London Borough of Hammersmith & Fulham

# Joint Health Overview & Scrutiny Committee

## Agenda

**Monday 1 October 2012**
**4.00 pm**
**Courtyard Room**

The meeting on 26 September 2012 was adjourned at 2pm and is scheduled to reconvene at Hammersmith and Fulham at 4pm on Monday 1 October 2012.

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Date Issued: 27 September 2012

# 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 |
| Vaughan | LB Hammersmith and Fulham |
| Usher | LB Wandsworth |
| Weale | Royal Borough of Kensington and Chelsea |
| Williams | Royal Borough of Kensington and Chelsea |

**For further information contact:** Andrew Davies, Policy and Performance Officer
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## 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**

- 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**

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# 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 .....

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# 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

# North West London Joint Health Overview and Scrutiny Committee- Draft Report

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

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

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**The press and public are welcome to attend this meeting**

# Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members.

| Item | | Page |
|---|---|---|
| 6 | **Consideration of Joint Health Overview and Scrutiny Committee Draft Report** | 1 - 26 |

Draft report to follow.

**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.
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**Draft NHS North West London Joint Overview and Scrutiny Committee - Formal Consultation Response to "Shaping a Healthier Future"**

**Preface by Chair and Vice Chair [Members to note this will be included after the meeting on 26 September]**

**Contents [To be included]**

## 1 Introduction and Background

This report summarises the outcome of the work of the North West London Joint Overview and Scrutiny Committee (JHOSC) in respect of the proposals set out by NHS NW London in the formal consultation document "*Shaping a Healthier Future".*

The JHOSC was established in shadow form during the pre-consultation period and comprises of elected members drawn from the boroughs geographically covered by the NHS NW London proposals. The list of members and co-opted members are at Appendix 1.

We formally adopted the following terms of reference:

- *To consider the 'Shaping a Healthier Future" consultation arrangements - including the formulation of options for change, and whether the formal consultation process is inclusive and comprehensive*
- *To consider and respond to proposals set out in the 'Shaping a Healthier Future" consultation with reference to any related impact and risk assessments or other documents issued by or on behalf of NHS North West London in connection with the consultation.*

During the formal consultation period between 2 July and 8 October 2012 we met in public on five occasions at different locations across North West London, taking evidence in person from a range of witnesses, listed in Appendix 2, and considering witness statements set out at Appendix 3. We would like to thank all them for taking the time and effort to help with the scrutiny process and to inform the conclusions we have reached. We have also appreciated the effort made by NHS NW London to communicate complex information to JHOSC members during both the pre-consultation and formal consultation periods.

Emergency care, maternity and paediatric services are all especially emotive issues for the public and have a strong local resonance. As a JHOSC we have always looked at the proposals for redesign and relocation of services objectively, from the perspective for North West London as a whole, respecting the responsibility of Borough OSCs and individual local authorities to give voice to more local views. We have been careful not to act as a rallying point for opponents or supporters of particular elements of the proposals.

## 2 Summary and Overall Comments

The JHOSC welcomes the opportunity to comment on the Consultation document "Shaping a Healthier Future".

We believe a strong case has been made by NHS North West London for the need for change and for difficult decisions to be made. We accept that "do nothing" is not an option and it is in everyone's interests to ensure that there is a sustainable service platform across North West London.

We are however not convinced that the specific proposals presented by NHS NW London are supported in their current form, without further clarification on significant issues. There are several primary reasons for these are:

- Key elements of the plans remain opaque;
- Information on the future shape of services for patients is absent;
- Measurable outcomes for the proposals are underdeveloped;
- Impact on local populations and groups with protected characteristics have not been developed in sufficient detail;
- Key risks have either been underestimated or mitigations not identified or shared;
- The proposals have been driven by a desire to move care out of tariff;
- The consultation process has not been fit for purpose.

In addition there are a number of secondary reasons

- There is insufficient evidence of ownership by key partners and by staff;
- Critical workforce issues have been underappreciated;
- There is insufficient evidence of alignment across health and social care system.

Our view, leaving aside comments on the specific proposals, has been that the ultimate critical test is whether NHS NW London has truly managed to create confidence and trust in both the process and the content of its proposals. We do not believe that this test has been passed at this point in time.

We have identified a number of recommendations throughout the report, which we believe will strengthen the proposals and address concerns we have identified. These are highlighted in bold at the end of each section. These have been gathered together in Section 4 for ease of reference.

## 3 Main Themes

### 3.1 Case for Change

Overall

We welcome the setting out of the case for change and the clarification of the underlying principles for change to emergency and urgent care and aspects of maternity and paediatric services. This is much needed. We accept the necessity of addressing long-standing quality and patient safety issues. The problems with quality and performance across sites, services and providers, referenced in "Shaping a Healthier Future", have also been supported in evidence received by the JHOSC. We welcome the focus on addressing these issues across North West London.

We also understand there are a number of important drivers which make change a matter of priority. These are convincingly listed in the extensive paperwork issued by NHS NW London. In particular JHOSC notes

- the increasing onward pressure on public finances

- the relentless increase in people presenting acutely
- the changing pattern of local populations and demographic change
- the potential and impact of new technologies and treatment
- the challenge of implementing and sustaining good performance

We agree with the underlying principles and building blocks which "Shaping a Healthier Future" promotes as the basis for future emergency care provision; namely

- a network of different skills and capabilities which connect the NHS to an integrated health, social care and housing system;
- transparent patient pathways and protocols which ensure patients gain timely access to the right services for their needs
- an appropriate combination of Accident and Emergency and Urgent Care Centres providing 24/7 services
- comprehensive efficient and accessible out of hospital arrangements
- requirement for cost-effective provision and the delivery of better outcomes at lower cost.

The case is made for urgent change to hospital-based emergency care with the underlying implication being that failure to adopt a coordinated proposal (such as Option A) might require emergency action to protect quality and safety. Equally every reassurance is given throughout the proposals that no change to physical capacity and location will actually be made until out of hospital provision is in place, which may take 3 to 5 years. At the same time the proposals also try to provide reassurance that only positive benefits will be felt by the public in terms of quality and safety. There is an underlying sense of both immediate threat and unhelpful manipulation in these arguments which clouds an objective assessment of what might actually be the end result for patients over a realistic timescale.

Integrated Vision

We feel the case for change would be stronger, be better understood and have a greater chance of success if it could be located in a clear and agreed strategy on integrated health, care and housing for North West London. We believe that in this respect the proposals are not radical enough. We feel the model used focuses on a top-down, closed NHS model rather than a more up-to-date approach which values the active engagement of partners, staff and the public in co-designing solutions to complex problems of health, social care and housing.

Impact on Patient Experience

We recognise that the clinical standards in respect of emergency care are seen as being unacceptable in some respects and a key driver for change. But in the consultation documents we see too little recognition of the importance of the associated wider patient experience (customer service, access and convenience for example) as part of the assessment of quality and safely.

It is potentially a strength that the proposals are presented as clinically-led (although in truth this means largely senior clinicians). This should not however overshadow well-established customer intelligence about local services. We believe a simple, balanced and owned means of tracking

forward progress which takes a rounded view of patient experience is important. The JHOSC is willing to provide this if desired.

Option Appraisal

We note the technical process followed to appraise the options and are broadly supportive of the conclusions reached in arriving at the eight options. We feel the criteria used can be seen as fair and have been applied objectively.

We are more concerned about the criteria used to arrive at a recommended option. Here the emphasis in the evaluation moves critically from clinical and impact issues to a much narrower analysis of Net Present Value. This means we are essentially presented with a clinical option appraised and prioritised because of specific financial considerations.

Financial Case

We do not see it as our role to examine in forensic detail the financial assumptions presented in support of the proposals. We see it as more constructive to look for independent assurance that the financial information included in the business case is robust, embraces a range of different scenarios and is properly validated.

This reflects our concern that the true financial picture will only be placed in the public domain on the publication of business plans by providers for their service development and site rationalisation plans. These will follow completion of the consultation process. Given the changes to the commissioning landscape this means that financial commitments may be made now which will not be adhered to, possibly for very good reasons, by those making decisions in the future. This is a governance issue of some importance where independent verification on a continuing basis might help to allay any fears and strengthen public accountability. It is not clear where responsibility for this continuing oversight will lie.

Concern has been expressed by some members of JHOSC about the motivation behind the case and whether it is a means of moving a financial burden for care from the NHS balance sheet to other agencies and to the public themselves. This is not explicit in the documentation and is not something we feel able to comment on directly. However we share a worry that the financial position of a number of the NHS Trusts gives legitimate concern that resources may not be available to support either the plan, nor to manage the costs of transition and double-running which might be involved in delivery.

Delivery

It is the view of the JHOSC that there are significant weaknesses in the case when it moves from overall principles and the high-level clinical case (and option appraisal process) to explanation about how the proposals would actually work in practice.

In terms of building confidence that the plans will work in practice we share the view of National Clinical Advisory Team (NCAT) in respect of emergency services that more work must be done on the

- flow of dependency patients in A&Es and then into hospital beds

- the case mix for A&Es and UCCs
- modelling admission rates and lengths of stay.

The absence of this crucial information undermines the credibility of the overall proposals.

We note that the Office of Government Commerce (OGC) recommended that NHS NW London identify the benefits for patients proposed for each Borough together with who owns them and how they will be measured. We believe that the response to this recommendation has been to develop a typology of major hospital and local hospital. This means not enough detail has been provided to establish exactly what will happen to patients borough by borough – something which also undermines confidence in the credibility of the consultation.

We ourselves have received a high level of process responses to questions where factual answers would have been expected. For example, we have requested detail on equalities impact. NHS NW London has responded that further work has been commissioned from an external consultancy, Mott McDonald, which undertook the initial high-level assessment. This work is timed to support the decision-making process and so will report in early 2013, rather than provide information we believe is essential to proper consultation. Equally, in respect of travel and transport, work has focused on transfer of patients by blue-light transport. Much less thought and effort seems to have been spent on the nitty-gritty issues which matter to local populations – the actual implications for friends and family who are visitors or patients or those who need to make regular hospital visits as part of their on-going care.

We have to conclude that there is an underlying problem with preparedness for consultation by NHS NW London on important issues. This has presented them with problems meeting reasonable expectations for plans and data to support the consultation. This has had knock-on effects. As the detailed work has not been completed in some areas NHS NW London have relied on providing high-level reassurances about what might possibly happen in future and process answers, which have proven unconvincing at JHOSC and public meetings.

We feel strongly that more work should have been completed before the consultation process was entered into and that this should have tested with boroughs and the public to ensure it genuinely addressed their concerns.

<u>Non-Emergency and Urgent Care Services</u>

We also believe the impact on mental health services, which are so intertwined with emergency and urgent care, has been underestimated in the work to date. A&Es and UCCs offer an easily accessible entry point for those presenting with the full range of emergency, urgent and less urgent mental health issues. The way complex interconnections between emergency care and mental health will be handled in future have not emerged from the consultation clearly or in sufficient detail.

We also feel that the implications for maternity and paediatric services and those with long-term conditions have been treated as secondary components in the proposals and insufficient information is contained in the evidence available to JHOSC, the public and the staff concerned about what can be expected in future.

<u>Social Care</u>

Reviews of this scale do not happen in isolation. Whilst we understand the constraints, a more holistic approach to service transformation would have been beneficial to residents across all the boroughs and in ensuring that out of hospital care is aligned with hospital reconfiguration. Adult social care needs to be fully engaged in developing plans for seamless care pathways.

On the basis of the above we believe that important component elements relating to services, especially as they impact on specific sites, need further evidence of planning and buy-in from clinical staff in those locations and from the public.

Managing the Transition

We have been struck by the absence of any narrative about how the transition between the current system and the new system will be managed. We cover risk issues arising from this elsewhere but we were not reassured that quality and safety issues have been thought through and sufficiently planned for the transition period.

**We Recommend**

**That NHS NW London demonstrates how flow through the system will be optimised through the whole system and be truly patient centred.**

**That work on integration is co-designed with organisational partners, professional groups and the public to ensure that there is a proper consideration of the breadth and complexity of issues affecting those with long-term conditions and the necessary financial flows this ensuring that the money follows the patient from acute settings to primary and social care.**

**That NHS NW London undertakes a quantitative and qualitative assessment of current patient outcomes and experience in the services covered by Shaping a Healthier Future is undertaken by December 2012, in a form to be agreed with patient groups.**

**That work is brought forward which shows that the financial consequences arising from the both the hospital and out of hospital plans have been considered across the public and third sector, as well as within the NHS system, and that commitment to the necessary funds has been secured against tight financial settlements.**

**That measurable quality improvement metrics should be developed to establish what could be expected from the proposals and to allow progress to be monitored by the public and by Health and Well-being Boards should the proposals be approved.**

**That NHS NW London provides public reassurance that its formal audit processes include validation of the work of the external consultants used to provide the core financial modelling for the proposals**

### 4.2 Impact on Care

Central to the proposals is the distinction between an Accident and Emergency Department (A&E) and an Urgent Care Centre (UCC). The concept of a network of different skilled professionals working across different facilities tailored to meet levels of care is sensible and logical. We accept that the number of A&Es could be reduced within the context of an effective network, provided there was sufficient evidence this would provide safe, accessible, appropriate care. We welcome the clarification, in evidence from the College of Emergency Medicine, that "in a circumscribed geographical area, of high population numbers, and good road links such as North West London, the optimal number and configuration of Emergency Departments may be fewer than currently is the case".

All the evidence we received supports the aim of making full and better use of a range of health professionals through well-organised 24/7 provision of emergency care.

Our first set of concerns is about the lack of convincing information about exactly how the network will work. We have pressed, as others (including NCAT) have, for evidence that the patient flows and the detailed work on service provision site-by-site have been completed. This needs to be done to instil confidence that the proposals deliver credible, consistent, properly planned services. Our conclusion is that the detailed work is still being developed and that this should have been completed before consultation was entered into.

We appreciate that there is no UK agreed or validated definition of an Urgent Care Centre, nor any agreement about the cases and conditions that may be treated there, and that there are examples of different models across the sub-region. We believe this places even more importance on the local definitions of A&E and UCC provision, which are used in this specific consultation, being clear and as importantly, having demonstrable ownership amongst those critical to front-line delivery.

We have received evidence that there would appear to be significant differences of view between consultants and between consultants and GPs about what would actually be offered in an UCC and how the network and pathways would operate. This goes beyond definitions. Our concerns are about lack of agreement about the numbers and case mix for each facility in the network and about whether the proposed changes will actually reduce hospital attendances or admissions.

We have been disappointed in the lack of clarity in response to our questions on basic detail. We have seen no evidence that

- the patient flows are clear
- staffing requirements have been fully modelled and that these have been tested against different scenarios
- contingencies have been considered should patient flows and population predictions change
- existing hard-pressed physical spaces, such as the emergency provision in Northwick Park Hospital, can absorb higher throughput
- sites which are affected by a "down-sizing" of services remain sustainable, will not suffer reputational loss and are able to function as local hospitals

- clear, local agreements that the plans as described will work and implementation plans detailing resources agreed.

We have not received convincing explanations about the proposed division of A&Es into 'major and standard' and 'minor' facilities, about what constitute 'major' and 'standard' cases and what are the differential outcomes attributed to the UCCs as a result of whether they are attached to an acute facility or stand alone. We have reluctantly to conclude that the models of care, the patient volumes and case-mix and the movement of patients between proposed UCC and A&E facilities still remain unclear.

The absence of core information makes proper evaluation of the proposals difficult. It also makes support for the proposals dependent on confidence that detailed planning will be done AFTER the main decision to proceed is given. We have serious concerns about the being the right way to proceed when what is being proposed might involve an irreversible loss of physical capacity in various important hospital sites. We think it is inappropriate to make support for such serious change essentially an act of faith and trust in future planning processes.

The recommendations of NCAT following their visits in April 2012 emphasised the importance of developing operational, financial and workforce models for A&Es and UCCs and an integrated governance system. We had wanted to see evidence that all parties involved, including the front-line professional staff of all disciplines, GPs and the professional bodies, had a shared confidence that both the principles and the practice were settled. This we believe would have provided a firm basis for going out to public consultation. We have to conclude on the basis of what has been presented to the JHOSC that such agreements do not exist.

NHS Trusts' Wider Plans

We would not expect full business case assessments for each component part of a change programme to be in place at this stage. This would involve unnecessary or excessive costs. But the absence of even summary information from provider trusts about their wider plans, of which the emergency care proposals are clearly an important part, has been a serious and alarming omission from the consultation documents. As a result, for example, we are concerned that the future planning processes and merger plans within North West London might increase costs and complexity, which would significantly alter the assumptions on which the preferred option is presented.

What the proposals mean for each site affected has we believe been underplayed during the process. The focus on emergency care hides deeper changes. For example it has proven impossible for the JHOSC to get a simple, consistent or convincing picture of what local people and staff could expect to see at Charing Cross Hospital as a result of the removal of emergency services and other facilities and services related to them. We have been frustrated by the absence of transparency from key providers, such as Imperial College Healthcare NHS Trust, on their future development plans for sites and services. We are concerned that by treating this as a stand-alone consultation the implications for larger-scale financial and clinical plans, at a time if significant change in the NHS, have been fully factored into the proposals.

Measurement

Significantly more work seems to have been done on the Net Present Value and financial sustainability of the NHS organisations than on the impact of changes for quality and safety, for patient experience and for local populations. There is a lack of measurement and focus on outcomes, in all parts of the process, and important recommendations from external bodies about various metrics have yet to be implemented.

**We recommend**

**That NHS NW London demonstrates the change in flow through the system and what is actually going to happen to patients, borough by borough.**

**That NHS NW London shares in details their proposals for improving the quality of out of hours care and measuring that improvement, given the interdependency of out of hours and urgent care.**

**That NHS NW London provides further information on how urgent care will actually become safer and how safety will be managed during the transition.**

### 4.3 Out of Hospital Care

We appreciate that changes in out of hospital care are seen as pivotal to successful implementation of changes to the hospital service. We fully support the emphasis placed on out of hospital care, but because of its non-inclusion in the consultation, we are unable to comment on whether sufficient levels of investment in resources and relationships have been allocated or will be available when needed.

We believe that much more quantified plans for out of hospital provision, which have the tangible support of delivery partners, of the public and of professional bodies, are needed before there can be confidence that community services will be in a state of readiness to play the part required of them under "Shaping a Healthier Future".

We note that out of hospital proposals have not yet reached a stage where most non-NHS partners across NHS NW London, not least the local councils, seem able to express support, to commit to playing their part in its delivery or to sign up to resource implications. Currently the public agencies lack a compelling joint vision. This is pressing, as it is difficult to imagine how the Health and Well-being Boards will be able to provide assurance to the Department of Health around these proposals if they have not played an active part in their design.

In the context of out of hospital care it is clear that a number of councils are suspicious that there might be significant cost-shifting from NHS budgets to adult social care and housing. In our view this concern needs urgent attention before the emergency care proposals as a whole can be regarded as credible.

We have lacked convincing evidence about the timescale for the further development and implementation of out of hospital proposals. In the absence of locally agreed plans between key agencies and given the lack of staff buy-in at this point, we believe the projected timescale of 3 years has to be treated with caution and might be considered optimistic.

We fully support the view that building capacity amongst primary care clinicians and improving quality – especially out of hours - is critical to the success of the programme and to the maintenance of safe acute services. At present satisfaction levels with access to GP services in North West London are below national averages. This makes building capacity to the right standard, as rapidly as required to make "Shaping a Healthier Future" work, a significant challenge. We are not convinced adequate allowance has been made so far for the effort, time and cost required to skill-up and quality-assure the GPs and local services, given the low baseline in some areas. We believe strongly that acute service reform should only proceed when there has been a thorough independent verification of measurable improvements in the quality of community services, taking into account the views of patients.

There are also number of other critical path issues that we feel should be addressed:

- the extent to which small-scale integrated care pilots can be confidently extrapolated as providing the expectations of capacity placed on them by Shaping a Healthier Future.
- the ability for community services to meet the needs of highly transient populations in some areas;

- the extent to which out of hospital care can actually reduce the relentless increase in unscheduled demand – especially out of hours.

**We recommend**

**That proposals for out of hospital care are developed further, with the direct involvement of non-NHS partners, to arrive at agreed resource models for each borough and that this process reports to relevant Health and Well-being Boards.**

**That Health and Well-being Boards need to strengthen joint commissioning between local authorities and CCGs to deliver better coordinated care which promotes independence and avoids costly hospital admissions.**

**That a clear commitment by all parties that work on improving community services is completed to agreed, measurable standards across North West London in advance of any decisions being taken in respect of "Shaping a Healthier Future"**

**That a joint approach to engagement of both staff and the public in the development and co-design of out-of-hospital services is developed between the shadow Health and Well-being Boards in support of integrated care**

**That an independent assessment is made of the proposed ICP model, the resources needed to make it work and the extent to which housing and social care have been involved across NHS NW London and the confidence that can be placed in the anticipated reduction in emergency admissions.**

**That plans to improve GP performance in NHS NW London are made explicit and the measures and timescales for this improvement to be published as an adjunct to "Shaping a Healthier Future" documents.**

**That urgent work is undertaken as part of wider modelling of patient flows to clarify the scale of the transient population attending A&Es and what provision will be made for them in terms of out of hospital provision**

**That the evidence that out of hospital provision will reduce admissions to acute services is published by NHS NW London**

### 4.4 Travel, Accessibility and Equalities Impact

Travel and Transport

Travel has emerged as a critical issue for people in their engagement with "Shaping a Healthier Future". The impact of proposed changes on patients and on their families has been one of the most commonly raised issues. We share concerns about the specific impact the proposals as they stand, will have on the ability of some local populations in North West London to access services without additional cost or inconvenience.

We are disappointed that NHS NW London did not engage earlier and better with the public about these travel issues, which could have been anticipated. This applies to the most vulnerable groups, where we recognise useful work has been done during the actual consultation period by NHS NW London in focus groups and other forms of discussion, and for the population in general.

Emergency Ambulance Provision – "Blue Lights"

We appreciate the importance of the detailed analysis on blue-light activity and are broadly reassured about that the likely impact of all three options on key emergency ambulance performance will not be detrimental, provided investment is made in the London Ambulance Service – a commitment which NHS NW London has made in JHOSC sessions.

We agree that it made sense for NHS NW London to mirror the way stroke and trauma emergency ambulance activity was modelled successfully in 2011 across London. We are reassured that the modelling work on blue light traffic has been based on extensive analysis of data and has involved the expertise of other agencies appropriately.

We do not fundamentally dispute the underlying assumption that the public might be prepared to be transported to centres which promise better quality and safety in respect of emergency blue light provision. However, equal emphasis needs to be placed on the complex impact of changes on non-urgent transport, where decisions and choices, based on personal circumstances, play a much more critical role in the ability of patients and their relatives to access care.

Non-urgent Transport

It is to be regretted that that the real nuts and bolts of travel for patients, their families and carers for routine and non-urgent emergency care, for other services and for follow-up procedures, has not received the same level of attention, by the NHS and its planning partners, as blue light traffic. There is no intelligence available on the likely number of patients who might use public transport to access major hospital services. It seems to have been only during the actual consultation process that the Travel Advisory Group (TAG), set up by NHS NW London to get to grips with the impact of the proposals, has seriously started to identify and prioritise the implications and begin the process of working through what would be needed to mitigate their impact. However, this has not prevented reassurances being given at the public roadshows by the NHS and in the focus groups for protected groups that action will be taken to manage negative implications. We cannot see how these assurances can be given when Transport for London and other agencies have confirmed in evidence to us that they are not in a position to give guarantees on resources being available in the timescales suggested by the consultation.

Provider Trusts who would have a better picture of local patterns of travel and attendance do not seem to have been willing to play an active enough part in the discussions at TAG. Thus far, no convincing data has been gathered for example on the public usage of public transport, on taxi usage (current and predicted), on the impact of different levels of private car ownership on access. If, for example, Central Middlesex were to become a "cold" site, with current services relocated into a relatively affluent area, the implications for travel will fall disproportionately on more disadvantaged and poorer populations, with lower levels of car ownership. Work on what choices would be made by members of the public and the implications for their access to care as a result have not been undertaken in a way that might have been expected.

If the blue light impact is similar and not detrimental for each option, the way non-urgent transport needs to change becomes more critical to the assessment of the quality of patient experience. We accept that this is not easy territory but more work, involving the public directly, needs to be done urgently.

Equalities Impact

We recognise that NHS North West London commissioned a high level equalities impact assessment from the management consultancy Mott McDonald which indicated that 91% of the local population are likely to be "unaffected". However, this has to be regarded as a high level assessment and masks serious potential variations in the impact on vulnerable populations. We would have liked to have seen a much more detailed analysis before consultation was entered into, so that local people and their elected representatives would have firm information with which to engage during the formal consultation process.

As a consequence we have to register serious concerns about the likely impact on protected groups and vulnerable communities in the absence of any evidence to the contrary. This is a serious issue. More importantly the failure to anticipate and provide the information required so far has been a significant cause of anxiety for those individuals and groups. The situation has not been helped by the widely-reported problems with getting access to printed copies of the consultation document generally and in specific languages.

We received evidence on the positive efforts made by NHS NW London to connect to the protected groups identified in the Mott McDonald assessment. We have not been shown any formal recording of the focus groups nor have the issues identified been shared in any purposeful way with agencies outside the NHS or with JHOSC or OSCs. We have noted comments in analysis by others about whether the requirements of the Equality Act 2012 have been met but believe this is outside our remit to comment on directly.

**We Recommend**

**That an alternative approach to equalities impact assessment is developed as a matter of urgency which meets the criteria of being locally owned, specific to each borough, publicly accountable and involving of other public bodies, local staff, their representatives and the public.**

**That investment is made in permanent capacity within the NHS and its partners to undertake continuing equalities impact assessment of service changes such as Shaping a**

**Healthier Future, instead of further use of external management consultancies.**

### 4.5 Risk Analysis

There are a number of risks which arise from any proposal for complex change – in the development and consultation and decision-making phases, as well as in respect of implementation. It is established as a routine part of sound governance for the Board responsible for development and delivery of proposals to identify key risks, to agree appropriate mitigations and to monitor their impact on a continuing basis.

We have sought information on risk identification and mitigation from NHS NW London and have been unable to identify the "comprehensive and auditable process" for risk management recommended by the Office of Government Commerce. Towards the end of the consultation process we shared with NHS NW London a summary of the risks which emerged from the evidence we had taken. This is included below :

**RISKS IDENTIFIED BY MEMBERS OF NW LONDON JHOSC SCRUTINISING SHAPING A HEALTHIER FUTURE : WORKING**

| Theme | Risk |
|---|---|
| **Case for Change** | The money available in the system reduces and hence there is neither the capital nor the revenue available to implement the plan or that the finances no longer flow in the way envisaged. |
| | Issues raised by NCAT, Expert Clinical Panels and the OGC Health Gateway Review have not been effectively responded to. |
| | Case for change places too much confidence in the evidence of small scale pilots and their replicability and scalability as part of a major change programme. |
| | Local authority or CCG Commissioners are not bought into the plan or behave independently of it. |
| | CCGs do not commission in a way that is consistent with the proposals. |
| | The business cases for the individual components of the plan do not align with the proposed changes and assumptions set out in the plan. |
| **Impact on Acute Care** | Risk to patient quality of moving care to providers who lack the capacity or capability to respond to increased demand. |
| | Clinical education and the speed of implementation of research are compromised as established patterns of provision are disrupted. |
| | As services are transferred it will be difficult to maintain quality in those providers undergoing significant change as capacity or morale may reduce. |
| | Staff who have traditionally worked in hospital settings may choose not to work in the community. |
| **Out of Hospital Care** | Demand for acute services is not reduced and so resources designated for investment in community services are no longer available, |
| | Proposed integration through Health and Well-being Boards of a coherent model of prevention and promotion of mental and physical health and well-being is running parallel to an NHS focused change programme leading to missed opportunities for improved patient experience. |
| | Lack of sufficient capacity and capability across the system while new health and social care architecture is being built compromises the governance, capacity and coherence of greater integration with local government. |
| **Travel and accessibility** | Pattern of informal care is broken as carers or those self-managing long term conditions have to travel further afield to receive care. |
| | Staff do not wish to travel further afield. |
| | Lack of Equalities Impact Assessment that takes into account full range of impacts then impacts negatively on the ability of partners to assess proposals and for those proposals to change accordingly. |
| **Analysing Risks** | Lack of a risk register from NHS NW London compromises ability of partners to work towards shared |

| | |
|---|---|
| | or aligned mitigations. |
| **Underlying Assumptions** | Proposals tie up resource in estate that is no longer fit for purpose rather than in promoting a 21st Century vision of healthcare. |
| | Component parts of the leadership necessary to deliver change programme are not yet in place. |
| | External factors in the wider economy create higher levels of transience or deprivation than anticipated. |
| | Delivery of change programme is restricted by the length of time it takes to for staff to develop new skills and the cultural change programme required. |
| | Change is delayed by active resisted or sabotaged by staff, unions or key professional groupings. |
| | Risk of insufficient external challenge to stress testing and sensitivity analysis my lead to over reliance on NPV and 'group think'. |
| **Consultation process** | Lack of public engagement in an open discussion misses the opportunity to embed the unified approach to health and well-being that is set out in policy and does not build a sustainable platform for further transformational change. |
| | Lack of engagement with the public compromises political deliverability |
| | Failure to engage those response for the delivery of the proposed changes by those leading the change up to March 2013 comprises deliverability. |
| | The public do not appreciate the proposed models of care and hence their behaviours do not change. |

We do not accept the argument used by NHS NW London that it would not be possible nor appropriate to do a full risk analysis on the implementation of the three options prior to the start of consultation, beyond that necessary to understand whether implementation risks were a differentiator between options and the extent that implementation risks might undermine the underlying strategy. There is information in the Business Case looking at the criteria, the capital and the sensitivity analysis, but we have not received any adequate assurance that there are proper processes governing risk analysis and mitigations suitable for a project of this size and complexity.

**We Recommend**

**That the Board of NHS NW London commissions and publishes a full risk analysis for the programme which identifies the mitigations for "Shaping a Healthier Future" during development, transition and implementation.**

### 4.6 Underlying Assumptions

Workforce Issues

Change on this scale needs to focus on the skills, motivation, recruitment and retention of staff. We fully accept that the network depends on having the right staff in the right place, with new working arrangements between consultants, middle grade staff, nurse specialists and GPs. It can be seen as an opportunity to create a genuine network of expertise embracing a wide range of different skills and professional backgrounds. There is no reason to believe such arrangements could be put in place with the involvement of professional and education and training bodies, but we have seen insufficient evidence that this is the case.

Workforce information is included at various places in the documents, including an estimate of impact on certain groups (such as GPs and ambulance staff). There is only really high-level information included in the Business Case. Under Option A it is estimated that 81% of workforce would "not be affected", with 79% under Option B and 81% under Option C. The main consequence identified for affected staff is to move location to provide services either within a neighbouring hospital or within the community. In addition between 750-900 extra staff are identified to deliver planned improvements to care outside hospital.

Workforce Model

We are concerned that this underestimates the likely impact on individual staff. There does not seem to be an overall workforce plan or model from which the figures derive, nor a group responsible and accountable for gaining agreement with professional bodies that the model is sound.

We would echo very strongly the assessment of the NCAT Emergency and Urgent Care Report and maternity and paediatrics report about priority areas on workforce following visits to NHS NW London earlier in 2012. In particular we would support fully its assessment that more work needs to be done on :

- capacity and capability in out of hospital services
- workforce models to support UCCs and A&Es
- involving staff at all levels in leading change
- integrated training strategy for A&Es and UCC multi-professional workforce.

In addition we believe further reassurance is needed that :

- planned changes to workforce – especially nursing – will not impact negatively on patient care
- supply and demand calculations have been made for all groups of staff in relation to acute settings and out of hospital
- staff who have chosen to work in acute settings will transfer happily into the community
- plans for re-tooling existing staff and creating new teams in the emergency care network for new roles are in place, properly costed and included in local plans

- the workforce implications of the transition period have been addressed and that adequate staffing levels can be guaranteed without an overreliance on agency staff.

At present the main mitigation shown around workforce risks is the proposed development of a workforce strategy in September 2012, a date that has already passed.

Staff Engagement

We also want to comment directly on what we see as the lack of engagement with staff and professional bodies and unions. The whole area of staff engagement seems to have been treated as a secondary issue, taken forward in a fragmented way and left to individual NHS Trusts to pursue. From the evidence we received from the Royal College of Nursing it could be concluded that "Shaping a Healthier Future" has, for many staff, been a top-down exercise on which progress has been reported to them, rather than something which they have been able to shape by active involvement. We are aware that many problems can arise with proposals at the implementation stage where the implications for staff are addressed too late and the negative impact of staff's lack of ownership and buy-in makes implementation problematic. There a risk this may now happen here, compounding problems created by lack of wider engagement from the outset with the public.

Leadership

The absence of a professional assessment of fundamental workforce seems in part to do with the way the whole project has been structured. There seems to have been no organising intelligence looking at the workforce issues in the round. Some of the numbers and training issues changes, relating to the implementation of standards, were discussed by the Clinical Board, though it was the Finance group (which includes Finance Directors from all provider Trusts, but not Human Resources or unions) that considered and agreed the workforce data and assumptions in the analysis. The concern has been largely to do with numbers not people.

Pace of change.

It would be wrong not to note concerns that other significant changes to the landscape of accountability and operation in the public sector might also reduce the speed at which changes could be introduced - with new organisations, responsibilities, accountabilities, commissioning and financial arrangements coming into place.

We have heard evidence from clinicians that they have concerns about the pace of change. We are aware that plans for significant change can be sabotaged by questioning the pace of proposals. We are also aware, as one witness put it, that it is easier to steer something that is already moving.

Public education.

We found the evidence provided by the College of Emergency Medicine compelling around the complexity of emergency care. "There is an overlap between the case mix that may be seen in an Emergency Department and those that can be seen in the UCC. Which facility is better for the patient may not be easily defined at the initial assessment for a significant number of patients".

This suggests there is real potential for confusion amongst the public and a danger, as a result, of even reduced speed of access to the right care and treatment arising from the separation of A&E

and UCC facilities. If it is difficult for the professional staff to be clear on where a patient should go how much more difficult will it be for a member of the public at a time of stress?

Serious doubts have to be raised about the reliance of the plans for change on a programme of wholesale re-education of the public about emergency care. In deprived communities there is the potential for language and other barriers to mean that care pathways might not be effectively communicated. The 111 service which is designed to enable people to make informed choices about their care will help in this regard. However, it will be a challenge to enable people to make informed choices within the timeframe available. In our view this adds an additional requirement for convincing evidence that changing the public's understanding is a credible platform for major change in the timescales proposed.

Population

Concerns have been expressed that the NHS NW London proposals are based on old population figures. The 2011 Census indicates significant population increases across the sub-region and there are concerns about under reporting of transient populations. We have received assurances from NHS NW London that planned population growth has been factored in to their proposals. They have also assured us that their plans will be tested against the new Census figures. We believe that it will be important that Public Health (England), through local Directors of Public Health, are involved in the process to ensure that there is a shared view of the impact of population change across the NHS and local authorities.

Resilience

Testing the resilience of the proposals matters, as the changes could have a profound effect on well-established patterns of care and estate. We believe a far too narrow approach to sensitivity analysis has been taken throughout the process. The Business Case information only looks at the implications of different options in terms of calculations of Net Present Value. In itself this material is not easy to follow and certainly has proven a stumbling block for even the most interested members of the public. More critically we are concerned that, leaving aside the scenarios of different patients included in the documents, the whole set of proposals have been tested predominantly in abstract rather than human or real world terms.

**Emergency Planning**

We received reassurances from the NHS London Emergency Preparedness team that "the North West London health system described in the proposal will have sufficient resilience built-in to handle surges in demand such as those posed by concurrent major incidents."

We are interested to note that they also comment that "the numerical modelling that has been done to date shows that the plans will generate an excess of bed capacity in the order of 10% over what is required for the area." We understand the need to cover contingencies but would like to see more recognition in future resource planning that this excess capacity does not represent an inefficient use of estate and believe this should form part of a joint process of stress-testing around resilience to be led by Directors of Public Health and NHS Trusts.

**We recommend**

**That a properly-constituted Strategic Workforce Group involving professional bodies and unions and employers be established to provide leadership on workforce issues relating to "Shaping a Healthier Future".**

**NHS NW London produces a workforce strategy and explores more flexible working arrangements between networks.**

**That Public Health Directors across the six boroughs provide collective reassurance about the population assumptions and the associated needs profiles**

### 4.7 Consultation Process

Any changes to A&E provision are notoriously difficult for the public to accept and for staff to embrace. This means that the process of consultation needs to be grounded in a genuine commitment to engage with the public, with staff and with partners from the outset - in identifying the key issues and co-designing the solutions together. This builds necessary trust and confidence and reduces public anxiety.

Public Engagement

We believe that the consultation has been taken forward according to a clear communication plan, but that this has consistently fallen short of an effective process of engagement. We feel that the website and different written material did get across the main arguments across but fell short of actively helping people get to grips with the likely implications for them, their families and communities. Whilst both the pre-consultation and consultation communication plans include what might be reasonably expected of a traditional NHS consultation – public meetings with senior clinical and managerial presence, focus groups, hotlines etc. - the numbers reached directly by the process seem very low. Several respondents have given examples of the full consultation document not being available in key locations such as public libraries or available in community languages.

Consultation Period

We have throughout questioned the wisdom of conducting a consultation over the summer months at the same time as the Olympics, the Paralympics and the holiday season. We would suggest the consultation has as a result failed to allow local populations sufficient time to digest and engage with the plans and their likely consequences. The added problem this summer has been distractions of proposed mergers, reconfigurations, financial challenges and changes to responsibilities across the public sector in North West London.

Consultation Model

But our concerns about the consultation process are more fundamental than timing. We question the underlying approach and the extent to which this has had the feel of a marketing exercise rather than a properly conducted consultation exercise. There is a strong feeling amongst JHOSC members that the NHS has adopted a perfectly logical process but one which has not given room for proper consideration of (high-level) clinical and financial decisions on individuals and communities. Our impression is that the drive has been to meet the minimum requirements of the Four Tests in the NHS Act rather than open up serious issues beyond NHS professional ranks.

There is certainly evidence of clinical leaders supporting the development and public presentation of the proposals. What is less evident is whether other clinical staff, who are critical to changing public behaviour and delivering change, are supporting these leaders. The CCGs seem to have been used as proxies for direct engagement with GPs, who from evidence we received, have in some areas met separately and been extremely critical and unsupportive in areas where the changes appear to impact most. We feel a much clearer commitment to a compelling model of engagement which enables more co-production with staff and the public was needed earlier and should be adopted for the future.

Patient Involvement

NHS NW London has placed considerable reliance on the Patient and Public Advisory Group (PPAG), a network of LINks Chairs, as the main path for patient involvement on the inside of the process. We question whether this is appropriate as the authority and capacity of PPAG members to carry the weight of responsibility is questionable. We also believe the role of a small number of PPAG members at the heart of the decision-making process compromises their independence and ability to represent a wider public view effectively and also places unreasonable demands on the few individuals to cover complex issues which should be addressed in the open.

There has been far too little engagement of staff and their representatives about the proposed changes. We have reflected our recommendation on workforce issues elsewhere but the eye seems to have been taken off the value of engaging with professional organisations and trades unions on the proposals in any consistent or effective way. This has undoubtedly lost some key potential allies and a source of valuable intelligence and support.

It would not be unfair to criticise NHS NW London for creating a situation where unnecessary anxiety and scope for opposition has been created by the failure to be in a position through inadequate preparation to anticipate and engage with the legitimate concerns of local people.

Remit for Consultation

We also understand that there are dangers that too many issues might be included in a formal consultation. The challenge is where to draw the line. We feel that the decision to consult on changes to hospital provision, but not on the out of hospital plans on which the proposal depend, has not served the consultation well. By focusing on only one part of an integrated system it has re-inforced an unhelpful and old-fashioned division between hospital and non-hospital care and between NHS and non-NHS provision.

We were surprised that social media and creative methods of encouraging engagement were not more widely used and partnerships established with others to extend engagement rather than just message-giving. Boroughs and third sector partners seem to have been largely ignored as sources of help and expertise in engaging with communities they know well. This may reflect the bulk of the budget being spent on expensive external communication and public relations experts rather than those with in nurturing sustainable local commitment and developing greater public involvement skills within the public sector.

A key concern is that virtually nothing of any significance about the proposals has altered over the nine months of development and engagement. This is not a sign of the strength of the proposals but an indication that a top-down, un-engaging process has been running. It is hard to avoid feeling that this has been an essentially closed NHS process, intended to promote a highly-developed proposal, rather than to engage meaningfully with the public and staff in shaping the future. Our conclusion is that the consultation process has failed to meet the standards that should be expected for such important changes to service and local facilities, which potentially affect local people significantly.

**We recommend**

**That the Department of Health is encouraged to develop and promote a model for all NHS public consultations which sets out standards for positive engagement with partners, staff and the public at all stages of pre-consultation and consultation**

**That a clear statement of approach to involvement is produced relating to the proposals in "Shaping a Healthier Future" and that an independent governance process is put in place to monitor its progress, involving independent public representatives**

**That an audit of engagement expertise both within the NHS and in partner organisations is undertaken and a development programme established to strengthen capacity for future consultation processes**

## 4 Conclusions and Recommendations

We have throughout the scrutiny process for the "Shaping a Healthier Future" sought evidence about the way the consultation process has been run, about the core content and impact of the proposals and about the way risks involved in the proposals have been identified and mitigated.

We would conclude that there is a need for urgent action to improve emergency care which we support. Decisions need to be made and action taken.

We have been open minded about the overall approach to consultation but we cannot avoid the conclusion that the fundamental issues now faced by NHS NW London in moving forward are ones of trust and confidence amongst the public, with staff and with partners on whom it relies.

We cannot however lay aside the concerns which have emerged from our work simply to support a decision to act. We believe that the recommendations we are making in this report will help strengthen the proposals and could help address deficits of process and substance, which we feel exist.

We conclude by gathering these recommendations together in one place for ease of reference.

**We Recommend**

- That the JHOSC is constituted to provide continuing scrutiny of the development of proposals and the responsiveness to this report and other responses received to the consultation.
- That NHS NW London demonstrates how flow through the system will be optimised through the whole system and be truly patient centred.
- That work on integration is co-designed with organisational partners, professional groups and the public to ensure that there is a proper consideration of the breadth and complexity of issues affecting those with long-term conditions and the necessary financial flows, thus ensuring that the money follows the patient from acute settings to primary and social care.
- That NHS NW London undertakes a quantitative and qualitative assessment of current patient outcomes and experience in the services covered by Shaping a Healthier Future is undertaken by December 2012, in a form to be agreed with patient groups.
- That work is brought forward which shows that the financial consequences arising from the both the hospital and out of hospital plans have been considered across the public and third sector, as well as within the NHS system, and that commitment to the necessary funds has been secured against tight financial settlements.
- That measurable quality improvement metrics should be developed to establish what could be expected from the proposals and to allow progress to be monitored by the public and by Health and Well-being Boards should the proposals be approved.
- That NHS NW London provides public reassurance that its formal audit processes include validation of the work of the external consultants used to provide the core financial modelling for the proposals

- That NHS NW London demonstrates the change in flow through the system and what is actually going to happen to patients borough by borough.
- That NHS NW London shares their proposals for improving the quality of out of hours care given the interdependency of out of hours care and urgent care.
- That NHS NW London provides further information on how urgent care will actually become safer and how safety will be managed during the transition.
- That proposals for out of hospital care are developed further, with the direct involvement of non-NHS partners, to arrive at agreed resource models for each borough and that this process reports to relevant Health and Well-being Boards.
- That Health and Well-being Boards need to strengthen joint commissioning between local authorities and CCGs to deliver better coordinated care which promotes independence and avoids costly hospital admissions.
- That a clear commitment by all parties that work on improving community services is completed to agree, measurable standards across North West London in advance of any decisions being taken in respect of "Shaping a Healthier Future"
- That a joint approach to engagement of both staff and the public in the development and co-design of services is developed between the shadow Health and Well-being Boards in support of integrated care in support of integrated care
- That an independent assessment is made of the proposed ICP model, the resources needed to make it work and the extent to which housing and social care have been involved across NHS NW London and the confidence that can be placed in the anticipated reduction in emergency admissions.
- That plans to improve GP performance in NHS NW London are made explicit and the measures and timescales for this improvement to be published as an adjunct to "Shaping a Healthier Future" documents.
- That urgent work is undertaken as part of wider modelling of patient flows to clarify the scale of the transient population attending A&Es and what provision will be made for them in terms of out of hospital provision
- That evidence that out of hospital provision will reduce admissions to acute services is published by NHS NW London
- That an alternative approach to equalities impact assessment is developed as a matter of urgency which meets the criteria of being locally owned, specific to each borough, publicly accountable and involving of other public bodies, local staff, their representatives and the public.
- That investment is made in permanent capacity within the NHS and its partners to undertake continuing equalities impact assessment of service changes such as Shaping a Healthier Future, instead of further use of external management consultancies
- That the evidence that out of hospital provision will reduce admissions to acute services is published by NHS NW London

- That the Board of NHS NW London commissions and publishes a full risk analysis of the successful implementation of the programme which identifies the mitigations for the risks identified for "Shaping a Healthier Future" during development, transition and implementation

- That a properly-constituted Strategic Workforce Group involving professional bodies and unions and employers be established to provide leadership on workforce issues relating to "Shaping a Healthier Future".

- NHS NW London produces a workforce strategy and explores more flexible working arrangements between networks.

- That Public Health Directors across the six boroughs provide collective reassurance about the population assumptions and the associated needs profiles

- That the Department of Health is encouraged to develop and promote a model for all NHS public consultations which sets out standards for positive engagement with partners, staff and the public at all stages of pre-consultation and consultation

- That a clear statement of approach to involvement is produced relating to the proposals in "Shaping a Healthier Future" and that an independent governance process is put in place to monitor its progress, involving independent public representatives.

- That an audit of engagement expertise both within the NHS and in partner organisations is undertaken and a development programme established to strengthen capacity for future consultation processes.

[Members please note the following Appendices will be added to the final document]

Appendix 1 Members of the JHOSC

Appendix 2 List of Witnesses attending meetings

Appendix 3 List of Witness Statements received