Public Document Pack

North West London Joint Health Overview and Scrutiny Committee

Wednesday 26 September 2012 at 10.00 am
Council Chamber, Brent Town Hall, Forty Lane, Wembley, HA9 9HD

Membership:

Councillors:

Ivimy (Chair)	LB Hammersmith and Fulham
Bryant	LB Camden
Chatterley	LB Richmond (Co-opted Scrutiny Committee Member)
Collins	LB Hounslow
D'Souza	City of Westminster
Fisher	LB Hounslow
Gulaid	LB Ealing
Harrison	LB Brent
James	LB Harrow
Jones	LB Richmond
Kabir	LB Brent
Kapoor	LB Ealing
McDermott	LB Wandsworth
Mithani	LB Harrow
Richardson	City of Westminster
Usher	LB Wandsorth
Vaughan	LB Hammersmith and Fulham
Weale	Royal Borough of Kensington and Chelsea
Williams	Royal Borough of Kensington and Chelsea

For further information contact: Andrew Davies, Policy and Performance Officer
andrew.davies@brent.gov.uk

For electronic copies of minutes, reports and agendas, and to be alerted when the minutes of this meeting have been published visit:
www.brent.gov.uk/committees

The press and public are welcome to attend this meeting

Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members.

Item Page

1 Apologies for Absence

2 Welcome and Introduction

3 Declarations of Interests

4 Minutes of the Last Meetings (4th and 6th of September) 1 - 18

5 Witnesses and Additional Evidence 19 - 116

- NHS NW London – Formal Witnesses
  - Anne Rainsberry
  - Daniel Elkeles
  - Mark Spencer
  - Lisa Anderton
- Patient and Public Advisory Group: Trevor Begg
- Overview and Scrutiny Committees Summaries
- Other

6 Consideration of Joint Health Overview and Scrutiny Committee Draft Report

Draft report to follow.

7 Next Steps

8 Any Other Business

Date of the next meeting: Date Not Specified

Please remember to ***SWITCH OFF*** your mobile phone during the meeting.

- The meeting room is accessible by lift and seats will be provided for members of the public.

- Toilets are available on the second floor.
- Catering facilities can be found on the first floor near The Paul Daisley Hall.
- A public telephone is located in the foyer on the ground floor, opposite the Porters' Lodge

Joint Health Overview & Scrutiny Committee (JHOSC)

Minutes

Tuesday 4 September 2012

PRESENT

Committee members:
Councillors Lucy Ivimy (Chairman)
Ms Maureen Chatterley (LB Richmond, Co-opted Scrutiny Committee Member)
Councillor Sheila D'Souza (City of Westminster)
Councillor Pamela Fisher (LB Hounslow)
Councillor Abdullah Gulaid (LB Ealing)
Councillor Pat Harrison (LB Brent)
Councillor Sandra Kabir (LB Brent)
Councillor Anita Kapoor (LB Ealing)
Councillor Sarah McDermott (LB Wandsworth)
Councillor Mary Weale (RB Kensington & Chelsea)

Also Present : Dr Ruth Brown (Vice President (Academic and International) of the College of Emergency Medicine), Dr Marilyn Plant (GP and PEC Chair of NHS Richmond), Dr Adam Jenkins (Chairman of Ealing, Hammersmith and Hounslow LMC), Dr Mark Spencer (Medical Director, NHS NW London), Dr Tim Spicer (Chairman, Hammersmith & Fulham Clinical Care Commissioning Group), Dr Susan LaBrooy (Medical Director, Hillingdon Hospital), Luke Blair (Communications Lead, SAHF), Lisa Anderton (Assistant Director of Service Reconfiguration), Mark Butler (JHOSC Support)

Officers: Jacqueline Casson (LB Brent), Kevin Unwin (LB Ealing), Sue Perrin (LB Hammersmith & Fulham), Lynne Margetts (LB Harrow), Deepa Patel (LB Hounslow), Gareth Ebenezer (RB Kensington & Chelsea), Ofordi Nabokei (LB Richmond), Mark Ewbank (City of Westminster)

Apologies:
Councillor John Bryant (LB Camden)
Councillor Mel Collins (LB Hounslow)
Councillor Krishna James (LB Harrow)
Councillor Sue Jones (LB Richmond)
Councillor Vina Mithani (LB Harrow)
Councillor Sarah Richardson (LB Westminster)
Councillor Caroline Usher (LB Wandsworth)
Councillor Rory Vaughan (LB Hammersmith & Fulham)
Councillor Charles Williams (RB Kensington & Chelsea)

1. WELCOME AND INTRODUCTIONS

The Chairman welcomed those present to the meeting.

2. MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 2 August 2012 at LB Harrow were approved and signed as a correct record, subject to the following amendment:

Ms Maureen Chatterley to be shown as having given her apologies, instead of as present at the meeting.

3. DECLARATIONS OF INTEREST

There were no declarations of interest.

4. MAIN THEMES OF THE MEETING

Main themes of the meeting:

- Core change proposals and centralisation of care
- Proposals on Urgent Care Centres and Accident & Emergency provision
- Impact on local populations
- Out of Hospital Care – community and service preparedness
- Levels of professional support for proposals

Dr Ruth Brown, Vice President (Academic and International) of the College of Emergency Medicine presented the views of officers of the College. Dr Brown had been a consultant in Emergency Medicine since 1996 and worked in North West London for ten years. However, she was not speaking on behalf of any organisation within the North West London sector.

Dr Brown stated that there was an inherent risk in any emergency and urgent care service of identifying the exact level of service for patients. There was an overlap between the case mix that might be seen in an Emergency Department and those patients who could be seen in an Urgent Care Centre (UCC).

The College standard for an Emergency Department included the presence of a ST4 (higher specialty trained) doctor or equivalent 24 hours a day, as well as consultant presence and leadership. Whilst a consultant presence 24 hours a day was advantageous, it might not be possible or optimal use of resources in smaller departments. The College believed that there should be sufficient consultant numbers to provide a presence 16 hours a day, every day.

The model of a network of Emergency Departments, some of which would not have a full range of supporting specialties, but all of which had immediate

access to diagnostics, specialist advice and rapid transfer was recognised to be the model of the future by the College.

Dr Brown noted the lack of an agreed or validated national definition of an UCC, or of the cases, or definition of the cases and conditions that might be treated in such a facility. The College viewed an UCC as a suitably designed physical facility with appropriately trained staff able to see and manage a limited range of conditions. These conditions usually included: the minor exacerbations of chronic illness, which did not require life saving treatment or admission; and minor illness requiring limited procedural interventions followed by outpatient or community treatment. The College believed that UCCs must be part of an Emergency Care network, and must have the same immediate access to diagnostics, specialist advice and transfer where required. In addition, if the UCCs were to see the full range of ages, appropriate provision for safeguarding children and vulnerable adults would have to be in place, as well as access to mental health, drugs and alcohol services.

The College believed that the Emergency Department staff (doctors and nurses) would usually be capable of providing care for the full range of conditions suitable for an UCC. However, whilst the College recognised that GPs were trained and competent in managing the conditions that might be expected to present at the UCCs, it considered that the majority of GPs did not manage the full range of UCC conditions on a day to day basis. The College believed that many GPs did not have the ongoing recent experience of managing minor injuries or illnesses that required direct interpretation of diagnostic tests such as X-rays and ECGs. In addition, the College believed that many GPs in inner city practices did not routinely undertake minor procedures in their surgeries.

Whilst emergency nurse practitioners (ENPs) were a valued and effective workforce in Emergency Departments, the majority of ENPs worked within a limited range of protocols. In addition, not all ENPs were nurse prescribers, limiting their ability to autonomously treat patients.

The College agreed that in North West London, the optimal number and configuration of Emergency Departments might be fewer than the current number. Integrating the Emergency Departments and UCCs into one network might in future prove to be the best model.

Dr Brown outlined some of the practicalities of such a network, including workforce aspects which required further modelling and requirements for additional staff and refresher training. The College considered the lack of middle grade (ST4 and above) doctors to provide safe 24 hour care to be a priority and high risk area.

The College recommended a carefully planned phased approach to allow the system to adjust to an individual closure or change before embarking on a further closure. However, for departments with an uncertain future, this would lead to difficulties in staff recruitment.

The College considered that the wholesale changes proposed carried an inherent risk for patients, and that the public health and public education impact was considerable.

The financial impact of change from an Emergency Department to an UCC and the physical demands of reconfiguration of facilities was complex. In the experience of the College and the limited available evidence, the provision of care in UCCs was not necessarily lower cost than that of junior doctors within an Emergency Department. The College believed that provision of 24 hour staffing in an UCC to provide consistently rapid assessment and treatment, regardless of surges in activity, would be considerably more expensive.

Dr Brown commented on the impact on the London Ambulance Service, and specifically the need to model the impact of re-direction of ambulances and the increased number of inter-hospital transfers. In addition, there was a need to model repatriation of patients to their local hospital and patient pathways and bed numbers. Whilst early discharges were welcomed, there was a need for robust and reliable community services to be in place.

The network relationships would be key, and governance, including protocols, pathways, agreed management plans and shared care arrangements were essential.

The College considered that the proposals must take into account the provision of care and information to the transient population, both of commuters into London and overseas visitors.

The impact on education and training might be profound.

In conclusion, Dr Brown stated that the documents reviewed by the College suggested that there was further work to demonstrate the clarity of evidence and inform the issues.

Dr Brown then responded to questions.

A member queried whether the proposals had been driven by Accident & Emergency department requirements and whether the needs of patients and hospitals generally had been though through. Dr Brown responded that there was a lack of clarity in respect of the delivery of services, which needed to be addressed immediately.

A member queried whether an UCC could function effectively without an Accident & Emergency department. Dr Brown responded that there was not a definition of cases treated in UCCs or proposals for ensuring that the 'right patients' attended and the arrangements for patients who could not be treated. Workforce and financial modelling was needed to determine if an UCC without an Accident & Emergency Department was viable.

A member queried whether there were adequate trained doctors to run UCCs and the finance to provide these services. Dr Brown responded that there was a major workforce problem in respect of middle grade doctors. Modelling of

GP and nurse recruitment was required to show the risks and specifically to address the management of surges throughout the day. Whilst Dr Brown was unable to comment on finance, she considered that the proposed reconfiguration was likely to cost more.

A member queried attendances at an Emergency Department by patients who could have been treated at a GP surgery. Dr Brown responded that the issue was one of patient education. Existing UCCs had removed the less intense cases from Accident & Emergency Departments. Whilst the challenge was to reduce attendances by a further 40/50%, it would not be possible to reduce staff in the same proportion as the residual cases would be more intense. In addition, such a staffing reduction would make rosters unstable.

A member queried whether recruitment of middle grade doctors was easier in those hospitals with a reputation as a centre of excellence in teaching and research. Dr Brown responded that this was normally the case, but there were also candidates who were seeking a lesser role if, for example, they had other commitments. In addition, the role of non-trainee doctors was fundamental. Whilst ENPs could play a leading role in UCCs, there was a spectrum of patients, outside their competencies.

A member queried the timescale. Dr Brown estimated that it would take three/five years for the re-education of patients and at least five years for the reconfiguration of services.

A member queried the functioning of networks and whether there would be disparity of access. Dr Brown responded that the concept was well developed with stakeholders, and the structure included provisions for the evaluation of Accident & Emergency Departments/UCCs. Strands of work were required to look at training, patient pathways and complaints. The networks, including virtual networks, would face the challenge of putting in place standards which ensured equal access.

Dr Marilyn Plant then presented her views as a GP and PEC Chair of NHS Richmond, and from her experience of service redesign at Queen Mary's Hospital, Roehampton.

Dr Plant referred to variations in the quality of emergency care and unacceptable variations in patients outcomes. Data had demonstrated over 500 excess deaths in London annually attributable to differential staffing between weekday and weekend working.

Dr Plant referred to the problems in modelling and evaluation of data, and specifically the lack of information in respect of emergency care delivered in GP surgeries. Organising services in such a way to deliver emergency care consistently over 24 hours, 7 days a week was not affordable in the current configuration.

In London, there was an over reliance on hospital care and substantially higher rates of Accident & Emergency Department attendance, and inadequate provision of primary care. There was a need to consolidate

emergency services on fewer sites to deliver high quality care and move towards a community based model.

Dr Plant highlighted the workforce risk of a delay between a decision to implement change and actual implementation.

In conclusion, Dr Plant stated that it was not possible for the status quo in the NHS to be maintained.

A member asked Dr Plant's opinion on the issues which the JHOSC should raise and whether UCCs were the weakest link in the proposals. Dr Plant responded that the UCCs were an area of controversy. The JHOSC must listen to the evidence and take a view. The proposals were not evidence based and it would be difficult to educate the public. The telephone number '111' was a single point of access and, if used correctly, would direct a patient to the right place for care. Dr Plant stressed the importance of integrated working, and the desire to improve services, including proposals for the estate, which was of variable quality.

A member queried the impact on GPs of the proposals. Dr Plant responded that patients would be able to access GPs without necessarily being registered. UCCs would augment, not replace, GPs; they would provide a more responsive service and meet increasing demand. GPs needed to provide a more flexible accessible offer, for example in respect of opening times.

In respect of the consultation documentation, Dr Plant considered that neither the pre-consultation business case nor the consultation document were comprehensive, and did not clearly explain the issues or the options to the public.

A member queried the biggest risks of the service reconfiguration. Dr Plant responded that the biggest risk was that the service reconfiguration did not happen and secondly that it happened badly, through for example, disputes across boundaries. Dr Plant spoke of the need for the NHS to address the challenges and for vision to transform the service from one where every hospital aimed to provide everything.

A member referred to the threat to Ealing of the downsizing of the estate and the re-provision of a smaller facility plus a substantial housing development.

Dr Adam Jenkins, Chairman of Ealing, Hammersmith and Hounslow LMC, presented the opinion of GPs. Dr Jenkins stated that similar but less extensive plans had been the basis of earlier proposals in 'Healthcare for London' in 2008, whereby care such as outpatients, urgent care and diagnostics was to be transferred out of hospital into 150 'polyclinics'. Dr Jenkins believed that 15 extra healthcare centres had been provided.

Although the proposals were led by CCG Chairmen, there was concern amongst GPs that they were actually management driven for the explicit purpose of cutting costs. The preferred option would decrease the nine

general hospitals to five major hospitals, one specialist hospital, an elective hospital and two local hospitals, and decrease the number of beds from 3500 to 2500. Current bed occupancy in these hospitals varied between 93 and 97%, and on occasion reached 100%. The decrease in the number of beds in NW London seemed ambitious and contingent on some very big assumptions about the reduction of acute admissions due to changes in chronic disease management in primary care and the development of Out of Hospital Care.

Some of the reconfigurations seemed less controversial: Central Middlesex Hospital becoming a local/elective hospital; Hammersmith Hospital becoming a specialist hospital retaining maternity services; and moving the Western Eye Hospital into the St. Mary's site.

The proposals to remove Accident & Emergency facilities from Ealing and Charing Cross Hospitals, leaving UCCs to deal with walk-in emergencies would completely remove Accident & Emergency facilities from the boroughs of Hammersmith & Fulham and Ealing. Analysis showed that approximately 10-30% of Accident & Emergency attendees could be dealt with at an UCC and worked best with the back up of an Accident & Emergency Department. Under the proposals, patients who needed Accident & Emergency expertise would have to be transferred to a major hospital. With the removal of an Accident & Emergency Department, a hospital would lose general surgery, paediatrics and maternity and this would be the first stage of being down graded to a local hospital with diagnostic facilities, a few overnight beds and outpatient services. Current buildings were too large for such a reduced service, and it was assumed that a smaller facility would be build.

There would be an impact on the remaining Accident & Emergency Departments and increased demand for beds in the major hospitals and increased pressure on waiting lists and waiting times in Accident & Emergency Departments.

GPs agreed that a critical mass of staff and activity was required to produce high quality care. However, the elderly, frail and disabled were likely to be disadvantaged, and might be denied access to services because of transport difficulties.

Dr Jenkins considered that since 2004, there had been a progressive disinvestment in both community and GP services, and little capital investment in infrastructure and buildings for years prior to this.

Dr Jenkins stated that the number of GPs close to retirement age was substantial and that the number of 'training' GP registrars was falling. GP practices were not replacing staff when they left, in order to reduce costs. A number of the proposed new services were already available in Ealing (GP extended hours, Ealing hospital 24/7 UCC, primary care minor operations, the ARISE team, Integrated Care Pilot and pre-discharge planning), but hospital admissions were not declining. GPs did not have confidence that the proposed investment would be made prior to these proposals going ahead.

Dr Jenkins stated that mental health services were not addressed, whilst a number of Accident & Emergency attendances had mental health issues.

The proposals referred to 750-900 extra staff to run new community services, who were already working in NW London. It was assumed that these were the staff who had been made redundant from hospitals who had little or no training in primary care.

In conclusion, Dr Jenkins stated that GPs accepted that there was a need to change and evolve, but there was an underlying concern that 'Shaping a Healthier Future' was making significant assumptions about how costs would be saved. It was hoped that CCGs would ask their practices whether they supported the proposals.

A member noted the lack of support from GPs for the closure of Ealing Accident & Emergency Department. A member suggested that use of an UCC was a failure on the part of primary care and noted the cost of £52 per attendance. Dr Jenkins responded that UCCs provided a range of diagnostic facilities, not available in GP practises and removed minor procedures from Accident & Emergency Departments. Dr Jenkins outlined the way in which his practice worked to provide dedicated sessions for patients requesting emergency appointments. However, patients might attend an UCC if a GP did not provide the required response or because an UCC was more convenient.

A member commented on the high percentage of Accident & Emergency Department attendees who were admitted. Dr Jenkins responded that 'Payments by Results' was an inappropriate payments system.

The Committee received written witness statements from:

Axel Heitmueller, Director of Strategy and Business Development, Chelsea and Westminster NHS Foundation Trust
Hillingdon Hospitals NHS Foundation Trust
Julie Lowe, Chief Executive, Ealing Hospital NHS Trust
James Reilly, Chief Executive, Central London Community Healthcare NHS Trust
Alison Elliott, Director of Adult Social Services, Brent Council
Councillor Julian Bell, Leader of the Council and Councillor Jasbir Anand, Portfolio Holder, Health and Adult Services, Ealing Council
Barry Emerson, Emergency Preparedness Network Manager, NHS London
R.L. Wagner, Programme Manager, Better Services, Better Value, NHS South West London

Members noted the importance of the alignment of the 'Shaping a Healthier Future' proposals with Social Services.

Members requested a copy of the risk register. Dr Spencer responded that there was a programme risk register, but he did not believe that this would meet the committee's requirements.

5. PUBLIC CONSULTATION: PROGRESS REPORT

Mr Luke Blair updated on the public consultation, which was now in its second phase with further road shows. There had been some 460 attendees at the first round of road shows.

The consultation documentation had been translated into 15 languages and current circulation figures were: 60,000 full consultation documents; 548,000 summary consultation documents; 18,000 postcards and 5,000 posters.

The NHS would check that the consultation documents had been received and displayed by libraries.

850 responses had been received.

Action:

NHS NW London would provide:

1. A breakdown of responses by borough.
2. The independent review of the consultation.
3. The Equalities Impact Assessment.

The NHS would not agree to an extension of the consultation, on the basis that a 14 week period was adequate.

Action:

All boroughs/OSCs would provide a summary of the main issues relevant to the JHOSC by 18 September.

6. DATES OF NEXT MEETINGS

26 September, LB Brent

Meeting started: 10am
Meeting ended: 1pm

Chairman .....

Contact officer: Sue Perrin
Committee Co-ordinator
Governance and Scrutiny
☎: 020 8753 2094
E-mail: sue.perrin@lbhf.gov.uk

This page is intentionally left blank

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES

Thursday, 6th September, 2012

PRESENT:

Chair:
Lucy Ivimy (LB Hammersmith & Fulham)

Councillors;
Pat Harrison (LB Brent)
Sandra Kabir (LB Brent)
John Bryant (LB Camden)
Abdullah Gulaid (LB Ealing)
Anita Kapoor (LB Ealing)
Rory Vaughan (LB Hammersmith & Fulham)
Krishna James (LB Harrow)
Mary Weale (LB Kensington & Chelsea)
Sheila D'Souza LB Westminster)
Sarah Richardson (LB Westminster)
Ms Maureen Chatterley LB Richmond (Co-opted Scrutiny Committee Member)

Also Present - Witnesses addressing the Joint Committee
Simon Cooper - Transport for London
Daniel Elkeles – Director of Strategy, NHS, N.W London
Catherine Jones - Transport for London
Jeffrey Lake - Acting Consultant in Public Health, NHS N.W London
Peter McKenna - Assistant Director of Operations West, London Ambulance Service
Abbas Mirza - Communications and Engagement Officer, NHS N.W London
Russell Roberts – Principal Transport Planner, London Borough of Ealing
Dr Mark Spencer Medical Director, NHS N.W London

Officers:
Mark Butler (JHOSC Support)
Gareth Ebenezer (Kensington and Chelsea)
Jacqueline de Casson (Brent)
Laurie Lyle (Ealing),
Lynne Margetts (Harrow)
Deepa Patel (Hounslow).
Kevin Unwin (Ealing),

1. Apologies for Absence
(Agenda Item 1)

Apologies for absence were received on behalf of Councillors;
Mel Collins, Pam Fisher (LB Hounslow),
Vina Mathani (LB Harrow),
Charles Williams (RB Kensington & Chelsea)
Sarah Richardson (LB Westminster)

2. Urgent Matters
(Agenda Item 2)

The Chair requested that each of the individual Overview and Scrutiny Committee's that make up the JHOSC, submit a short report to the next meeting, by no later than the 18th September, 2012.

The Chair said that the report should summarise what each Overview and Scrutiny Committee believes are the key issues and main areas of concern relating to Shaping a Healthier Future.

3. Matters to be Considered in Private
(Agenda Item 3)

There were none.

4. Declarations of Interest
(Agenda Item 4):

There were none.

6 Main Themes of the Meeting
(Agenda Item 5)

The Chair welcomed all those in attendance, and advised that the main purpose of the meeting was to consider evidence from relevant witnesses concerning transport issues, and the equalities impacts associated with the programme.

The Chair commenced consideration of the item by inviting Daniel Elkeles, Director of Strategy, NHS N.W London to provide a brief address the Joint Committee, on the transport and travel impact of the new proposals.

Daniel Elkeles advised the Joint Committee that a travel model had been developed using the Transport for London 'HSTAT' travel time database to conduct a travel time analysis.

He said that the main impacts of travel in NW London will be that Ambulance blue light travel will take a maximum of 30 minutes to travel to a major hospital in N.W London, and 95% of the local population of N.W London will be able to get to a major hospital within 18 minutes.

He said that in terms of private car travel, the time taken to arrive at a major hospital will be 54 minutes or less, at any time of the day, and that 95% of the local population will be able to arrive at a major hospital within 32 minutes, even during peak hours.

He said that with regard to public transport, the maximum time taken to arrive at a major hospital from anywhere within the N.W London area, has been calculated at 93 minutes or less at any time during the day, and 95% of the local population can expect to reach a major hospital in the N.W London area within 54 minutes or less, during the rush hour.

He said that overall the proposed reconfigurations are not likely to substantially affect people's ability to receive care, as there was very little difference between each of the different options, and the proposals have a relatively low impact on maximum and average travel times, due to the current proximity of hospitals in the N.W London area. He added that more care would be provided closer to home.

He said that the key issues going forward will remain travel impacts, and the requirement to undertake future joint planning with other related agency groups.

The Chair thanked Daniel Elkeles for his address, and invited Members to comment and ask questions.

In response to a point from a Member of the Joint Committee, Daniel Elkeles advised that residents of Richmond would normally travel to Charing Cross and West Middlesex to access treatment, however, if these hospitals do not become major hospitals under the new proposals, residents of Richmond Borough will be required to travel either to Chelsea, or Westminster hospitals. He added that South London were not planning for Kingston Hospital to be one of their major hospitals.

In response to a point from a Member of the Joint Committee, Daniel Elkeles advised that a great deal of travel information has been analysed to date, including looking at where people would go to access treatment and services under the three different options.

He said that NW NHS London had worked with 'Transport for London (TfL), to come up with transport journey times, and the difference between each of the three proposed options was small.

In response to a point from the Chair regarding the maximum travel time of 93 minutes, and how many people are likely to be significantly affected by the new proposals, Daniel Elkeles advised that the numbers affected significantly will be in the minority, however he did not have the exact figures with him at the meeting.

He said that such information could be deduced from looking at the 'S' curve statistics, which is used to assess the travel times for the local population of N.W London for various hospital configurations. He gave an undertaking to circulate this information to all Members of the JHOSC.

In response to a point from a Member of the Joint Committee, Peter McKenna (London Ambulance Service), advised that the London Ambulance Service had undertaken a 91 day travel exercise of what investment will be required under the new reconfiguration proposals, and these costs have been factored into the proposed model.

In response to a point from the Chair of the Joint Committee, Daniel Elkeles advised that specific groups such as the elderly and the disabled do currently receive transport services, which are provided by the NHS, and that all hospitals in the N.W London area should currently operate a standard NHS policy on travel concessions.

He added that NHS NW London would discuss the issue of transport mapping with TfL in order to significantly facilitate journey times, however these talks could not take place until a decision on which option to implement has been taken.

He said that in addition, it is hoped that the work that is being carried out with regards to the 'Out of Hospital Strategy,' and the work currently being undertaken with regards to equality impact assessments will help to improve travel arrangements and mitigate impacts on all 'protected groups.'

Abbas Mirza (Communications and Engagement Officer), advised that he was leading the work of the Equalities Impact Steering Group, and said that he had begun work to ensure the participation of hitherto marginalised groups, and that he intended to improve engagement with these groups.

He said that he has spoken with numerous people regarding their concerns, in particular blue light travel and travel to hospices and 'dial–a-rides.' He said that wherever possible he had sought to reassure these people of the importance of arriving at the right hospital for treatment, rather than arriving at a hospital because it is nearer.

In response to a point from a Member of the Joint Committee, Daniel Elkeles advised that the costs of travelling, and the impact on local people of the new proposals is expected to remain at the same or similarly consistent levels. There was expected to an significant environmental impact associated with the proposals, detailed in the carbon emissions modelling which had been circulated to Members. There were opportunities to offset increased emissions from longer journeys with more care being delivered closer to home.

In response to a supplementary question from the Chair of the Joint Committee concerning car parks, Daniel Elkeles said that NHS NW London would seek to increase car park space capacity at those hospitals where this is possible, however, realistically the increase of car park space or capacity, is only likely to take place at the larger hospital sites.

In response to a point from a Member of the Joint Committee, Daniel Elkeles advised that the NHS NW London's website contains, through the available travel tool, up to date, and detailed information in connection with specific journey times to each of the proposed major hospitals.

At this point the Chair invited Catherine Jones and Simon Cooper, representatives of Transport for London (TfL), to address the Joint Committee.

Catherine Jones and Simon Cooper advised Members that they had first met with clinicians from NW London back in February 2012 to discuss travel times, and that since then a number of meetings had taken place which had led to valuable information sharing and ideas exchange.

They advised that TfL had provided information for the 'Kinsey' travel advisory group report, and that TfL had looked at bus plans and had reviewed and discussed transport modelling, peak and non-peak times of travelling, and had undertaken a number of comparisons between different hospital sites.

They advised that a travel document has subsequently been prepared, and they will arrange for this document to be circulated to all Members of the JHOSC.

In response to a question by the Chair to the TfL representatives regarding whether or not TfL agree with the analysis provided by NW London, Catherine Jones said that TfL had provided the data, however their position is to remain neutral, as the role of TfL as a transport advisory group is to look at issues such as; the planning of routes, journey times, timetables, cost-effectiveness and flows of people. She said that the TfL also works with public liaison groups in each borough to talk about such issues.

Daniel Elkeles said that it was important to note that the vast majority of the current journey's will not change under the reconfiguration proposals. However NHS NW London will continue to consult with all stakeholders on the proposed changes to acute services, so that better outcomes and cost effectiveness can be achieved.

In response to a question from a Member from Richmond Borough Council, Daniel Elkeles gave an undertaking to provide information to that Member concerning travelling modelling in the Richmond area.

The Chair thanked Catherine Jones and Simon Cooper for their contributions, and invited Peter McKenna, 'Assistant Director of Operations West,' London Ambulance Service, to address the Joint Committee.

Peter McKenna advised that the London Ambulance Service had looked specifically at delivering time in the most appropriate settings, and had attended a number of meetings of the 'Transport Steering Committee,' during which the Ambulance Service were advised of the options and proposed changes to current services.

He informed Members that currently the Ambulance Service take the most acutely ill from the start of the patients journey, to specialist sites across London. He said that likewise trauma patients are taken from the start of their journey, to any one of 4 specialist trauma sites across London.

He said that the Ambulance service prefer to travel further if necessary, in order to get to the right place for patients, so that the patients receive the best treatment.

He said that the Ambulance Service had been consulted on the proposed travel times, and had looked at all 3 options, and they were satisfied with the times quoted in each of the options.

He said that the major consideration for the Ambulance Service is how the proposals will impact upon the London Ambulance Service capacity to ensure that appropriate response times can be maintained.

In response to a point from a Member of the Joint Committee, Peter McKenna said that average blue light times in London were generally 12.7 minutes. He added that statistically heart attack patients in London, have a better chance of survival than in any other major city in the UK.

In response to a supplementary question from a Member of the Joint Committee, Peter McKenna advised that where a heart attack patient attends their local hospital seeking treatment, there is an immediate transfer policy in place to take them to a major hospital, where the patient can receive specialist treatment.

In response to a question from a Member of the Joint Committee, Peter McKenna advised that the Ambulance service supports the proposed changes, and have identified what their requirements will be to adapt to the changes, however this cannot be confirmed until final decisions on the options are made.

The Chair thanked all those who had contributed to the item concerning the impact of the new proposals on travel and transport.

The Chair then invited Jeffrey Lake, Acting Consultant in Public Health, NHS NW London to advise the Joint Committee, on the impact of the new proposals in relation to equalities matters.

Jeffrey Lake advised the Joint Committee on the main findings of the equalities impact strategic review, which he said is in response to the legislative requirements of the Equalities Act 2010, which requires public sector bodies to demonstrate compliance with public sector equality duty.

He provided a brief presentation on the equalities assessment work currently being undertaken in N.W London, and summarised the methodology undertaken in assessing the potential impacts of the reconfiguration proposals with particular regard to those with 'protected' characteristics, who are people considered to have a higher propensity to require access to major services, and those who are most likely to be vulnerable to change.

He said that, such groups typically include; age, disability, gender reassignment, race, religion and sexual orientation. He said that from these demographics, profiling is done and a map is created and critical areas identified.

He said that much of the equalities work carried out seeks to identify disproportionate needs for services closer to home such as; 'accident and emergency (A&E), elective complex and non-complex surgery, emergency surgery, obstetrics and paediatric services.

He said that overall the impact on equalities was positive, with little significant difference between each of the three options. He added that this information has been shared with the public health teams.

In response to a question from a Member of the Joint Committee, Daniel Elkeles advised that across all of the protected groups there were advantages in terms of care being provided closer to home, which obviates the need for travelling to hospital for treatment.

He said that the new proposals also enable more care to be provided in the community. He said that an example of this, is the integrated care pilot for diabetes, where consultants can see the patient in their local GP practice.

In response to a question from a Member of the Joint Committee concerning the absence of any mention of mental health services in the proposals, Jeffrey Lake said whilst it is true that proposals concerning mental health were not mentioned specifically, current local mental health services will not change significantly. He said that mental health services will however be bolstered in A&E departments, and 'Urgent Care Centres' will also be accessible for mental health patients.

In response to a question from a Member of the Joint Committee, Jeffrey Lake said that all three options were considered from an equalities perspective, and the findings remained generally consistent throughout.

In response to a question from the Chair of the Joint Committee, Jeffrey Lake said that current models of good equalities practice include efforts to liaise with groups from different ethnic communities within Ealing, such as the; Afro-Caribbean, Bosnian and Herzegovinian, Somalian and South East Asian communities.

Dr Mark Spencer, Medical Director, NHS NW London, said that it was important to note that the issue of equalities was one of the main drivers that had led clinicians in NW London to look at change to improve care across all of its sites. He said that currently there were examples of disparate care across NW London, and the new proposals sought to put this right, and redress the balance.

At this point the Chair invited Russell Roberts, Principal Transport Planner, London Borough of Ealing to address the Joint Committee.

Russell Roberts said that the Borough had identified a number of issues that they would like to see addressed, including;

- An independent validation of the travel modelling undertaken to date
- More detailed explanation of why Hillingdon and Northwick Park hospitals had been selected as major hospitals in the initial phase of options development described in the Pre Consultation Business Case
- A potential over-estimation of levels of car ownership in London, as levels were below the national average

In addition it was felt that further detail was required on the following:

- services provided outside of hospitals
- services to be provided at urgent care centres
- the impacts of the proposals regarding the expected population increase in Ealing, in line with the new census.

Sheila D'Souza (LB Westminster), said that she believed that the out of hospital strategy will be absolutely pivotal to the success of the proposed reconfiguration.

She cited diabetes as an example, and said that she hoped that specialists will provide better care, and bring services into local communities, thus providing better outcomes for the local population.

Rory Vaughan (LB Hammersmith & Fulham), said that it was important to recognise that new census data indicates that populations across NW London are increasing significantly, and that this needs to be borne in mind when considering the impact of the new proposals.

The Chair concluded the proceedings by thanking all those present for their attendance and contributions to the meeting.

7 Date of Next Meeting

(Agenda Item 13)

Resolved: That the next meeting of the JHOSC take place on Wednesday, 26th September, 2012.

The meeting ended at 10.00pm

www.ealing.gov.uk

Health and Adult Social Services Standing Scrutiny Panel, Ealing Council

Submission to the JHOSC

The Health and Adult Social Services Standing Scrutiny Panel wishes to submit the following points on the Shaping a Healthier Future programme to the JHOSC. These points are drawn from consideration of the Pre Consultation Business Case (PCBC), and from the Panel's meeting on 26 July, which considered the programme's proposals and heard views from concerned residents and local clinicians.

The response is comprised of a number of points, based firstly around concerns relating to the approach and deliverability of the programme itself, and secondly on how the programme impacts on Ealing. Much of the latter debate refers to Ealing Hospital, on behalf of which the Panel has heard many representations. However, the Panel also wishes to state clearly that it opposes the downgrading of any hospital which serves residents, with Charing Cross, Central Middlesex and Hammersmith being valued assets in the local health economy.

Deliverability of the Programme

A fact that has struck Panel Members, and which has been reflected in discussions as part of the JHOSC, is the scale of change required in primary and community care. It is of course key to the programme that investment in primary and community care proves successful in shifting activity away from acute settings, to realise the goals of improving care quality whilst at the same time reducing costs, in order to respond to the demanding financial environment that the NHS in North West London is faced with.

The PCBC states that this improvement work needs to be completed by 2015, and as the Panel have seen through scrutiny of Ealing's Out of Hospital Strategy, initiatives are already underway. Moreover, it welcomes the PCBC's assertion that no reforms to shift activity from acute services will be implemented until capacity improvements to primary and community services are in place. However, the Panel has a number of concerns relating to the deliverability of this aspect of the programme, and the time frame it is required to happen within.

The backbone of this transformation will be an additional 765 – 890 staff working in primary and community settings, and the Panel notes the PCBC's assertion that many of these staff will come from the acute sector. However, the Panel feels there may be a conflict between this proposal and that outlined in the PCBC, re-stated by programme representatives on 26 July, that no acute reforms will take place until capacity improvements have been realised. The Panel queries how this additional community capacity can be realised without releasing staff from acute care first, and whether there may be, for example, an intended reliance on agency staff to ensure adequate staffing levels. This is not clear from the PCBC, and the Panel considers this a potential risk to the timely delivery of this aspect of the programme, a risk which is arguably made quite real when it

talks about the importance of having to develop successful workforce transition policies – policies which are not elaborated on any further.

The Panel also feels that there are risks around the scale of change required. As the PCBC highlights, there will be investment of approximately £138m into out of hospital care, which is expected to deliver 100,000 fewer spells of activity in A&E, 55,000 fewer non-elective procedures, 10,000 fewer elective spells, and 600,000 fewer outpatient appointments. However, the Panel feels that the standard of some current services, plus the importance of making this capacity available rapidly, presents a significant obstacle. Realising improvements in primary care, for example, seem particularly large – of the 80 GP practices across Ealing, only 4% were meeting statutory requirements and guidance in terms of estates at the time of the last review, and satisfaction with access to GP services low for North West London are considerably below national averages. And yet building this capacity quickly is vital to the maintenance of safe acute services.

There is also a potential challenge in terms of public education to ensure that residents access the right facilities at the right time, and that they are aware of different care settings and the standards that apply to them. The Panel notes proposals for the 111 Service in this regard, which is due to go live in Ealing early next year, and which is aimed at supporting people to make informed and appropriate choices. Nevertheless, the number of potential options open to people within the care environment, set against a background of rising attendances at accident and emergency departments, means this will be no easy task within the time frame available.

These challenges become even more pressing when it is considered that, as the PCBC points out, once a course of reconfiguration is decided on it can be increasingly difficult to recruit and retain staff as vacancy rates increase, sites become less attractive to trainees, and planned improvements are halted. This, in turn, could impact on safety in particular as smaller units struggle to retain their staff. Taking these points into account, the Panel therefore feels that greater time should be given to developing out of hospital care, accompanied by an effective monitoring programme (proposals for which are not set out in the PCBC), to ensure that this investment is being appropriately delivered and capacity transfers are in place, before any decision to reconfigure acute services is taken. It seems that NHS North West London is taking a significant risk in setting itself the timetable outlined in the PCBC.

The Panel also queries the criteria that will be used to decide whether reforms to primary and community services have been successful. Programme representatives and the PCBC itself state that this is an issue of capacity and efficiency – the sector should be seeing increased levels of activity with sufficient capacity to absorb transferred cases from the acute sector. However, the Panel also asks whether patient experience should also be a factor. If the ultimate aim of the programme is to improve services, then the views of patients about the accessibility and quality of primary and community services should be taken into account before acute services are reformed.

Finally, there is also a question of deliverability around maternity and paediatric services *after* these reconfigurations are in place. It is acknowledged that meeting the requirement for additional workforce in order to meet expected clinical quality standards will be 'extremely challenging' and that 'there may need to be further work to review service configuration in maternity and paediatrics in the future.' The Panel would like to place on record its concern at this, and query what future maternity services might look like if appropriate staffing levels are not met.

Sensitivity Analysis and Risk Management

The Panel is concerned as a result of its own analysis and evidence submitted to the JHOSC that a risk register for delivering the programme has not been compiled for any of the three possible options. The JHOSC heard evidence that the reason this work has not been undertaken is because no decision about a particular course of action has yet been taken, with detailed risk analysis being completed once an option has been decided on – sensitivity analyses in the PCBC are pointed to instead.

Panel Members do not, however, agree with the logic of this approach. In view of the scale of the programme to be undertaken, with such a large shift of care into the community and fundamental re-modelling of acute services, they feel that an analysis of the risks to delivery, complete with mitigations, should have been provided in the PCBC to give a credible and detailed picture of how the dangers to delivering the programme will be managed. As will be discussed elsewhere in this submission, there are a number of risks that the Panel feel should have been assessed and presented as an integral part of the arguments in the PCBC, such as equalities impacts and risks around staff recruitment and retention once the decision to reconfigure is taken.

Moreover, the sensitivity analysis provided in the PCBC offers no mitigation for a potentially dangerous combination of risks. It is acknowledged that if a combination of scenarios occur simultaneously, it would result in a situation which is worse, by the programme's own parameters, than the base case or 'do nothing' scenario. This includes underperformance on reducing length of stay, delivery of QIPP savings at 60%, and underperformance on consolidation savings and reduction of fixed costs. However, no description of how likely these risks are to occur is given, and no possible mitigations are offered. Given how serious such an eventuality would be and the potential implications for services that might follow, the Panel does not feel this is acceptable.

GP and Community Support, and Early Implementation of the Consultation

The Panel was concerned to hear at its meeting on 26 July that not all GPs across Ealing supported the programme's proposals. Representations made at the meeting drew the Panel's attention to a recent meeting of Ealing Hospital consultants and 35 general practitioners, out of a total population of 340, which was convened to discuss the plans. At this meeting, 33 GPs resolved that they were not in favour of the preferred option and the proposed downgrade of Ealing hospital. Concerns were expressed about the potential for Urgent Care centres to function as stand-alone facilities (which will be discussed further on in this submission) and the ability of the out of hospital sector to realise the additional capacity required.

Subsequent input from the local Save Our Hospitals campaign has stated that the many of the GPs that attended were those who used Ealing hospital the most, but also that there was representation from GPs in Acton, predominantly concerned about the future of Charing Cross. It has been emphasised that many GPs who attended were representing their whole practice, which would be between 4 and 8 GPs. The Panel heard that the consultants had received a number of emails expressing similar concerns from a number of GPs who could not attend that meeting.

Taking the above into account, and acknowledging the work to engage with clinicians described in Chapter 10 of the PCBC, Panel Members remain concerned about a possible lack of broad based GP support for the programme, particularly as their buy-in and co-operation will be a key element in

driving improvements to out of hospital care. The Panel queries how the programme and CCGs will take on board the views of GPs it engages with throughout the consultation process, and what the programme's response will be if it transpires that significant numbers of GPs do not support the proposals. The JHOSC itself heard similar queries about consultation between CCGs and local GPs expressed by Dr D. Adam Jenkins, Chairman of Ealing, Hammersmith and Hounslow Local Medical Committee, at its meeting on 4 September.

Regarding the consultation process itself, the Panel heard representations from concerned members of the public that, three weeks after the opening of consultation, copies of the full consultation document had not been distributed to key locations such as local libraries, and were not available in alternative languages. Panel Members also heard disappointment from a representative of a faith group that the programme had not contacted them in order to raise awareness of the consultation amongst their members. Whilst the JHOSC signed off the consultation plan, and the Panel appreciates how programme representatives have engaged with it over the previous months, it is nevertheless disappointed to hear of these issues with the implementation of the consultation some weeks after it opened. Similarly, Panel Members were concerned that, in the first round of eight engagement events, only 300 people had attended. The Panel heard at its meeting in July that consideration was being given to extending the consultation period as a result of the difficulties in circulating the full consultation document, a proposal which was subsequently discounted at the JHOSC meeting on 4 September with the reason that it was felt the 14-week consultation period remained adequate. The Panel wishes to place on record that its disappointment with that decision.

Finally, one Panel Member has discovered problems when attempting to use the journey planner on the programme's website, which advises members of the public how long a journey by ambulance, private car or public transport might take to hospital sites. The Member in question entered a range of postcodes for which the journey time from their home was known, and received results which they knew not to be realistic, and which differed from TFL's journey planner. The Member reported that 'having put through a series of postcodes in close proximity to a number of hospitals, errors of this type are commonly found.' On contacting the programme, these faults were acknowledged, and said to result from the individual geographical areas around which the programme's database is built. The Panel understands that this is being worked on, and supports the programme for its approach in building such a calculator in the first place, as a means of making transport impacts more transparent. However, it nevertheless wishes, in a similar manner to the above, to register its concerns about the errors in the route finder, for reporting likely incorrect travel times to users of the route finder in the early part of the consultation.

Presentation and Use of Data

Many of Members' concerns in this area centre on how figures are presented in the consultation document and PCBC, when contrasted with some of the more detailed statistics in the appendices to that document, particularly Volume 18, Appendix L. For example, in the main consultation document, figures are used to show that 14% of A&E attendances would be affected under the preferred option. However, the more detailed breakdown of possible impact presented in Chapter 17 and Appendix L shows that for major and standard A&E admissions (as opposed to minor admissions, which are assumed to be seen in Urgent Care Centres at local hospitals), 28% of total activity (admissions) will be affected under the preferred option. The Panel feels that the more detailed breakdown of activity impacts, including the figure for major and standard A&E cases,

should have been presented in the consultation document, to provide a full, accurate and easily accessible picture for members of the public seeking to engage with the consultation.

Panel Members have also expressed concerns that the full consultation document does not mention the potential for reduction in staff numbers, or the fact that Ealing hospital services will be supplied in one-fifth of the current area. The document also quotes figures stating that impact on overall care activity across North West London will be low, rather than additional figures in the PCBC which show how activity will move by hospital site under each of the options, which Members do not feel is being as transparent as possible about local activity impacts.

The Panel also queries the division of A&E attendances into 'major and standard' and 'minor' in Chapter 17 and Appendix L. It is clear that the latter are those which will be dealt with by Urgent Care Centres, but no definition is offered of what 'major' and 'standard' cases are respectively. Although the Panel understands from the PCBC that Urgent Care Centres will treat patients that do not require hospital admission, there is potential for confusion about the nature of an A&E admission when looking at the activity figures provided in the PCBC - numbers of admissions assigned to these categories come in at 49.7% of total A&E admissions for major and standard admissions, and 50.3% for minor admissions, but Panel Members have been informed by programme representatives that Urgent Care Centres will handle up to 70% of all A&E cases, and no mention is made in chapter 8 of the PCBC or Appendix L of UCC's handling 'standard' A&E cases. Similarly, in Chapter 17, it is stated that 55% of A&E activity would remain at Ealing under the preferred option. It would therefore have assisted Panel Members and members of the public in their understanding of how Urgent Care Centres will work and the activity levels they will handle if these categories had been elaborated on, and this information incorporated into the main body of the PCBC along with what proportions of each type will be handled by UCCs.

Finally, Panel Members note that the activity modelling in Chapter 17 and Appendix L uses Hospital Episode Statistics (HES) as its data source. Chapter 17 acknowledges that, for A&E attendances, there is some inconsistency in this dataset – the HES website states that is experimental, likely to be incomplete, and that there are definitional differences from the official source of A&E Data, Quarterly Monitoring of Accident and Emergency (QMAE). Whilst the Panel understands that HES data potentially provides a fuller picture of activity than QMAE, it feels that the risks associated with the use of this dataset should have been discussed in the PCBC, and that it should have set out the reasons why the advantages of this dataset outweighed these risks when compared to using the official statistics compiled by the Department of Health.

The basic point to emphasise is that the Panel feels that the consultation document and the PCBC should have explained more fully the data sources employed, the way data was used, and presented in the main clinical arguments figures which provide as much detail as possible, to enable readers to engage with and assess the arguments completely.

Community Need and Access to Services

At the Panel's meeting on 26 July it heard evidence from a consultant working at Ealing Hospital who highlighted what the Panel feels to be a significant omission in the approach to the PCBC – namely that the health needs and local characteristics of the populations around the hospital sites that are at risk of being downgraded are not discussed. This evidence is present in the separate Equalities Impact document compiled by Mott Macdonald, but as a result there is no systematic consideration

of the equalities characteristics identified and the impact of the three reconfiguration proposals in the options development and arguments put forward in the PCBC.

The communities around Ealing hospital currently experience high levels of multiple deprivation and health deprivation and disability, as highlighted by the 2010 national indices of deprivation. Dormer's Wells and Norwood Green are amongst the most deprived in Ealing on these indices, as are significant parts of South, East and Central Acton. The national indices capture, in relation to the domain of health deprivation and disability, areas with high rates of people who die prematurely or whose quality of life is impaired by poor health or disability. For example, Ealing's Joint Strategic Needs Assessment for 2010 highlights that Dormers Wells and Norwood Green, along with surrounding wards Southall Broadway and Southall Green, suffer from the highest mortality rates in the borough in relation to cardiovascular disease.

As representations from clinical staff at the Panel's meeting on 26 July highlighted, the blue light analysis presented in chapter 12 of the PCBC shows that those areas which are most affected by increases in travel times if Ealing Hospital loses its Accident and Emergency Unit coincide to a large extent with these deprived areas. This is reflected in Mott Macdonald's modelling on the Equalities impact of the changes – figures 3.1 and 3.2 of that document show that the greatest number of 'critical equality areas' in the borough are located in the vicinity of Ealing hospital and in Southall for both major hospital and maternity services. The Panel notes that this is also the case for Acton, in relation to the reduction of services at Central Middlesex that will impact on older people, over 64.

In relation to accessibility of services to these communities, Mott Macdonald's travel analysis states that 'significant' travel impacts on critical equality areas will be 'very low' if the preferred option is implemented, and that none of the population will, under blue light conditions, experience an increase in journey times of 10 minutes for either major or maternity services. Similarly 'low' impacts are modelled for private car travel. However, the analysis is clear that the impact percentages for users of public transport are 'far higher', with 20% of the populace in critical equality areas experiencing an increase in journey times of over 10 minutes to access major hospital services, and 61% of the populace having a journey of over 30 minutes (an increase of 17%). Figures for maternity services are 8% and 50% respectively. These increases would result in a total of 108,588 people across NW London, the majority of which are in Ealing, potentially experiencing significant travel impacts.

The equalities analysis goes onto state that these impacts are more likely to affect visitors than patients, as trips to affected services are more likely to be made by ambulance than public transport, 'with the exceptions of elective complex surgery and possibly maternity services.' However, no description of the likely number of patients who might use public transport for major hospital services is offered, or indeed for patients travelling by private car, where there is a 6% increase in the number of people who will have to travel for over half an hour – as the JHOSC heard at its meeting on 6 September, actual numbers of journeys likely to be taken by each mode of transport are not yet available, and are to be worked up shortly. Therefore, whilst NHS NW London points to the fact that low levels of activity overall will be affected under the preferred option (9%), it remains that, with journey numbers, the equalities impact assessment is not able to tell us exactly how many people from critical equality groups will be affected by significant travel impacts.

Moreover, the public transport modelling in the PCBC, in Appendix H (separated from the main analysis in chapter 12), seems to support the local reality that there are currently poor public

transport links between Ealing and West Middlesex Hospitals. That appendix predicts a shift of only 14% of patients from Ealing to West Middlesex if the preferred option was implemented, which arguably reflects the fact that there are no direct bus links and the subsequent difficulty of getting there. A submission from the Chief Executive of Ealing Hospital to the JHOSC also emphasises the Trust's belief that more people will travel to Hillingdon hospital because of the better quality transport links, although only 15% of patients using public transport are expected to make this journey. There is also no consideration in the PCBC about the cost impact of these longer journeys on those who must undertake them, and this extends to those using taxis, otherwise covered by private car modelling and therefore assumed to be impacted relatively minimally.

Fundamentally however the Panel feels that any arguments about the limited predicted disruption to travel times, assuming the concerns above are discounted, do not alter the inequitable fact that if the preferred option was implemented, it would make accessing major hospital services more difficult for some of the most vulnerable communities in Ealing. As Mott Macdonald point out, people living in areas of deprivation make greater use of primary care and emergency departments, and less use of preventative care. They are more likely to need emergency complex services. Moreover, these groups are more likely to use public transport and to not have access to private cars, owing to the co-prevalence of health and income deprivation in these areas.

The programme seeks to assure us that there will be better health outcomes for patients in these categories, with more routine care for long term conditions available in the community and a local hospital with facilities for treatment of conditions such as COPD and diabetes, as well as a 24/7 Urgent Care Centre. However in deprived communities there is the potential for language and other barriers to mean that care pathways might not be effectively communicated or understood, leading to a lack of clarity about how to access care and potentially to health consequences for the local population – this poses a problem of public education about care pathways which the Panel feels is a key risk to the effective delivery of the programme, discussed earlier.

Mitigations for these risks are outlined in the equalities impact report, but as this stands apart from the PCBC and there is no risk register available for the programme, the Panel is unable to see how the programme will tackle these issues and put such mitigations into practice**.** The Panel is concerned that the net result is that, as it stands, communities suffering the poorest health conditions in the borough will be hit hardest by these service changes, and it is unclear as to how the impact on these populations will be addressed.

Concern over lack of Co-Location of UCC and A&Es, and Future Quality of Care

Related to the above point are views expressed to the Panel by clinicians at Ealing Hospital about the risks involved in separating Urgent Care Centres from Accident and Emergency facilities, again taking into account the characteristics and needs of the local population in Ealing.

At the meeting on 26 July, a member of clinical staff advised Panel Members that there were a number of 'late presenters' to the A&E department in the borough – those who turn up to A&E sometime after their injury or complaint was first experienced, and where their condition may have deteriorated. This is of particular concern owing to the high rates of long-term conditions in the borough, and again in the locality around Ealing hospital. In addition, and owing to the diverse population which Ealing Hospital serves, large numbers of patients do not have English as their first

language, leading to communication difficulties – the Panel heard the example of a patient describing pain as a simple headache, when in fact this could in fact be a sign of meningitis.

Both of these factors often meant that people turned up 'late and sick', and on top of this, presented a challenge to diagnose. However, as Ealing hospital had co-located Urgent Care and Accident and Emergency services, it meant that patients, once diagnosed with a serious condition requiring emergency treatment, could be escalated to Accident and Emergency rapidly. Under the preferred option this would not be the case, with patients having to wait an additional period of time for an ambulance to take them to West Middlesex University Hospital**.**

This is not therefore purely an issue of travel time from a local to a major hospital, but about how fast the local healthcare system can respond to critical healthcare needs which may be identified late. The Panel shares the concerns expressed that this is an issue in Ealing, and feels it is another strong argument against downgrading hospital sites.

In addition to this, Panel Members have raised concerns about the programme's potential impact on patient care, as well on local hospital sites themselves. Members have, for example, queries about patient pathways after discharge from acute services, where outpatient appointments will be needed. It has been suggested that these appointments might take place in local hospitals, to make them easier to access for the local populace. However, Panel Members have expressed concerns that this could possibly lead to deteriorating standards as the consultant or team which carried out the initial procedure might not see that patient at follow up.

Why Ealing should be maintained as a Major Hospital

The Panel would also like to take this opportunity to state publicly its support for the staff and services offered by Ealing Hospital. As stated earlier, this should not be interpreted as an argument in favour of downgrading other hospitals such as Central Middlesex and Charing Cross, which is a product of the way the consultation has been constructed. These are, rather, arguments in favour of a hospital which sees the largest single group of referrals from Ealing PCT, and serves, as we have seen, key equality groups.

The first argument the Panel would like to put forward is to re-state the importance of Ealing hospital in serving the communities in which it is based, and in particular, the expertise it has built up in this respect. This is acknowledged in Mott Macdonald's report when it states that:

'In recognising that over 100 languages are spoken across their local Borough, Ealing Hospital NHS Trust has been working with members of the public and voluntary and community organisations to improve patient information and access to services. Developments include a central booking point for face-to-face interpreting and 24/7 telephone interpreting services. Within Ealing Hospital NHS Trust, a resource for all staff has been developed, which contains information about the religious and cultural needs of our local community to enable staff to provide more culturally sensitive care.'

Ealing has adapted to serve the needs of its communities and provides a strong basis on which to continue to provide culturally attuned major hospital and maternity services. Indeed, it is recognised by Mott Macdonald's report that, in terms of accessibility of services for critical equality groups, the retention of Ealing hospital as part of option 7 leads to the lowest adverse impact of all the options put forward for consultation. The Panel feels that this evidence is missing from the options

development process in the PCBC, and should have been taken into account when assessing quality of care and accessibility of services.

With regards to the quality of services provided at the site, the Panel notes that the PCBC scores every Trust equally for clinical quality, reflecting the fact that post investment, standards would be increased and that there was not felt to be sufficient variance between Trusts in terms of performance to choose between them. However, the Panel would like to emphasise a number of positive indicators related to major hospital services, taken from East Midlands quality observatory data for acute trusts, as referenced by, but not discussed in, the PCBC. These include excellent performance on SHMI for emergency and elective care, patient safety incidents, medication errors, and MRSA infection rates, indicators on all of which are considerably above the national average.

In short, the Panel feels that Ealing Hospital demonstrates performance that shows that it provides a solid foundation on which to invest and improve services. This view is reinforced by a submission to the Panel by the consultant body of Ealing Hospital, stating that:

'In national comparisons of hospitals, Ealing hospital has met all its recent clinical and financial targets and turned a surplus last year. Our recent Dr Foster review showed that we are performing as expected on all the patient safety measures and do much better than the average when it comes to managing emergency patients safely, particularly those with complex medical conditions. CQC passed Ealing Hospital without any restrictions. We are immensely proud of the excellent emergency and other services that we offer to our local people, and we are determined they should continue.'

Finally, there was a good deal of discussion at the meeting on 26 July, as there is throughout the PCBC, about the preferred option being a more effective use of estates as it retains West Middlesex University Hospital. It is noted that West Middlesex is a PFI building, and that should Ealing Hospital be retained as a major hospital, the payments on that estate will need to be maintained. This, in turn, also means that options which retain Ealing Hospital as a major site score poorly on financial options analysis. The Panel does not agree however that these considerations are what should be driving the programme's options development. It does not feel that Ealing's residents should lose highly valued and community focussed services because of a particular approach to financing taken elsewhere in London, and that the kinds of factors discussed in this submission - such as clinical quality, proximity to vulnerable groups and community focussed services - should be given greater weight.

Councillor Abdullah Gulaid and Councillor Anita Kapoor

Chair and Vice-Chair of the Health and Adult Social Services Scrutiny Panel, Ealing

This page is intentionally left blank

APPENDIX 1: UPDATE ON "SHAPING A HEALTHIER FUTURE" CONSULTATION RESPONSE

INTRODUCTION

- "Shaping a Healthier Future" (SAHF) is NHS North West London's proposed programme of change for Out of Hospital and Hospital services across an area which comprises 8 boroughs and a combined population of over 1.9m people

- If implemented, there will be significant changes to services offered by Hospitals in NWL. Four out of nine Hospitals, including Ealing Hospital, will lose their A&E department. There will be a significant reduction in the scope and breadth of services provided at Ealing Hospital, including emergency and maternity services

- NHS NWL has stated that the changes are necessary owing to the need to save money, improve the quality of care, reduce health inequalities and create a sustainable model for healthcare that will meet challenges associated with increases in population, life expectancy, and the number of people acquiring long-term conditions. As part of the proposals, NHS NWL have committed to investing in community and out of Hospital services

- The proposals are subject to formal consultation which closes on 8th October 2012. As part of its response, the Council has commissioned an independent review of the proposals and the business case which underpins them. This independent review will form the basis of the Council's response to the consultation and the process of developing the review will inform submission of evidence to appropriate bodies able to ensure views are fed up to the Secretary of State

Ahead of the completion of this independent review, the purpose of this report is to:

1. Summarise local stakeholder's perspective on the Shaping a Healthier Future proposals and views expressed so far about the implications for Ealing
2. Set out the structure of the independent review report, in order to give Members an opportunity to comment on the scope and approach
3. Set out the timetable for development of the independent review and process for submission of the consultation response, showing opportunities during the process for local stakeholder engagement

To these ends, this appendix is structured in two sections:

SECTION 1: Summary of local stakeholders' perspectives on Shaping a Healthier Future and implications for Ealing (page 2)

SECTION 2: Independent review: structure and approach (page 11)

SECTION 1: Summary of local stakeholders' perspectives on Shaping a Healthier Future (SAHF) and implications for Ealing

The independent review will pull together a technical analysis of the SAHF business case with evidence submitted by local stakeholders.

This analysis and discussions with stakeholders are currently in progress.

Ahead of completion of the independent review report, this section aims to summarise some of the key arguments in response to SAHF proposals made so far by local stakeholders, in particular clinicians, through various channels, including:

- Meetings of the Joint Health and Overview and Scrutiny Committee
- Meetings of the Save Our Hospitals Campaign
- Reviews carried out by professional bodies such as the National Clinical Advisory Team
- Public statements made by local clinicians and Hospital consultants

Local stakeholders' perspectives on the background and context

Table 1 below shows that eight boroughs with a combined population of over 1.9m will be affected by the SAHF proposals:

Table 1: Population affected by SAHF

Brent	311,200
Ealing	338,400
Hammersmith & Fulham	182,500
Harrow	239,100
Hillingdon	273,900
Hounslow	254,000
Kensington & Chelsea	158,700
Westminster	219,400
Total:	**1,977,200**

As part of their strategy for providing sustainable and fit-for-purpose healthcare for this large and increasing population, NHS NWL have committed to investing more money on services provided outside Hospitals and in the local community (figures of £138m for investment in out of Hospital services in NWL have been trailed). Under the SAHF proposals the GP practice is placed "at the heart" of delivering an integrated service. Additionally, a new 111 number will be set up for patients to call for medical assistance, in order to reduce the number of attendances and admissions to Hospitals. In defence of plans to reduce A&E provision, NHS NWL have argued that Urgent Care Centres (UCCs) will be increasingly able in the future to cope with a range of medical emergencies.

NHS NWL have proposed three options in which five hospitals in NWL remain "major". NHS NWL have argued that each "major" hospital will require 100-200 additional beds, delivering a total reduction of 482 beds across NWL.

All three “major” Hospital options retain Northwick Park, Hillingdon, and St Mary’s Hospital as three of the five. The other potential “major” hospitals are:

- Option A: Chelsea & Westminster and West Middlesex
- Option B: Charing Cross and West Middlesex
- Option C: Chelsea & Westminster and Ealing

All options include the closure of Hammersmith A&E.

Option A is NHS NWL’s publically stated preferred option, which means Central Middlesex and Ealing Hospital would be downgraded to ‘local’ hospital status and lose their A&E services. Also under Option A, the Western Eye Hospital and the Hyper-Acute Stroke Unit at Charring Cross would be relocated to St. Mary’s Hospital.

General points and concerns

Whilst all stakeholders approached so far appear to agree that “no change” is not an option for NHS NWL, and whilst some aspects of the aims and objectives of Shaping a Healthier Future seem appropriate (i.e. the need to try to keep people out of Hospital where possible, and to that end, the need to invest in community health provision), there are a significant number of concerns about the proposals and the process used to develop them.

In general terms, these concerns relate to:

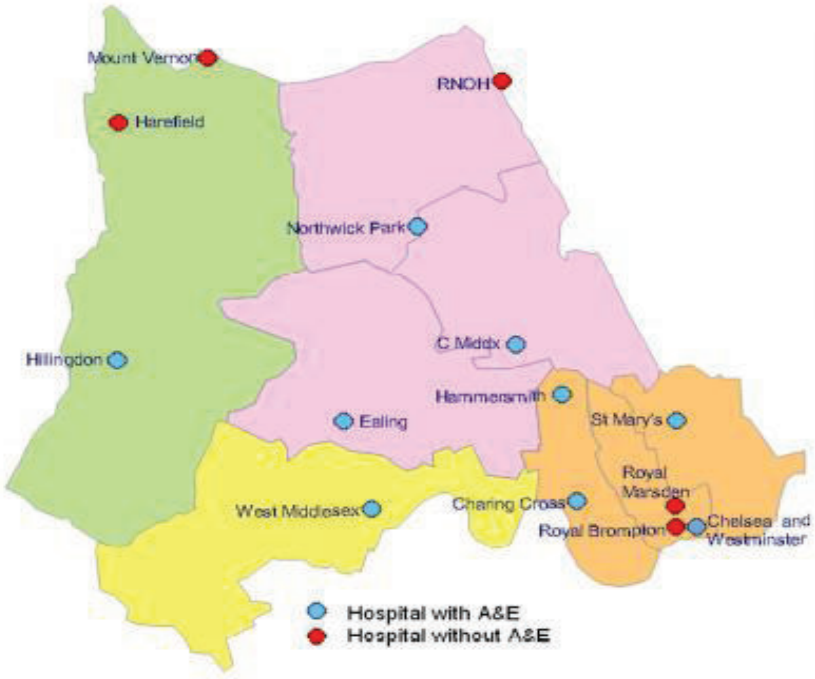
- The scale of the proposed changes lack of precedent for these
- Insufficient detail about risk and project management of significant change
- The approach to engagement with local people, clinicians and appropriate bodies in development and questioning of the proposals
- The modelling and methodologies that have been used in development of the proposals
- The capacity of community and local GP services to cope with the additional pressure on out of Hospital services which some stakeholders believe will result from implementation of SAHF
- The pace of proposed changes, potential lack of time for new approaches to bed in
- Capacity for negative effects to be multiplied when combined with other factors, such as the significant financial challenges facing social care

General points raised in relation to Accident and Emergency (A&E) provision

NHS NWL has stated that NWL has more A&E departments per person than other parts of the country (no specifics are provided on other London areas) and more than average use of A&Es, partly because access to GPs is poor. Under their plans they say that Urgent Care Centres could address this problem and non- emergent issues would be dealt with elsewhere.

Figure 1 below shows a map of current provision of healthcare services in NWL, in particular the location of current A&E facilities.

Figure 1: Map of Hospitals in NWL currently with and without A&E departments



- The UK currently has an average of 249,048 people per A&E department
- NWL currently has 219,689 people per A&E, a 13% "advantage" compared to the national average
- However, the figure rises to 247,150 - an "advantage" of only 0.77% - if Central Middlesex A&E is excluded. Under SAHF, three additional A&Es in NWL would close, bringing the number of people per A&E to 395,440, a "disadvantage" of 52% compared to the national average

General points raised in relation to Maternity services

NHS NWL concedes that the number of women who need maternity services is increasing and pregnancies are becoming more complicated. The rate of maternal deaths in London has doubled in the last five years, reaching twice the rate in the rest of the UK. Babies born outside of normal working hours are also at a higher risk of dying, which is associated with a lack of access to senior staff at these times. Maternity units typically cannot meet recommended midwife staffing levels and do not have enough nurses to care for sick babies.

Local clinicians argue that recruitment of midwives is known to be a national issue; complications arising from local health inequalities in Ealing (e.g. 17% prevalence of diabetes in some Southall wards; up to 25% of Ealing Hospital inpatients having diabetes or diabetic related-problems compared with 10% nationally) are driving increased likelihood of c-section births in Ealing Hospital. Loss of maternity services as proposed in SAHF could therefore have significant implications for the Ealing population.

Specific concerns raised by key stakeholders

Building on general concerns about the potential strain on A&E services and loss of maternity services in NWL, local clinicians have raised a number of specific issues with the SAHF proposals. These will be developed, investigated and substantiated further through the independent review, but headlines so far are as follows:

a) A significant number of Ealing GPs are opposed to the proposals.

- A meeting between NHS officials advocating the SAHF proposals and Ealing GPs attracted 35 representatives of practices made up of between 4-8 GPs, which some Consultants opposed to the proposals have argued is a representative sample of the 340 GPs in Ealing borough
- 33 of the 35 General Practice representatives (94%) voted against the SAHF plans during the meeting

b) Urgent Care Centres are not a suitable substitute for A&E services, and the nature and drivers of demand for A&E services in NWL is misunderstood.

- The independent review report will model impact of the proposals on A&E services across Hospitals North West London in order to illustrate the potential impact in terms of patient flow, as local stakeholders have raised concerns in relation to the capacity of some Hospitals in NWL to cope with demand for A&E services and the capacity of Urgent Care Centres (UCCs) to fulfil the role that SAHF assumes they will play in future
- In terms of points that have been raised so far, Ealing A&E and the UCC collectively see approximately 110,000 patients a year. Of these 65,000 are managed at the Care UK-run UCC, but 17,000 are sent through to Ealing A&E (46 patients per day). 1/3 of this number (over 5,600 per year) have to be admitted to the Hospital direct and the total number of Type 1 A attendances at Ealing A&E stands at 45,000 per year and has not changed in the last year. Consultants at the Hospital have argued that rotas at Ealing Hospital are fully staffed, and clinicians argue performance at Ealing Hospital compares favourably with neighbouring Hospitals
- Clinicians have argued that the merger with North-West London will strengthen capacity to deal with a range of health needs, including emergency situations, and that SAHF unhelpfully pre-empts and precludes opportunities through the merger to deliver some of the key objectives of SAHF
- Clinicians have argued that in some circumstances, it is more important in terms of health outcomes to get to a Hospital which offers specialist services than to get to a Hospital per se. For example, heart attack and stroke patients can benefit from access to centralised facilities for thrombolysis. However, patients in these circumstances constitute a small percentage (3-4%) of the current emergency workload
- Clinicians have argued that the Urgent Care Centre deals only with certain types of care need; that the SAHF proposals therefore risk delayed access to care for patients who cannot be treated by the UCC; and outcomes for patients are better when an UCC and A&E department work together. A summary of the cases/conditions excluded by UCCs is attached as Appendix B
- Of the 46 patients per day coming to Ealing who cannot be managed by the UCC alone and require a review, 1/3 are admitted and contribute to annual figure of 45,000 Type 1 A attendances to Ealing

- The removal of impatient beds will mean 46 patients presenting at Ealing will need to be transferred to major acute hospitals each day. Modelling of the impact of this arrangement on patient safety; costs; and strain on the local ambulance service has apparently not been carried out sufficiently
- Patients wishing to travel to the nearest A&E as an alternative to the UCC could push remaining A&E services to breaking point, as Central Middlesex Hospital A&E is open only during the day

c) The National Clinical Advisory Team (NCAT) have identified a number of issues with the proposals.

- On the 18th April 2012 visitors from the National Clinical Advisory Team were invited by the SAHF programme board to assess the SAHF proposals. The NCAT team, Dr. D Colin-Thome, Dr Tajek Hassan and Mrs C McLaughlin were provided with evidence in the form of project and risk plans, models of the impact of the reconfiguration, and a series of meetings with members of the CCGs, scrutiny committees, clinicians and patient groups across NWL
- Their full report is extensive and will be reviewed in greater detail as part of the independent review. At a headline level, the report raised a number of issues with the proposals as expressed by stakeholders and which emerged through their own review of the supporting evidence, including:
    - Insufficient modelling of impact of out of Hospital provision on admissions and lengths of stay
    - Insufficient operational detail for the public, particularly in relation to proposed community provision
    - Lack of outcome-focused standards for out of Hospital services, and a recommendation that these need to be developed further

d) Other valuable services, such as maternity services which have developed organically to meet the specific needs of the local population, will be lost as a result of the Shaping a Healthier Future Proposals.

- One other justification for change put forward is to cease the maternity unit at Ealing Hospital, as it is "small and has trouble recruiting midwives to manage rotas and has very high emergency caesarean rates"
- Some local clinicians have argued that recruitment of midwives is known to be a national issue and that locally, plans to address this are being taken forward through the merger between Ealing and Northwick Park Hospitals, a process which some clinicians have argued has been guided throughout by relatively close engagement with clinicians
- Complications arising from local health inequalities (e.g. 17% prevalence of diabetes in some Southall wards; up to 25% of Ealing Hospital inpatients having diabetes or diabetic related-problems compared with 10% nationally) are driving increased likelihood of c-section births in Ealing Hospital. Furthermore, other Hospitals in NWL not under the threat of closure have higher c-section birth-rates than Ealing
- General concerns have been raised about the lack of bed space to meet demand, in the light of the estimated overall reduction of over 480 beds across NWL

e) Patients will be confused as to how to access services in the future, and the most disadvantaged and vulnerable will suffer disproportionately.

- NHS NWL have stated that over 90% of the local population will be unaffected by the proposals. However, some stakeholders have argued that this figure appears to be based on an "averaging out" across the NWL population. Initial scrutiny of Ealing statistics – which will be investigated further through the technical analysis in the independent review – illustrate that 53% of Ealing inpatients will be affected by the proposals
- Clinicians have raised a number of issues relating to clarity over where to go for treatment, arguing the new proposals will make it difficult for people to understand where to go to access services. Presenting with a condition not handled by a particular facility could result in costly transfers and delayed access to care, which clinicians have argued could have a significant negative impact on health outcomes and undermine arguments about the financial benefits of the proposals
- Concerns were echoed in the National Clinical Advisory Team (NCAT) review, which discovered that there was general confusion on the part of patient groups and clinicians on the impact of the proposals: "The clinical teams are concerned that the out of Hospital strategy will not deliver, the movement of staff across departments will not happen and the aspirations of reconfiguration will not deliver. The patient groups do not understand how things will work if this reconfiguration happens and are finding it difficult to describe what services at any one of the nine hospitals will look like" (NCAT Report, page 9)
- A number of concerns have also been raised in relation to the efficacy of accessing services by telephone (e.g. the 111 number). Previous research has shown that telephone access "seems to disproportionately serve populations with the lowest expected need". Furthermore, recent evidence has shown that since NHS 111 pilots began, there has been a 17% increase in people presenting at UCCs and walk-in centres across England – a sign of increasing demand which does not seem compatible with the SAHF proposals
- Furthermore, there are concerns about the proposals resulting in triage services not being administered by medically trained personnel, which could drive additional pressure on GP and emergency care services

f) There are serious concerns about flaws in the modelling of patient transport and blue light times.

- Local clinicians and the Council's transport planning department have raised a number of serious concerns about the modelling of patient transport and "blue light" times. Assumptions relating to transport times are being reviewed and analysed as part of the independent review
- In terms of potential impact on Ealing residents arising from changes to Hospital provision in NWL, some of the transport times which have been quoted in support of proposals are:
    - Acton to St. Mary's (Paddington) in 15 minutes
    - Acton to West Middlesex in 20 minutes
    - Acton Main Line station to Paddington in 12 minutes
- Many of the key stakeholders familiar with the realities of travelling across the borough do not recognise these travel times as realistic estimates. The travel time analysis figures obtained by authors of the SAHF proposals do not appear to have been independently validated, and the longest travel times given appear to refer to areas which have one of the

safeguarded hospitals closest to it, suggesting that options have driven travel time analysis rather than the other way around

- Additionally, particular concerns have been raised in relation to transport issues affecting members of disadvantaged communities, the elderly, and people who do not own a car. Car ownership is significantly lower in London than the national average (42.9% of all Greater London households do not own a car, according to the Travel in London Report 4, 2012, by TfL), therefore reliance on public transport for journeys is higher. The national average figure used by McKinsey in the modelling of transport access is therefore misleading and should not have been used
- There is a deficiency of direct bus links to West Middlesex or Hillingdon Hospitals from Ealing, and access to Northwick park Hospital via 2-3 buses depending on starting location in NWL, with journey times varying between 50-80 minutes and costing £5.40 per person, per round trip. Concerns are that this will encourage people to either call ambulances or not seek treatment, which risks poorer clinical outcomes and/or increase pressure on ambulance and other services
- People without access to a car may be reliant on taxis, especially when in unfamiliar areas, and this can be very expensive. This could prove disproportionately disadvantageous to members of deprived communities. On a related point, arguments put forward in the proposals suggesting they will enable greater "patient choice" are underpinned by assumptions that all people are able and can afford to travel greater distances to access facilities
- Studies on patient recovery have shown that visits by relatives can help reduce Hospital stay times so lack of access for relatives could lengthen stays and increase costs. It is not acknowledged in the business case that families making for hospital trips also often use taxis, which has the capacity to have a significant financial impact on patients' families and social support networks
- There is no real modelling of the capacity of local transport infrastructure to cope with out of Hospital and community provision. Significant further work will be required to assess the true level of accessibility of health services provided outside the Hospitals in NWL
- On a related note, the proposals do not take into account the impact of significant future local developments (e.g. Southall Gas Works large new residential and mixed use development) on access to healthcare provision. Significant further work will need to be done in this area, in order to assess the extent to which the proposals are "future proof" in terms of transport and accessibility
- There is a general lack of information relating to assumptions around staff travel between NHS sites

g) There are serious concerns about the capacity of community based health provision to cope with the "fall-out" from changes to NWL Hospitals.

- There are concerns that in the interim between announcing closure of A&E services and actually closing them, Hospitals will find it difficult to recruit and staff rotas safely, in effect precipitating "closures" of services ahead of planned timetables, and before community services are able to provide some of the services which used to be provided by NWL Hospitals
- Clinicians argue the capacity for local GPs to "take up the strain" as a result of the changes is overplayed. The scale of the shift in provision is without precedent, and other areas have struggled to establish effective processes which connect GP and Hospital provision. One example of this is the example of St. George's in Tooting no longer taking GP referrals owing

to pressure on services and risks around achievement of waiting time targets, which has occurred ahead of planned closure of A&E at St. Helier's Hospital, which is expected to further increase pressure on St. George's, GPs and local community health services

h) The Value for Money arguments underpinning the proposals are flawed.

- Clinicians have raised a number of additional concerns about NHS NWL's argument that the proposals will deliver better Value for Money for the local population
- In part this is because there is a lack of detailed information about how costs have been modelled – e.g. costs of enhancing quality and capacity of UCCs; impact on the ambulance service; and costs of secondary transfer of patients within the region (the latter a concern also flagged by the National Clinical Advisory Team)
- Clinicians have expressed concerns about the trailing of a £20m figure for a rebuild of Ealing Hospital ahead of the close of the consultation. They have also argued that Ealing patients will lose out as a result of £138m being made available for NWL health services (including building and refurbishing of health centres) which is in fact spread across all NWL boroughs
- Concerns have also been raised about the use of a Net Present Value calculation which appears to double-count certain key financial measures – this is being investigated further as part of the technical analysis in the independent review
- Questions have been raised by local stakeholders about the extent to which the proposed merger between Ealing Hospital NHS Trust and North West London Hospitals NHS Trust have been accounted for in the business case which underpins SAHF
- A study which NHS officials have used to support an argument that "if you get admitted to hospital on a Friday night, compared to a Monday morning, you're eight per cent more likely to die" also shows patients are more likely to die on a Wednesday than a Sunday, and that costs associated with centralisation of certain health services may not justify the outcomes in such a challenging economic climate
- It is not clear how funds allocated under the proposals to community services are supposed to stretch to meet demand arising from the cessation of such a range of NWL Hospital Services happening at the same time
- Clinicians also point out that the proposals are taking place in the context of significant reductions in funding for related and support services – e.g. significant reductions in funding for local social care – which could compound negative outcomes for the most disadvantaged and vulnerable in Ealing

i) The assessment of impact on equality and human rights falls short of the requirements set out in the Equality Act 2010.

- Neither the methodology used in the business case nor the actual proposals put forward within it have been subject to a sufficient or appropriate equality assessment
- The population in NWL is more ethnically diverse than the national average, and suffers to a greater extent than the average from high incidences of TB, COPD and HIV. This has not been taken into account in the modelling which underpins the options put forward
- There has been little engagement with the local population so far over the proposals – only 360 people engaged with events about the proposals, amounting to one in five thousand of the NWL population. Consultation documents have been issued late, over the summer

period when many people are not at home to read proposals or attend engagement events, and it has been argued that information in the consultation document is not easily accessible for migrants and people for whom English is not their first language

- There are particular concerns about transport issues affecting members of disadvantaged communities, the elderly, and people who do not own a car
- Assessment of equality impact of the proposals does not take adequately into account the barriers to access of services by migrants, those not living in households, and those whose first language is not English, who are less likely to use telephone or booked services as an alternative to Hospital based provision
- Complications arising from local health inequalities (e.g. 17% prevalence of diabetes in some Southall wards; up to 25% of Ealing Hospital inpatients having diabetes or diabetic related-problems compared with 10% nationally) are driving increased likelihood of c-section births in Ealing Hospital. Furthermore, other Hospitals in NWL not under the threat of closure have higher c-section birth-rates than Ealing, which has developed a particular service offer in relation to maternity to meet the particular needs of its population

SECTION 2: The Independent Review: structure and approach

Independent review

The Council has commissioned an independent review to examine the business case underpinning SAHF, look again at the models and methodologies used to analyse key metrics, review the conclusions set out in the consultation document and business case, and present a balanced overview of the strengths and limitations of the proposals.

The review will form the basis of the Council's response to the formal consultation.

Key activities associated with development of the independent review are set out below.

Structure of the independent review report and overview of key activities

Contents	Description	Activities
Executive Summary		
1.1 Executive summary	Summary of report	TBC
Introduction: purpose and content		
2.1 Statement of purpose	Outlines Ealing's intend to respond fully to the consultation process, the intent of the document and high-level approach	TBC
2.2 Overview of the proposals	Describes the proposed changes, particularly the consequences of 'Shaping a Healthier Future' on Ealing	TBC
Review: investments in local primary care infrastructure		
3.1 Review of out-of-hospital strategy	Reviews the out-of-hospital strategy and, reviews the argument that it is positive given current community services and should be implemented before any reconfiguration takes place	TBC
3.2 Other	E.g. The development of clinical standards for out of hospital and hospital care	TBC

Contents	Description	Activities
	Review: process	
4.1 Review of the pre-consultation process	Explores issues in the pre-consultation process, incl. the lack of engagement with DPH and lack of adequate engagement with the local Ealing/NWL population	• Stakeholder interviews (see section following this table)
4.2 Review of the consultation process	Explores issues relating to the consultation process in particular the timeline and discusses the rationale for holding the consultation during the summer	• Stakeholder interviews (see section following this table) • Analysis of resident survey
4.3 Impact of change in NHS governance structure	Discusses the rationale for not waiting until CCGs and HWBs are instated	• Stakeholder interviews (see section following this table)
4.4 Other	E.g programme assurance	TBC
	Review: methodology	
5.1 Critique of sequential approach of options appraisal	Reviews aspects of the methodology and approach, particularly the sequencing of criteria in order to narrow down options and a review of the proxies and assumptions of elements of data	• Analysis of impact of methodology change (i.e. if barriers sequenced differently) • Analysis of impact of methodology is different data sets are used
5.2 Assessment of evaluation criteria	Critical review of the evaluation criteria, addressing the impact that selection of certain criteria or data points have over others	• Review criteria, comparison of data points • Discussion of absent inequalities analysis
5.3 Neglect of current clinical performance measures	Analyses the current clinical performance and assesses the impacts of the changes on these measures; critiques the rationale for excluding the clinical performance as key evaluation criteria	• Gather CQC and HES for data baseline data • Analysis of current performance for clinical outcomes of each hospital (e.g. relative to national/London average) • Assessment of impact that a clinical outcomes approach would have on evaluation
5.4 Neglect of current market and local	Assesses particular needs of Ealing that are not taken into	• NWL/Ealing market analysis • Demographic analysis

Contents	Description	Activities
population needs	considering. Discusses the extent that Ealing Hospital has evolved to address local needs. Addresses the impact of Ealing/NWLH merger	• Inequalities analysis • Incorporation of above analysis into bed modelling (needs based, rather than QIPP) • Validation with Ealing Council
5.5 Transport analysis methodology	Reviews the assumptions, data and approach deployed in the transport analysis, in particular its use in determining that Northwick and Hillingdon are to remain unaffected	• Review of Mott MacDonald and Gateway reports • Analysis of land values and review land capital receipts • Apply an inequalities analysis to the travel time analysis • Inclusion of out of area hospitals into blue light and drive time analysis • Stress testing of analysis • Analysis of relationship between blue light time and outcomes
5.6 Financial analysis methodology (including the impact of the merger on the financial case)	Reviews the methodology and approach of the financial modelling, exploring issues such as the lack of cumulative scenario analysis, lack of baselining and the NPV method	• Analysis and critique of Ealing/NWLH merger impact on financial case • Propose sensitivities in the costs of creating community services • Assess validity of not baselining each hospital's plan (e.g. CIPS) • Lack of cumulative scenario analysis • Review need for upside potential? • Critique of NPV double-counting benefits and capital • Alignment of Trust assumptions around savings (model, as is, is based on variable forecasts)
5.7 Other	E.g Equality Impact Assessments	TBC
Review: application and outcomes		
6.1 Readiness of other facilities to absorb excess demand	Reviews the ability of other hospitals to absorb cases that otherwise would have gone to hospitals affected by proposed changes set out in "Shaping a Healthier Future" and the readiness of primary and community care to deal with the	• Collect patient volume data • Analysis of case mix • Analysis of efficiency / productivity at each site and scope of improvement needed to receive new services • Scenario analysis

Contents	Description	Activities
	additional workload resulting from the out of hospital strategies	
6.2 Critique of assumptions of reconfiguration on clinical outcomes	Reviews evidence that supports hypothesis that reconfiguration will lead to better outcomes	• Data supporting highlighting that people do not act rationally/optimally (challenge of model ability to handle variation) • Challenges of communicating changes • Benchmarking and secondary research • Review of case studies demonstrating that similar reconfigurations do not lead to beneficial outcomes • Modelling of multiple sensitivities
6.3 Implications of reconfiguration on staff	Assesses the impact of the reconfiguration of performance, effectiveness and staff motivation	• Analysis of efficiency / productivity • Benchmarking / secondary research on examples of reconfiguration adversely affecting workforce • Stakeholder interviews (staff) • Review of staff transfers (i.e. why no redundancies?)
Conclusions and recommendations		
7.1 Summary of key findings	Overview of the report	TBC
7.2 Recommendations and suggested next steps	On the basis of the findings, sets out a general response and suggests alternatives and a series of next steps as appropriate	TBC

Summary of key stakeholders contributing additional evidence to the independent review

In addition to technical analysis of the business case, the independent review will draw on evidence submitted by local stakeholders, through public meetings, public statements and additional information through one-to-one discussions with the consultants co-ordinating the review report.

In terms of the one-to-one discussions with key stakeholders, the following has been arranged:

Interviews Already Carried out

Interviewee	Organisation
Dr Onkar Sahota	SOH campaign
Colin Standfield	SOH campaign
Jackie Chin	Public Health
Cllr Abdullah Gulaid	LB Ealing
Dr Jenny Vaughan	SOH Campaign

Interviews scheduled for Tuesday 4th September

Interviewee	Organisation
Julian Bell	LB Ealing
Gareth Shaw	SOH campaign
Bridget Olsen	SOH campaign
David Archibald	LB Ealing

Interviews scheduled for Tuesday 11th September

Interviewee	Organisation
Nick O'Donnell (transport planning)	LB Ealing

Further interviews taking place between 11th and 28th September

Anne Rainsbury: 7th September

Cllr Gregory Stafford: 12th September

Cllr Nigel Bakhai: 12th September

Cllr Jasbir Anand

Dr. Mohini Parmar, CCG Chair

Virendra Sharma, MP

Steve Shrubb, CE of West London Mental Health Trust

In the process of being confirmed

David Carson from the Primary Care Foundation

Chief Executives of West Middlesex and Ealing Hospitals

APPENDIX 2: Urgent Care Centre Exclusion List

care UK
fulfilling lives

URGENT CARE CENTRE EXCLUSION LIST

ACS/MI
Acute anaphylaxis
Actively suicidal/deliberate self harm (not suicidal ideation)
Acute confusion
Alcohol or drug intoxication (likely to need obs)
Alleged rape (with major injury)
Children with complex fracture of upper or lower limb likely to require manipulation
Complex fractures/pelvic fractures/hip or long bone fractures
Colles fracture
Collapse state
Currently having seizure
CVA/TIA (separate pathway)
Dental injury (Northwick Park maxfax)
Dvt or suspected Dvt
Extensive burns
Fever with oncology
Hematuria post abdominal injury
Inhalation of smoke or fumes
Mandible dislocation
Major Head injury
Meningitis or suspected meningitis
Multiple injury/trauma
Needle stick injury
Overdose
Penetrating eye injury
Poisoning
Pregnancy with persistent vomiting
Psychosis
PV bleeding (heavy)(pregnancy less than 20 weeks to ED and more than 20 weeks to obstetrics)
Pregnant with abdominal trauma
Paediatric white card holders (will directly go to paediatrics)
Patients with gp referral letter to go to speciality direct
Renal colic (blood positive on urine dipstick)
Severe pain (requiring parental analgesia)
Severe breathing difficulties
Shoulder dislocation
Sickle cell crisis
Significant epistaxis
Significant haemoptysis/heamatemisis
Gunshot injury
Significant stab wound
Unconscious
Uncontrollable haemorrhage
Unresponsive floppy child

This page is intentionally left blank

1. Introduction

1.1 "Shaping a healthier future" is NHS North West London's proposed programme of change for both out of hospital and hospital services and this is Hammersmith & Fulham Council's response to the proposals. They represent a radical reconfiguration of local health services, including a reduction in the scope and breadth of services provided at Charing Cross Hospital and, to a lesser extent, at Hammersmith Hospital. Given that they will have a profound and lasting impact on local health services, services that are of the utmost importance to local people, the Council is committed to responding fully to the consultation.

1.2 The Council considers that there are several key flaws in the proposals. Broadly, these can be categorised as fundamental problems with the consultation process and methodology, failure to take account of current relative clinical outcomes, and a lack of due regard for the impact on the people who live and work in Hammersmith & Fulham. The proposals are consequently seen as unsafe from the Council's perspective.

1.3 The Council, through its Scrutiny committee, will therefore decide whether to refer the process to the Secretary of State based on the criticisms set out in this document. Further, if the final decision is taken to close the A&E departments at Charing Cross and Hammersmith Hospitals, then the Council, again through its Scrutiny committee, will decide whether to refer this to the Secretary of State as it will represent a significant detrimental impact on health services for local residents. Irrespective of any decision or outcome the Council also expects to see, and be consulted on, detailed plans for the future of the Charing Cross site.

2. Context

2.1 "Shaping a healthier future" is NHS North West London's proposed programme of change for both out of hospital and hospital services. The proposals are now subject to formal consultation, closing on 8 October 2012. This document forms Hammersmith & Fulham Council's response to this consultation. It is presented in this form to encapsulate the whole range of issues that the Council wishes to cover in its response, which would not be possible using the standard consultation response form provided.

2.2 The proposals represent NHS North West London's response to the significant challenges facing the NHS, namely the need to improve the quality of care and reduce unwarranted variation; the need to improve the health of local people and reduce health inequality; and the need to address substantial financial challenges to ensure that services and organisations are sustainable for the long term.

2.3 The proposals represent a radical reconfiguration of local health services, with an increased emphasis on out of hospital care and a reconfiguration of NW London's hospitals. For Hammersmith & Fulham, this means a reduction in the scope and breadth of services provided at Charing Cross Hospital (most notably including a downgrading of the Hospital's A&E and the removal of complex

medicine and surgery services) and, to a significantly lesser extent, at Hammersmith Hospital (both hospitals are currently managed by Imperial College Healthcare NHS Trust).

2.4 Hammersmith & Fulham Council (hereinafter "the Council") is determined to champion the interests of residents by playing a full and positive role in ensuring that the people living and working in Hammersmith & Fulham have access to the best possible healthcare and enjoy the best possible health. Given that NHS North West London's proposals will have a profound and lasting impact on local health services, services that are of the utmost importance to local people, the Council is committed to responding fully and positively to the consultation.

2.5 In this context the Council recognises the need for local health services to improve and develop to meet the changing and growing demands of local people, against a backdrop of the increasing financial challenges that have resulted from the overall pressure on public sector expenditure. Indeed, the Council faces exactly the same challenges in relation to its own services and statutory responsibilities.

3. The Council's position

3.1 In order to inform, inter alia, this consultation response, the Council commissioned an independent review into the proposals. This has identified a number of fundamental flaws in the approach taken by NHS North West London to determine the changes that should be made to local health services. Broadly the key flaws can be categorised as:

- Fundamental problems with the consultation process and methodology;
- Failure to take account of current relative clinical outcomes; and
- Lack of due regard for the impact on the people who live and work in Hammersmith & Fulham.

3.2 Taken together, these flaws mean that in effect NHS North West London's proposals have not been developed in a sufficiently robust way and are consequently seen as unsafe from the Council's perspective.

3.3 The review final report, which should be read in conjunction with this consultation response, is attached as Annex A. Its principal conclusions, which are endorsed by the Council, are as follows:

- The objectives of "Shaping a healthier future" are appropriate (i.e. of improving service quality and reducing unwarranted variation, improving the health of local people through the provision of better care, and ensuring that organisations are financially viable for the long term);
- The current provision of local healthcare is not acceptable, as it is too often characterised by unacceptable levels of quality and service and unwarranted variation, substantial health inequalities, and an unsustainable financial position;

- The adequacy of the pre-consultation engagement of key stakeholders, notably patients, public, clinicians and the Council itself is open to challenge;
- The extent to which the requirements of the 2010 Equality Act have been met in determining the impact of proposals on protected groups at a borough level is open to challenge;
- The timing of the consultation is open to challenge. Consideration should be given to amending the current timetable to allow for further consultation with the affected parties, detailed impact assessment work to be undertaken and revisions to be made to the decision making arrangements;
- The decision making arrangements are inappropriate. Consideration should be given to amending the arrangements to ensure that any decisions are made by the new NHS and local government arrangements that come in to effect on 1 April 2013, rather than key decisions being made by organisations on the eve of their abolition;
- The programme's objectives are appropriate (i.e. of preventing ill health; providing easy access to high quality GPs; and supporting patients with long term conditions and to enable older people to live more independently).
- The assumption that NW London has an over-provision of acute hospitals is open to challenge. If the preferred option for restructuring is adopted, adult acute bed provision in NW London will be reduced to just over half of that required;
- The underlying financial model used to establish the "base financial position" has not been subject to independent verification and cannot necessarily be relied upon to support true comparisons between hospitals. In some cases it is also at odds with organisations' own views of their underlying financial position;
- The proposed clinical standards and visions are appropriate;
- The proposed improvement of Out of Hospital care is appropriate. Given the current shortcomings in primary care, detailed plans should now be developed for urgent implementation;
- The Out of Hospital improvements should be fully implemented before irrevocable decisions and changes are made concerning hospital reconfiguration;
- The methodology used to identify and choose between the various reconfiguration options is open to challenge as it contains a number of fundamental flaws;
- The options appraisal and the resultant preferred option (and secondary options) are open to challenge, on the grounds of the sequential approach (which potentially distorts conclusions), the selective choice of indicators, the absence of an assessment of actual quality and performance, the lack of sufficiently detailed assessment in critical areas (e.g. travel times) and the practical application of the indicators (including a high level of double counting);
- The proposal to designate Charing Cross Hospital a "Local Hospital" and the proposed service reductions at Charing Cross Hospital and Hammersmith Hospital is not based upon a sound premise given the flaws in the methodology;
- The readiness of the local health system to cope with the scale of change proposed has not been demonstrated;

- The scale of change proposed, and in particular the significant and potentially adverse impact on the people of Hammersmith & Fulham, has not been adequately explained or addressed;
- Further significant work should be done to understand, in substantially more detail, the impact on local people; and
- There should be a more transparent articulation by the NHS of the motivations behind the proposals, most notably the need to reduce expenditure.

3.4 The Council, through Scrutiny, will therefore seek to refer the process to the Secretary of State based on the criticisms set out in paragraph 3.3 and in more detail below.

3.5 If the final decision is taken to close the A&E departments at Charing Cross and Hammersmith Hospitals, then the Council, again through Scrutiny, will seek to refer this to the Secretary of State as it will represent a significant detrimental impact on health services for local residents.

3.6 This consultation response now explores these issues, concerns and conclusions in more detail.

4. The pre-consultation and consultation process

- **Engagement**

4.1 In light of the significance of the proposals, the pre-consultation engagement should have been extensive and comprehensive. It should have involved all key stakeholders and should have set out very clearly the emerging implications of the proposals, particularly for those most affected and for those most vulnerable. In the view of the Council some aspects of the engagement process are open to challenge.

4.2 Inadequate public consultation took place during the development of the proposals. Public participation was largely confined to three pre-consultation engagement events that were attended by in total approximately 360 members of the public (about one in five thousand of the NW London population). Crucially, given the large scale impact on the people of Hammersmith & Fulham, there were no specific attempts to engage with local people during the pre-consultation period.

4.3 In particular, the work done to engage with hard-to-reach and vulnerable groups is open to challenge. The business case makes reference to section 149 of the Equality Act 2010 and briefly references work to engage and consult vulnerable groups. However detail is not explicitly provided on the nature of engagement, the issues and concerns raised by those groups, and the programme's response. This is an important and unfortunate omission, given the legal requirements and the diverse nature of Hammersmith & Fulham's population.

4.4 The business case states that the programme has been clinically led and supported by GP commissioners and hospital clinicians. However the extent to

which this work has been influenced by the management consultants engaged to produce the report and their own views and models is not clear. The extent to which the programme is genuinely supported by front-line clinicians across NW London and in particular Hammersmith & Fulham is not clear. Local anecdotal evidence indicates that there are a significant number of local clinicians (GPs and hospital clinicians) that have serious concerns about the proposals and that consequently do not support them.

4.5 Furthermore, the business case equates support from the leaders of the "shadow" clinical commissioning groups (CCGs) with support from GPs in general. Simply because the proposals are supported by the chairs of the "shadow" CCGs and their boards this does not automatically equate with the support of local GPs. There is anecdotal evidence that a number of local GPs have significant concerns about the proposals and their implications for Hammersmith & Fulham.

4.6 The summary of clinical engagement meetings attended by programme representatives has no specific mention of Imperial College Healthcare NHS Trust clinicians. Given the implications for Imperial, local clinicians in particular should have been actively targeted for engagement and their responses explicitly used to shape the proposals.

4.7 It appears that public health clinicians and professionals have had only limited engagement in the development of the proposals. Public health directors have not had a formal connection with the programme, have not been engaged in the modelling and options appraisal, and have not been given an opportunity to assess the impact of the proposals on the health of local people. This is a significant omission. It is clearly essential to understand the impact of the proposals on each borough's population. The Directors of Public Health, given their statutory roles and responsibilities, should have played a key role in this.

4.8 The statements made in the business case relating to wider engagement and involvement in shaping the proposals are also open to challenge. While sound, the stakeholder engagement principles do not address the apparent democratic deficit in the process. It is difficult to see how such proposals can be legitimised democratically without both the active engagement and support of local government. Currently, significant aspects of the proposals do not have the support of the Council.

4.9 The stakeholder mapping makes reference to the "political" stakeholder grouping including various local government representatives (Health Overview & Scrutiny, Councillors and Cabinet Members). Explicitly the chapter states that "there has been significant engagement with political stakeholders throughout the pre-consultation period". Contrary to this statement senior members and officers within the Council have not been engaged effectively in the development of the proposals.

4.10 While it is intended that more work will be done to engage the public and that "this will include work with local authority colleagues who support voluntary and

community sector networks… who are able to access a large number of community members through the work they undertake", this engagement activity should have taken place before the development of the pre-consultation business case.

4.11 The NHS, in pursuing such service changes, is legally required to engage with Health Overview & Scrutiny Committees. For this programme a Joint HOSC has been set up but this operated in shadow form until July 2012 and so has not been given sufficient time to be established before being asked to make crucial decisions. The adequacy of engagement with scrutiny is open to challenge.

4.12 The extent to which the views expressed by stakeholders have been taken into account in shaping the proposals is open to challenge. In a number of cases themes arising from engagement activities do not appear to have been explicitly addressed (e.g. the impact on protected groups; further explicit consideration given to mental health and the elderly). The business case does not but should have set out how each issue raised has been addressed.

- **The "Four Tests"**

4.13 The business case asserts that the current NHS "Four Tests", required to be met by all reconfiguration proposals before they can proceed, have been met. This is open to challenge. Support from GP commissioners has not been demonstrated conclusively, as engagement with the newly developing CCGs is often given as evidence of engagement with GPs but CCGs are not yet statutory bodies and their leaders are not necessarily representative of the individual member practices.

4.14 The business case references a wide range of engagement activities but this is insufficiently evidenced. The substance of the discussions is not included. The response of the various groups to the proposals is not provided. The impact that those responses had on the proposals is not clear.

4.15 The core argument for reconfiguration is restated, namely that there are currently unacceptable variations in the quality of services across NW London and that "there are significantly improved outcomes for patients and improved patient experience when certain specialist services are centralised". However this theoretical hypothesis has not been tested against the actual outcomes and current patient experience in NW London.

4.16 It is also stated that the clinically led nature of the development of the proposals has "ensured that the clinical vision and standards lead the reconfiguration proposals". This is open to challenge. The achievement of the clinical vision and standards can be decoupled from the reconfiguration proposals. The business case states that "all London providers will be held to account against [the clinical] standards over the next three years and local GPs in their clinical commissioning groups are putting in place processes to ensure they are delivered". This is open to challenge. It suggests that plans are

proceeding prior to consultation. It also potentially reinforces the point that the clinical standards can be delivered without the need for radical reconfiguration.

4.17 The business case states that "'Shaping a healthier future' has maintained the balance between providing integrated, localised care and safe, high quality services, centralising services where to do so would significantly improve service provision". This is open to challenge, particularly from a Hammersmith & Fulham perspective. There is no assessment of how local people really feel about the proposed reduction in service at Charing Cross Hospital and Hammersmith Hospital. There is no evidence that this will enhance their choice of care.

- **Equalities Impact Analysis**

4.18 The equalities impact analysis carried out in July 2012 looked at the impacts of the proposed options on populations with protected characteristics within NW London and does not provide a detailed disaggregation of data at borough level. However, the high level identification of potential equality "hotspots" notes that, for major hospital services, Hammersmith & Fulham has the second most numerous critical equality areas in NW London and for maternity services the most numerous (joint with Brent).

4.19 The business case states that "overall the difference between the three options for consultation was found to be minimal with Option 6 likely to give rise to a higher level of adverse effects to the protected groups". However, from a Hammersmith & Fulham perspective, the equality impact analysis highlights that the preferred option has a disproportionate effect on younger people (aged 16 to 25) and older people (aged over 64).

4.20 The business case states that the July 2012 analysis was seen as the first piece of work in the analysis of the proposed configuration on protected groups and that further work will be undertaken during the consultation period. Given the risks of change to vulnerable groups, such detailed work should have been completed before consultation.

- **Timing and decision-making**

4.21 The timing of the consultation, decision-making and implementation processes are open to challenge. Decision making is due to take place from October 2012 to January 2013, with implementation from January. Notwithstanding the fact that the consultation period runs for fourteen weeks (just two more than the statutory minimum) it is not good practice to consult over the summer when stakeholders are not able to give the consultation their full attention.

4.22 Further, the proposals have been developed during a time of major organisational change within the NHS. The 2012 Health Act abolishes Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) from 1 April 2013, replacing them with local CCGs and the NHS Commissioning Board. The business case states that all NW London CCGs have been established. This is

not strictly true. The current PCT and SHA structures are still in place (albeit on a clustered basis) and are still statutorily responsible for local health services until 31 March 2013. "Shadow" CCGs have been set up as sub-committees of PCTs and are currently participating in a formal assessment process to support their eventual establishment and authorisation by early 2013 for them to "go live" on 1 April 2013.

4.23 Crucially, PCTs and SHAs will still be in place at the conclusion of the consultation and will formally make the decisions on "Shaping a healthier future", shortly before their abolition. The JCPCT (Joint Committee) of the eight PCTs has taken the decision to proceed to consultation on the proposals and will "ultimately, take the final decision on whether to proceed with proposed service changes".

4.24 Given the significance of the proposals, it is far more appropriate for any decision to be considered and made by the eight CCGs, once established and authorised, after 1 April 2013. It will clearly be impossible to hold PCTs (and their officers) to account for these decisions once they have been abolished. The new CCGs should clearly take responsibility for such matters, once they are statutorily able to do so. They have a stake in the future and can subsequently be held to account for those decisions.

4.25 In addition the 2012 Health Act also establishes Health & Wellbeing Boards (HWBs) from 1 April 2013. HWBs will be hosted by local authorities and will have responsibility for the strategic oversight of health and healthcare in their area. Their membership will comprise senior representation from local authorities, CCGs and the NHS Commissioning Board. They will be responsible for their area's Joint Strategic Needs Assessment (JSNA) and, in response to their JSNA, will lead the development of Joint Health & Wellbeing Strategies (JHWS). CCGs, in developing their own commissioning plans, are statutorily required to have regard for their local JHWS and they will account to HWBs for their decisions and actions, and for the performance of local health services.

4.26 It would therefore seem highly inappropriate for significant decisions to be made about local health services just before HWBs are established. HWBs should be given an opportunity to properly consider the implications of "Shaping a healthier future" for their local people and they should be clearly involved in the governance and decision making arrangements.

- **Programme assurance**

4.27 A review of the programme was undertaken by the National Clinical Advisory Team (NCAT), which highlighted, amongst other points, the importance of "[ensuring] capacity and capability exists within the Out of Hospital services to operate 24/7". Similarly, in looking at the proposals for maternity and paediatrics, NCAT stated "the need to ensure that community services are in place before closing acute services". Currently this capacity and capability is not in place.

4.28 The Office of Government Commerce (OGC) also undertook a Health Gateway review in April 2012. They gave the overall programme an amber/green assessment. In their summary of recommendations they highlighted the following:

- "Identify clearly the benefits to patients proposed for each Borough, together with who owns them and how they will be measured;
- Develop and agree the future vision for the Charing Cross site, with the engagement of local clinicians, prior to consultation".

4.29 To date it appears that neither recommendation has been fully complied with. In particular the Council has not been engaged in the relevant discussions.

5. Methodology

5.1 There are key aspects of the methodology used by NHS North West London in drawing up 'Shaping a healthier future' that are open to challenge.

5.2 The general flaws with the underpinning principles and analysis can be summarised as follows:

- Insufficient exploration of alternatives to hospital reconfiguration;
- The absence of any detailed independent verification of the baseline financial model provided by local NHS Trusts to support the proposals; and
- The unnecessary combining of much needed proposals to strengthen primary and community services with proposals to reconfigure local hospitals.

5.3 In terms of the methodology used to identify the initial "long-list" of eight potential options, the key issues can be summarised as follows:

- The absence of detail regarding the difference between the patient case-mix of traditional A&Es and the newly proposed Urgent Care Centres;
- The sequential nature of the methodology does not provide the opportunity for all of the options to be tested on a truly comparable basis;
- The exclusive focus on organisations and institutions, rather than the needs and preferences of local people;
- The use of "location" as the primary driver for the development of options, rather than other factors including the needs of local people and the relative quality of local hospital services;
- The lack of supporting detail for the decision to propose the reduction to five "major" hospitals; and
- The use high of level rather than detailed travel times and other measures of access to determine the location of the eight options;

5.4 In terms of the methodology then used to differentiate between the eight options, the key issues can be summarised as:

- The explicit absence of consideration of the potential to integrate services and impact on health inequalities from the options appraisal;

- The explicit disregarding of the current relative quality of service provided by NW London's hospitals;
- The use of Trust level, rather than hospital level, data;
- The inappropriate use of estates data as a proxy for measures of patient experience (contrary to local evidence);
- The explicit disregarding of real patient experience data;
- The absence of any measure of access and travel times to differentiate between the options;
- The use of a spurious argument concerning the correlation between the number of NHS trusts, rather than individual hospitals, offering services and patient choice;
- The absence of sufficient detail in the assessment of the relative capital costs and transition costs of each option;
- The use of marginal differences in estimated financial viability of NHS Trusts;
- The use of a Net Present Value calculation that double counts all of the financial indicators;
- The inappropriate use of staff survey results and the baseline financial model as a proxy for readiness to deliver; and
- The inconsistent assessment of co-dependencies with other strategies.

5.5 In light of the cumulative impact of the above, the Council considers that the methodology is fundamentally unsafe and the conclusions reached are consequently open to challenge.

5.6 Specifically this brings into question NHS North West London's preferred option, which includes downgrading Charing Cross Hospital and Hammersmith Hospital, and transfers key services, including A&E, to Chelsea & Westminster Hospital. The differences between the hospitals reached using the methodology are confined to:

- The patient experience assessment, driven by an inappropriate use of estates indicators;
- The patient choice assessment, driven by a spurious argument about the number of NHS Trusts managing Major Hospitals;
- The financial surplus assessment, that has not been subject to verification and the materiality of which is subject to challenge;
- The Net Present Value calculation, that double counts previous measures and is subject to challenge; and
- The workforce assessment that inappropriately underrates Imperial Trust compared with Chelsea & Westminster.

5.7 In more detail:

- **The case for change**

5.8 The proposals are predicated on the need for substantial change that must start now. Included is an assessment of the changing demands on the NHS in NW London but it is not clear if the business case takes account of the fact that more

than 20,000 extra homes are planned for Hammersmith & Fulham in the next 10 to 15 years.

5.9 The business case states that services also need to be redesigned to be more affordable and to ensure that money is spent in the best way. However, the business case does not explore any real alternatives to service reconfiguration that could be pursued in order to achieve the savings required.

5.10 In addition, the proposals are based on a number of academic studies, which provide the core evidential sources for supporting the need for centralisation of specialised services and specialist teams. However it is not clear what alternative models and concepts were considered. It is also not clear how these fundamental concepts were evaluated, considered and agreed.

5.11 Reference is made to a number of changes recently made in NW London and the moves to already centralise critical services in order to deliver high quality (e.g. in Major Trauma and Stroke services) and the improvements in integrating care. However, the business case states that more change is needed.

- **Principles and objectives**

5.12 The principles and objectives - to prevent ill health in the first place; to provide easy access to high quality GPs and their teams; and to support patients with long term conditions and to enable older people to live more independently - are appropriate. However the key enabler identified in the business case is securing much needed improvements in primary and community care, not hospital reconfiguration. No evidence is provided that demonstrates that the improvements required in GP services are dependent on hospital reconfiguration. Given the current low levels of patient confidence in GP services, improvements need to be made before the burden on those services is further increased as a consequence of reductions in hospital services.

5.13 There is also clear evidence of the need for local hospitals to improve the quality of care, given the relatively low levels of patient satisfaction and staff confidence and the marked variation against clinical indicators as evidence. Clearly, again, the intention to improve the quality of care should be supported. However this does not in itself alone automatically lead to a need to reconfigure hospital services. In the first instance the focus should be on improving performance within the current configuration. The options for this are not sufficiently addressed in the business case.

5.14 One of the key arguments for hospital reconfiguration and rationalisation is that the limited availability of senior medical personnel (particularly at weekends) has a detrimental impact on clinical outcomes. There are clear indications in fact that many of the current outcomes are satisfactory, notwithstanding the limited availability of senior medical personnel and specialist teams. The business case does not explore other ways of securing sufficient cover that are not dependent on service rationalisation.

5.15 The business case also states that "with NW London's growing population it is increasingly hard to provide a broad range of services around the clock at the existing nine acute hospital sites to the standards…patients should expect". This is open to challenge. It is not clear what alternatives to service rationalisation have been explored in order to address this issue. The argument is made for rationalising A&E departments that "we have more A&E departments per head of population than other parts of the country and this makes it harder to ensure enough senior staff are available", but this statement is not supported by quoted evidence. It is not clear whether the pattern in NW London has been compared with truly comparable populations. It is also not clear that local outcomes in A&E departments support this theoretical proposition.

5.16 In light of the above, the business case concludes that the area has an overprovision of acute hospitals for the size of the local population when compared with the average for England. This is open to challenge. Comparisons should not just look at the size of population but also relative complexity and need. It is not clear if this assessment is based on a comparison with similarly complex and growing populations.

- **The financial model**

5.17 Financial analysis is a key element of the underpinning rationale for the proposed changes but there are aspects of the financial model that are open to challenge.

5.18 It is again asserted that there are "extreme financial pressures" facing the NHS in NW London leading to the need for unprecedented levels of efficiency savings (4% per annum). Consequently, the business case states that "a major part of any future configuration of health services in NW London is the degree to which it can help address the financial challenge and create a sustainable health economy". This drive to ensure financial sustainability is clearly appropriate but the link between financial sustainability and reconfiguration is not unequivocally made.

5.19 The baseline financial modelling has been completed, using the respective organisations' own actual and forecast information for the financial year 2011/12. It appears that this information has been not been independently verified. Indeed, there is recognition that further work will be required to complete a "Generic Economic Model" to support any capital business cases. This is necessary analysis that should have been completed before consultation began.

5.20 Current savings plans are already assumed within the financial baseline position. These represent a reduction in acute hospital income of between 9% and 15% based on current levels of patient activity, mainly focused on reductions in outpatients and non-elective activity. This differentially affects the NHS Trusts in NW London. The variation in savings figures between Trusts increases the difficulty in making genuine comparisons. In addition there is no assessment of the realism of these assumptions.

5.21 High level financial forecasts for 2014/15 are set out by Trust. In total this indicates a forecast overall deficit of £8m (0.44% of total budgets), with Chelsea & Westminster the only Trust in what is deemed to be a viable position with a forecast surplus of £8m or 2.61% of turnover (Charing Cross Hospital has a forecast surplus of £1m or 0.44% and Hammersmith £2m or 0.63%). The forecast figures are directly informed by the assumptions around savings. Were Imperial to deliver savings equivalent to Chelsea & Westminster, the forecast position for Charing Cross and Hammersmith would be deemed to be viable. Equally, were Chelsea & Westminster to plan to deliver savings only at Imperial's level, it would not be deemed to be viable. The differences between Trusts are in reality marginal and subject to significant change depending on changes in the underlying assumptions and actual delivery.

- **Clinical model**

5.22 The business case sets out the proposed models of healthcare to be implemented across NW London and the clinical standards that have been designed to improve overall quality. The three core principles all appear sound. However, in applying them, it is also important to take into account the actual quality of care (and outcomes), other factors and constraints (e.g. the specific needs of local populations), and to allow sufficient time for each phase of development to be established before moving to the next phase.

5.23 A significant part of the business case is devoted to setting out proposals to change and improve Out of Hospital care, including the individual high level strategies developed by the shadow CCGs. While the proposals are sound, a great deal more work is required before implementation. It is stated that the developments planned for Out of Hospital care will take the pressure off local hospitals but the proposals to reconfigure hospital services are due to begin implementation before the Out of Hospital developments have been fully implemented. The two programmes of development should be decoupled. The Out of Hospital strategies should be fully implemented and evaluated before any final decision is made on hospital reconfiguration, let alone before reconfiguration actually starts.

5.24 Locally, there is much that is sound in the Out of Hospital strategy developed for Hammersmith & Fulham. However these proposed improvements are not dependent on hospital reconfiguration and in many instances simply reflect good practice in delivering high quality GP and community services. In light of the substantial investment enjoyed by the NHS over the last ten years, the longstanding evidence of relatively poor quality in primary care and the health challenges facing local people, it could be argued that these improvements should already have been secured. These improvements should now be further developed and implemented as a matter of urgency.

5.25 The principles and standards proposed for Out of Hospital care are sound. However, the practical development of this model for Hammersmith & Fulham should be developed with the full involvement of all parties, including the Council, and should be developed to specifically meet the needs of local people. Currently

the eight CCG level strategies appear somewhat generic and lack sufficient detail to support implementation.

5.26 The business case also provides helpful illustrative patient "journeys" to describe the impact of the proposed improvements in care. However, again the improved journeys do not appear to require reconfiguration per se, rather the improved management and delivery of care in line with the proposed clinical standards. Again, it can be argued that there is a case for "decoupling" the delivery of the standards from the proposals for reconfiguration of hospitals.

5.27 Having proposed a number of clinical principles and standards, the business case sets out the proposed service models for delivering the proposed principles and standards. At the heart of the proposals is a model comprising eight settings of care, ranging from "home" to "specialist hospital". In particular it proposes a distinction between "local hospitals" and "major hospitals", with fewer services provided at the former (e.g. an urgent care centre rather than a full A&E department).

5.28 In support of this model, it is stated that "primary care [is] at the heart of the change" It states that "at the moment variable quality of primary care services and poor coordination between services mean that more people end up in hospital than need to", although this isn't quantified in the business case. This should be tested further. Again, given current capability in primary care it could be argued that these services need to demonstrably improve before reducing hospital capacity. A common framework has been developed for improving primary care. This does not require formal consultation and should be decoupled from the case for reconfiguration and implemented as a matter of urgency.

5.29 Within the framework proposed for hospital care, there is a proposed model for "local hospitals" as defined in the model. It states that over 75% of care that would be delivered in a District General Hospital (DGH) can be delivered from a "local hospital". The implication is that up to a quarter of activity would be transferred to another hospital.

5.30 The business case describes the "local hospital" as "a seamless part of the landscape of care delivery…networked with local A&Es". However the implication is that a percentage of patients attending the urgent care centre of a "local hospital" in the first instance will then have to be transferred to the A&E department of a "major hospital" with the consequent increase in inconvenience and risk. Insufficient information is provided on the detailed implications of this assumption. It is not clear from the business case how many patients will require escalation to A&E from Urgent Care Centres or how many current A&E patients will be treated at Urgent Care Centres.

5.31 The conclusion reached in the business case is that "none of the current existing nine acute hospital sites in NW London is able to deliver the desired level of service quality that will be sustainable in the future". However this is not supported by empirical evidence.

- **Options appraisal**

5.32 At the core of the business case is a sequential options appraisal model (described as a "funnel" in the business case) that is used to identify a small number of options. The sequential nature of the option identification process does not provide the opportunity for all options to be tested on a truly comparable basis, as some options will (or may) have been discounted before a specific element of appraisal is applied, and therefore options that may well have scored well in terms of later elements of the appraisal are dismissed before an assessment can be undertaken.

5.33 The other fundamental challenge to the methodology relates to its almost exclusive focus on organisations and institutions, rather than the needs and preferences of local populations. Hammersmith & Fulham in particular is home to a highly diverse population. Ultimately any proposals to substantially reshape health services need to be developed, at least in part, on a sufficiently detailed needs basis. This is a major omission in the current methodology.

5.34 A number of key principles were established to inform the options development process, although it is not clear what alternatives were considered. The business case states that the principles were then used by clinicians to agree "that the options development process would be driven by the location of the major hospitals in NW London to ensure the appropriate delivery of urgent and complex secondary care across London". This decision to give primacy to "location" as the primary decision making driver should be challenged. Other factors should have been used, including the current quality and performance of services, the differential needs of local people, and the current and potential interdependencies (i.e. the impact of the proposed changes to urgent and complex secondary care on other services).

5.35 The business case states that a number of "hurdle criteria" were used to establish the right number of major hospitals (and thereby determine the proposed reduction from the current nine). The objectives of delivering acute clinical standards, deliverability and affordability are not in themselves contentious. However the criteria developed to meet the objectives are restrictive and do preclude consideration of other options for meeting the objectives.

5.36 For example, clinicians concluded that "their desired clinical standards could not be met if all nine current NW London acute sites … were to become major hospital sites". The business case does not provide the evidence for this conclusion. Given its importance in underpinning the proposal to reduce services provided at four of the nine sites, including Charing Cross and Hammersmith Hospitals, this is a significant omission.

5.37 The clinicians considered evidence about factors that were judged to contribute to high quality clinical care. The business case states that as a result of this consideration clinicians "identified that there should be between three to five major hospitals in NW London to support the projected population of 2 million", with a view that more than five major hospitals leading to sub-optimal

care. The proposals centred on five as the proposed number, primarily in light of current capacity constraints. The detailed evidence base for this decision to propose five major hospitals is not provided with the business case and is therefore open to challenge.

5.38 The identification of the options for location of the five major hospitals is entirely predicated on an analysis of the impact of changes to travel times. This is open to challenge. It is clearly appropriate for other factors to be considered, including relative clinical performance, population need and the interdependencies of other services.

5.39 The analysis in the business case demonstrates that the majority of the options would have an impact on Hammersmith & Fulham. The loss of a major hospital at Chelsea & Westminster or Charing Cross would see an increase in journey times of 48-57% and similarly the loss of a major hospital at St Mary's or Hammersmith would see an increase in 13-39%. This needs to be related to the actual numbers of people affected, as population density, and levels of deprivation, are generally higher in Hammersmith & Fulham than in the outer London boroughs. In addition it is not clear that the business case takes sufficient account of the fact that Hammersmith & Fulham is the second most congested borough in London.

5.40 However, the analysis concludes that because of the reported disproportionate impact on local people should Northwick Park or Hillingdon no longer provide major hospital services, it is proposed that they should both be major hospitals in the new configuration. This is open to challenge on two counts.

5.41 Firstly, the travel times analysis is insufficiently detailed. As the predicted routes have not been included in the analysis, it is not clear whether the assumed routes have sufficient capacity for the additional patients/visitors to the major hospitals or what impact (in terms of delays) this could have on the network as whole. It is also not clear whether the delays calculated consider any future growth on the network. A more detailed analysis of the impact on travel times is due to be completed by the NHS by the end of the consultation but this should have been available at the start. Secondly, no other factors beyond an analysis of travel times have been used at this stage to determine the location of the proposed "Major Hospitals".

5.42 The conclusion of the analysis of travel times is that in addition to Northwick Park and Hillingdon, the remaining three major hospital sites should be at i) either Charing Cross or Chelsea & Westminster, ii) either Ealing or West Middlesex, and iii) either Hammersmith or St Mary's. This is articulated by the eight options that are subject to further evaluation in the business case.

5.43 In order to evaluate the options, a number of criteria were developed. Some suggested by clinicians and patients were not accommodated, including integration of services, health equality across NW London, and support for preventative care and help for patients to manage their own conditions. These

exclusions are open to challenge. Their inclusion would go some way to addressing the inadequate population focus of the current proposals.

5.44 On the clinical quality criterion (the highest ranked by clinicians and patients), the position has been adopted that "current clinical quality at Trust level was not a useable proxy for future clinical quality at site level after reconfiguration was complete". This is a contentious statement and is open to challenge. It was proposed because the assessment used current mortality rates at Trust rather than site level. Given the importance of the quality aspect of the option appraisal, site level information should have been secured in order to allow for appropriate and necessary comparisons. The management teams of a number of the respective trusts have indicated that this information is available at site level. Regarding distance and time to access the service (again a highly important criterion for patients and the public), the business case places much less emphasis on this issue given that the criterion was a fundamental part of the basis for identifying the eight options. This is open to challenge. A much more detailed analysis on a more granular individual population and group basis should have been used to inform the options appraisal.

5.45 The subsequent option appraisal assesses the eight options against: quality of care; access to services; value for money; deliverability; and impact on research and education. Key aspects of the actual application of the evaluation criteria are open to challenge.

5.46 Regarding clinical quality, the business case sets out mortality rates by Trust for 2010/11. It would have been appropriate for the scores to have been disaggregated and examined in more detail on a site basis to give a much clearer view of relative respective clinical quality. However this has not been done. Instead, the business case states that "the reconfiguration is being pursued to achieve the clinical standards and the improved clinical quality through the reshaped clinical service models…After reviewing the data available on clinical quality, local clinicians agreed that all eight options…had been designed to achieve the highest levels of clinical quality and that the additional data reviewed at this stage of the evaluation did not provide any significant information that allowed them to differentiate between options on this basis". This is highly contentious and is open to challenge. Relative clinical quality is clearly of the utmost importance to patients, the public and clinicians. Should the current data really be inadequate for the purposes of site level comparisons, steps should have been taken to secure adequate data and for a detailed assessment to have been undertaken to inform the options appraisal. This issue alone undermines the credibility of the options appraisal.

5.47 The patient experience element of the quality criteria includes an assessment of the quality of the respective estates across the nine sites, based on the assumption that there is a correlation between the quality of the hospital or clinic where a patient is treated and their experience (although only very limited theoretical evidence is explicitly quoted to support this statement and it is contrary to local evidence). In order to use this as a comparative measure of patient experience the business case uses nationally collected site level

information (from ERIC returns) in terms of the proportion of space deemed to be not functionally suitable as NHS space and the age of the estate. This makes a large assumption that there is direct correlation between the age and the quality of the estate and it does not take into account in any way current patients' views of the respective sites. Therefore the information's use in this way is open to challenge.

5.48 More appropriately, the patient experience criteria also incorporate recent patient experience data. It should be noted that Imperial College Healthcare NHS Trust has the highest score in respect of the rating of the care received by patients and their assessment of the respect with which they were treated and the second best score in relation to patients' desire level of involvement in their care. However, the business case states that "the difference between all the scores is minimal and indeed the national scores have a very small range. Local clinicians did not feel that using this data in isolation gave them sufficient basis to differentiate between the options". This is open to challenge. Given its source and focus, this is a much better indicator of respective patient experience than the "proxy" estate indicator.

5.49 In terms of the quality criteria, the options appraisal affords the highest rating to the options that retain both Chelsea and Westminster or West Middlesex. In light of the previous comments, this conclusion is open to challenge as it is not based upon a genuinely robust assessment of quality between the nine sites.

5.50 In terms of distance and time to access services, all of the options have been rated the same "in recognition that this analysis has been used in the development of the options and that the analysis has not enabled any differentiation between the options". This is open to challenge. Access was rated as a highly important issue by patients and the public and it is not credible to suggest that there is no difference at all between the options

5.51 In terms of patient choice (included within the access criteria), emphasis is placed on patient choice benefitting from a greater number of Trusts (not sites) offering services. Specifically the business case states that "those options that locate a major hospital at Chelsea and Westminster rather than at Charing Cross result in five Trusts having a major hospital. Where Charing Cross is designated a major hospital then only four Trusts have major hospitals, and Imperial Trust would contain two major hospitals instead of one". This argument is open to challenge on two counts. Firstly, no evidence is provided to support the proposition that patient choice is enhanced by the number of Trusts as opposed to sites offering services to patients. Secondly, the distribution of sites between NHS organisations is not fixed and can be changed. Were it deemed beneficial, the management of the Charing Cross site could transfer from Imperial Trust to Chelsea & Westminster Trust. In summary, again, the conclusions of this element of the evaluation are open to challenge.

5.52 In terms of value for money, the evaluation uses a number of criteria. In terms of the estimated capital cost of the additional capacity required by the reconfiguration the only real difference highlighted is between those options that

include Hammersmith Hospital as a Major Hospital (Options 1 to 4) and those that don't (Options 5 to 8). In terms of relocating maternity and other services, this has a significant impact on any option where Charing Cross Hospital is designated as a Major Hospital, as it currently has no maternity services at present. If the capital cost of such a relocation is truly prohibitive, this element of the model could be looked at again.

5.53 Estimates are also included of the value of capital receipts to be generated by the disposal of land associated with each option. This calculation is based on the same average value per hectare for all sites, and therefore is not really a credible assessment of the likely capital receipts associated with each option. Therefore these assumptions are open to challenge.

5.54 Finally in terms of capital costs, an estimate has been made of the cost associated with establishing the new "Local Hospital" model within each of the relevant options. The same value has been used for each of the relevant options, limiting the value of this as an evaluation criterion between options.

5.55 The overall conclusion reached in the business case is that Options 1 to 4 have a much higher capital cost than Options 5 to 8 (which are ranked equally for this criteria). The capital cost element of the value for money criteria is open to challenge. It is based on very high level figures (often crude averages) and is not a properly assessed estimate of the true capital costs impact of each option.

5.56 The value for money criteria also includes an assessment of the likely transition costs associated with each of the options. This assessment uses an average cost assumption of "12 months disruption at £250 cost per bed-day". The basis for this calculation is not provided. On this basis, there is a difference of approximately £30m (or 50%) between each of Options 1 to 4 compared with Options 5 to 8. There is no significant difference between Options 5 to 8 and they have consequently all been ranked equally. This is open to challenge, as further more detailed work should be done to secure a better estimate of likely transition costs.

5.57 The value for money element also looks at the financial viability of the hospital sites and NHS Trusts in NW London, and the impact on this of reconfiguration. Clearly this is a key motivation underlying the proposals. This uses the financial base case information referred to in the financial model section above, so the issues identified with the model also directly impact on this assessment. Compared with the "do nothing" assumption that forecasts an £8m deficit across the acute sector, all of the reconfiguration estimates improve the position, ranging from a forecast total surplus of £12m (Option 8) to £47m (Option 5). These values equate to 0.66% and 2.58% of total revenue respectively. This is arguably a marginal difference and the actual outcome will be influenced by many other factors, most notably the effectiveness of financial management and control within the hospitals and the effectiveness of GP commissioners in managing patient demand. However this information is used to differentially rank the options. This is open to challenge.

5.58 Finally in terms of value for money, a Net Present Value (NPV) calculation is included, bringing "together all of the financial evaluation issues through a discounted payment profile, calculated over 20 years". The values are reported relative to the financial base case "do nothing" assessment. In effect, because this calculation uses the previous elements of the value for money calculation, it double counts the impact of each element.

5.59 The overall value for money assessment in the business case gives the highest rating to Option 5 and the second highest rating to Options 6 and 7. However this is open to challenge. The differentiation between Options 1 to 4 and Options 5 to 8 is primarily a function of the capital costs estimate. As suggested above, the capital estimates work needs to be significantly strengthened to arrive at the true capital cost of each of the estimates. The differentiation between Options 5 to 8 is entirely a function of the impact on site and Trust viability and the NPV calculation. Both the methodology and the application are open to challenge, as this does not give a sufficiently accurate differential value for money assessment between the options.

5.60 The deliverability criteria include an assessment of the workforce using recent national staff survey results. The business case states that "Chelsea and Westminster can be seen to have scores that are statistically better than the scores achieved by other Trusts". This is open to challenge. Imperial's scores are not significantly different from Chelsea and Westminster's scores, and yet options that include Chelsea and Westminster as a Major Hospital are rated higher.

5.61 The deliverability criteria also include an assessment of the expected time to deliver each option. This assessment should be challenged. It includes again (double counting) information from the financial base case based on the premise that "it is very difficult for Trusts facing such financial difficulties to make the changes in services as part of the reconfiguration". No evidence is provided in support of this statement. The assessment also uses again the assessment of new capacity required (a double count). Finally, it incorporates an assessment of the movement of adult and maternity beds. Again the potential relocation of maternity services has a big impact on the assessment, weighting the overall assessment in favour of the options that designate Chelsea and Westminster a major hospital. Were the maternity element to be decoupled from the consideration of A&E and complex medicine and surgery different results would be likely. Currently, in overall terms this assessment of expected time to deliver ranks options 5 and 6 as equal highest.

5.62 Finally, in terms of deliverability, the assessment includes a consideration of co-dependencies with other strategies, to take account of other work and initiatives going on within NW London and beyond. The issues taken into consideration were:

- Changes to the designation of the Major Trauma Centre at St Mary's;
- Current location of stroke units;

- Changes to the location of the Hyper Acute Stroke Unit (HASU) at Charing Cross.

5.63 Options requiring the relocation of the Major Trauma Centre from St Mary's were ranked the lowest and the options that designated St Mary's a Major Hospital were ranked relatively high. However, the same logic was not applied to the HASU at Charing Cross. The potential relocation of this unit was not used to differentiate between options. This is open to challenge. The assessment gave Options 5 and 6 the highest rating.

5.64 The last element of the option appraisal was an assessment of the impact on research and education. In terms of potential disruption, no differentiation was made between the options beyond seeking to protect the position at Hammersmith and St Mary's (as they scored particularly well in the 2011 National Training Survey). The ultimate conclusion of this element is that it is critical for research to be co-located with clinical delivery and therefore Options 5 to 8 were ranked the highest.

5.65 The summary evaluation ranked Options 5, 6 and 7 the highest, with Option 5 ranked the highest, stating that Option 5 "was significantly better than the other options"64. As stated above this is open to challenge. The options appraisal is open to challenge in terms of the sequential approach, the selective choice of indicators, the absence of an assessment of actual quality and performance (a key weakness), the lack of sufficiently detailed assessment in critical areas and the practical application of the indicators (including a high level of double counting).

5.66 Significantly, the only differences between the assessment of Option 5 (which has Charing Cross Hospital designated a "Local Hospital") and that of Option 6 (which has Charing Cross designated a "Major Hospital") are:

- The patient experience assessment, driven by an inappropriate use of estates indicators;
- The patient choice assessment, driven by a spurious argument about the number of NHS trusts managing Major Hospitals;
- The financial surplus assessment, the accuracy and materiality of which is subject to challenge;
- The Net Present Value calculation, that double counts previous measures and is subject to challenge; and
- The workforce assessment, that inappropriately under rates Imperial Trust compared with Chelsea and Westminster.

5.67 It should be noted that the business case does include a sensitivity analysis, testing the robustness of the options appraisal. The sensitivity analysis itself is reasonably sound. However, it is entirely predicated on the core assumptions and principles that underpin the option appraisal and consequently exhibits the same flaws.

- **Readiness**

5.68 The proposals assume that the various parts of the NHS in NW London have (or will have) the capability and capacity to implement the proposals but there is currently insufficient capacity and capability in primary and community services to support the proposed changes, which include the removal of 1,000 adult beds from the acute sector.

5.69 In percentage terms, Chelsea & Westminster is estimated to have the largest number of excess beds of all nine hospitals in the analysis and it is stated that "having this number of beds without reducing the number of sites in an inefficient and expensive use of buildings". However, there is no evidence that alternatives have been explored that could deliver the necessary efficiencies. In particular, given that over a third of the adult bed capacity at Chelsea & Westminster is estimated to not be required in the medium term, it is notable that the business case does not explore other ways of ensuring that Chelsea & Westminster is viable, other than the transfer of activity from Charing Cross Hospital.

5.70 While the proposals include plans to strengthen "Out of Hospital" care, these developments are currently not planned to be fully implemented until some time after the hospital reconfigurations have commenced. No decisions should be finally made about hospital reconfiguration until the Out of Hospital strategies have been implemented and performance assessed as successful against a number of appropriate metrics.

6. Clinical outcomes

6.1 The proposals do not take adequate account of the respective quality of services currently provided.

6.2 Current clinical quality is insufficiently analysed and reflected within NHS North West London's proposals. However, even in light of the restricted information used, Imperial College Healthcare NHS Trust scores relatively well in terms of quality. This can be summarised as follows:

- Imperial has the lowest (best) rating in NW London in terms of hospital standardised mortality rates (HSMR), significantly below the other trusts in the area;
- Imperial has the lowest (best) rating in NW London in terms of the summary hospital-level mortality indicator (SHMI);
- Imperial is statistically better than could be expected in terms of the number of deaths in low risk conditions;
- The assessment of Imperial's quality of services using the NHS aggregated quality dashboard indicates that the Trust has 50 of 62 measures where it performs above the national average;
- Imperial has the highest score in NW London in respect of the rating by patients of the care they have received and patients' assessment of the respect with which they were treated.

6.3 In light of the above, it is highly inappropriate to seek to transfer services away from Charing Cross and Hammersmith Hospitals. This would put at risk that current quality and potentially expose local people to:

- The adverse effects of increased travel time and delayed access to emergency services, and the impact on the population of the other proposed changes (e.g. to maternity services);
- The impact of primary and community services not being improved as proposed, whilst hospitals proceed to reduce their capacity; and
- The heightened impact on the most vulnerable groups of people in Hammersmith & Fulham's diverse population.

7. Impact

7.1 Insufficient account has been taken of the adverse impact on people who live and work in Hammersmith & Fulham.

7.2 Analysis of the preferred option indicates that currently each A&E in NW London serves an average population 5% less than the national average. If the preferred option is implemented the cuts will result in each remaining A&E serving an average population that is 52% larger than the national average.

7.3 The analysis supporting the preferred option indicates that 91% of current patient activity will be unaffected by the reconfiguration proposals.

7.4 However, the 91% calculation relates to NW London as a whole, from an NHS provider perspective. The significant impact of reconfiguration on patient activity will be the movement of activity from Charing Cross and Ealing. Consequently the specific impact on the population of Hammersmith & Fulham is much more significant. The business case estimates that for the preferred Option the percentage of Hammersmith & Fulham activity impacted by the reconfiguration is as follows:

- 40.0% of inpatient admissions
- 11.5% of outpatient attendances
- 23.0% of A&E attendances

7.5 After Ealing, Hammersmith & Fulham's residents face the most disruption and change as a result of the proposals. Indeed the impact on Hammersmith & Fulham and Ealing is significantly greater than for any of the other boroughs. For both boroughs, it is essential that before any decisions are made, the impact of these changes is tested on a needs based population basis, rather than being primarily driven by the need to ensure NHS Trust organisational sustainability. For Hammersmith & Fulham, this should be undertaken by the new CCG in partnership with the Council (and its new public health directorate) and the new Health and Wellbeing Board.

7.6 Furthermore, these changes would have a detrimental impact on the new Hammersmith & Fulham CCG's ability to influence the care commissioned for

local people. Effectively the proposals fragment Hammersmith & Fulham's health care across many different providers. It is unlikely in consequence that Hammersmith & Fulham will be a major commissioner of any of the receiving NHS Trusts.

8. Additional issues

- **Implementation**

8.1 A key issue in terms of implementation is the relationship between the implementation of the Out of Hospital strategies and the acute hospital reconfiguration. The business case states that the "Out of Hospital transformation should begin immediately and that this critical improvement work needs to be complete by the end of March 2015. Subject to decision making and having the necessary capacity and efficiency improvements in place, implementation of changes to acute provision could then be complete in full by March 2016".

8.2 The outline plan set out in the business case shows the out of hospital improvements being in place by the end of March 2015, but crucially it shows the hospital transition work commencing in the first half of 2013. This is open to challenge. The business case itself refers to the "challenging schedule" to deliver the improvements in Out of Hospital care. These improvements should be in place demonstrably (with performance measured against robust metrics) before the hospital transition work is started. Although the business case refers to a number of risks associated with delaying the hospital transition, the risks of reducing hospital capacity before the alternatives are in place are greater.

- **Benefits and disbenefits**

8.3 The business case is proposed on the basis that implementation of the changes will result in benefits for local people, patient, staff and the NHS organisations themselves. The benefits (improved outcomes, patient experience etc) would clearly be welcomed, and most are largely the result of meeting the proposed clinical standards. However the business case does not consider alternative options for delivering the clinical standards other than reconfiguration. The Council does not consider this approach to be robust or satisfactory.

8.4 Beyond stating the risks associated with the transition period, the business case does not provide an assessment of the likely disbenefits that could result from the proposals. These should be tested further via an assessment of the impact on Hammersmith & Fulham's population, with particular reference to:

- Clinical outcomes: the potential for these to be adversely affected by increased travel time and delayed access to emergency services, and the impact on the population of the other proposed changes (e.g. to maternity services);
- Primary care development: the impact of services not being improved as proposed, whilst hospitals proceed to reduce their capacity;

- Equality and human rights: the impact on the most vulnerable groups of people (particularly children and older people) in Hammersmith & Fulham's diverse population;
- Increased complexity: the establishment of a new "tiered" system of local healthcare (including "local" and "major" hospitals) has the potential to significantly confuse patients and the public; and
- Loss of expertise: the potential significant loss of clinical expertise and excellence at Charing Cross Hospital which has established a world-class reputation

- **Motivation**

8.5 The business case and consultation set out a number of clear reasons for the proposals, including a "case for change" predicated on the need to improve the quality and sustainability of local health services. However, there are arguably other drivers influencing NHS North West London that have not been fully articulated in the business case.

8.6 Such a key driver will be the national imperative to ensure that all NHS provider trusts become Foundation Trusts in the next few years. It should be noted that of the thirteen NHS organisations in NW London, five (38.5%) are Foundation Trusts and eight (61.5%) are NHS Trusts. There are relatively fewer Foundation Trusts in NW London than on average nationally. It is Government policy to eventually move all NHS trusts to Foundation Trust status once they have been confirmed as viable in service and financial terms. Imperial College Healthcare NHS Trust is not yet a Foundation Trust. A significant motive underlying the business case will be the desire to ensure that all local organisations are "fit" to become Foundation Trusts. However, this is not explicitly stated in the business case. This motivation, and its implications, should be clearly articulated.

8.7 In addition, the need to ensure the viability of current NHS organisations and structures should be balanced against the need to meet the needs of local people. The latter should be given primacy, and the organisational arrangements should be tested and shaped to meet those needs.

8.8 However, the primary driver is clearly the need to reduce costs in light of the growing demands on health services, the current exposed financial position of a number of local NHS Trusts and the low level of additional funding that the NHS will receive in light of the current macro-economic position. This is the main driver for change and yet it is somewhat underplayed in the business case. This is open to challenge. The primary motivations behind the changes should be clearly and transparently set out for patients, the public and staff.

9. Next steps

9.1 Taken together, the flaws in the process and methodology underpinning 'Shaping a healthier future' mean that in effect NHS North West London's proposals have not been developed in a sufficiently robust way and are consequently seen as unsafe from the Council's perspective.

9.2 The Council, through its Scrutiny committee, will therefore decide whether to refer the process to the Secretary of State based on the criticisms set out in this document. Further, the proposal to take a final decision on hospital and service reconfiguration before new health management arrangements are properly instituted requires consideration at the highest level.

9.3 If the final decision is taken to close the A&E departments at Charing Cross and Hammersmith Hospitals, then the Council, again through its Scrutiny committee, will decide whether to refer this to the Secretary of State as it will represent a significant detrimental impact on health services for local residents.

9.4 However services and hospitals are reconfigured, the Council will expect clear and comprehensive out of hospital provision to be put in place before any other changes are made. Irrespective of any decision or outcome, the Council also expects to see, and be consulted on, detailed plans for the future of the Charing Cross site including, for example, the implications for the teaching hospital, the effects on local employment and plans to dispose of or redevelop any part of the site.

ENDS –
LBHF-FCS: CPD-Policy
11 September 2012

Shaping a Healthier Future for North West London – main issues for Harrow

The NW London JHOSC has asked for each borough to provide a summary of their main issues relating to the Shaping a Healthier Future (SaHF) proposals and consultation so that they can feed into the JHOSC's response report.

It should be noted that Harrow will be holding a special meeting of its Health and Social Care Scrutiny Sub-Committee on 19 September to discuss the impact of the SaHF proposals in Harrow and the consultation to date. Therefore the key points given below are indicative thoughts pending the outcomes of this special meeting – these may change in Harrow's final response to the SaHF consultation.

The large majority of Harrow residents use acute services at Northwick Park Hospital and to a lesser extent Central Middlesex Hospital (as part of the same trust - NW London Hospitals Trust). As part of all the options put forward for consultation, Northwick Park Hospital retains its services as a major hospital and Central Middlesex Hospital becomes a local hospital and elective care centre. We note the current plans to merge NWLHT and Ealing Hospital Trust and therefore the option to downgrade Ealing Hospital to a local hospital will also have ramifications for Harrow's local hospital trust.

Main issues for Harrow:

- **Implementation of the out of hospital strategy** as a foundation to ensuring changes in acute services succeed – the need to transform primary, community and social care because of current variations in quality and access will include needing to ensure that the capacity and capability exists within the services to operate 24/7 at a high level and this includes implications for social care services. The delivery of the out of hospital transformation underlies the implementation of each option as it delivers a reduction in acute activity and delivers efficiencies and productivity improvements and thereby creates additional capacity in receiving major hospital sites.

- **Poor patient satisfaction with primary care in Harrow** - especially access to GP appointments and out of hours services. Harrow patients, in the 2010/11 patients' survey, score these with 56.3% and 57.8% satisfaction respectively – both ranking in the bottom 10% nationally.

- **Capacity and infrastructure at Northwick Park Hospital** to take on the growth in demand in its services and the additional patient flow. Under each of the options there are significant increases in inpatient and outpatient activity and A&E attendances at Northwick Park Hospital forecast. There is a need to invest in Northwick Park Hospital's services, workforce and estate to make it best positioned to be able to accommodate a growing number of patients.

- **Travel, transport and access issues for Northwick Park Hospital** – ensuring that the ambulance, private car and public transport journeys are not adversely impacted by the increased patient flow to Northwick Park Hospital. Northwick Park underground station (Metropolitan line) is not a step-free station as it does not have lifts, ramps or escalators at the station. Nearby stations at Harrow on the Hill (Metropolitan line) and Kenton (Bakerloo and Overground lines) also lack step-free access. There may also be travel issues for the staff transferring from other hospital sites to Northwick Park Hospital in terms of getting to/from work each day if travelling to Northwick Park Hospital takes longer or is more difficult than their original place of work.

- **Workforce issues in the short and medium term** – many staff will be impacted by the proposed changes for example in staff transferring to different sites, the need to recruit more consultants (paediatrics), changes to maternity services. This will also impact on those staff at major hospitals who will see their hospitals grow in demand. The proposals have the best chance of succeeding in implementation stage if all staff have been fully involved and engaged in the plans for change.

- **NW London Hospitals Trust** – even following its proposed merger with Ealing Hospital, regardless of which option is implemented, the trust is forecast to remain in deficit in 2014/15 following the changes because of the financial forecasts for Central Middlesex Hospital. Central Middlesex Hospital will not achieve financial viability and this will impact on the trust's overall position. The trust holds the ambition to become a foundation trust in the near future.

- **Long term feasability** of proposed changes – the closure of hospital A&Es raises questions about the future of hospitals in the longer term e.g. Central Middlesex Hospital and possibly Ealing Hospital. There is real concern that services will diminish incrementally at hospitals downgraded to local hospital status, as fewer and fewer services stay clinically viable.

- **Communications** to residents regarding the rationale for changes in acute services and out of hospital transformation – the appropriate use of primary care and Urgent Care Centres is highlighted as one area which could benefit from concentrated effort in communicating key messages to the general public.

Councillor Krishna James
Chair of Harrow Health and Social Care Scrutiny Sub-Committee
Harrow's member on the NW London Joint Health Overview and Scrutiny Committee

London Borough of Hounslow

Hounslow Health & Adult Care Scrutiny Panel Draft Response to Shaping a Healthier Future Consultation

The two nominated Hounslow Cllrs on the Joint Committee Health Overview & Scrutiny Committee for NW London have met with local health commissioner and provider representatives to help formulate the Hounslow Health & Adult Care Panel's response to the Shaping a Healthier Future Consultation and ensure that it reflects any local concerns.

At the time of writing, Councillors were still awaiting feedback from colleagues at West London Mental Health Trust and the Director of Public Health on the proposals. Any specific issues raised by these colleagues will be reflected in the Panel's final response.

The Panel have not yet decided if in their final response they will support a particular Option in the consultation document. This will be determined following further discussion with the Chair and Panel Members. Emerging headline messages that will inform the final response are as set out below:

Access to primary care & Population Growth rate in Hounslow
Historically, access to primary care services in Hounslow has been an issue for residents. In 2008, a national Department of Health initiative identified that Hounslow PCT was in the 25% of PCTs with worst provision. Members recognise that parts of the borough have seen rapid population growth which can lead to inconsistencies in access and access issues in general. The 2011 census figures show that there has been a 17% increase in population figures. *This is the fifth highest increase across all authorities in England and Wales.*

The success of the proposals relies on comprehensive out of hospital care services being in place which have appropriate capacity for the local population. The Panel remains concerned about appropriate capacity being available in out of hospital care to divert patients from hospital.

The Commissioning Consortia has highlighted the challenge of ensuring that Urgent Care Centre's are not used as an "overflow" for patients who are unable to access urgent appointments in their local GP Practice. There is a tension between urgent and planned primary care appointments which needs to be resolved. The Panel strongly believes that this is a key challenge which is instrumental to the successful delivery of the proposals. The Panel in their monitoring role will consider how this issue is resolved at a local level.

Robust Contract Levers for General Practice
The NHS Commissioning Board must put in place robust contract levers to help ensure that GPs deliver the quality standards and vision for primary care set out in the consultation document. There should be clear contractual levers for non-compliance which are closely and effectively managed.

Finances
It is imperative that the Hounslow CCG is in financial balance when formally constituted in April 2013; *there must not be a transfer of legacy debt from Hounslow PCT to the newly formed CCG.* The Panel see this as a key risk of implementing the proposals set out in the consultation document.

Transport
As a result of the proposals, residents may need to travel further to access specialist services. This includes attending follow up appointments. The CCG in Hounslow has recognised this is a new problem with hospitals adopting more stringent policies on what can be provided. We know from evidence received from the JHOSC that some patients have been deterred from attending follow up appointments where transport is not made available.

We see this as a risk to patient care. *Patients must not be deterred from attending follow up appointments because of the cost of travel.* There needs to be a review of hospital transport criteria to ensure consistency in what hospitals provide so that vulnerable patients who have no other means to get to appointments receive the support they need.

If following the consultation West Middlesex is designated a major hospital it is imperative that there is an additional bus route put in place to allow Ealing residents to travel to the hospital site. Current transport links are very poor. We believe that there is a business case in terms of population to support the additional route.

Risk Assessment
The Panel is aware of the request made by the Joint Health Overview & Scrutiny Committee to see a risk register in relation to the programme. The Panel understands that this has not yet been completed and will be worked up following the adoption of a specific option.

The Panel is extremely surprised that a programme of this scale does not identify headline risks and mitigating actions *in relation to the implementation and delivery of the proposals at the outset.* The Panel does not find this to be a satisfactory or robust approach to risk management and cannot understand why implementation and delivery risks will only be considered fully following the completion of the consultation process.

Equalities Impact Assessment
The Panel recognise the work that has been done to date on establishing the equalities implications of the proposals. The Panel feels this is too high level and lacks detail. The Panel would like to see more work carried out at a borough level. Local authorities have a wealth of information and knowledge on vulnerable groups and this should be drawn on to develop a more detailed understanding of what mitigation action is required to ensure all residents in NW London are able to benefit from the proposals.

Further comments to follow

Public Understanding of changes
The Panel believes that this continues to be one of the key challenges of the programme. They are aware that the new 111 number (to be introduced in April 2013) will be instrumental in providing sign posting services to residents which should direct them to right care first time.

There needs to be a high profile national campaign which is adequately funded and ensures good public awareness of this number.

West Middlesex Hospital
If following the consultation West Middlesex Hospital is designated a major hospital and Charing Cross is designated a local hospital we would question the automatic allocation of the Hyper Acute Stroke Unit (HASU) currently at Charing Cross to St Mary's. Moving the HASU to St Mary's would leave a wide part of the borough exposed. It is not sufficient to explain this rationale by saying that both these hospitals are within the Imperial group. This move, including what it means from a geographical point of view needs to be looked at closely. We are of the view that if West Middlesex Hospital is designated a major hospital, then there is a case for locating the HASU there. We know that there is flexible capacity in the hospital's specialist stroke unit which could accommodate this. This would strengthen services for our residents and also those in the neighbouring borough of Richmond.

Charing Cross/Imperial
There are a significant number of Hounslow residents in the east of the borough who use services at Charing Cross. The Panel understands from Hounslow CCG that the majority of patients who are currently referred to Charing Cross would be able to continue to receive services at this site if the hospital following the consultation was designated a local hospital.

The Panel is aware however that Charing Cross has a number of specialist services, in particular cancer care and neurosciences. The Panel are not clear as to whether these services would continue to be located at the Charing Cross site if it was designated a local hospital or in time would be moved by Imperial to another hospital site.

It is the Panel's view that Imperial needs to be much clearer about what their plans are going forward. The Panel have a limited understanding as to what the Charing Cross site will look like if it is designated a local hospital. This may be outside the remit of this consultation but it is fundamental in helping members explain to their residents what services they can continue to access at Charing Cross.

In addition the Panel are concerned about the investment that will be needed to upgrade the St Mary's site (19 million). Where will this money come from?

The Panel also want more clarity as to who will gain from the selling off of any hospital estate if Charing Cross is designated a local hospital. Money must flow back into services and ultimately to the patient, it should not be used to upgrade estate.

In relation to the maternity unit at Queen Charlotte's and Chelsea Hospital, the Panel are concerned that not enough has been done to inform the public that this service is not at risk and that there will be 6 rather than 5 maternity services in NW London. This issue needs to be addressed.

Chelsea and Westminster
Members of the Panel know from information shared by health colleagues that Chelsea & Westminster has a recognised reputation for the delivery of high quality, outstanding services. The Panel would not want to see access to these services put at risk as a result of the reconfiguration proposals.

Work force Development
The Panel have heard from the CCG that this is instrumental to the success of delivering the proposals. Staff are traditionally trained to work either in a community or hospital setting. There are a different set of skills that will be needed for staff including nurses and clinicians to work in the community. Retraining will be necessary. The Panel would wish to see a strategic approach to work force development undertaken with CCGs supported at a regional level to provide appropriate training to staff. This should include access to specifically tailored and funded courses and guidance.

Urgent Care Centres
The Panel are aware that a number of witnesses providing evidence to the JHOSC have focussed on UCCs and have highlighted them as a key risk area. The Panel are keen to see an agreed definition of Urgent Care developed and a definitive list of conditions that can be treated in Urgent Care Centres agreed. The Panel see this as a priority; particularly in light of the need make sure that the public understand how and where they go to access care.

21st September 2012

This page is intentionally left blank

A5

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

HEALTH, ENVIRONMENTAL HEALTH AND ADULT SOCIAL CARE SCRUTINY COMMITTEE – 27 SEPTEMBER 2012

REPORT FROM THE TRI-BOROUGH EXECUTIVE DIRECTOR FOR ADULT SOCIAL CARE

SHAPING A HEALTHIER FUTURE – CONSULTATION

The NHS started a formal consultation process on major NHS reorganisation in North West London on 2 July 2012. NHS North West London has produced a 'Shaping a healthier future - Consultation document'[1]. A draft consultation response for the Royal Borough of Kensington and Chelsea is set out in Appendix A.

FOR DECISION

1. BACKGROUND

1.1 There are 1.9 million people living in North West London – this covers the eight boroughs (Brent, Ealing, Harrow, Hillingdon, Hounslow, Hammersmith and Fulham, Kensington and Chelsea and Westminster). The NHS in North West London covers nine acute and specialist hospital trusts, two mental health trusts, four community health providers, 423 GP practices and 1,187 GPs. The annual health budget of the NHS in North West London is in the region of £3.4 billion.[2]

1.2 NHS North West London is made up of a 'cluster' of Ealing, Hounslow, Hillingdon, Brent, Harrow, Chelsea and Westminster, Hammersmith and Fulham and Westminster primary care trusts. This is London's largest primary care trust cluster. There are 8 shadow Clinical Commissioning Groups in North West London.

1.3 McKinsey was selected in November 2011 to complete the 'North West London service reconfiguration pre-consultation

[1] Shaping a healthier future - Consultation document http://www.healthiernorthwestlondon.nhs.uk/sites/default/files/documents/Shaping%20a%20healthier%20future%20-%20Consultation%20document_0.pdf

[2] Taken from Dr Mark Spencer's slide presentation to NWL OSC Chairs at the informal meeting with NHS NWL on 16 January 12.

preparation' exercise. McKinsey then developed 'options for acute service configuration but also options for different models of community, mental health and primary care' [3] and drew together other work being done in the sector.

1.4 The NWL cluster in its 'Commissioning Strategy Plan 2012-15'[4] described the proposal for a sector wide service change programme to deliver improved services to patients in NWL. The covering letter to 'NWL Commissioning Intentions 2012-13'[5] (presented to NWL Board in November 2011) said 'In 2012-13, we need a step-change in delivering new models of care in order to address the clinical and financial context and elements of our existing plan that we have not yet made progress with.'

1.5 Projections show the £3.4bn health economy is unsustainable in its current form, with a potential overspend of £1bn by 2015. The plan is to move the local health economy to a more sustainable clinical and financial basis.

2. SHAPING A HEALTHIER FUTURE[6]

2.1 'Shaping a healthier future' is the programme to reorganise healthcare in North West London, including changing the number and functions of the major hospital sites. This will include reducing the number of sites offering A&E and Maternity services.

3. MAJOR HOSPITAL SITES

Current Major Hospital sites

3.1 North West London currently has nine sites providing an A&E service. These are:

- Charing Cross (Imperial College Healthcare NHS Trust)
- Chelsea & Westminster NHS Trust

[3] HSJ article: London cluster to consult on 'ambitious' reconfiguration plans http://www.hsj.co.uk/news/exclusive-cluster-to-consult-on-ambitious-plans-to-make-health-economy-sustainable/5038194.article

[4] NWL Cluster 'Commissioning Strategy Plan 2012-15' is available at: http://www.northwestlondon.nhs.uk/publications/?search=&pct=0&category=1604&pp=20]

[5] 'NWL Commissioning Intentions 2012-13'is available at: http://www.northwestlondon.nhs.uk/publications/?search=&pct=0&category=1604&pp=20]

[6] Shaping a healthier future http://www.northwestlondon.nhs.uk/shapingahealthierfuture/

- Central Middlesex (North West London Hospitals Trust)
- Ealing Hospital NHS Trust
- Hammersmith (Imperial College Healthcare NHS Trust)
- Hillingdon Hospital NHS Trust
- Northwick Park (North West London Hospitals Trust)
- St Mary's (Imperial College Healthcare NHS Trust)
- West Middlesex University Hospital NHS Trust

Five Major Hospital sites[7]

3.2 To deliver the volume of activity needed the consultation options are for five Major Hospitals. Accident and Emergency (A&E) services across NWL are set to be significantly reconfigured. The 'Shaping a healthier future - Consultation document' asks whether there is public support for one of the three options.

Box I: Three options for five Major Hospitals in North West London

Option a – The preferred option

Along with Hillingdon Hospital and Northwick Park, Major Hospitals are:

- Chelsea and Westminster
- St Mary's
- West Middlesex

As a result, Hammersmith would become a specialist hospital (similar to its current status) and Charing Cross downgraded to a local hospital.

Option b

Along with Hillingdon Hospital and Northwick Park, Major Hospitals are:

- Charing Cross
- St Mary's
- West Middlesex

As a result, Hammersmith would become a specialist hospital (similar to its current status) and Chelsea and Westminster would be downgraded to a local hospital.

Option c

Along with Hillingdon Hospital and Northwick Park, Major Hospitals are:

- Chelsea and Westminster
- Ealing
- St Mary's

As a result, Hammersmith would become a specialist hospital (similar to its current status) and Charing Cross downgraded to a local hospital.

We have been informed that, whichever option is chosen, 'all nine hospitals are likely to remain open as hospitals providing, at the least, around 75% of their original activity.'

[7] The consultation document (page 9) defines a major hospital as providing full A&E, emergency surgery, maternity and inpatient paediatric services.

4. JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

4.1 Local Overview and Scrutiny Committees[8] have joined together to form a joint committee to scrutinise the proposals for the NHS in NWL. The first formal meeting of the North West London Joint Health Overview and Scrutiny Committee took place on 12 July at Kensington Town Hall.

4.2 Attendees at JHOSC meetings from the Royal Borough are Councillor Mary Weale and Councillor Charles Williams.

5. CONSULTATION RESPONSE

5.1 Subsequent to the 11 September Public Meeting, a Royal Borough of Kensington and Chelsea consultation response has been produced (Appendix A). Box II summarises the main conclusions.

Box II: Royal Borough of Kensington and Chelsea's main conclusions

Support

We support the clinical case for change and the direction of travel towards improved out of hospital care. For NHS NWL to be able to deliver its plans they have to get the out of hospital part right. **We support the preferred option - Option A.** The Chelsea and Westminster Foundation Trust has a modern hospital building which achieves excellent clinical outcomes on the Fulham Road. It should continue to provide a full Accident and Emergency Service.

Concerns

However, there are a number of concerns for which we seek reassurance:

- That all NHS and Foundation Trusts in NWL post-implementation of the proposals are financially robust.
- That the new system will have sufficient capacity to provide services to what is likely to be a growing and ageing population. This relates to reduction in bed numbers especially but also to out of hospital provision.
- We would like external reassurance that Chelsea and Westminster and St Mary's have the capacity to meet increased demand from A&E closures at other hospitals
- If the A&E Department was to close at Charing Cross we wish to be reassured that there are satisfactory plans for the future use of the Charing Cross site and relocation of specialties currently interdependent with the A&E Service.
- We are concerned at the poor quality of buildings at St Mary's so we would like to see the detail on the plans to build capacity there
- That there were robust plans in place to stop bed blocking and delayed discharge. It is recognised that this Council needs to contribute towards this.
- That the out of hospital recommendations (as set out in section 5) are addressed by NHS NWL. We really want the out of hospital part of NHS NWL's plans to be successful.
- On the timings for the delivery of the programme. What are the triggers for

[8] This includes: City of Westminster, LB Brent, LB Ealing, LB Hounslow, LB Harrow, LB Hammersmith & Fulham, RB Kensington & Chelsea, LB Wandsworth, LB Richmond and LB Camden. It does not include LB Hillingdon.

making changes to the plans if things are not working out as expected?

6. RECOMMEMDATION

6.1 The Health, Environmental Health and Adult Social Care committee is asked to approve the consultation response, as set out in Appendix A (subject to any additional suggested changes the committee wish to add).

6.2 The finalised consultation responses will be sent to the JHOSC to aid them with their deliberations.

6.3 The formal consultation ends on the 8 October 2012. The finalised consultation response can be submitted to: consultation@nw.london.nhs.uk [9]

FOR DECISION

Andrew Webster
Tri-borough Executive Director of Adult Social Care

Background papers used in the preparation of this report: None other than those mentioned through this report.

Contact officer: Mr. H. Bewley, Tri-borough Adult Social Care Senior Policy Officer Tel: 020 7361 3607 and E-mail: henry.bewley@rbkc.gov.uk

[9]Those to be copied into the response include: Leader (RBKC), Tri-borough colleagues (Cabinet Member and Chair HOSC), Dr Anne Rainsberry (London Regional Director, NHS Commissioning Board), Chair (C&W), Chair (ICHT) Chair (WL CCG) and Daniel Elkeles (Accountable Officer for INWL CCGs).

APPENDIX A:

ROYAL BOROUGH OF KENSINGTON AND CHELSEA

CONSULTATION RESPONSE

'SHAPING A HEALTHIER FUTURE IN NORTH WEST LONDON' (NHS REORGANISATION IN NORTH WEST LONDON)

1. BACKGROUND

1.1 We welcome this opportunity to comment on 'Shaping a healthier future - Consultation document'[10] - NHS North West London formal consultation on major NHS reorganisation in North West London (NWL). It is imperative that NHS NWL is able to ensure that all its 1.9 million residents are able to enjoy the best care available, wherever they live.

1.2 This Overview and Scrutiny Committee (OSC) is composed of democratically elected councillors who are in close touch with the views and wishes of people living in the local areas they represent. Its membership represents a body of opinion with considerable experience of health matters. Additionally, a number of our members have had direct experience of working in the health service in various capacities. However, we have taken the view that, as a body, we would not wish to in effect pass a clinical judgement on whether individual hospitals are equipped to deliver a particular service under the proposals.

1.3 On Tuesday 11 September the Royal Borough of Kensington and Chelsea hosted a Special Public Meeting on 'Shaping a healthier future in North West London' in the Small Hall, Kensington Town Hall. There was in excess of 150 people in attendance.

1.4 This response looks in detail at the case for change, the criteria used, acute care, travel and transfers, out of hospital services and future work. Box 1 sets out a summary of our main conclusions.

[10] Shaping a healthier future - Consultation document
http://www.healthiernorthwestlondon.nhs.uk/sites/default/files/documents/Shaping%20a%20healthier%20future%20-%20Consultation%20document_0.pdf

Box 1: Royal Borough of Kensington and Chelsea's main conclusions

Support

We support the clinical case for change and the direction of travel towards improved out of hospital care. For NHS NWL to be able to deliver its plans they have to get the out of hospital part right. **We support the preferred option - Option A.** The Chelsea and Westminster Foundation Trust has a modern hospital building which achieves excellent clinical outcomes on the Fulham Road. It should continue to provide a full Accident and Emergency Service.

Concerns

However, there are a number of concerns for which we seek reassurance:

- That all NHS and Foundation Trusts in NWL post-implementation of the proposals are financially robust.
- That the new system will have sufficient capacity to provide services to what is likely to be a growing and ageing population. This relates to reduction in bed numbers especially but also to out of hospital provision.
- We would like external reassurance that Chelsea and Westminster and St Mary's have the capacity to meet increased demand from A&E closures at other hospitals
- If the A&E Department was to close at Charing Cross we wish to be reassured that there are satisfactory plans for the future use of the Charing Cross site and relocation of specialties currently interdependent with the A&E Service.
- We are concerned at the poor quality of buildings at St Mary's so we would like to see the detail on the plans to build capacity there
- That there were robust plans in place to stop bed blocking and delayed discharge. It is recognised that this Council needs to contribute towards this.
- That the out of hospital recommendations (as set out in section 5) are addressed by NHS NWL. We really want the out of hospital part of NHS NWL's plans to be successful.
- On the timings for the delivery of the programme. What are the triggers for making changes to the plans if things are not working out as expected?

2. CASE FOR CHANGE AND CRITERIA USED

Case for change

2.1 On 30 January 2012, NHS North West London released 'Shaping a healthier future - Case for Change'[11]. NHS NWL presents a compelling case why NWL's health services must change. Clinical quality is a major factor in the 'case for change'. Box 2 sets out highlights from the 'case for change'.

Box 2: 'Shaping a healthier future - Case for change' includes[12]

- NHS North West London has a £3.4 billion annual health budget and needs to find £1 billion of required savings by 2014/15.
- Some local units are already having to reduce the hours they are open because not enough clinical staff, of the right level and expertise, are available.

[11] 'Shaping a healthier future - NHS North West London - Case for Change (30 January 2012)' is available at:
http://www.northwestlondon.nhs.uk/shapingahealthierfuture/

[12] All these facts were taken from 'Newsletter 1: Shaping a healthier future - Service change in North West London (31 January 2012)' available at:
http://cavsacommunity.posterous.com/shaping-a-healthier-future

- Fewer than half of emergency general surgery admissions in London are reviewed by a consultant within 12 hours.
- 130 extra lives could be saved each year in North West London if better consultant cover could be provided at A&Es on weekends.
- In some NW London hospitals, more than half of staff do not recommend them as a place to work or to be treated.
- No maternity services in North West London score more than the national average in terms of care during labour and birth, postnatal care, and support for breastfeeding.
- Six of the eight boroughs in NW London are in the bottom 10% nationally for patient satisfaction with out-of-hours GP service.
- Life expectancy in different parts of NW London varies by as much as 17 years.
- We are living longer but not always healthier; there is an increasing prevalence of lifestyle-related diseases that, if we can't prevent, we need to manage better.

2.2 Many of the reasons for reform are not new, and past attempts to address these and reform NWL's health services have failed. We are alarmed that the healthcare system in North West London has been allowed to deteriorate (as reflected in the 'Case for Change') despite its problems having been known about for many years.

Institutional inertia

2.3 The NHS must be bold and make difficult decisions about much loved institutions. Furthermore, care must be designed around the needs of the patient and not those of NHS institutions. To deliver a truly 'patient centred' NHS, all reforms must improve access to, and the accessibility of, health services.

Criteria for NHS reconfigurations

2.4 The Secretary of State identified four key tests for service change[13], which are designed to build confidence within the service, with patients and communities.

2.5 We are pleased that clinicians have a major role in developing proposals, and expect them to be involved in explaining to the public that proposals strive to improve patient care rather than save money.

2.6 We consider that the criteria used to develop the proposals are fundamentally sound. We are able to support the direction of travel underlying the consultation paper.

[13] NHS Chief Executive Sir David Nicholson outlined the criteria for NHS reconfigurations in the letter 'NHS Reconfiguration guidance' available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_117899

2.7 Whatever option is finally chosen for changing the NHS in NWL, we believe the remaining trusts must be financially sound.

3. ACUTE CARE

Major hospital re-organisation

3.1 NHS NWL has proposed options with five Major Hospitals. No sites are reported to currently have the capacity to deliver the volume of activity needed with less than five major hospitals. The most favoured hospital configuration (Option A), based on quality of care, transport, value for money and quality of estate was continuing Major Hospitals at: Chelsea and Westminster; Hillingdon; Northwick Park; St Mary's; and, West Middlesex. As a result, this would mean a cessation of major, acute services (24/7) at Ealing Hospital, Hammersmith Hospital, Charing Cross Hospital and Central Middlesex Hospital. The consultation also proposes that the Western Eye moves to St Mary's.

3.2 The implementation plan suggests changes to acute provision could be completed in full by March 2016.

Chelsea and Westminster Hospital

3.3 In the course of our committee's deliberations we have visited the Chelsea and Westminster Hospital to gain a better understanding of how the Foundation Trust will respond and accommodate the NHS NWL's proposals if Option A is chosen. We looked at capacity at the Chelsea and Westminster and discussed the potential at the site for expanding A&E and for the provision of extra beds. We have heard how they wish to positively respond to NHS NWL's Option A. Professor Sir Christopher Edwards, Chairman, Chelsea and Westminster Hospital NHS Foundation Trust, told the 11 September meeting at Chelsea and Westminster had 'Clear plans for the development of A&E.'

Centralising specialist care

3.4 We broadly support the principle to centralise specialist care where this will lead to improved clinical outcomes.

3.5 We agree with NHS NWL's clinical case for reducing the number of major acute hospitals in North West London to five.

3.6 However, we will not give blanket approval to all the proposals for centralising specialist care as we would have to examine the clinical benefits of each particular proposal.

3.7 We are concerned that the care for people with multiple health needs (often referred to as 'co-morbidities') are not adversely affected by the increased specialisation of hospital care. We recommend that NHS NWL clearly outlines how people with multiple health needs are affected by the changes.

3.8 Having considered all the evidence we support Option A (subject to concerns expressed elsewhere). This option has serious ramifications for Charing Cross Hospital.

Charing Cross Hospital and St Mary's Hospital

3.9 Councillor Linda Wade asked about the future of Charing Cross Hospital at the 11 September meeting. Dr Tim Spicer, Medical Director, Shaping a healthier future programme, told the meeting that if Option A is accepted Charing Cross will become a 'local hospital'. If this was to happen complex elective surgery and complex elective medicine would close at the Charing Cross and need to be moved elsewhere.

3.10 Councillor Robert Freeman asked questions on: (1) the future of the specialist services currently provided at Charing Cross; (2) the suitability of the built environment at St Mary's if specialist services are to be transferred there.

3.11 Imperial College Healthcare Trust has substantial infra-structure constraints (e.g. Imperial has significant financial problems, they are not a foundation trust and the majority of the St Mary's estate is old and in many cases unsuited for contemporary patient care needs). For Imperial to cope with the influx of these specialised departments there will need to be substantial funding made available to increase and improve the physical infrastructure.

3.12 Dr Julian Redhead, Clinical Programme Director, Medicine, Imperial College Healthcare NHS Trust, responded by talking about the benefits of co-location of service on the St Mary's site, which would improve services/outcomes for patients.

3.13 Mr Brendan Farmer, Director of Strategy at Imperial College Healthcare, said there was a large amount of space at Imperial that could be redeveloped, the financial situation at

Imperial was improving and it was hoped in time to move to Foundation Trust status.

3.14 We believe patient care must not be downgraded if/when Charing Cross departments - such as hyper-acute stroke care, neurology, elective orthopaedics, rheumatology – are moved. We would like to see the detail of the future plans for all the specialist services currently based at Charing Cross.

3.15 We would also like to see more detail on the plan for the Charing Cross site. We note 'recommendation 3' of the Health Gateway Review[14] was 'Develop and agree the future vision for the Charing Cross site, with the engagement of local clinicians, prior to consultation.'

Emergency care

3.16 The report, 'Acute medicine and emergency general surgery – case for change'[15] pointed out that there were many avoidable deaths in emergency care due to understaffing. The report pointed to 'stark' differences in consultant hours across hospitals at evenings and weekends, and named those with the patchiest cover. We support NHS NWL's actions to tackle the problems caused by understaffing in emergency care.

3.17 We note 'recommendation 6' of the Health Gateway Review[16] was 'Clarify the service models for Urgent Care Centres and Accident & Emergency Departments.'

Bed capacity

3.18 The implementation plan suggests that if they are chosen as Major Hospitals: St Mary's would need 62 new beds, West Middlesex 58 and Chelsea and Westminster 9.

3.19 The OSC has visited Chelsea and Westminster to find out more about their plans. They told us they were planning 30 extra beds and gave their reassurance that they will be able to deliver their new beds. Chelsea and Westminster is planning to increase capacity but we still need reassurance that they will be able to cope with the additional admissions

[14] A Health Gateway Review 0: Strategic assessment was carried out on NHS North West London Shaping a Healthier Future in April 2012 (It reported on 4 May 2012).
[15] HSJ: 500 avoidable deaths a year in London due to understaffing http://www.hsj.co.uk/exclusive-500-avoidable-deaths-a-year-in-london-due-to-understaffing/5034589.article
[16] A Health Gateway Review 0: Strategic assessment was carried out on NHS North West London Shaping a Healthier Future in April 2012 (It reported on 4 May 2012).

resulting from a larger A&E without reducing the availability of the hospital for non A&E admissions. We would also like to know more about the plans for 62 new beds at St Mary's (in addition to all services transferred from Charing Cross). How will they deliver their contribution to NHS NWL's plans?

Hyper-Acute Stroke Unit

3.20 In 2009 it was obvious the hyper-acute stroke unit should be co-located with the major trauma unit, like all the major trauma units in London. During the consultation RBKC's OSC wrote, 'The OSC supports the proposal for a hyper acute stroke centre to be based at St Mary's hospital alongside a major trauma centre. Healthcare for London should again clearly articulate the need and benefits of co-location on the St Mary's site to the relevant commissioners and Imperial Healthcare NHS Trust.'[17] We question the decision-making that placed the hyper-acute stroke unit at Charing Cross Hospital for such a short time.

Paediatrics services

3.21 The issue of paediatrics came up a couple of times at 11 September meeting. We would like more detail on future plans for paediatrics services.

3.22 Professor Sir Christopher Edwards, Chairman, Chelsea and Westminster Hospital NHS Foundation Trust, told meeting that the Chelsea and Westminster were to make major investment in paediatrics and so all services will be provided from the 1st floor of the hospital.

Maternity services

3.23 NHS NWL's Case for Change highlighted the poor maternity service in NWL. More than 100 mothers have died in childbirth in London in the last five years, twice the rate in the rest of the country.[18] Two inquiries have been held into the high

[17] Overview and scrutiny committee on health - 18 March 2009 http://www.rbkc.gov.uk/COMMITTEES/Document.ashx?czJKcaeAi5tUFL1DTL2UE4zNRBcoShgo=d786M36KuepWa9SZOICDyY6qo3MQJCRiI64uEHiL6UeEu7MFehVWqA%3d%3d&mCTIbCubSFfXsDGW9IXnlg%3d%3d=hFflUdN3100%3d&kCx1AnS9%2fpWZQ40DXFvdEw%3d%3d=hFflUdN3100%3d&uJovDxwdjMPoYv%2bAJvYtyA%3d%3d=ctNJFf55vVA%3d&FqPlIEJYlotS%2bYGoBi5olA%3d%3d=NHdURQburHA%3d&d9Qjj0ag1Pd993jsyOJqFvmyB7X0CSQK=ctNJFf55vVA%3d&WGewmoAfeNR9xqBux0r1Q8Za60lavYmz=ctNJFf55vVA%3d&WGewmoAfeNQ16B2MHuCpMRKZMwaG1PaO=ctNJFf55vVA%3d

[18] Independent: Doubling of maternal death rate blamed on shortage of midwives http://www.independent.co.uk/life-style/health-and-families/health-news/doubling-of-maternal-death-rate-blamed-on-shortage-of-midwives-7689172.html

maternal death rate in London in the last four years and both have found maternity services wanting compared with the rest of the UK.

3.24 The Care Quality Commission report 'Our Market Report'[19] (June 2012) pointed out midwife numbers are not increasing in line with demand at a number of maternity services in London. NHS NWL could re-examine the allocation of funding for midwifery and commits appropriate expenditure.

3.25 We note 'recommendation 8' of the Health Gateway Review[20] was 'Clarify the service model for Maternity services.'

3.26 The NHS NWL's pre-consultation business case only considers home or hospital births. However, the recent Birthplace Study found freestanding midwifery units are both safe and clinically and cost-effective.

3.27 NHS NWL must ensures that there is a range of birthing options available to meet varying local need, one option is freestanding midwifery unit for low risk women.

Mental health

3.28 Two questions were raised about the impact of proposals on mental health services at the 11 September meeting. We recommend that NHS NWL clearly articulates how it will ensure sufficient resources will be allocated to meet the challenges facing NWL's mental health services.

Workforce

3.29 The major changes proposed will require professionals to acquire new skills and work differently; notably many current hospital nurses could be required to transfer to the community setting.

3.30 There is a danger that the Major Acute Hospital and specialist units may have a magnet effect, drawing the more experienced and better trained staff away from other NHS services.

[19] CQC: Our Market Report (28 June 2012) http://www.cqc.org.uk/media/cqc-publishes-first-full-analysis-performance-and-risk-health-and-social-care

[20] A Health Gateway Review 0: Strategic assessment was carried out on NHS North West London Shaping a Healthier Future in April 2012 (It reported on 4 May 2012).

3.31 We recommend that NHS NWL publish a workforce strategy that will enable the delivery of any changes to health services. This should include the exploration of flexible working arrangements, allowing opportunities for staff rotation within, and between, networks.

Nursing in hospital

3.32 We note that hospital trusts in London have been advised they can safely cut spending on nursing staff, in some cases by 50%, according to reports obtained by Nursing Times.[21] NHS London suggests 'aligning staffing levels with clinical need' and reducing agency spend. Nursing Times obtained the NHS London's trust-by-trust breakdowns of where it sees the potential for nursing budget reductions, following a freedom of information request. The suggested savings include: £54m at Imperial College Healthcare Trust.

3.33 We seek a reassurance that any planned changes to the nursing workforce in NWL is not going to negatively impact on the quality of care and patient mortality rates.

4. TRAVEL AND TRANSFERS

4.1 A gentleman raised a question about transport times at the 11 September meeting.

Travel arrangements

4.2 If ill people have to travel further it takes time, it costs money. If people choose not to do so they might get ill and die earlier. Some relatives, friends and carers will have to travel greater distances to a hospital destination.

4.3 With the preferred option there will be increased activity around the major hospital sites: Chelsea and Westminster; Hillingdon; Northwick Park; St Mary's; and, West Middlesex. This will need to be carefully accommodated/managed.

4.4 Every hospital should have updated travel plans, developed in liaison with Transport for London (TfL) and the relevant local authority (ies). This should include provision of clear travel information and car parking.

[21] Nursing Times (3 April 12): Trusts in London told they can slash nurse budgets by up to half http://www.nursingtimes.net/exclusive-trusts-in-london-told-they-can-slash-nurse-budgets-by-up-to-half/5043366.article?blocktitle=Latest-news&contentID=6840

Cross-border co-ordination

4.5 North West London is not a self-contained entity, and patients travel in either direction across the boundary to receive NHS care. We recommend that NHS NWL works closely with colleagues from the surrounding area and NHS London to explore the implications of any reforms on patients crossing boundaries.

4.6 NHS Clusters and Ambulance Services serving areas adjacent to North West London's borders need to be fully involved in forward planning for the new arrangements. Joint working 'across the borders' will need to be undertaken to produce transfer protocols which will provide clarity to Ambulance Services and hospitals.

London Ambulance Service

4.7 Centralisation of specialist care may involve critically ill or injured patients spending longer in ambulances. We understand, where appropriate for better care, the ambulance service will bypass hospitals to go to better specialist services provided elsewhere. However, the need for additional and longer journeys must not impact negatively upon the service provided to other emergency patients.

4.8 We recommend that the London Ambulance Service (LAS) and TfL are involved from the outset in developing proposals for specialist care in order to advise on travel times. NHS NWL must work with these organisations to agree the updating of travel plans to underpin any expansion of a hospital's services.

4.9 Any centralisation of specialist care should only take place once the LAS receives the necessary resources for additional vehicles and training that these new care pathways will require. These resources will need to be available on a continuing basis to ensure that training in the best triage methods is offered by paramedics at scene.

Transfers

4.10 Traditionally, transfers between hospitals (and from hospital to community-based care) have not been an area of strength. This can result in distress to the patient (and their relatives, friends and carers), and can adversely affect recovery.

4.11 It is important that the proposed new arrangements for transfer from specialist centres to Major Acute Hospitals, and from Major Acute Hospitals to community, operate smoothly from inception. Patients need to be transferred at the clinically correct time, and robust protocols will need to be in place to ensure smooth transfers between hospitals, and an adequate bed base to cope with demand. Patients and their carers should have arrangements explained clearly to them.

4.12 We recommend that clear clinical and administrative protocols for the transfer of patients are agreed with all relevant service providers, and established before the new systems go 'live'. We also recommend that there are systems in place for monitoring transfer arrangements, to allow early corrective action to be taken where necessary.

5. OUT OF HOSPITAL

5.1 The importance of getting out of hospital services right was stressed on several occasions at the 11 September meeting. An improvement in out of hospital services will lead to a significant improvement in people's health. We fully support the focus on out of hospital and all the analysis showing the work needed to improve out of hospital services.

Large scale move to primary/community care

5.2 NHS NWL's plans for A&E activity is to reduce the level across NWL to about 70 per cent of what it is now (Pre-Consultation - Business Case[22]).

5.3 The implementation plan claims out of hospital improvements will reduce the need for 391 acute beds.

5.4 The proposed move from acute to primary/community care is predicated on the success of: prevention; new out of hospital services; and, integrated care services. The next three sections of this response will look at these subjects in turn.

5.5 Given the scale of the shift to the community, NHS NWL should have given far more thought to social care. A whole-systems approach needs to be taken. We are particularly concerned about the lack of understanding of the financial

[22] Pre-Consultation - Business Case
http://www.northwestlondon.nhs.uk/publications/?category=4924-Shaping+a+healthier+future+-+Pre+Consultation+Business+Case+-+21+June+2012-d

impact of the proposals on social care. Section 6 of this response will look at finance.

Prevention

5.6 The main focus of the consultation proposals is heavily upon achieving clinical outcomes. Much of NHS NWL's plan is to ensure patients receive high quality care once they become sick. The pathways and working groups all have had a medical/ill-health focus.

5.7 We would like to underline the crucial role of prevention in the broader healthcare context. Intervention 'upstream' can prevent the need for hospital treatment later. Increasing the public's awareness of healthy lifestyles and tackling the root causes of ill-health is crucial. Such as an increased provision of 'plain English' advice aimed at promoting a better understanding of the personal health factors (e.g. lack of exercise, smoking, eating too much of the 'wrong' sort of foods) which may contribute to a greater likelihood of ill-health. The benefits to society, individuals, and in terms of long-term cost-effectiveness, cannot be over-emphasised.

5.8 We recommend a long-term strategy to promote healthy, sensible lifestyles, particularly among the young, should be developed for the NHS in NWL, in collaboration with local government (inc. Public Health). More joint working could take place between NHS and local authorities around the promotion of healthy lifestyles.

Helping people stay out of hospital

5.9 We also need to do more to support people to take control of their own health conditions. NHS and social care staff working in the community can help people manage their long-term conditions and prevent the need for emergency hospital admission. Sufficient resources will be required to fund key professionals who provide rehabilitation and treatment in the community following the proposed (by NHS NWL) earlier discharge from hospital.

5.10 We recommend the NHS in NWL should ensure a suitable investment is made in rehabilitation and prevention in order that the benefits to acute-end care can be maximised.

New out of hospital services

5.11 We agree that North West Londoners could benefit from the provision of a broader range of services in the community. We are fully supportive of the move to provide more services out of hospital. A description of the CCG Out of Hospital strategies is contained in Box 3. NHS NWL need to ensure change improves the accessibility of health and social care services and the physical access to facilities where these are provided.

Box 3: Out of Hospital Strategies[23]

NWL NHS has developed four out of hospital 'quality standards':

1. Individual Empowerment & Self Care - Individuals will be provided with up-to-date, evidence-based and accessible information to support them in taking personal responsibility when making decisions about their own health, care and wellbeing
2. Access, Convenience & Responsiveness - Out-of-hospital care operates as a 7 day a week service. Community health and care services will be accessible, understandable, effective and tailored to meet local needs. Service access arrangements will include face-to-face, telephone, email, SMS texting and video consultation.
3. Care Planning & Multi-Disciplinary Care Delivery - Individuals using community health and care will experience coordinated, seamless and integrated services using evidence-based care pathways, case management and personalised care planning. Effective care planning and preventative care will anticipate and avoid deterioration of conditions
4. Information & Communication - With an individual's consent, relevant parts of their health and social care record will be shared between care providers. Monitoring will identify any changing needs so that care plans can be reviewed and updated by agreement. By 2015, all patients will have online access to their health records

Out of Hospital Strategies are being developed by each of the clinical commissioning groups (CCGs) in the NWL sector to turn aspiration, as set out in the standards, into action. Developing themes include:

- Easy access to high quality, responsive care to make out-of-hospital care first point of call for people
- Clearly understood planned care pathways that ensure out-of-hospital care is not delivered in a hospital setting
- Rapid response to urgent needs so fewer people need to access hospital emergency care
- Providers working together, with the patient at the centre to proactively manage Long Term Conditions, the elderly and end of life care out-of-hospital
- Appropriate time in hospital when admitted, with early supported discharge into well organised community care

CCG out-of-hospital care strategies will need to deliver (from the implementation plan):

- A reduction in demand for acute services, which will enable the proposed changes to acute sites to take place Improvements in urgent care, with Urgent Care Centres (UCCs) in place on all local hospital sites and all UCCs operating at the level of the best UCCs in NW London – treating minor illnesses and injuries and therefore delivering around 70% of former A&E activity
- Improvements in access to care, with out of hospital care operating a 24 hour, 7 days a week service, with practices working in networks, and community and social services aligning provision to these networks
- New ways of working with staff organised within multi-disciplinary groups across providers to deliver improved, integrated care for patients
- A clinician-led system for making sure that out of hospital standards are consistently met by all providers, regardless of type, size or location.

[23] Taken from Powerpoint presentation found at:
http://www.northwestlondon.nhs.uk/shapingahealthierfuture/

Standards

5.12 The standards suggested by NHS NWL should be weighted more heavily towards the quality of the care (this is actually being delivered) rather than on providing information. For example there could be standards to ensure clinical quality, the availability of quality facilities and an able workforce.

5.13 If the 4 standards, plus savings and activity impact, are to be used as the basis to develop a set of performance matrixies we suggest you also add - what actually happens to health outcomes.

CCG Out of Hospital strategies are still at too high a level

5.14 The implementation plan suggests out of hospital improvement work needs to start immediately and be complete by the end of March 2015. We agree with the Shadow Joint Health Overview and Scrutiny Committee (JHOSC) and Health Gateway Review that much more detail on action is needed:

- When the Shadow JHOSC fed-back on NHS NWL's Draft Consultation Document they said, 'It is vital to include detail on the out of hospital strategy in the document as the proposed reconfiguration will rely on it if it is to be successful.'
- Recommendation 7 of the Health Gateway Review[24] was 'Provide more detail on proposed Out of Hospital services with a focus on implementation.'

5.15 We recommend NHS NWL provides far more detail on the implementation of the Out of Hospital service. CCGs need to set out detailed implementation plans for their Out of Hospital Strategies.

Integrated Care

5.16 We agree that North West Londoners could benefit from a move to more integrated care. The early results from the integrated care pilot are promising.[25] However, it has not yet been fully evaluated.

[24] A Health Gateway Review 0: Strategic assessment was carried out on NHS North West London Shaping a Healthier Future in April 2012 (It reported on 4 May 2012).
[25] The 'early signs of success' of the NWL integrated care pilot can be found in the BMJ article, 'Integrated care: a story of hard won success' (31 May 2012) available at: http://www.bmj.com/content/344/bmj.e3529

5.17 It is unusual to roll-out a service before the pilot has been fully assessed.

5.18 Much of plans in 'Shaping a healthier future' have been predicated on success coming from roll-out of integrated care in NWL:

- The consultation document highlights, 'The GP practices taking part in the pilot have so far reduced emergency admissions to hospital for elderly people by 7% and have created 20,000 individual care plans for their patients.' (Page 21 of the consultation document)
- The financial model predicts large savings.

5.19 When integrated care pilots have been evaluated there has been 'no evidence of the anticipated reduction in emergency admissions' and 'no significant impact of the pilots on secondary care costs.' Details on the Department of Health's evaluation is set out in Box 4.

Box 4: Report on evaluation of integrated care pilots[26]

National evaluation of Department of Health's integrated care pilots This two-year study, commissioned by the Department of Health, looked at 16 sites across England which formed the Integrated Care Pilot programme. The research carried out by Ernst & Young, RAND Europe and the University of Cambridge considered the impact of better integrated care on elderly people at risk of emergency hospital admissions and the treatment of conditions including dementia and mental health problems. It analysed staff and patient views on the work of the pilots as well as the impact on hospital admissions and length of stay.

The research found no evidence of the anticipated reduction in emergency admissions for patients who received an intervention. Balancing the unanticipated persistence of emergency admissions, there were reductions in outpatient attendances, which may have been due to moving services into primary care settings, an aim of several of the sites. Reasons for the observed reduction in elective admissions (especially in chemotherapy for cancer) are less clear. Taking these changes together, there was no significant impact of the pilots on secondary care costs.

In conclusion, integrated care activity throughout the 16 pilot sites has to date resulted in changes to the delivery of care that have led to improvements in staff experience and organisational culture. The interventions had high appeal to staff involved, and it is suggested that if continued they may bring about improvements in outcomes relating to patient care and longer-term cost savings.

5.20 We question the assumption that the roll-out of the INWL integrated care pilot across the whole of NWL will give the level of benefits predicted (i.e. an assumption that emergency admissions to hospital for elderly people will be reduced by 7%).

[26] DH: Report on evaluation of integrated care pilots (DH, 22 Mar 12)
http://www.dh.gov.uk/health/2012/03/report-on-evaluation-of-integrated-care-pilots/

Social care 'marginal' to integrated care schemes with NHS

5.21 We note social care professionals were 'marginal' to flagship government integrated care pilots designed to integrate support for people with long-term conditions.[27] Most of the 16 integrated care pilots concentrated on joining up different parts of the NHS with no change in the role of social care in providing support. This is despite the pilots being targeted at improving care for people with social care needs, including those with dementia, other mental health problems, end-of-life care needs, substance misuse and other long-term conditions.

5.22 'Most of the pilots focused on the integration between primary and secondary care, with social care often playing a marginal role in the wider integrated care agenda,' said the evaluation. 'In fact, the role of social care in integration had been regarded as unchanged for most sites.'

Joint Working

5.23 Sustainable reform will require effective partnerships with local authorities - as the distinction between 'health' and 'social' care becomes increasingly blurred. Barriers to good joint working should not be erected. We recommend the three local boroughs should look at jointly commissioning appropriate services with the NHS across all three boroughs.

5.24 The NHS and local authorities must work together in partnership, and steps must be taken to prevent partners working to different (and potentially conflicting) priorities. Disagreements about who pays for which aspects of care can undermine patient well-being. Partners must have a shared understanding of their required contribution to avoid disputes over 'cost-shunting' (see next section on finance).

5.25 Health and wellbeing boards will develop a high-level joint health and wellbeing strategy that spans the NHS, social care, public health, and could potentially consider wider health determinants. The values underpinning a good strategy, taken from paragraph 5.7 of the Draft Guidance[28], are set below.

[27] DH: National evaluation of Department of Health's integrated care pilots http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_133124

[28] Draft guidance on joint health and wellbeing strategies http://healthandcare.dh.gov.uk/draft-guidance/

Box 5: Values that underpin good joint health and wellbeing strategies

The values are:

- setting shared priorities based on evidence of greatest need
- setting out a clear rationale for the locally agreed priorities and also what that means for the other needs identified in JSNAs and how they will be handled with an outcomes focus
- not trying to solve everything, but taking a strategic overview on how to address the key issues identified in JSNAs, including tackling the worst inequalities,
- concentrate on an achievable amount – prioritisation is difficult but important to maximise resources and focus on issues where the greatest outcomes can be achieved
- addressing issues through joint working across local the local system and also describing what individual services will do to tackle priorities
- supporting increased choice and control by people who use services with independence, prevention and integration at the heart of such support.

5.26 We recommend health and social care professionals work more closely together to both improve outcomes and reduce the costs of care for people whose needs cut across both sectors. Health and Wellbeing Boards need to take the initiative to increase joint commissioning between of local authority and CCG - to better coordinated care which promotes independence and avoids costly hospital admissions. Joint Health and Wellbeing strategies need to be focused on affecting real change rather than explaining what already exists.

Finance

5.27 The figures for the reduction in acute services are optimistic unless there is substantial investment in primary/community care.

5.28 In section 6.3 'Recurrent investment to transform out of hospital services' (Chapter 6 - Financial base Case – version 4) it says 'Based on 3 year planning assumptions regarding the overall scale of the change, investment of around £105-£120 million has been allocated.' [*However, in the accompanying picture the figures used are £84m + £54m contingency = £138m.*]

5.29 Then the document goes on to say, 'The £80-£90 million [*presumably the £84m figure*] relates to the transitional funding that each CCG has identified that they need. The £25-30m other investment relates to costs to support delivers of Out of Hospital standards, inducing increased primary care access, care planning, IT etc. This £25-30m figure is based on the sum of all the CCG plans.

5.30 The CCGs have estimated the additional investment required in Out of Hospital care to meet the new Quality Standards agreed by local clinicians. These are based on 'high level assumptions'. Additionally some of the investment planned will overlap with existing CCG investment.

5.31 The investment in Out of Hospital care to meet Quality Standards is planned as £25-£30 million, split across the standard domains as follows:

- Access, convenience and responsiveness ~ £12-15 million
- Care planning and multidisciplinary care ~ £10-£12 million
- Individual empowerment ~ £1 million
- Information and communication ~ £2 million'

5.32 It is unclear whether the sums to be provided will be adequate to address all aspects of implementation, allowing for unforeseen circumstances, and possible areas of additional expenditure. Under-funding of the proposals could serve to seriously undermine NHS NWL's aspirations.

5.33 We recommend that the NHS ensures that 'the money follows the patient' and resources are reallocated from acute trusts to primary and social care to reflect changes in the way that patients are treated.

Social Care

5.34 The plans will have a major impact on social care. NHS NWL should have quantified the impact on social care.

5.35 North West London Health Scrutiny Chairs and support officers met with NHS NWL on 29 February. A Tri-borough officer categorically stated to Dr Anne Rainsberry (now Regional Director [London], NHS Commissioning Board) that the financial modelling should be for health and social care because only then would the impact on social care be quantified.

Question: (1) What is the financial impact of NHS NWL's proposals on social care? If not quantified, why not? How have NHS NWL factored in any increased burden on social care? (e.g. paying for the additional costs be put upon local authorities)? How does NWL NHS know this level of funding is appropriate? What level of social care do NHS NWL require to make their plans work? (2) Underfunding in social care could

lead to costs being shunted to the NHS in NWL, has this been quantified?

5.36 We recommend that the proposals for NWL's health services, fully quantify the impact on social care services. The NHS need to ensure that local authorities are funded for any increased demands for social care services following on from the proposed reductions in hospital treatment.

Other out of hospital comments

Access to Primary Care Services

5.37 The Royal College of Physicians has called for 'access to primary care to be improved so patients can see their GP out of hours, relieving pressure on A&E services'.[29] The General Medical Council has reported a record number of complaints about doctors.[30] We recommend the improvement of access for residents at GPs and other local primary care services - to a high quality. Patients need to be able to be seen more quickly at a time convenient to them.[31] All health professionals promote patient-centred care and treat all patients with dignity at all times.

Carers

5.38 Greater health and social care in the community will place additional demands on unpaid carers. We recommend NHS NWL analyse the impact of their proposals on carers, and state the actions that they will take to ensure their proposals do not increase the burden on this often 'hidden army' of dedicated individuals.

Workforce

5.39 The major changes proposed will require professionals to acquire new skills and work differently; notably many current hospital nurses could be required to transfer to the community setting. We recommend NHS NWL publish a

[29] The RCP report on 'Acute hospital care could be on the brink of collapse' (13 September 12) is available at: http://www.rcplondon.ac.uk/press-releases/acute-hospital-care-could-be-brink-collapse-warns-rcp

[30] Independent (18 September 12): Complaints about doctors reach record high http://www.independent.co.uk/life-style/health-and-families/health-news/complaints-about-doctors-reach-record-high-8151975.html

[31] Almost a quarter of Britons would not see a doctor for a complaint because of the hassle of getting an appointment, according to Cancer Research UK. Independent (18 September 12): http://www.independent.co.uk/life-style/health-and-families/health-news/public-putting-off-visiting-gps-8151973.html

workforce strategy that will enable the delivery of the proposed changes to the health and social care services. Resources for workforce development must not be diverted in these times of financial difficulty. We suggest flexible working arrangements are explored, allowing opportunities for staff rotation within, and between, networks.

Planning longer-term care pathways

5.40 Adult Social Care need to be engaged fully in developing plans for a seamless care pathways, following front-end clinical treatment. We recommend there is early involvement of hospital social work teams in planning longer-term care pathways.

6. FUTURE WORK

Timing of delivery

6.1 A number of questions were raised on 11 September about the timing of the delivery of the proposals. Dr Susan LaBrooy, Medical Director, Shaping a healthier future programme, told us that delivery would be 'over the next 5 years'. The implementation plan suggests changes to acute provision could 'be completed in full by March 2016'. We seek clarity on the timings of the delivery of the different parts of NHS NWL planned actions.

6.2 The timetable for implementation of the proposals is a challenging one. It will be critically important to ensure that the transition period is managed well, and that the service to patients does not suffer.

6.3 The plan for NWL includes specialists, acute hospitals, community health services, mental health and prevention of ill-health. It is a master plan that encompasses everything. 'Big bang' reform can be risky, and 'teething problems' with new health services could have fatal consequences. We recommend that a staged approach is undertaken to implementing new care pathways. Results must be evaluated with learning fed into any subsequent roll-out.

6.4 The scope 'for change' to be built into the plans was raised when Cllr Louis Mosley asked about the possibility, or not, of phasing in the delivery (e.g. changing proposals depending on the early successes/failures).

6.5 A detailed action plan will need to be drawn up which sets out measures to ensure the new networks are achieved. The action plan will need to include contingency provisions covering steps that would need to be taken if arrangements fail.

Financing the change over

6.6 We have not heard whether additional 'pump-priming' resources will be available to run the existing services at the same time as pilot pathways are developed and tested. The new services that support patients need to be in place and operating effectively before any changes or closures of existing units are made.

Monitoring and Evaluation

6.7 The consultation proposals are far-reaching in reshaping services in North West London, and there is clearly a need for their implementation to be carefully scrutinised.

6.8 We recommend that NHS NWL ensures there are robust arrangements for data collection and analysis in place by December 2012.That the proposed changes are monitored closely, in order to identify the impact on service provision, health outcomes, patient experience, and to ensure that other services provided have not experienced an adverse impact. We would expect a review report on the findings to be published 12 months after implementation.

7. CONCLUSION

7.1 In conclusion, we support the clinical case for change and the direction of travel towards improved out of hospital care. For NHS NWL to be able to deliver its plans they have to get the out of hospital part right.

7.2 **We support the preferred option - Option A.** The Chelsea and Westminster Foundation Trust has a modern hospital building which achieves excellent clinical outcomes on the Fulham Road. It should continue to provide a full Accident and Emergency Service.

7.3 However, there are a number of concerns for which we seek reassurance:

- That all NHS and Foundation Trusts in NWL post-implementation of the proposals are financially robust.
- That the new system will have sufficient capacity to provide services to what is likely to be a growing and ageing population. This relates to reduction in bed numbers especially but also to out of hospital provision.
- We would like external reassurance that Chelsea and Westminster and St Mary's have the capacity to meet increased demand from A&E closures at other hospitals
- If the A&E Department was to close at Charing Cross we wish to be reassured that there are satisfactory plans for the future use of the Charing Cross site and relocation of specialties currently interdependent with the A&E Service.
- We are concerned at the poor quality of buildings at St Mary's so we would like to see the detail on the plans to build capacity there
- That there were robust plans in place to stop bed blocking and delayed discharge. It is recognised that the Council needs to contribute towards this.
- That the out of hospital recommendations (as set out in section 5) are addressed by NHS NWL. We really want the out of hospital part of NHS NWL's plans to be successful.
- On the timings for the delivery of the programme. What are the triggers for making changes to the plans if things are not working out as expected?

7.4 Our experience of the consultation process delivered by NHS NWL has been a positive one. We wish to be kept informed throughout the delivery of the 'Shaping a Healthier Future in North West London' programme and given an early indication if plans did not progress as hoped.

Councillor Fiona Buxton Cabinet Member for Adult Social Care, Public Health and Environmental Health *Royal Borough of Kensington and Chelsea*	**Councillor Mary Weale** Chairman, Health, Environmental Health and Adult Social Care Scrutiny Committee *Royal Borough of Kensington and Chelsea*

This page is intentionally left blank

PAPER NO. 12-554

WANDSWORTH BOROUGH COUNCIL

ADULT CARE AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE – 12TH SEPTEMBER 2012

Report by the Director of Adult Social Services on the consultation on *Shaping a Healthier Future*, proposals for the reconfiguration of acute health care services in North West London

SUMMARY

The Clinical Commissioning Groups for North West London have issued a consultation document*, Shaping a Healthier Future*, on proposals for a reconfiguration of acute services in North West London. This bears many similarities to the parallel *Better Services, Better Value* proposals for the reconfiguration of acute services in South West London. The significance of *Shaping a Healthier Future* for Wandsworth is that 10-20% of Wandsworth residents using acute hospital services do so at the Chelsea and Westminster Hospital. Changes to acute services in North West London may also result in a flow of patients into hospitals in South West London. Whilst the preferred option put forward for consultation avoids these risks, the second option involves the downgrading of the Chelsea and Westminster Hospital to a 'local hospital', which would both remove a range of services popular with Wandsworth residents and would have a knock-on impact on St George's Hospital. The third option considered would involve a similar downgrading of the West Middlesex Hospital. Whilst this would not have a significant direct impact on Wandsworth residents, it would result in a significant additional flow of patients to Kingston Hospital, which is used by a large number of Wandsworth residents, particularly from the west of the Borough. It is doubtful whether Kingston Hospital would have the capacity to cope with this additional demand.

A Joint Overview and Scrutiny Committee, on which Wandsworth is represented, has been established to evaluate and respond to consultation on the overall proposals being put forward under *Shaping a Healthier Future.* The response to consultation proposed in this report focusses specifically upon the impact of the proposals on Wandsworth residents. Accordingly, it is supportive of the preferred option and draws attention to the potentially adverse impact on Wandsworth residents of the two alternatives presented.

1. **Recommendations.** The Adult Care and Health Overview and Scrutiny Committee are recommended to agree the proposed response to consultation on *Shaping a Healthier Future* set out in Paragraph 14 below.

2. If the Overview and Scrutiny Committee approve any views, comments or additional recommendations on the report, these will be submitted to the Executive or to the relevant NHS body as appropriate for their consideration.

3. **Introduction.** On 2nd July the eight clinical commissioning groups covering North West London published a consultation document, *Shaping a Healthier Future,* setting out proposals for reconfiguration of acute services in their area. The summary of the consultation document is attached as the Appendix to this report. The deadline for responses to consultation is 8th October 2012.

4. **Proposals for consultation.** The rationale and the nature of proposals for service change is very similar to that being advanced through the *Better Services, Better Value* proposals covering South West London, with the case for change being both clinical and financial. The clinical case is that for certain critical functions of acute hospitals – accident and emergency, maternity and paediatric services – better outcomes are achieved with a high level of consultant cover at all times, including weekends. A reduction in the number of units is required if this is to be achieved. At the same time, there are activities currently undertaken in hospitals for which better outcomes and user experience could be achieved in primary care. The financial case for change is that the number of major hospitals in the area will become increasingly unaffordable, given the financial stringency facing the NHS, and that if planned action is not taken to rationalise services there will be a series of forced cuts which will be much more harmful.

5. The proposed model involves an overall shift of care out of hospital, with primary care being strengthened through additional investment and networking of GP services. Acute hospitals will be divided into two categories:

   (a) local hospitals will provide urgent care centres, outpatient and diagnostic services, specialist clinics and rehabilitation services. Queen Mary's Hospital, Roehampton, is cited as an example of a local hospital;

   (b) major hospitals will provide all of the above and will additionally offer accident and emergency services and trauma care, emergency surgery and intensive care, obstetrics and midwifery, and inpatient paediatrics.

6. In addition, it is proposed that there should be at least one elective care centre undertaking planned elective surgery. There are also some specialist hospitals in North West London, such as the Royal Brompton, the Royal Marsden and Harefield Hospital. These hospitals are largely unaffected by the proposals.

7. Of the nine hospitals in North West London, it is proposed that five will become major hospitals, three will be local hospital, and the Hammersmith Hospital, which is currently a general acute hospital with some specialist services, will become a specialist hospital. Under the various options, either one or two of the local hospitals will also provide an elective care centre.

8. It may be noted that the scale of change is much greater than that proposed in South West London, involving the closure of four accident and emergency departments rather than just one. However, the current level of acute hospital provision in North West London is much greater than in South West London: 1.76 acute hospital beds per 1,000 population, compared to 1.34. Even after the implementation of the changes, North West London will have one accident and emergency department per 395,000 population, compared with the one per 469,000 population proposed for South West London. The *Shaping a Healthier Future* proposals involve a commitment of £120 million to strengthen primary and community care services; the *Better Services, Better Value* proposals for South

west London do not make a similar commitment to investment in primary and community care.

9. *Shaping a Healthier Future* presents three possible options for the configuration of acute hospitals:

   (a) *Option A*, the preferred option, identifies St Mary's Hospital, the Chelsea and Westminster Hospital, the West Middlesex Hospital, Northwick Park Hospital and Hillingdon Hospital as major hospitals. Hammersmith Hospital would become a specialist hospital, and Charing Cross Hospital and Ealing Hospital would become local hospitals. The Central Middlesex Hospital would become both a local hospital and an elective care centre;

   (b) Under *Option B* the major hospitals would be St. Mary's Hospital, Charing Cross Hospital, the West Middlesex Hospital, Northwick Park Hospital and Hillingdon Hospital. Hammersmith Hospital would become a specialist hospital, and the Chelsea and Westminster Hospital and Ealing Hospital would become local hospitals. As under Option A, the Central Middlesex Hospital would become both a local hospital and an elective care centre;

   (c) Under *Option C* the major hospitals would be St Mary's Hospital, the Chelsea and Westminster Hospital, Ealing Hospital, Northwick Park Hospital and Hillingdon Hospital. Hammersmith Hospital would become a specialist hospital and Charing Cross Hospital would become a local hospital. Both the Central Middlesex Hospital and West Middlesex Hospital would become local hospitals with co-located elective care centres.

10. **Responding to consultation.** A Joint Overview and Scrutiny Committee has been established to respond to consultation on *Shaping a Healthier Future.* Wandsworth Council has been invited to join this Committee, in view of the significant number of Wandsworth residents using hospital services within North West London and has nominated CllrMrs Usher and Cllr Mrs McDermott as its representatives. Whilst the Joint Overview and Scrutiny Committee and the Overview and Scrutiny Committees within North West London will doubtless wish to take a view on the overall plans set out in *Shaping a Healthier Future*, the present paper focuses specifically upon the implications for Wandsworth residents. In practice, this means a focus on changes proposed for the hospitals used by Wandsworth residents and the possible interactions between the proposals in *Shaping a Healthier Future* and those in *Better Services, Better Value.*

11. **Use of North West London hospitals by Wandsworth residents.** Overall, in 2010/11, 16.1 % of elective day case activity for Wandsworth residents, 17.8% of elective inpatient activity, 22.6% of non-elective inpatient activity, and 14.8% of outpatient activity takes place in hospitals in North West London. In addition, in 2009/10, there were over 19,000 attendances at accident and emergency departments in North West London by Wandsworth residents. The following table breaks this data down to specific hospitals.

TABLE: PROPORTION OF WANDSWORTH RESIDENTS USING DIFFERENT HOSPITALS IN NORTH WEST LONDON IN 2010/11

Hospital	Elective day cases		Elective inpatient cases		Non-elective inpatient cases		Outpatient attendances		Accident and emergency attendances [1]
	No.	%	No.	%	No.	%	No.	%	No.
Chelsea and Westminster	2,278	11.1	822	12.1	8,078	19.6	49,606	12.3	15,111
Charing Cross	508	2.5	203	3.0	806	2.0	5,697	1.4	3,260
Hammersmith	251	1.2	75	1.1	194	0.5	1,635	0.4	
St Mary's	152	0.7	83	1.2	131	0.3	1,940	0.5	
Other NW London Hospitals	95	0.5	26	0.4	129	0.3	938	0.2	698
Total NW London	**3,284**	**16.1**	**1,209**	**17.8**	**9,338**	**22.6**	**59,816**	**14.8**	**19,069**

Note
1. Accident and emergency data is for 2009/10 and is recorded at Trust level, rather than for specific hospitals

12. It will be seen that the Chelsea and Westminster is by far the most significant hospital for Wandsworth residents, being used by over 10% of Wandsworth residents attending hospital for elective procedures, and almost 20% of those attending for non-elective treatment. Charing Cross is the next most used hospital, but accounts for no more than 2-3% of the acute care for Wandsworth residents.

13. **Displacement of activity.** An alternative way of considering the potential impact of changes to acute services in North West London is to review the way in which activity would be displaced if hospitals presently categorised as acute were recategorised as local hospitals. Calculations of potential displacement are included in the pre-consultation business case which was published alongside the *Shaping a Healthier Future* consultation document. It is noted that a closure of services at two hospitals within North West London would be likely to result in a significant displacement of services to hospitals in South West London. One of these is the Chelsea and Westminster Hospital, from which 8% of activity would be displaced to St George's Hospital. A further 19% of activity from any service closed at the Chelsea and Westminster would be displaced to St Thomas's Hospital, which would include a high proportion of the hospital's usage by Battersea residents. The other hospital from which a loss of services would have a potentially significant impact on South West London is the West Middlesex Hospital. Although usage of the West Middlesex Hospital by Wandsworth residents is minimal, it is a major provider of acute care for Richmond residents and it is estimated that 21% of the activity displaced by the closure of services at this hospital would present at Kingston Hospital. Kingston Hospital is one of the hospitals most used by Wandsworth residents, especially those living in the west of the Borough.

14. **Proposed consultation response.** Taking into account the analysis presented above, it is proposed that the Overview and Scrutiny Committee should respond to consultation on *Shaping a Healthier Future* as follows:

(a) *Option A* does not appear to have any significant adverse impact on Wandsworth residents. Accordingly, the Overview and Scrutiny Committee has no objection to the implementation of this option, if it is judged by the clinical commissioning groups for North West London to be in the interests of North West London residents;

(b) *Option B* would involve the loss of accident and emergency and maternity services, and of non-elective surgery at the Chelsea and Westminster Hospital. All of these services are used by a significant proportion of Wandsworth residents, and their loss would remove an option that many Wandsworth residents value. The displacement of activity to St George's Hospital would impose further pressure at St George's Hospital at a time when it will be expected to accommodate increased demands arising from the reconfiguration of services under the *Better Services, Better Value* proposals. The additional capacity proposed under *Better Services, Better Value* would be insufficient to cope with the extra flow of patients away from the Chelsea and Westminster Hospital. The Overview and Scrutiny Committee therefore opposes this option;

(c) Option C would result in a substantial shift of patients away from the West Middlesex Hospital to Kingston Hospital. As Kingston Hospital is likely also to be facing additional demands arising from the reconfiguration of services under *Better Services, Better Value,* there may be questions as to whether it would have the capacity to cope with this additional influx of patients. The Overview and Scrutiny Committee therefore cautions against adoption of this option and, if it is pursued, requests that detailed consideration is given to ensuring that the additional capacity required at Kingston Hospital is made available.

15. **Conclusion.***Shaping a Healthier Future* sets out proposals for acute healthcare services in North West London that bear many similarities to those being advanced through the *Better Services, Better Value* proposals in South West London. Its significance for Wandsworth residents lies in the fact that 10-20% of Wandsworth residents receiving hospital treatment do so in hospitals in North West London – principally the Chelsea and Westminster Hospital. There is also a risk that proposals from *Shaping a Healthier Future* may have an adverse impact on the proposed service model being put forward through *Better Services, Better Value.* A review of the options put forward under Shaping a Healthier Future suggests that the preferred option will not have any significant impact on Wandsworth residents or across South West London. However, the second option considered, which involves down-grading of the Chelsea and Westminster Hospital to a local hospital, would remove a range of services that are used by a significant proportion of Wandsworth residents and would result on additional demands on St George's Hospital at a time when it will be struggling to increase its capacity to meet the demands arising from *Better Services, Better Value.* The third option, under which the West Middlesex Hospital would become a local hospital and elective care centre, would not directly affect Wandsworth residents. However, the additional patient flow to the Kingston Hospital could exacerbate the challenges arising from the *Better Services, Better Value* reconfiguration, and it is unclear whether the hospital would have sufficient capacity to cope with the combined impact. For this reason, the recommended response from the Overview and Scrutiny Committee favours the preferred option and highlights the potential difficulties for Wandsworth residents entailed in the two other options on which consultation is taking place.

Town Hall
Wandsworth SW18 2PU

DAWN WARWICK
Director of Adult Social Services

4th September 2012

Background papers

The following background papers were considered in the preparation of this report:

Letter dated 27th April 2012 from Chief Executive of NHS North West London

Available from Dr. Richard Wiles (020 8871 6020) (rwiles@wandsworth.gov.uk)

All reports to the Overview and Scrutiny Committees, regulatory or other committees, the Executive and the full Council can be viewed on the Council's website (http://www.wandsworth.gov.uk/moderngov/uuCoverPage.asp?bcr=1) unless the report was published before May 2001, in which case the committee secretary jrichardson@wandsworth.gov.uk (020-8871-6022) can supply it, if required.

Westminster City Council

Westminster City Hall
64 Victoria Street
London SW1E 6QP

020 7641 6000
westminster.gov.uk

City of Westminster

COUNCILLOR SARAH RICHARDSON
Chairman, Adult Services and Health Policy & Scrutiny Committee

Direct line: (020) 7641 2636
Fax No: (020) 7641 3156
e-mail: srichardson2@westminster.gov.uk

Scrutiny Officer:
Mark Ewbank
Direct line: (020) 7641 2636
e-mail: mewbank@westminster.gov.uk

Dr Mark Spencer
Medical Director
NHS North West London
Southside
105 Victoria Street,
London SW1E 6QT

31st July 2012

Dear Dr Spencer,

'Shaping a healthier future' consultation

I am writing to you on behalf of the Adult Services and Health Policy & Scrutiny Committee at Westminster City Council.

We understand that the reconfiguration of hospital services in North West London aims to deliver the best possible healthcare to patients and the public given that health needs are changing. There are a number of challenges facing the health service including population change, clinical change (not being able to get to see GPs and higher than average A&E attendances), issues with the quality of estates and financial challenges. As such, we realise that a reconfiguration of this magnitude is necessary in order to meet these emerging serious challenges.

We would like to put on record our endorsement, in principle, of the clinicians' preferred recommendation of a reconfiguration of hospitals in North West London. The preferred option includes retaining, supporting and developing major hospital sites at St Mary's Hospital, Chelsea and Westminster Hospital, West Middlesex Hospital, Northwick Park and Hillingdon Hospital. Our Scrutiny Committee has visited the first two sites which are most frequently used by Westminster residents. We consider it exceptionally important that major services are easily accessible, continually staffed and available 24/7 for residents and visitors to Central London. We recognise the fundamental importance of two world class hospitals such as St Mary's and Chelsea and Westminster providing these acute services.

We will be responding to the consultation with a full reply, including an assessment of the move of Western Eye Hospital, before the end of the consultation period. However, we appreciate that these changes, if implemented, would mean a reduction in some acute services within one of our neighbouring, partner Boroughs. As such we would appreciate assurances that NHS NWL and Imperial will cooperate fully with our neighbouring Borough to mitigate the potential disruption that these changes may create.

Our endorsement is conditional on a number of key requirements for NHS North West London to satisfy, including:

- improving access for Westminster residents at GPs and other local services so patients can be seen more quickly and at a time that is convenient to them;
- delivering co-ordinated care plans for people, preventing deterioration in health and reducing admissions to hospital, alongside encouraging the improvement of discharge processes at acute facilities;
- reducing complications and poor outcomes for people with long-term conditions by providing more specialist services in the community.
- supporting more people to take control of their own health conditions;
- helping carers to support those with health and social care needs;
- sharing information across healthcare providers, in order to reduce errors and avoid patients having to give the same information many times;

We look forward to further engagement with NHS North West London as the consultation continues. We also remain committed to ongoing scrutiny to ensure that our residents and visitors will continue to receive health services of the highest quality if approval is given to implement this fundamental shift in healthcare provision.

Yours sincerely,

Sarah Richardson

Cllr Sarah Richardson
Chairman, Adult Services and Health Policy & Scrutiny Committee

cc: **Cllr Rachael Robathan**, Cabinet Member for Adults,
Cllr Dr Sheila D'Souza, Deputy Cabinet Member for Health
Sir Richard Sykes, Chair, Imperial College Healthcare NHS Trust
Mark Davies, Chief Executive, Imperial College Healthcare NHS Trust
Professor Sir Christopher Edwards,
Chairman, Chelsea & Westminster Hospital NHS Foundation Trust
Dr Mike Anderson,
Acting Chief Executive & Medical Director, Chelsea & Westminster Hospital NHS FT
Jeff Zitron, Chair, NHS North West London
Dr Anne Rainsberry, Chief Executive, NHS North West London
Dr Ruth O'Hare, Central London Clinical Commissioning Group
Dr Naomi Katz, West London Clinical Commissioning Group

City of Westminster

JOSC Representatives Views:

- Westminster residents currently use St Mary's Hospital, Chelsea and Westminster, St Thomas' and University College Hospital. Site visits have been made to all four and other local hospitals by the Adult Services & Health Policy & Scrutiny Committee who visited A&E, maternity and Paediatric facilities and asked about present capacity issues and scope/plans for expansion.

- The clinically recommended and preferred option works for residents and the million visitors and commuters who come into Westminster daily. We intend to hold Public Meeting to address the issues directly with NHS NWL on Monday 1st October.

- We note that proposals are clinically led. Expert witnesses at JHOSC repeatedly said that "business as usual" was not an option. One quoted an estimated 520 excess deaths each year due to inadequate staffing of what should be 24/7 emergency services at the current nine Major hospitals in NWL.

- We note that for the Acute Reconfiguration to go ahead from 2015, it is pivotal that Primary Care is transformed for the better, the CCGs' Out of Hospital Strategies are delivered, and quality of care improved vastly through better integration of health and social care across primary, community and acute sectors over the next 3 years. We believe that local authority Health and Wellbeing Boards and Health Scrutiny Committees will have important roles to play in leading and monitoring this at local level.

- There is a major need for us to **educate** the public about how best to use the reformed health services.

- There is a potential issue in relation to Workforce strategy which needs further detailed consideration, since out of hospital services need to be built up perhaps before surplus staff are released from the Acute sector for re-deployment

- There must be **absolute guarantees** that capital is available so that major estate and infrastructure issues at St Mary's are addressed in time to accommodate the extra service and capacity requirements to provide specialist health services in the 21st century.

- We note longer journey times to transport emergency cases to 5 instead of 9 sites. Essential that local ambulance service gets the additional crews and vehicles it needs

This page is intentionally left blank