of delivering high quality health care. For these reasons we are fully supportive of the premise that delivery of emergency services should be optimised and that additional services should be stratified for the appropriate delivery of the highest standards of healthcare. We further believe as an AHSC that the development of such a stratified and optimised service should proceed in an integrated manner with the academic mission in both research and education so that we can most efficiently translate research developments for the

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benefit of our patients and furthermore deliver an educational programme appropriate to the next generation of medical practitioners. Hence, we are fully committed to supporting the planning and delivery of health care towards the resolution of the issues addressed in SaHF and subsequent elements of this journey.

Based on previous work with NWL we recognise the value of separating elective from acute activities and can clearly see potential for expansion of the elective hospital model either on unique sites or organised as such on larger campuses. Such an approach has the potential to provide a more streamlined patient experience, better outcomes and substantial efficiencies not only in the delivery of quality care for patients requiring elective treatment but also in the delivery of acute and specialist care.

There is a large and unique concentration of specialist services in NWL strongly backed by the academic infrastructure required for the delivery of excellence in patient care. While Hammersmith is the focal point of this activity, bringing the Trust, the College, NIHR, MRC, and other stakeholders together within a specialist hospital, we see additional potential for further concentration of specialist services at Hammersmith. The delivery of specialist services in a rich academic environment provides the most appropriate milieu for the incorporation of translational research into service delivery for both patient benefit and wealth generation. We continue to build and invest in this location having recently opened the Imperial Centre for Translational and Experimental Medicine as well as planning for the Imperial West research campus. We see the potential for further specialist service augmentation should the Royal Brompton co-locate to the Du Cane Road Hammersmith site.

As an AHSC we will look to work with the CCGs to shape flexible configurations and service offerings for local hospitals including workforce planning/role redesign that link effectively with our range of both OOH and hospital services. We recognise the need for appropriate 'step down' facilities across the system as the hospital model evolves and again will work with colleagues to ensure these designs link effectively across the different settings of care.

### **Research**

The NHS constitution has clearly articulated the concept that "research is a core part of the NHS", recognises that the cost for research (and education) should be separately identified within NHS investment proposals and further emphasizes that patients should be provided with information regarding research that is of relevance to them. Excellence in patient care is increasingly based on the principle of stratified medicine where patients with a specific condition may be stratified according to genomic or phenomic characteristics to receive specific therapeutic approaches. This approach has been initially best exemplified in oncology where mutations in specific genes predict response or non-response to individual therapeutics. However, it is increasingly recognised in a range of both benign and malignant conditions that rigorous patient characterisation has the potential to transform medical management delivering better patient experiences and preventing the financial cost of inappropriate treatment. The AHSC through developments such as

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the molecular pathology laboratory and the MRC-NIHR Phenome Centre has globally one of the strongest collections of academic clinicians and scientists involved in translational research leading to stratified medicine.

Such research may occur within both an early stage translational framework (T1), or at a later stage setting incorporating community based research (T2). Within the AHSC we anticipate that T1 based translational science will largely be co-located with specialist services, usually but not exclusively at the Hammersmith site, while the elements of T2 will be distributed throughout the Trust and a range of community settings. The anticipated alignments within SaHF map to the expected direction of travel of the AHSC with the important proviso that the specialty services at Hammersmith should explicitly be strengthened by the transition in a manner which maps to the very considerable academic investment directly on the site and at Imperial West. We anticipate further strengthening of research disciplines at the St Mary's site which map to the projected range of major hospital services to be provided there. For example, such development could include research in bio-engineering and technologies that impact on acute trauma care.

In one embodiment of T2 research, chronic disease programmes depend on effective integration across settings of care, ie. hospital, community, GP and social care, and depend on utilisation of specific algorithms which encompass appropriate therapeutic approaches and patient education strategies. Within this context there is enormous capacity through research to enhance the links between service and academia in the development and testing of algorithms of care, of outcomes of population based measures and of implementation science of chronic disease management. Successful chronic disease management requires strong communication between the academic, acute and community sectors in development of research paradigms for testing, and strong integration between research-based informatics and the clinical informatics driving delivery of health care programmes. There is very substantial and demonstrable added value at both a service and research level from the establishment of shared disease registries and registry-based management of chronic disease. As the next phase of NWL integrated care begins to take shape there is merit in strengthening the linkages with Imperial's academics to both learn lessons from and develop the practical application of their experiences.

### ***Teaching***

The anticipated shift in healthcare services provides both substantial opportunities and significant challenges for developing and enhancing medical undergraduate and postgraduate training. Imperial College has one of the largest undergraduate medical schools in UK, with some 2,200 students in total. As SaHF's focus moves from service change to implementation and sustainability the huge implications on teaching multi-disciplinary staff across NWL will need to be considered. Currently Charing Cross (CXH) is the major centre for undergraduate medical education, housing two major lecture theatres (> 300 students) not available elsewhere, major teaching facilities, including anatomy, skills labs and computer rooms, communication teaching suites and various student laboratories. Additionally around



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1,000 medical students live within walking distance of CXH, which provides a sense of student community on this campus and is the social centre for all the medical students. All in all these facilities occupy in excess of 25,000 square metres of space.

Over time some elements of teaching for undergraduates, nursing and AHPs is likely to take place in primary, community and outpatient settings, requiring the appropriate staffing to teach and the space in which to teach to be available in GP practices and local hospitals. Linked to this, more elements within the system will be exposed to teaching, in parallel with patient care, and this will need to be built into placement re-design, individual services at a patient interaction level and the design of space/facilities. These changes are likely to require the reconfiguration of training circuits, via the Local Education and Training Board (LETB), with workforce redesign therefore impacting current medical and non medical commissioning plans. At an individual hospital site level, the stratification of hospital services will necessitate training activities shifting across sites as specific services move location. While this is easier to manage at a postgraduate level, at an undergraduate level it is more complex as sites become more specialised or change their nature significantly, ie. the local hospital model. Specifically, should CXH become a local hospital then it will be necessary to relocate the medical school, re-providing the current teaching facilities, as well as relocating doctors in training. Given that the College occupies over 25,000 square metres at CXH these are obviously significant changes that would require careful planning with an expectation under EL (96) 25 that capex requirements would be NHS funded as a NHS led initiative.

### ***Hospital options A, B and C***

Before explaining our perspective on the relative merits of the SaHF options it is important to articulate the range and performance of the AHSC's operations today. Imperial was the first AHSC in the country and has continued to demonstrate this pre-eminent position as the largest recipient of the latest BRC funding round, the major beneficiary from the NIHR's Patient Safety Translational Research Centre funding as well as being selected to lead the teaching of nine key postgraduate specialties across NWL. Both the College and the Trust have recently seen the appointment of new leaders who have reinforced their commitment to the development and delivery of the tripartite mission with the rapid appointment of an influential AHSC Director. The Trust has a reputation for the delivery of outstanding HSMR/SHMI performance that is consistently amongst the lowest in the country. The Trust is actively addressing its operating performance, which in the first half of 2012 has fallen short of requirements, and is expected to be performing in line with the Acute Trust Performance Framework by the end of Quarter 2 having already achieved a small recurrent financial surplus in Quarter 1 within a break-even budget for 2012/13. Assuming the Trust demonstrates sustainability in its performance and financial position it will solicit input from stakeholders on the appropriateness of bringing forward its Foundation Trust timetable that is currently scheduled for submission to the Secretary of State in 2015.

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The nature of our activities and sites today is as follows:

- Hammersmith is a major research centre with specialist clinical care and maternity that has seen significant academic capital investment on a site where the building stock is very mixed;
- St Mary's is a major acute hospital which will require significant redevelopment over the next ten years and currently operates with Western Eye located 500m away on Marylebone Road;
- Charing Cross is a major acute hospital with significant elective specialisation and is the hub for pathology and medical undergraduate teaching on a functional site that has many tenants; and
- All sites have significant postgraduate medical training roles totalling over 600 doctor in training posts with more than 200 currently at the CXH.

In summary all of SaHF's hospital options reinforce the nature of the Hammersmith as a specialist hospital and St Mary's as a major hospital but propose to significantly change the nature of Charing Cross (option A and C see CXH as a local hospital while option B sees it as a major hospital). Again under all the options and as part of a more major redevelopment we would relocate neurosciences and the hyper-acute stroke unit (HASU) from Charing Cross and co-locate with the Western Eye at St Mary's. This allows us to bring major trauma, neurosciences, the HASU and ophthalmology together providing patients with a more integrated service in a modern setting. We describe below the implications for each of the sites under the SaHF options and comment upon them:

**Hammersmith (HH)** –will, under all options, continue to be a major research centre with specialist clinical care and maternity. We will look to focus activities around 'areas of distinction' which will be defined over the remainder of 2012/13 supported by research co-location as described earlier. There are selective teaching implications from the closure of A&E with some under and postgraduate medical activities moving to St Mary's which, should include the education and training requirements of other acute care based healthcare professionals. This will require careful planning and will include capital resources with capex being for the NHS as a health led change. For example, the absence of undifferentiated take will change how consultants are revalidated and how clinical academics fulfil their obligatory training requirements. HH is a global centre of excellence in translational medicine, a status which requires continuing nurture and one which demands the close alignment of patient care and research. Hence it is critical that the processes for continuing delivery of specialist care are robust and efficient and do not endanger the patient throughput essential for the continued delivery of the aims and objectives of the AHSC. Specifically we see an opportunity for a major centre for translational medicine at HH (building on the existing academic resource including the molecular pathology laboratory and potentially othercentres) that will provide stratified medicine for NWL patients and potentially beyond.

**St Mary's (SMH)** – will, under all options, continue to be and grow as a major acute site. With the major trauma centre as a hub, we will relocate our neurological services and the HASU at this site as well as providing the appropriate acute cardiovascular support for trauma and the acute/specialist paediatrics services as we

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do today. One third of our beds are currently in the older buildings and as part of a more major redevelopment we are looking to re-provide for these, to take the opportunity to co-locate our ophthalmology services (Western Eye) at SMH and address any additional bed requirements from SaHF. With the closure of A&E at HH and potentially CXH (options A & C), St Mary's will need to pick up these additional medical under and postgraduate teaching requirements, which are significant, and will need to consider these additional space (>25,000 sq m) requirements in any NHS led redevelopment plans.

**Charing Cross (CXH)** – will, under all options, change significantly becoming either a local hospital (option A & C) or a major hospital (option B). We see the most practical option as follows, recognising that this 'end state' will require some time to achieve and being predicated on NHS confirmation to fund the education and research relocation/re-provision that is required by the College:

*CXH is designated as a local hospital with our active participation in the development of CCG led services; the Trust relocates its CXH clinical activities to SMH and HH; the College relocates, predicated on NHS confirmation to fund in full, the relocation of the medical school, other teaching activities, research and other academic activities to SMH and HH; third sector facilities at CXH are co-located with adjacent clinical services; mental health activities at CXH are relocated.*

This option accelerates the change of use at CXH and has major implications for clinical services, research and teaching both at the Trust and College as well as across NWL. This approach will require a very substantial cost in terms of planning, logistics and capital expenditure as this will necessitate the translocation of the facilities for medical education and research (at least 25,000 sq m) to new and substantial facilities at the SMH and HH sites. Very careful planning would be needed to ensure that there was no disruption to the architecture of the medical curriculum at Imperial College London or the excellence of its delivery in executing such a proposal. Further careful capacity planning for postgraduates will also be required to ensure that our quality of training can be maintained. In consideration of the importance of the College's substantial investments at and near to the HH site, it is also critical that there are active processes in place to ensure the necessary flow of patients requiring specialist care to the HH site so that this can further develop as a centre of excellence in translational and stratified medicine.

The Trust might seek to enhance the flexibility of its response as a willing participant in a partnership or merger with another local provider. West Middlesex (WMUH) has recently announced that they will seek a partner and the Trust is actively exploring this opportunity. Such an approach could mitigate some of the Trust's capital requirements at SMH and HH while improving the other local provider's viability. Should such an option be pursued, the AHSC would look to evaluate further opportunities around the development of NHS funded education and training facilities at the other provider.

Furthermore, consideration will need to be given to how Maggie's (third sector) remains connected to cancer where they provide a valuable service to patients

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including consideration to any capital requirements as well as an appropriate solution to the mental health services that are provided from CXH.

Considerable alignment will be required across the system, ie. CCGs, NTDA, NCB, etc, to deliver this 'end state' with joint recognition of not only the scale of the benefits but also the financial cost and risk.

### **Conclusions**

The AHSC supports the intent of SaHF and specifically states:

1. We will help the CCGs, as requested/required, to design and deliver their ambitious OOH strategies through strengthening GP provision, co-designing local hospitals, addressing issues relating to entry mechanisms to major hospitals, partaking in or managing selective long term condition services, and contributing to the public health agenda. We intend to continue to participate in the assessment of alternative economic models, such as capitation, and recognise the need to work together flexibly to achieve our objectives;
2. We support the designation of Hammersmith as a specialist hospital and would encourage others to support the establishment of a major genomics centre supporting the mission of this site in translational and stratified medicine;
3. We support the designation of St Mary's as a major acute hospital and look for support in developing its focus on acute trauma;
4. We support the designation of Charing Cross as a local hospital with our active participation in the development of CCG led services and additionally support the relocation of all Trust and College activities on the site to other locations within our Trust estate. This option presents very substantial opportunities, but also challenges, requiring the relocation of significant clinical services, relocation of research and re-provision of the medical school at St Mary's. It is predicated on NHS confirmation to fund in full the education and research relocation/re-provision that is required by the College;
5. Further work will be undertaken to quantify the revenue and capital implications of these changes in 4 (above) including the consideration of how a partnership or merger with another local provider could mitigate an element of these costs;
6. As SaHF moves towards implementation, it is critical that the implications for teaching and research are addressed in detail through extensive consultation with the AHSC and specifically the College, reflecting not only deliverability but sustainability across the NWL cluster;
7. It is important to note the priority given to medical research in the NHS constitution and how the AHSC as a global leader in the field of translational medicine can support this in NWL, specifically but not exclusively in the

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development of stratified medicine. Within the modern NHS it is important that research and clinical care continue side by side and that the reconfiguration of clinical services is matched by tight alignment with research facilities and activities that directly benefit the patient.

Finally we recognise that the JCPCT needs adequate information around capital build requirements as an input to their decision. We undertake to work with you to provide this with respect to the broader build requirements at St Mary's and Hammersmith under options A, as detailed above, by the end of the calendar year. We will incorporate a range of mitigation options within our models including for example the partnership or merger with another local provider.

This response has been informed by staff, received extensive debate and serious consideration by the AHSC and has been approved by our respective Boards. We thank you for the opportunity to share our perspectives and look forward to continued dialogue in our combined quest for building a world class patient care model in NWL.