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Committee Agenda

Title:	**North West London Joint Health Overview and Scrutiny Committee**
Meeting Date:	**Tuesday 13th March, 2018**
Time:	**9.30 am**
Venue:	**Room 3.6 and 3.7, 3rd Floor, 5 Strand, London, WC2 5HR**
Members:	**Councillors:** Mel Collins (LB Hounslow) – Chairman Shaida Mehrban (LB Hounslow) Ketan Sheth (LB Brent) Barbara Pitruzzella (LB Brent) Daniel Crawford (LB Ealing) Theresa Mullins (LB Ealing) Rory Vaughan (LB Hammersmith & Fulham) Sharon Holder (LB Hammersmith & Fulham) Vina Mthani (LB Harrow) Michael Borio (LB Harrow) Robert Freeman (RB Kensington & Chelsea) Catherine Faulks (RB Kensington & Chelsea) John Coombs (LB Richmond) Liz Jaeger (LB Richmond) Jonathan Glanz (Westminster City Council) Barbara Arzymanow (Westminster City Council)

Members of the public are welcome to attend the meeting and listen to the discussion Part 1 of the Agenda

Admission to the public gallery is by ticket, issued from the ground floor reception at City Hall, 5 Strand from 9.00am. If you have a disability and require any special assistance please contact the Committee Officer (details listed below) in advance of the meeting.

An Induction loop operates to enhance sound for anyone wearing a hearing aid or using a transmitter. If you require any further information, please contact the Committee Officer, Tristan Fieldsend, Committee and Governance Officer.

tfieldsend@westminster.gov.uk; 020 7641 2341
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Note for Members: Members are reminded that Officer contacts are shown at the end of each report and Members are welcome to raise questions in advance of the meeting. With regard to item 2, guidance on declarations of interests is included in the Code of Governance; if Members and Officers have any particular questions they should contact the Head of Legal & Democratic Services in advance of the meeting please.

AGENDA

PART 1 (IN PUBLIC)

1. WELCOME AND INTRODUCTION

2. APOLOGIES FOR ABSENCE

To receive apologies for absence.

3. DECLARATIONS OF INTEREST

To receive declarations of disclosable pecuniary or non-pecuniary interests, arising from business to be transacted at the meeting, from:

(a) All members of the Joint Committee;
(b) All other Members present in any part of the room or chamber.

4. MINUTES **(Pages 1 - 12)**

That the minutes of the meeting held on 23 January 2018 be taken as read and signed as a correct record.

5. MATTERS ARISING

6. A&E PERFORMANCE DATA **(Pages 13 - 30)**

Presentation and discussion of A&E performance data for 2017/18.

7. UPDATE ON SOC1 AND STP IMPLEMENTATION TIMELINES **(Pages 31 - 48)**

Briefing on SOC1 and a general update on the STP implementation timelines.

8. PERFORMANCE METRICS

Discuss progress on developing performance metrics.

9.	**EQUALITIES IMPACT ASSESSMENT** Discussion of EIA published in April 2017. Members can ask NHS CCG contacts questions or provide comments on the assessment.	**(Pages 49 - 70)**
10.	**ANY OTHER BUSINESS** Briefly discuss *Healthwatch Central West London Charing Cross Hospital: Experiences of Today, Questions for Tomorrow* (February 2018) report.	**(Pages 71 - 124)**

Stuart Love
Chief Executive
5 March 2018

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Joint Health Overview & Scrutiny Committee (JHOSC)

MINUTES

Tuesday 23 January 2017 – 9:30am – Council Chamber, Ealing Town Hall

Chairman:

Councillor Mel Collins (LB Hounslow)

Councillors:

Councillor Barbara Arzymanow (Westminster CC)

Councillor Michael Borio (LB Harrow)

Councillor John Coombs (LB Richmond)

Councillor Daniel Crawford (LB Ealing)

Councillor Shaida Mehrban (LB Hounslow)

Councillor Theresa Mullins (LB Ealing)

Councillor Rory Vaughan (LB Hammersmith & Fulham)

1. Welcome and Introductions

(Agenda Item 1)

The start of the meeting was delayed until 9:40am to allow time for members to arrive.

The Chair then invited Councillor Daniel Crawford of London Borough of Ealing to welcome the attendees to Ealing Town Hall.

2. Apologies for Absence

(Agenda Item 2)

Apologies were received from Councillor Ketan Sheth (LB Brent), Councillor Freeman (RB Kensington & Chelsea), Councillor Catherine Faulks (RB Kensington & Chelsea), Councillor Vina Mithani (LB Harrow), Councillor Sharon Holder (LB Hammersmith & Fulham) and Councillor Jonathan Glanz (Westminster City Council).

3. Declarations of Interest
(Agenda Item 3)

There were none.

4. Minutes of the meeting held on 5 December 2017
(Agenda Item 4)

Consideration was given to the minutes of the previous meeting of the Committee which had taken place on 5 December 2017.

The Chair advised the Committee that a series of amendments had already been tabled; these were not substantial changes, merely adjustments to inaccuracies.

The Committee requested that the amended version be emailed to them for agreement.

Resolved: That the minutes of the previous meeting of the Committee held on 5 December 2017 be agreed, subject to the satisfactory receipt of the amended version, as a true and correct record.

5. Matters Arising
(Agenda Item 5)

The Chair advised the Committee that there were five matters arising to be considered before the substantial agenda items, as follows:

Presentation of initial A&E data for Committee to discuss in preparation for the March 2018 JHOSC meeting

The Committee were advised that preliminary data was being pulled together at present and that officers would be able to give a clear picture on the performance over the winter period by March 2018.

However, the preliminary data did show that North West London, whilst not hitting the 95% target, was performing better than the rest of London and the England average. It was as resilient as any other system and the North West London CCGs were working with providers to build up as much capacity as possible.

Councillor Crawford stated that he was broadly happy with the figures being fed back so far, however he had some concerns. Were urgent care centres and walk-in centres included within the four hour A&E waiting time target?

It was confirmed that where such services were co-located within hospitals, then yes they were being included as that was how the data for the national target was set.

In response to this Councillor Crawford expressed concern that the A&E performance was potential misleading due to the inclusion of UCCs and walk-in centres and asked that his concerns be noted.

Councillor Theresa Mullins stated that it would be helpful to understand exactly how the data was calculated.

Councillor Vaughan agreed and requested that the A&E information being provided for the March 2018 meeting include an explanation of how it was calculated, to help the Committee understand how the figures were reached.

Councillor Vaughan also stated that it would be useful to understand how North West London worked alongside the London Ambulance Service, and how they worked together to combat the 'stacking' of ambulances at hospitals.

Update on London Hospital and Western Eye Hospital covenant issues

The Chair made reference to a query previously raised by the JHOSC regarding the possibility of covenant issues bequeathing land to the public. Was anymore now known about this?

Mick Fisher (Head of Public Affairs for Imperial College Healthcare NHS Trust) stated that he had been in conversation with the Director of Redevelopment who was unaware and so undertook a legal check, which revealed that there were no such covenants affecting the ability to enter into an agreement on the site.

Update on response from Councillor Collins to Royal College of Nursing letter

The Chair had drafted a letter which was to be sent by him on behalf of the JHOSC, and would respond to Royal College of Nursing concerns around the North West London Sustainability and Transformation Plan. He asked if Committee Members were satisfied with the draft letter, as no suggested amendments had been received to date.

Councillor Vaughan asked that the draft letter be recirculated to Committee Members with an agreement that Committee Members who wished to do so, would feedback by Friday 26 January 2018.

Equalities Impact Assessment (EIA) addition to the work programme for discussion at the March 2018 meeting

The Chair expressed concern that NW London appeared to be one of few areas without a substantive EIA in place. When was this likely to be seen?

It was advised that an EIA was in place, and that an analysis was undertaken in the previous year to ensure consistency across the capital.

The Chair asked if officers were happy to discuss this fully in March, and that in the meantime the EIA be circulated to Committee Members.

Officers confirmed that they were happy to discuss the EIA further at the March 2018 meeting of the Panel and that they would circulate the relevant documentation.

Implementation date/timelines for Sustainability and Transformation Plan (STP)

It was agreed that this discussion be deferred until the March 2018 meeting of the Committee.

Resolved: That

(i) the responses to the matters arising be noted;

(ii) that the Chair's draft letter to the Royal College of Nursing be recirculated to Committee Members; and

(iii) the updated EIA documents be circulated to Committee Members in advance of the March 2018 meeting of JHOSC.

6. Update from London Ambulance Service

(Agenda Item 6)

The Chair invited Ian Johns (Assistant Director of Operations for North West London, London Ambulance Service NHS Trust) and Catherine Wilson (Stakeholder Engagement Manager for North West London, London Ambulance Service NHS Trust) to provide an update to the Committee on progress made in improving the service.

It was advised that the London Ambulance Service (LAS) was currently undergoing significant internal reform. Following a poor rating from the CQC in 2015 which saw the service put under special measures, the service had worked diligently to improve the areas highlighted as concerns. Particularly significant improvements had been made in medicines management, staffing and levels of incident reporting.

Demands on the Service had been increasing during 2016/2017, with the LAS attending over 200 incidents a day during this period. Over 350 frontline staff had also been recruited during this time, and alongside this an action plan was in place to improve diversity and workplace culture.

The Service had moved to the new Ambulance Response Programme on 31 October 2017. The introduction of this had led to dramatic changes to how the LAS responded as a service. It was expected that the introduction of the changes would result in:

- Faster treatment for those needing it, to save 250 lives a year.
- An end to hidden waits for millions of patients, in particular the frail and elderly who, when ambulance services had been under pressure, had suffered unacceptably long waits.
- Up to 750,000 more calls a year getting an immediate response.
- New standards to drive improved care for stroke and heart attack patients.
- Updates to decades-old system following the world's largest clinical ambulance trial.

Data for the winter period was highlighted. It was advised that the business intelligence team was still 'cleansing' the data at present time, to remove anomalies that would unrepresentatively skew the data. The previous response category 1 aim time of 8 minutes had been lowered to 7 mins. The current response time was 7mins 16secs on average, leaving the service 16 seconds short of its targets. However, the services was now routinely in the top three performing trusts across the country, showing how much hard work had taken place since the special measures warning.

The staffing picture was discussed. Significant efforts had been made to recruit more staff and a recruitment campaign was being planned to increase this even further.

The frontline vacancy rate in particular had been improved due to UK and international recruitment; staffing levels were now at 92.5% filled, with staff turnover at 8%. This meant that there were more responders available to attend to emergencies. Further recruitment was being sought through attendance at job fairs across London, promoting the Trainee Emergency Ambulance Crew role and Emergency Medical Dispatcher role.

Work was taking place to identify why patients were suffering delays in transfers of care, initial results had shown that they were being dealt with in a much more timely fashion – a report was being prepared on this.

The LAS had entered the winter period with its most robust winter plan ever. The service had been bolstered with extra staff across all 24 hours of the day, and initial outcomes were showing positive results.

Close work had taken place with the wider NHS on managing hospital handovers. A significant number of measures had been put in place to manage hospital handover delays; this had seen a reduction from the delays experienced previously. Some of the key measures put into place had included seconding a senior manager to work specifically with the Emergency Care Improvement Programme (ECIP) on hospital handovers and a series of improvements being made to the Intelligent Conveyance function to help manage the flow of ambulance arrivals at emergency departments to help prevent delays in handover.

Cross-border working was referenced. The LAS Emergency Preparedness, Resilience and Response Team was in charge of planning for events and managing serious and major incidents when they were declared. In certain circumstances ambulance services might be requested to provide mutual aid. The mutual aid was co-ordinated by the National Ambulance Service Co-ordination Centre on a national framework which reduced the changes of misunderstandings, and ensured that resilience was not stripped away from other Trusts that might also be experiencing pressure. It was stated that New Year's Eve 2018 had been a strong example of significant collaborations and sharing of best practice.

Questions

Councillor Vaughan stated that he was pleased to hear that the workforce pressures had diminished. However, he sought reassurance that this workforce stability would be maintained, and enquired whether the service was continuing to recruit.

It was further advised that 150 staff from Australia had been recruited through a special recruitment programme – this was working well. The LAS was also taking advantage of a number of domestic university streams. Plans were in place to maintain the workforce, and work around reducing turnover was helping to alleviate previous pressures. A revolving recruitment programme was ongoing and consistently recruiting into roles where it was needed.

Councillor Vaughan then referred to hospital handovers and the issues of long stacking delays. He sought further comment on work being done to ensure that such a scenario did not recur.

It was advised that a lot of work had taken place over the previous 12 months to assess patients on whether transfer to an emergency department was the best option for them. If it was found that they would be equally well served, or even better served by treatment in a home based or alternative setting then this was what needed to happen.

A successful scheme had taken place through the rapid response team in Westminster – this scheme was now going to be transferred to Hounslow. One positive outcome from this was that a lot more elderly patients were getting the right care in a home setting rather than causing them undue distress with hospital trips.

The Chair asked for further information on cross-border working. There had been a number of concerning issues related to this in the build-up to Christmas. The Chair stated that whilst he was not sure that these had affected North West London directly, he was aware that in some places (particularly ambulances entering and leaving London) cross-border working had “left a lot to be desired”. He therefore sought reassurances that the LAS were confident that the approach to cross-border working was as safe as possible.

The Assistant Director of Operations for North West London, London Ambulance Service NHS Trust stated that he would feedback a more accurate detailed picture on cross-border working to the Committee in due course.

The Chair then made reference to possible cuts to funding for the London Air Ambulance Service and asked if this would impact upon collaborative working with them.

It was advised that information to date had indicated that there would be no cuts in funding to the London Air Ambulance Service.

The Chair then thanked officers for their full and comprehensive report and drew the item to a close

Resolved: That

(i) the report advising the Committee on progress made by the London Ambulance Service be received by the Committee; and

(ii) The Assistant Director of Operations for North West London, London Ambulance Service NHS Trust be asked to feedback further information on the success of cross-border working in the North West London region.

7. Investment into Charing Cross Hospital

(Agenda Item 7)

The Chair invited Professor Tim Orchard (Interim Joint Medical Director & Divisional Director for Medicine and Integrated Care, Imperial College Healthcare NHS Trust) and Professor Julian Redhead (Interim Chief Executive, Imperial College Healthcare

NHS Trust) to make a presentation to the Committee responding to requests for an update on recent and proposed investments at Charing Cross Hospital, as well as future plans for the site.

It was advised that as one of Imperial College Healthcare NHS Trust's five sites – Charing Cross had been an area of focus recently, and close work had been taking place with colleagues in the CCG to maintain stability at the site.

Charing Cross had been envisaged as part of future plans for developing into a 'local hospital'. The proposals around this were developed and reconfiguration had been approved by the CCG. In October 2013 the Secretary of State had supported the proposals in full, however adding that Charing Cross should still offer some form of A&E Service.

The Trust had published its own clinical strategy and estates plan in 2014 that included outline proposals for Charing Cross to become a 'local hospital' in line with Shaping a Healthier Future proposals.

Since then, the Trust and the CCG had put on hold subsequent work to engage patients and the public in the development of detailed plans for Charing Cross due to increasing demand for acute hospital services.

A commitment to not progress plans to reduce acute capacity at Charing Cross unless and until a reduction in acute demands was achieved – was formalised in the North West London STP in 2016. The STP added that Charing Cross would continue to provide its current A&E and wider services for at least the lifetime of the plan, which would run until April 2021.

Some of the largest ever investments in new facilities and equipment had recently been made at the hospital. Over the previous 18 months, some £6 million had been spent on major new developments, and close to another £8 million was being spent on replacing imaging equipment and the installation of two state-of-the-art LINAC radiotherapy machines so that the most advanced cancer treatments could be provided.

Maintenance spend at the hospital in the previous year had been another £6 million, with around a third of the total Trust spend being on backlog maintenance. Additionally, a multi-million pound refurbishment and expansion of the A&E department was currently being worked up. Work was expected to begin early in 2018 – the likely timescales however, meant that the improvements would impact after the winter period.

Questions

Councillor Vaughan stated that stability in the status of Charing Cross Hospital until at least 2021 was reassuring. However, the investment plans sounded more like "business as usual" rather than being a series of significant improvements as advertised. With regards to timetabled works over the next few years, was it correct that SOC2 (Strategic Outline Case Part 2: a technical document to secure capital investment in subsequent phases of Shaping a Healthier Future delivery) would not be timetabled anytime soon?

Professor Redhead stated that a sustained period of heavy investment in backdoor maintenance would be maintained, and that the Trust would continue to invest significantly in the hospital. He stated that the CCG had oversight of the timetables in relation to SOC2.

Clare Parker, the Chief Officer for the Central London CCGs, stated that the CCG recognised that getting services embedded and understood was the key focus at this point in time. SOC2 was not the current focus, and when a clearer view on this picture was available, it would be shared with all.

Councillor Vaughan stated that the Committee would like to receive at least a picture of when discussions would be taking place, and asked if an update of the current position of SOC1 could be provided.

The Chief Officer for Central London CCGs advised that assurance information requested by the NHS Improvement Board had been provided to them on 19 January 2018. It would be known by 9 February 2018 whether the information provided satisfied the questions, or whether further work was required for SOC1. By mid to late February 2018 it was hoped that a definitive timeline for progress of the business case would be available.

Councillor Vaughan asked if 'sign-off' on SOC1 would be the trigger for inaugurating SOC2. It was advised that SOC1 and SOC2 were viewed separately and one would not trigger the other.

Councillor Crawford expressed concern about the uncertainties faced by the public in regards to the long-term future of the sites – stating that the need for some form of clarity was pressing. The service received at Charing Cross Hospital was considered to be excellent, hence the strong wishes of the public for the site to retain its current status.

Professor Redhead stated that the Trust was trying to be as clear as it could be. An open day had taken place for the public and a policy of honesty and transparency was a through thread.

Councillor Theresa Mullins said that it was excellent to hear of the investment taking place at Charing Cross Hospital, and that the open day had acted as a valuable resource for giving patients peace of mind. She then enquired as to the long-term bed situation at the Hospital.

Professor Redhead advised that the Trust had needed to open more beds at the site and would continue to open beds where pressures needed to be met.

Councillor Theresa Mullins expressed concern about the future population pressures coming into Ealing, such as the large-scale Southall Gasworks development. She also expressed concern about miscommunications, which had led a lot of Ealing residents to believe that Ealing A&E had already closed.

The Chief Officer for Central London CCGs stated that the CCG made significant efforts to ensure that they were kept up to date with all site planning in the region – working directly with council planning departments on assumptions to ensure that they correctly aligned.

Councillor Crawford stated that he would welcome a commitment to revisit the cutting of beds at Ealing Hospital.

Councillor Barbara Arzymanow spoke about investment in St Marys Hospital and its long-term future. She stated that there was a lot of empty land and building space around this site and sought clarity on what was owned by Imperial Trust and whether there was an intention to sell any of this land or properties.

Professor Redhead stated that he would be happy to meet separately with the Councillor and discuss what was owned by the Trust in detail. He stated that there was no reason to believe that the Trust would sell anything that could not be returned to the Trust in the form of a capital investment.

Resolved: That the update on investment plans for Charing Cross Hospital be received by the Committee.

8. Performance Metrics for Shaping a Healthier Future Programme and STP
(Agenda Item 8)

The Chair advised the Committee that at the last meeting, the NWL Collaboration of CCGs had provided a paper intended to start a conversation responding to the Committee's question around the best measure on whether conditions were safe for changes to Ealing Hospital to go ahead.

The Chair asked for the Committee's opinions on a paper circulated in addition to the agenda, which detailed 11 high-level key questions to put to the CCG and asked how the Committee would like to take this forward.

Councillor Crawford stated that the paper contained some good suggestions. He felt that the two key elements were A&E attendance - what was a safe level? And additionally, how would it be judged whether there was sufficient capacity? He stated that the Health Scrutiny Committee at Ealing had been asking if it could visit a hub structure somewhere that was up and running to help the Committee understand what patients were going to get from these places.

Councillor Barbara Arzymanow advised that Westminster Council was preparing a piece of work on a new hub. There had been visits to existing hubs at Bromley-by-Bow and St Charles. She stated that London based Members did not have to go very far to see some excellent work taking place.

The Chief Officer for Central London CCGs stated that she would extend an invite to anyone who would like to visit the St Charles hub.

Councillor Vaughan stated that the suggestions listed made for a good starting point for discussions and for accruing data. Winter pressures had shown that people would often still go to A&Es as a first point of call. There was a question of education of the public – in helping them to understand the options available to them for care. With that in mind, he stated that he would like to see more on how people were going to be educated on changes.

Councillor Mehrban made reference to drop-in centres, stating that some of the centres in the London Borough of Hounslow had been working really well. There was a lot of strain on A&Es that could be relieved if more people made use of these walk-in clinics.

Rob Larkman (Chief Officer for Brent, Harrow and Hillingdon CCGs) advised the Committee that services were being shaped with initiatives in place to ensure that the appropriate type of care was available at every level of need throughout North West London.

The Chief Officer for Central London CCGs advised that detailed analysis was taking place on the types of people attending hospitals. She stated that the contents of the paper might lend itself to more detailed work with Councillors Crawford and Vaughan as those most affected by the changes, to then be brought back to the Committee at a later stage as the Committee was not always the best setting for such shaping exercises. Councillor Crawford and Vaughan stated that they would discuss this further outside of the meeting.

Resolved: That the discussion of performance metrics for Shaping a Healthier Future and the STP be noted.

9. Any Other Matters that the Chair Considers Urgent
(Agenda Item 9)

The Chair asked about the CCGs establishment of a Joint Committee. What was it going to do? What was its remit and composition?

It was advised that the Joint Committee would be a Committee of governing bodies, and would be accountable to the CCG. It was recognised that any decisions taken there might take away from local accountability, so officers were looking at how they engaged, to make sure that the public did not feel that this was case – research was taking place into initiatives such as the live streaming of meetings. It was not known at the moment how the setting up of such a committee would impact upon the JHOSC. Therefore knowing exactly how local scrutiny committees worked alongside the JHOSC would be helpful to the CCG.

A brief discussion took place into the back history of JHOSC's and the powers they arose from. Councillor Vaughan stated that there would be a good opportunity after May 2018's local elections to have a refresh of the remit, which would provide clarity to all.

Councillor Vaughan stated that he would welcome an update on SOC1 as a matter arising at the next meeting of the Committee.

Resolved: That

(i) the Committee be minded to undertake a refresh of its remit in the months following the local elections of May 2018; and

(ii) the Committee be minded to request a brief update on the position of SOC1 at the next meeting of the Committee.

Date of Next Meeting

Committee Members were advised that the date of the next meeting would be 13 March 2018.

Councillor Mel Collins
Chair.

The meeting ended at 11:40am.

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North West London
Collaboration of
Clinical Commissioning Groups

Joint Health Overview and Scrutiny Committee (JHOSC):

NHS in North West London: winter urgent and emergency care performance report

1. Urgent and emergency care performance for the NHS in North West London
2. North West London performance comparisons - across the capital and across the country
3. How we are planning ahead to mitigate the winter pressures and improve our performance long-term
4. Conclusion

1. Winter urgent and emergency care performance - North West London

1.1 Introduction

It's been a tough winter for the NHS across all parts of England and North West London is certainly no exception. However, the combination of many months of detailed planning and the hard work of our staff across every part of the system has meant that despite rising demand and continued delivery challenges, performance was still better here than in many parts of the country, and also better than our own performance last year.

In this section we will look at activity, which is the number of people attending, across our hospitals and also performance, which reports on waiting times. The NW London picture is compared to the rest of London and England in section 2.

1.2 Explanation of the national A&E waiting time standard

The national A&E waiting time standard is that 95% of patients are seen, treated and admitted to a hospital bed, or discharged, within four hours of arrival. Current planning guidance expects Trusts to be at 90% performance by September 2018 and achieving 95% in March 2019.

When a patient's journey time falls short of that target, it does not mean that a patient has received no care or advice at all within four hours. The patient journey may have progressed significantly and safely but not been completed in full within four hours, and these cases are included in the figures as a missed target.

If during the course of the patient's treatment, they are transferred (e.g. from an urgent care centre to an A&E) the clock continues. It does not stop until such time as the patient is admitted or discharged.

1.3 Types of A&E

There are three types of A&E attendances:

- Consultant-led facilities that manage the highest acuity patients (Type 1). There are seven in NW London
- Single specialty A&Es e.g. Western Eye (Type 2)
- Urgent Care Centres (UCC) (Type 3). There are nine in NW London

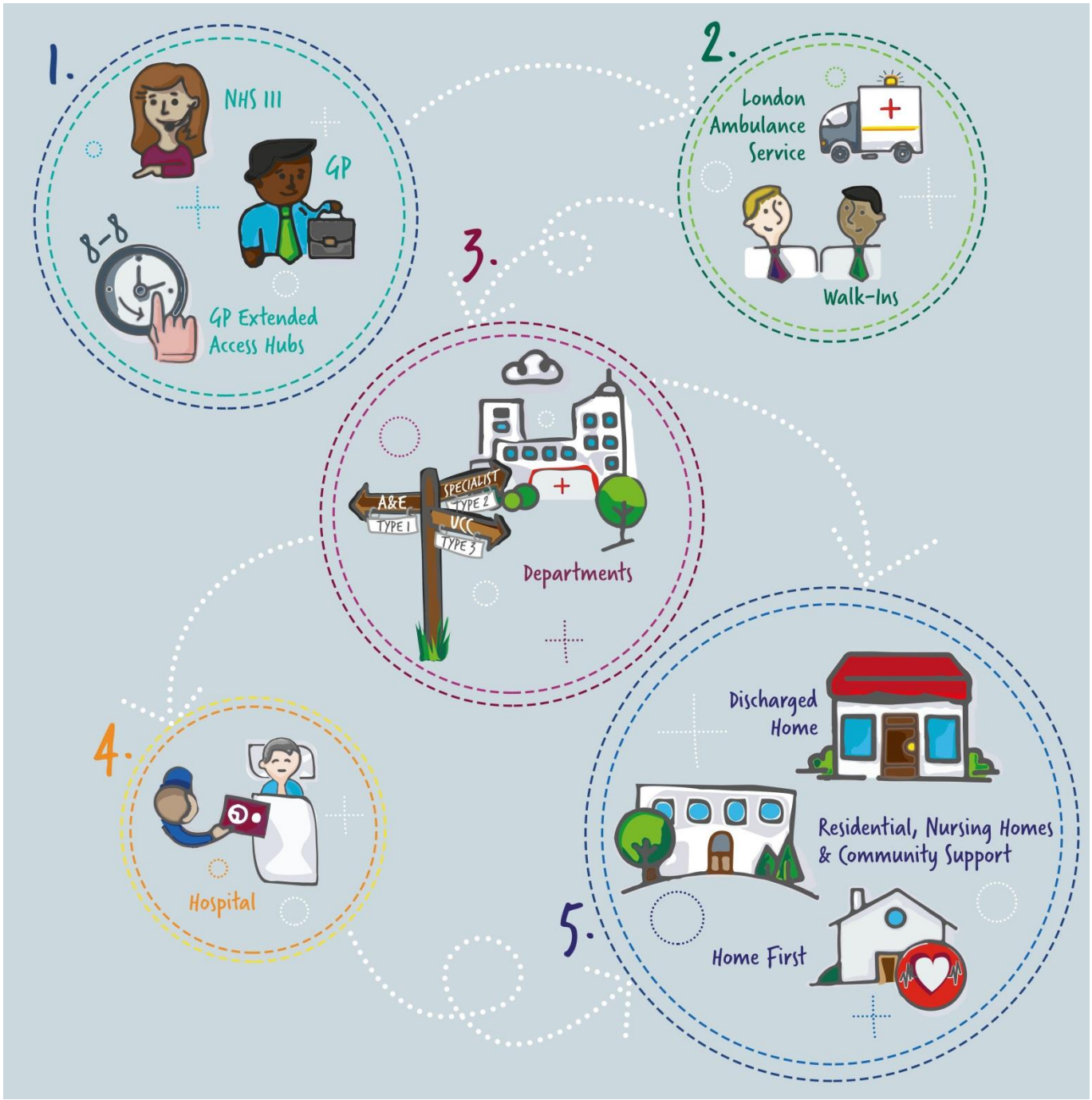
The tables below highlight where walk-in centres (which includes St Charles) have been included in the data. All walk-in centres provided by Central London Community Health NHS Trust (CLCH) or Hounslow and Richmond Community Healthcare NHS Trust (HRCH) are included in our data, as these are included in the national reporting figures.

1.4 Performance overview: January 2018

- Overall A&E performance is over 3% better than the same period last year. We do recognise that the NHS in North West London is not yet meeting the 95% target and we agree that there is more to do to improve performance.
- North West London is close to achieving the 90% target for the winter period as required by NHS England in the 2017/18 planning guidance.
- North West London A&E performance is on average better than London and England A&E performance over the winter period.

- There is also increased utilisation of discharge to assess pathways, where patients are discharged to home with support, and a full multi agency assessment is completed in the home.
- We have clear evidence that ambulatory care, and GP access hubs are being increasingly being utilised. This indicates that schemes to ensure patients are treated on alternative pathways are working.

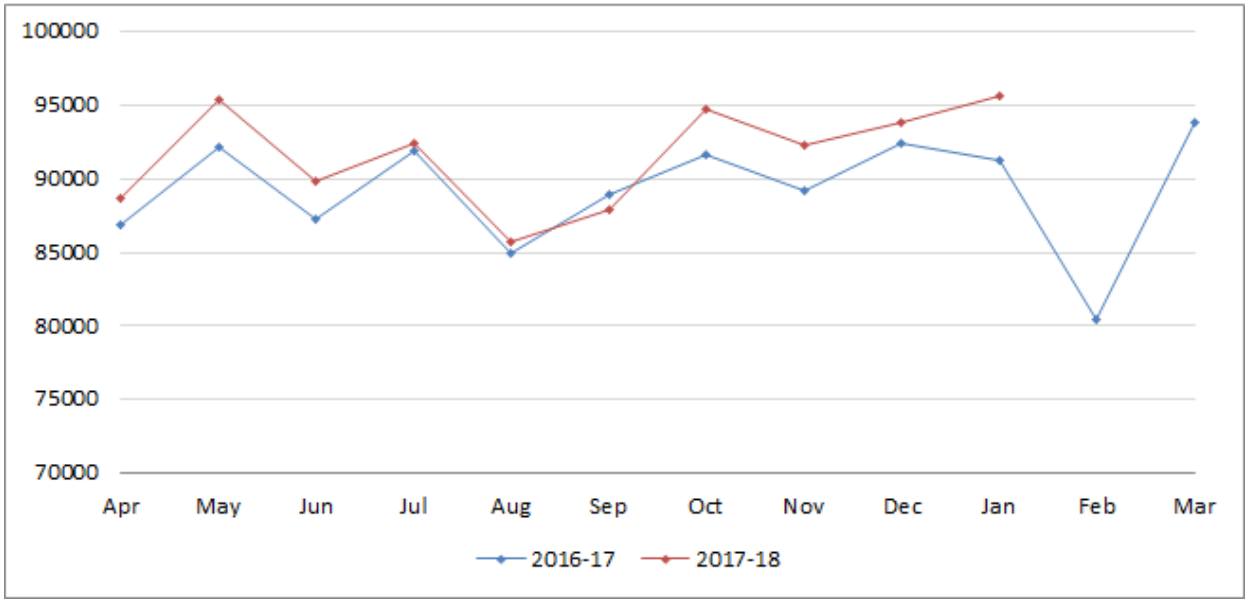
Fig. 1: Visual representation of the urgent care pathway



1.5 A&E activity

A&E all type activity has historically increased each year with a current increase of 2.2% total A&E attendances in 2017/18 financial year (to January 2018) compared to 2016/17.

Fig 2: A&E attendances (all types) by month - NW London acute hospitals (excluding walk-in centres (WICs))



The trend is replicated across consultant led units (type 1) as well as Urgent Care Centres (type 3). However there has been a greater increase in attendances at the higher acuity consultant led A&E attendances this year (3.0%) compared to UCC's 0.9%.

Fig 3: UCC (Type 3) attendances by month (excl WICs)

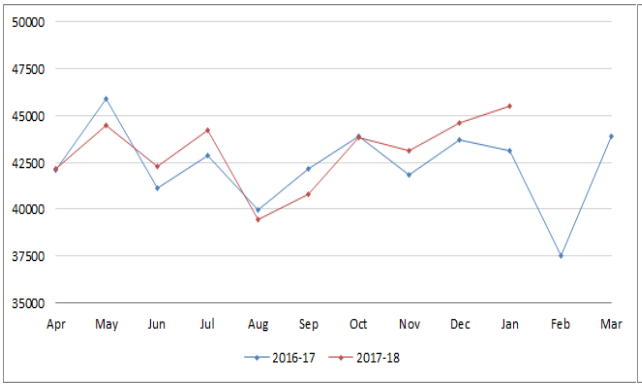
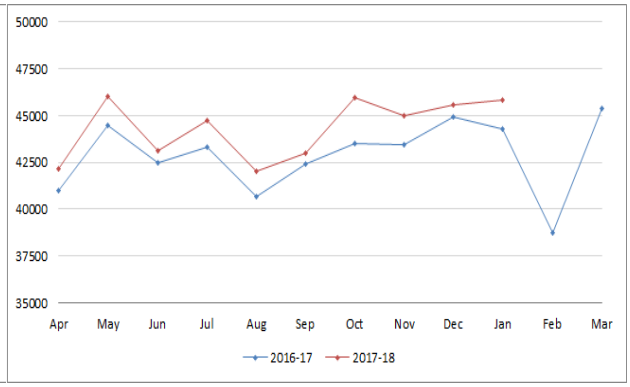


Fig 4: Consultant-led A&E (Type 1) attendances by month



There is evidence from seasonally adjusted analysis that the level of increase in A&E activity over the past four years is reducing. This may be due to admission avoidance schemes, such as the ambulatory care pathways referenced earlier.

1.6 A&E Performance: yearly comparison (2017/2018 compared to 2016/17)

Performance is measured against the A&E waiting time standard of 95% as set out in section 1.2 above.

All types

The graphs below show the overall NW London A&E performance (all types) for the past two years. This illustrates that nearly 9 out of 10 people are seen, treated and discharged/admitted within 4 hours.

Performance has improved by 2.4% in 2017/18 from October 2017 compared to 2016/17.

Fig 5: A&E performance (all types) month on month - NW London acute hospitals (incl. WICs)

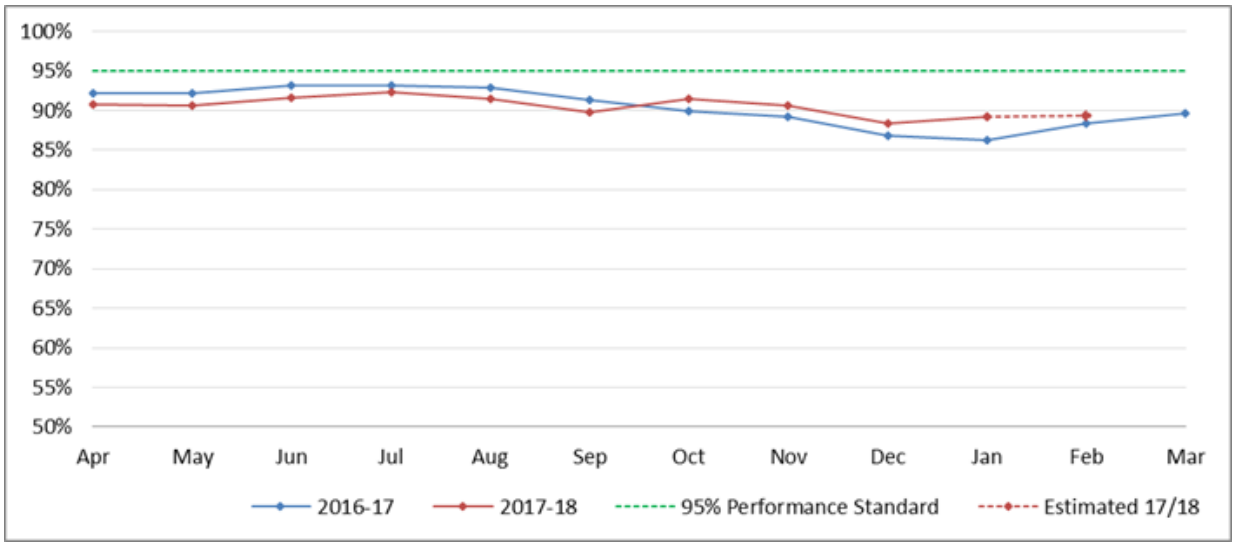


Fig 6: A&E performance (all types) by month - NW London acute hospitals (excl. WICs)

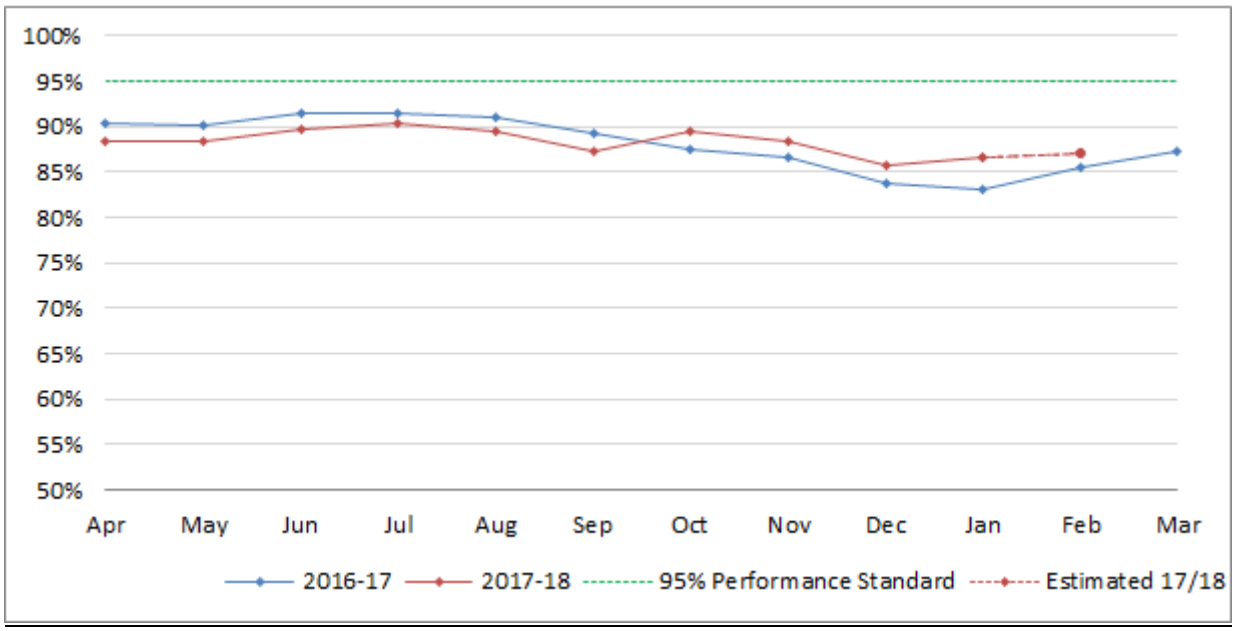
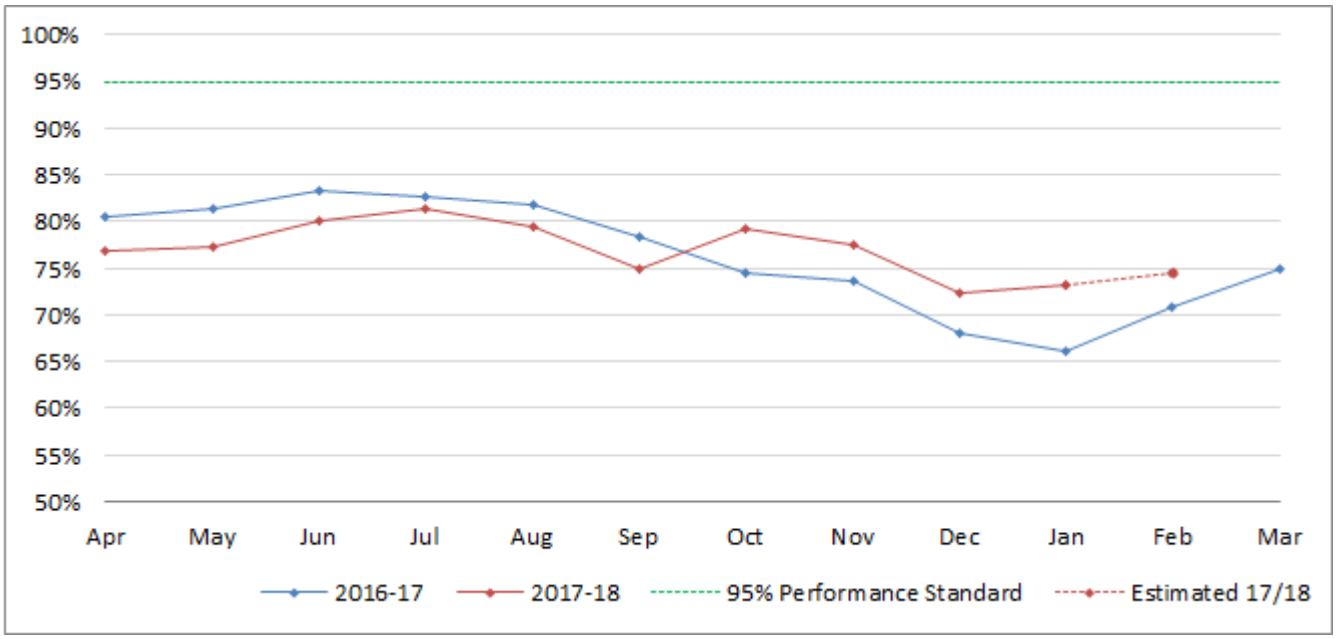


Table 1: All types A&E performance (reporting period October -January) - NW London (excl. WICs)

	2016-17	2017-18	% Difference
Chelsea & Westminster Hospital NHS Foundation Trust	89.44%	94.62%	5.18%
Imperial College Healthcare Trust	86.03%	85.84%	-0.20%
London Northwest Healthcare Trust	82.94%	84.36%	1.41%
The Hillingdon Hospital Trust	81.06%	84.19%	3.13%
NWL Total	85.21%	87.60%	2.39%

Type 1

Fig 7: A&E consultant-led units (type 1) performance by month - NW London



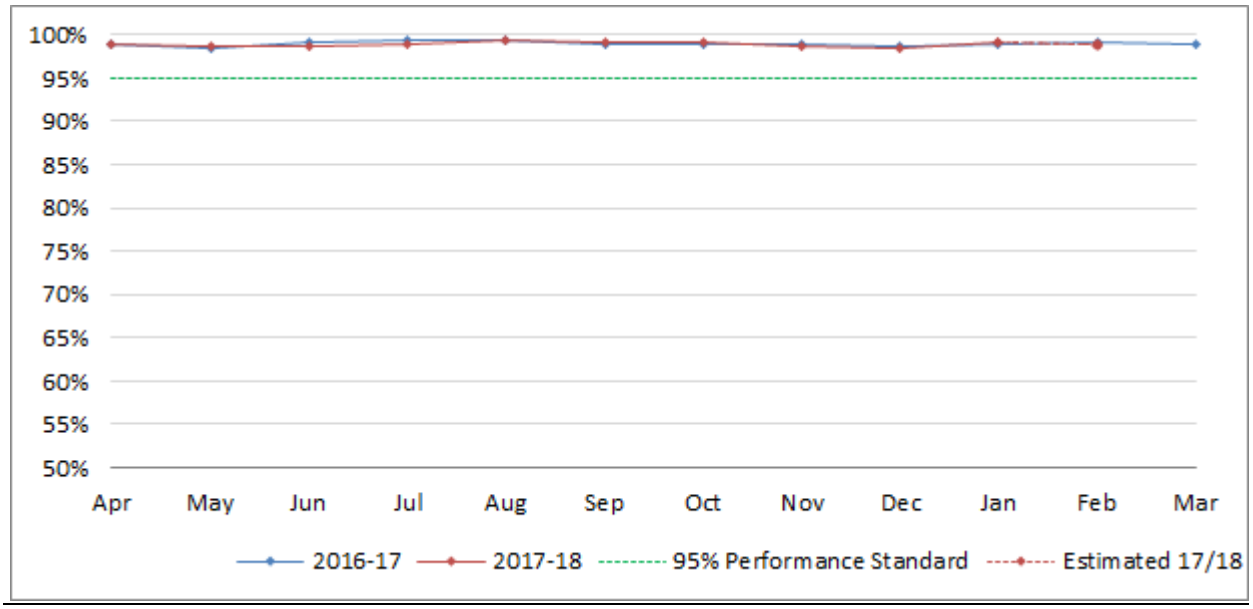
Consultant-led A&E units (type 1) performance improved by 5.0% during the winter 2017/18 compared to 2016/17. Although performance has deteriorated over the winter period compared to summer months. Improvement in performance has been mainly within consultant led units this means the highest acuity patients are being seen, diagnosed, treated and admitted and discharged more often within four hours over the last five months compared to the previous year.

Table 2: A&E consultant-led units (type 1) performance (reporting period October-January): NW London

	2016-17	2017-18	% Difference
Chelsea & Westminster Hospital NHS Foundation Trust	85.26%	92.39%	7.13%
Imperial College Healthcare Trust	67.53%	66.94%	-0.59%
London Northwest Healthcare Trust	59.79%	63.53%	3.74%
The Hillingdon Hospital Trust	55.04%	63.25%	8.22%
NWL Total	70.57%	75.57%	5.01%

Type 3

Fig 8: UCC (type 3) performance by month: NW London acute hospitals (excl. WICs)



Despite already being above the 95% standard, UCC performance has still seen an increase in performance of 0.1% from October 2017-January 2018 compared with the same period 2016-17.

2. North West London performance comparisons - across the capital and across the country

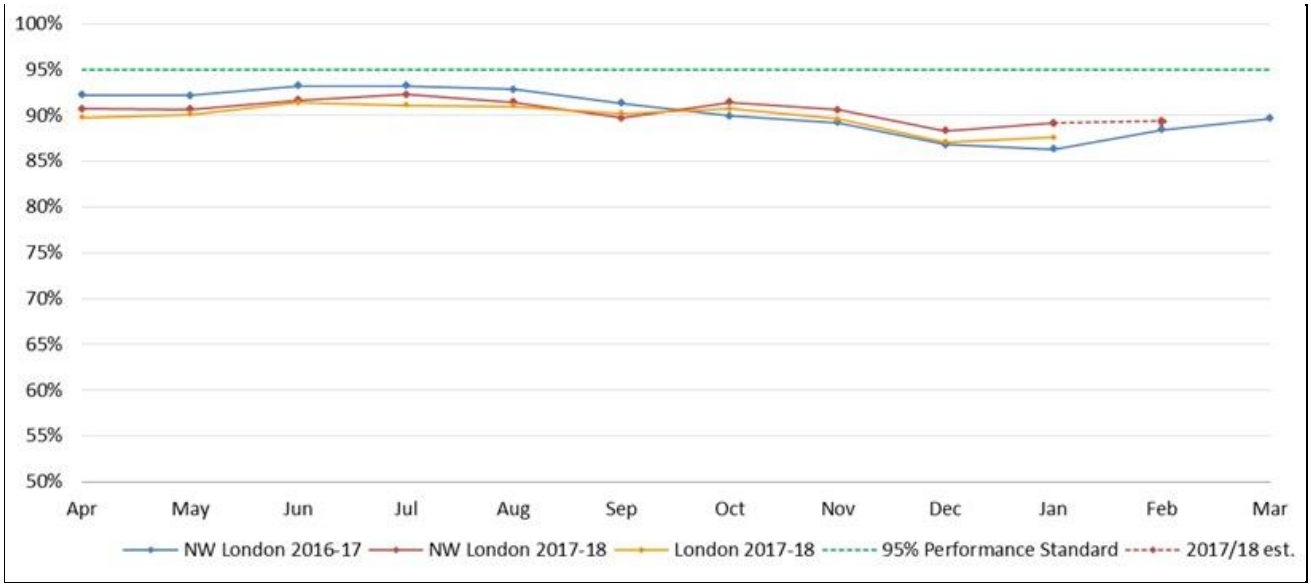
North West London performance (all types, including WICs) remains higher than that of both London and England as a whole. As the table below highlights, for January 2018 the performance in NW London was nearly 5% higher than England and over 2% higher than the London figure.

Table 3: A&E Performance January 2018 (Incl. WICs)

	Jan 2018
NW London all type performance (excl. walk in centres)	86.7%
NW London all type performance (incl. walk in centres)	90.0%
London (incl. walk in centres)	87.6%
England (incl. walk in centres)	85.3%

Pan-London performance between October 2017 and January 2018 has improved compared to the previous year.

Fig 9: A&E Performance 2016-17/17-18: North West London and London-wide



3. How we are planning ahead to mitigate the winter pressures and improve our performance long-term

Our transformation programme is about long-term change but the progress we've made to date is already showing the beginnings of a correlation between new community services, more self-care information, and improvements to the way people access acute care, and more sustainable levels of demand in our acute hospitals.

A number of these achievements which were implemented in time for winter 17/18 and have also helped us to cope with the winter pressures in North West London:

- Frailty services have started in all providers to navigate elderly and/or frail patients to the most appropriate service and ensure a full review of patients without the need to admit patients into hospital when they can be better cared for at home or in the community.
- Secured extra funding from NHS England for additional community capacity over the winter period to support safe rehabilitation outside of an acute setting.
- Two of our providers have had their A&Es refurbished with complete redevelopments at Northwick Park and Chelsea & Westminster in the last two years. This has improved the A&E infrastructure, including additional capacity for resuscitation bays and new assessment areas within these hospitals. This is expected to continue in 2018/19 with Imperial's plans to extend Charing Cross, and with the future plans to redevelop St Mary's Hospital.
- Discharge to Assess (D2A) has been rolled out across all North West London acute trusts helping discharge patients home with support as soon as thereby freeing up acute capacity earlier.
- All providers are implementing recommended best practice ("SAFER bundle") that recommends five areas best practice that Trusts should implement in order to improve their discharge processes. This includes expediting discharges before noon, "2 before 12:00", "Red to Green Days" which identifies any delays which lead to a patient being in hospital for longer than necessary and finally a multi-disciplinary review of all patients with a length of stay greater than 7 days.
- Free flu vaccine for Grenfell community.
- Significant improvements in services outside hospital, including:
    - 18 new local services delivered in GP practices
    - Evening and weekend access to a GP with 8am-8pm providing of primary care in every borough, seven days a week.
    - Free 24/7 NHS helpline ('Single Point of Access') for anyone who needs urgent mental health care.
    - Places of Safety established for people experiencing a mental health crisis.
- Public information campaigns on:
    - Self-care and health advice to help people stay well, with posters and leaflets
    - Use of 111 as a first port of call.
    - Pharmacy opening times over the Christmas and New Year period, and press campaign to encourage people to stock up on medicines before the holidays.
    - Flu vaccine - A campaign featuring Sir Trevor McDonald to encourage over 65s in particular to get the flu vaccine (in Hounslow, where he had the jab and where publicity was therefore strong, serious flu cases were among the lowest in the country).
    - In Ealing and Hounslow, we published *Your Child's Health*, locally-specific brochures, to give people information and advice on choosing the right type of care.

3.1 GP extended hours access

Extended access is now being provided across all boroughs, enabling patients to be seen seven days of the week, 8am – 8pm, by primary care. Patients are not necessarily seen in their usual surgery – groups of surgeries are working together to provide these extra appointments and provide more convenient appointment times with access to patients' records. Through 2017 there has been an increase in the number of patients seen in this way.

Direct booking via 111 is also available across North West London. This allows primary care appointments to be directly booked for patients who reach a primary care outcome following a call to 111.

Publicity campaigns, and local engagement, occurred both nationally and locally to raise awareness amongst residents of these services and it is expected that this will reduce demand on urgent care centres and general practice during 2018/19.

By November 2017 we offered an additional 21,000 appointments in NW London. On average there is a 60% usage of these extra appointments across NW London:

- Central: 2338 appointments (63% utilisation)
- West: 2327 appointments (45% utilisation)
- H&F: 1926 appointments (70% utilisation)
- Hounslow: 3523 appointments (57% utilisation)
- Ealing: 3102 appointments (60% utilisation)
- Brent: 6953 appointments (55% utilisation)
- Hillingdon: 542 appts (70% utilisation)[1]
- Harrow: 590 appts

3.2 Admission avoidance and ambulatory care

Schemes being implemented across North West London aim to divert appropriate patients from A&E and onto more appropriate ways of accessing the best care for their needs.

Ambulatory care pathways are an example of this. Ambulatory care is a patient focused service for conditions that may be treated at the hospital without the need for an overnight stay in hospital. Imperial are now managing 1300 pathways a month with 50% of pathways avoiding their A&E department completely.

Table 4: Average monthly ambulatory emergency care (AEC) activity by month

Trust	2016/17	2017/18
Imperial College Healthcare NHS Trust	1054	1584
The Hillingdon Hospitals NHS Foundation Trust*	N/A	526
London North West University Healthcare NHS Trust*	N/A	727
Chelsea and Westminster Hospital NHS Foundation Trust **	250	350

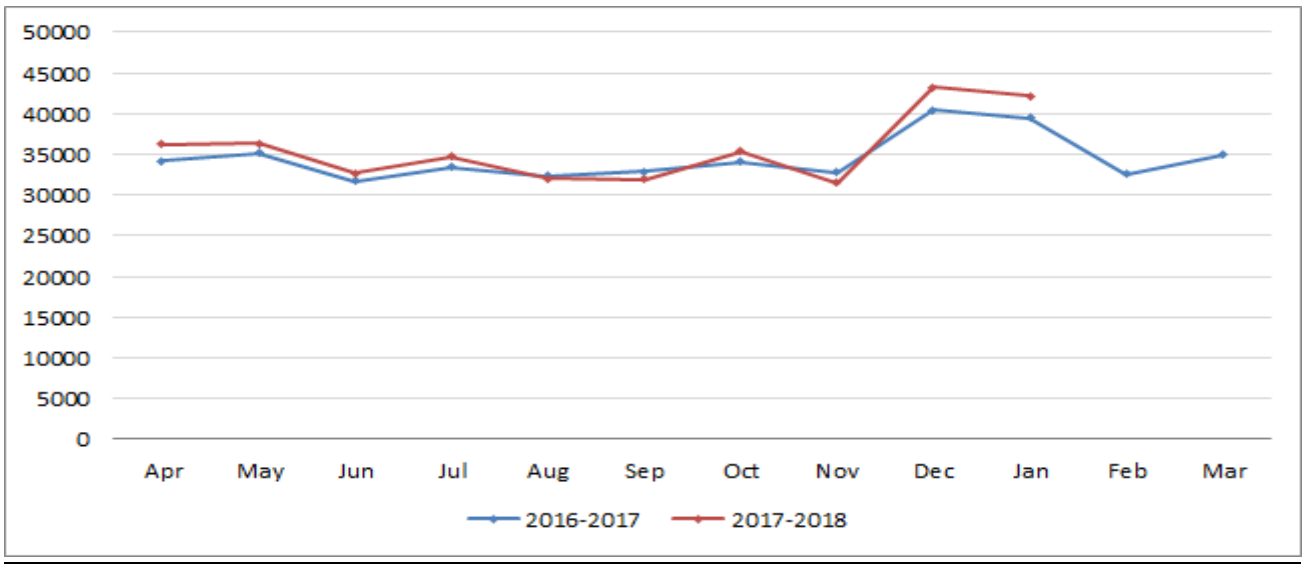
**Data only available from October 2017* ***Estimated*

[1] figure is due to increase with additional hubs

3.3 NHS 111

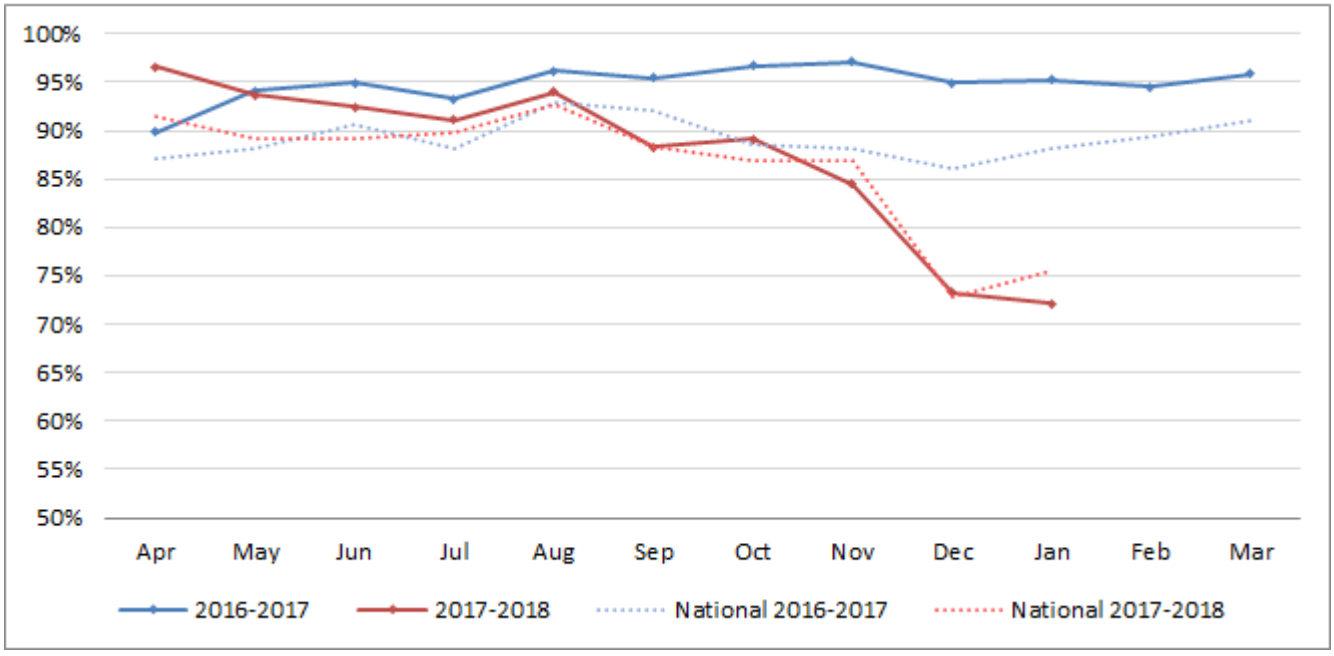
The NHS 111 telephone number enables the public to access urgent healthcare services.[2] The free 111 number is available 24 hours a day, 7 days a week, 365 days a year to respond to people's healthcare needs. The NHS has heavily promoted 111 before and during the winter period to triage demand and make sure patients can easily get accurate, clear health information so they can access the most appropriate services for their needs.

Fig 10: Total 111 calls by month – NW London



The number of calls to North West London 111 services has increased by 7% in December 2017-January 2018 compared to the same period last year.

Fig 11: Percentage of 111 calls answered in 60 seconds, by month – NW London

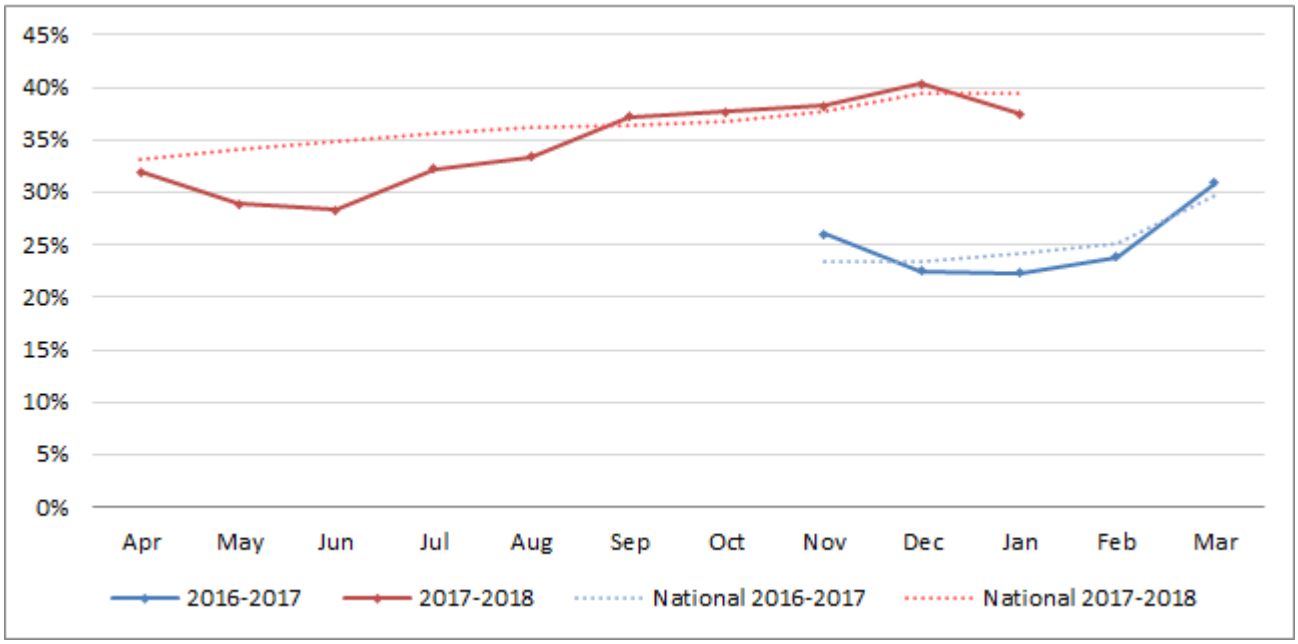


NHS England recommended that all 111 calls must be answered within 60 seconds and performance in this area has deteriorated in 2017/18. Performance has been mainly affected by increased demand as

[2] NHS 111 Minimum Data Set 2017-18.

well as an increase in staff sickness. As a result, 111 providers in NW London are revising their forecasting and ensuring rotas are sufficient to meet this increased demand which includes offering overtime incentives, reducing annual leave, sub-contracting call handling services and using agency staff to backfill shifts.

Fig 12: Percentage of 111 calls to any clinician by month

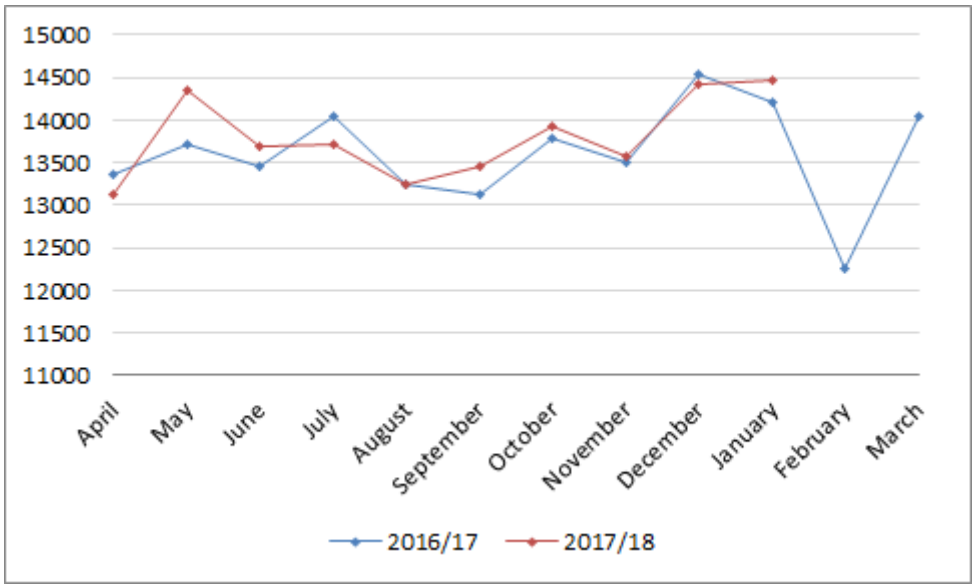


NHS England recommends that at least 40% of 111 calls are transferred to a clinician as this is likely to reduce the need for onward referral if a clinician is able to provide advice over the phone. This target was met in December and will be recovered in February following a challenging January.

3.4 London Ambulance Service (LAS)

LAS conveyances (transferring a patient to a point of care) have increased by 0.7% in 2017/18 financial year (to January 2018) and 0.6% higher in the winter period compared to 2016/17. This is lower than the increase in 2016/17 compared to 2015/16 which had an increase of 7.4%.

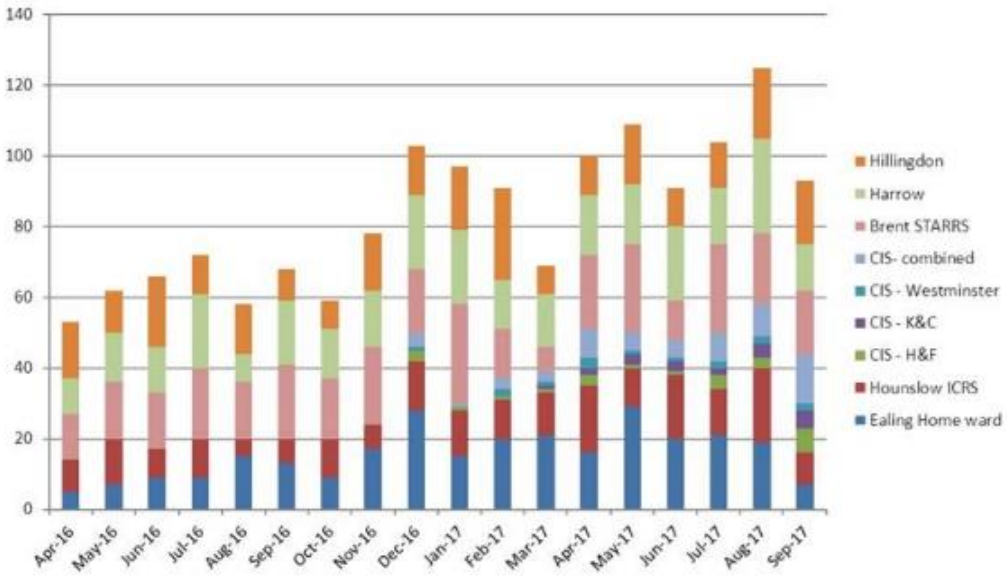
Fig 13: Number of LAS conveyances by month - NW London



The LAS contract has experienced sustained rises in demand year on year and has consistently over-performed against its financial plan. The agreed 2017/18 contract requires all London CCGs to implement demand management schemes to reduce 2017/18 activity by an average of 6.4% compared with 2016/17 activity. To support this work, NW London CCGs have worked with LAS on a programme, which includes the development of frequent caller services and improving the referral pathway between 111 and 999.

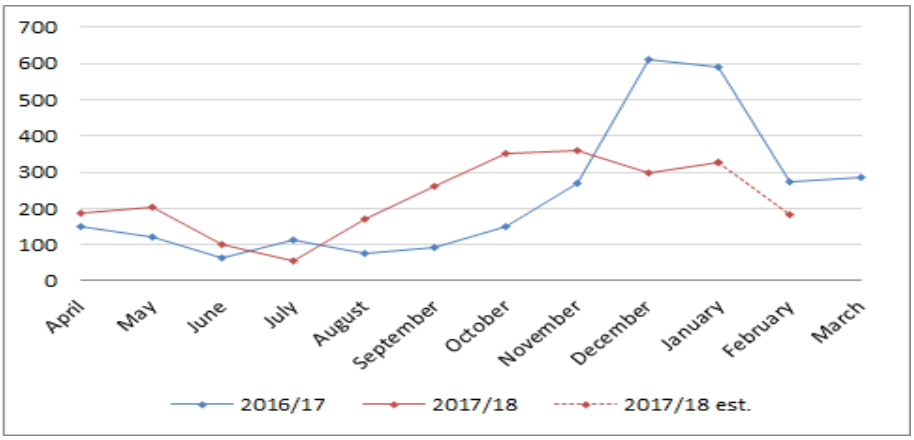
We have also worked with LAS to enable referrals to local rapid response services. There has been a 51% increase in LAS referrals to rapid response services across NW London. A robust communication strategy was launch in August 2017 and since April there have been 573 referrals by LAS accepted by rapid response services across NW London. This is a huge success in reducing NW London admissions.

Fig 14: LAS referrals to rapid response, by month – NW London



Wait times to LAS handover has also improved, when looking at the number of ambulances that wait to handover within the A&E department longer than 30 and 60 minutes. A 17% reduction in patients waiting in the A&E to be handed over by ambulance crew for over one hour and a 12% reduction for those waiting over 30 minutes (October - January) 2017/18 compared to the previous year. Further improvement in these waiting times is expected in February as actions to improve A&E flow take full effect.

Fig 15: Patients waiting in A&E to be handed over by ambulance crew for over one hour by month - NW London



The Ambulance Response Programme (ARP) aims to prioritise the sickest patients by avoiding 'stopping the clock' with a first responder, which was allowed under the old 8 mins response target. In summary the new standards are intended to:

- Prioritise the sickest patients quickly to ensure they receive the fastest response.
- Ensure national response targets to apply to every patient for the first time – so ending 'hidden waits' for patients in lower categories.
- Ensure more equitable response for patients across the call categories.
- Improve care for stroke and heart attack patients through sending the right resource first time.

3.5 Helping patients get safely home more quickly (improving the discharge pathway)

This winter, a greater emphasis has been placed on reducing the number of patients with a length of stay in an acute hospital of over seven days. There are many reasons for extended hospital stays but a proportion of stays will be as a result of unnecessary waits in the system. Some of these may be internal within the hospital, such as waiting for a clinical review, diagnostic test or referral to specialist services, but others will be a result of external delays outside of the hospitals control (e.g. support packages from social services or residential placement in the community). By reviewing these patients, social care, CCGs, community provides and the hospital team can address blockages within the inpatient stay to speed up discharge. A decrease in the number of patients staying in hospital over seven days is an indicator of improved patient flow.

The graphs below show an improvement over the winter months with three of the four NW London trusts below the 40% threshold.

Fig 16: Percentage of patients with length of stay seven days or more by month - NW London

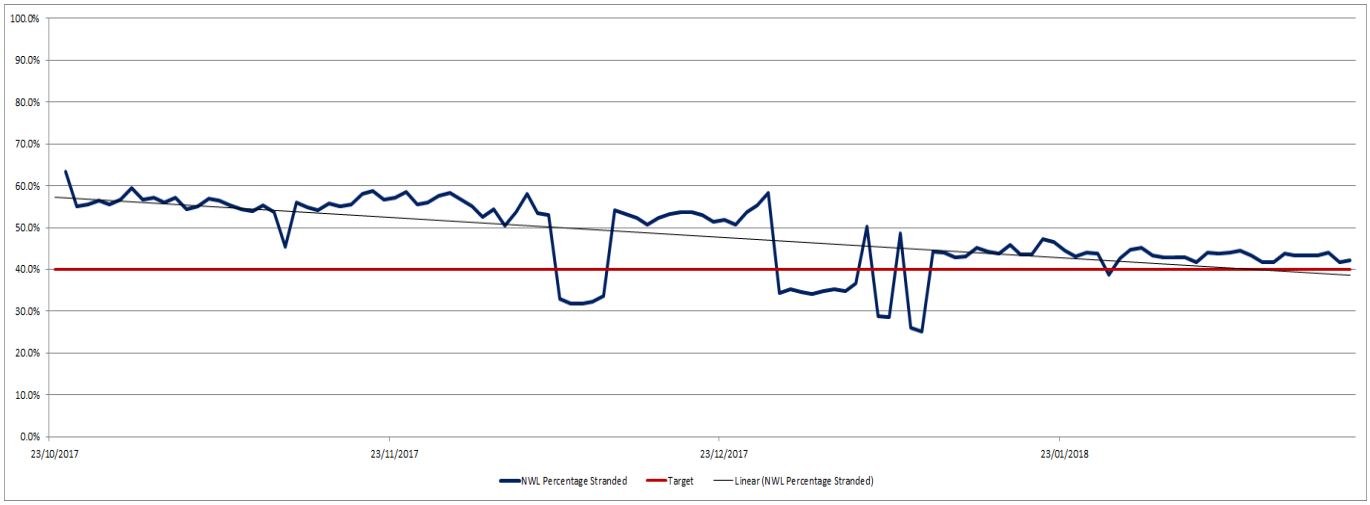
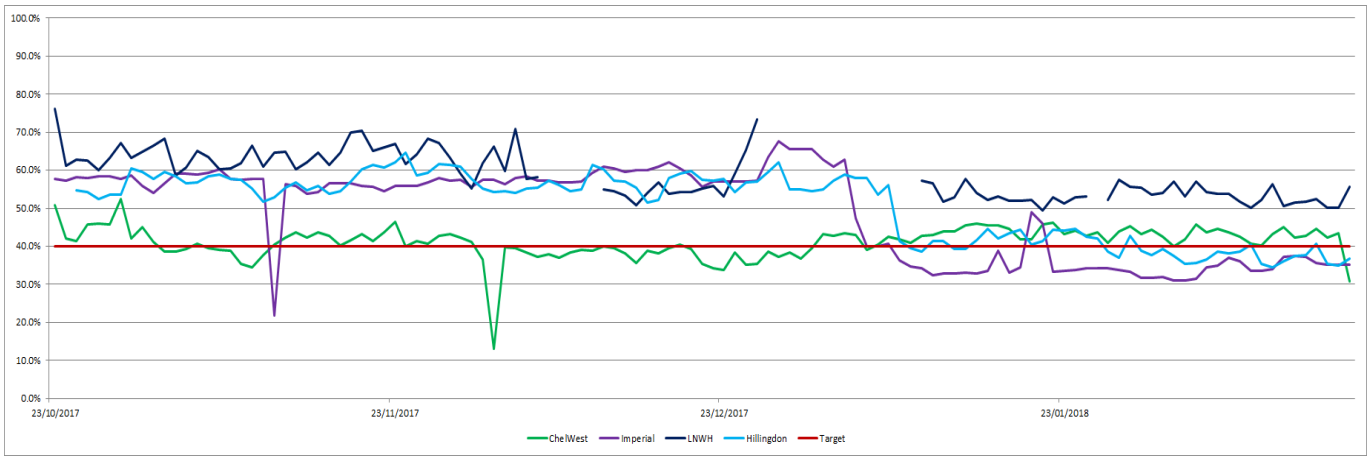


Fig 17: Percentage of patients with length of stay seven days or more by month: North West London providers



Breaks in line indicate that no data was submitted for this period by Trust

3.6 Delayed Transfers of Care (DToCs) in NW London

A 'delayed transfer of care' occurs when a patient is ready to leave a hospital or similar care provider but is still occupying a bed. Delays can occur for many reasons, for example when health or social care assessments are not completed, or when required equipment is awaited in the patients home or suitable care homes cannot be identified quickly enough. Delayed transfers can cause unnecessarily long stays in hospital for patients as well as affecting A&E waiting times for NHS care, as they reduce the number of beds available for other patients that require admission.

- The total number of delayed transfers across the whole of NW London between October-December 2017 overall was 5% lower than the previous year.
- Hillingdon has the lowest level of DTOCs of all the boroughs in London and all boroughs are within five days of their target set within November, a significant improvement in comparison to the beginning of the year.
- All the NHS acute Trusts are meeting the targets.

Fig 18: Total bed days lost due to DTOC by month - NW London acute trusts

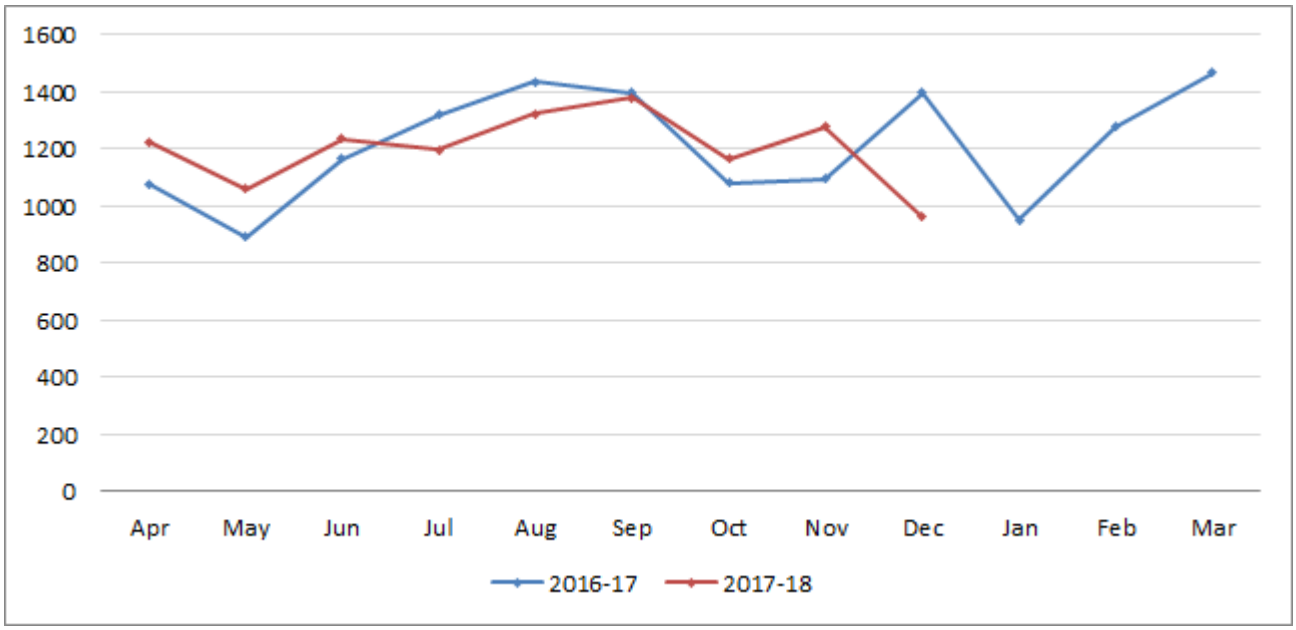
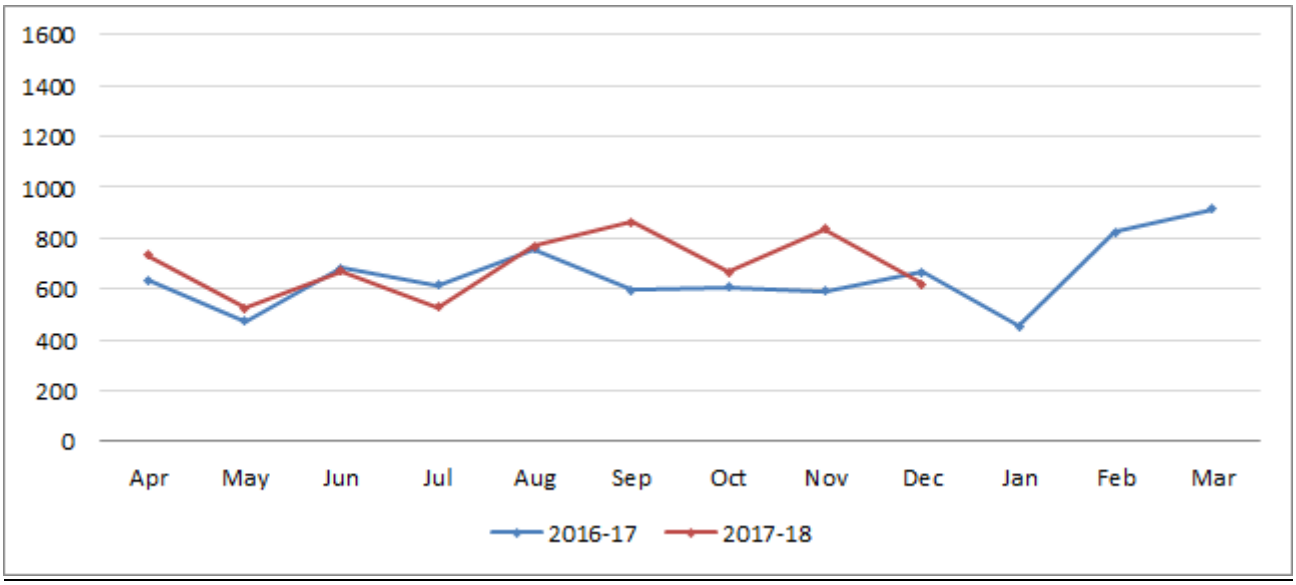
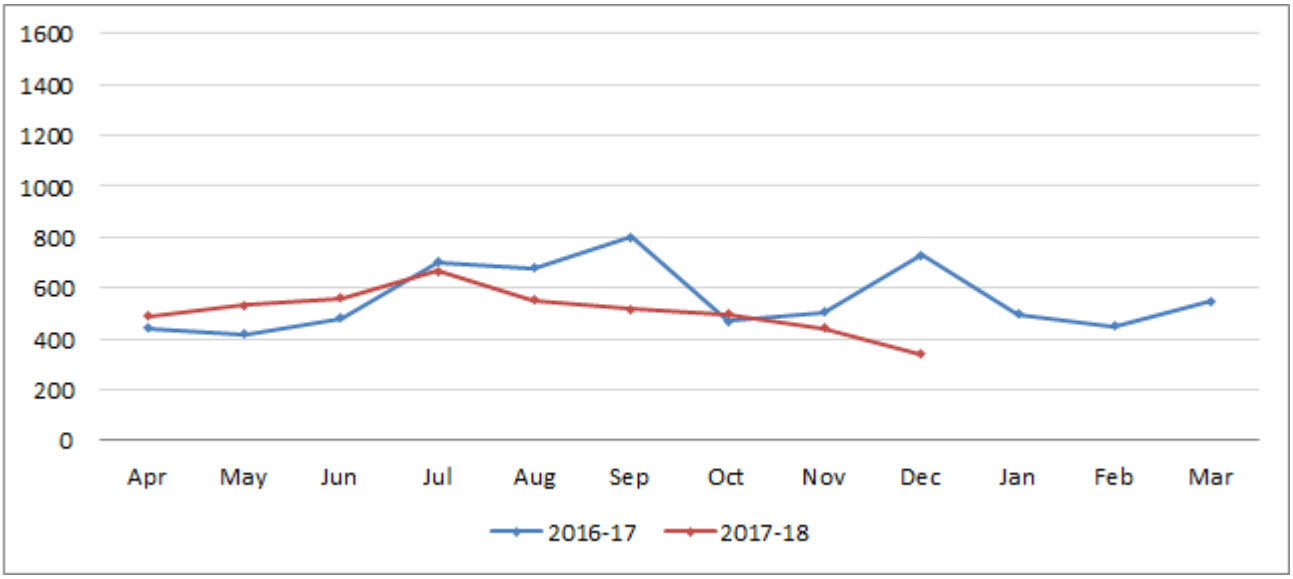


Fig 19: Bed days lost due to DTOC related to social care needs by month - NW London acute trusts



Delayed transfers with a delay attributed to social care are higher with a 12% increase in October-December 2018 compared to the previous year.

Fig 20: Total bed days lost due to DTOC related to health needs by month - NW London acute trusts



Delayed transfers with a delay attributed to social care are lower with a 33% decrease in October-December 2018 compared to the previous year.

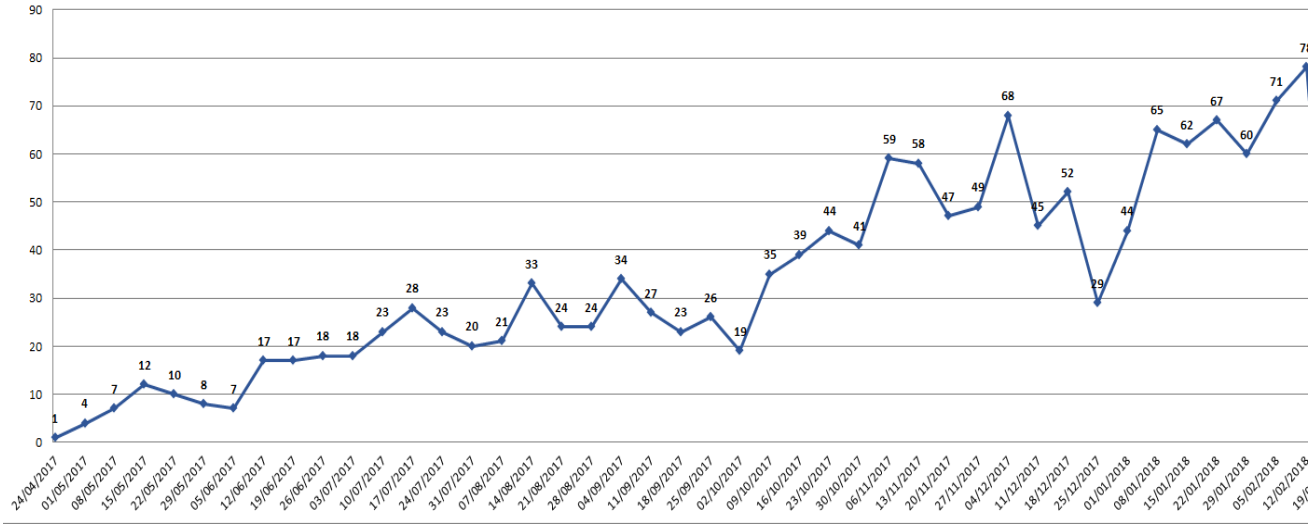
3.7 Discharge to assess

Discharge to assess refers to a situation in which people who are well and no longer require an acute hospital bed may still require additional care services, are provided with short-term, funded support in order to be discharged to their own home (where appropriate) or another community setting.

Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person."[3]

- All eight boroughs across North West London have designed and tested a new Home First pathways and are focused on implementation and wider sustainability planning.
- Over 1,450[4] patients have been discharged using Home first principles.
- The average age of those discharged under the pathway is 81.

Fig 21: Total discharge to assess (Home First) by week - NW London



- Brent Home First commenced on 24 April 2017. **362** patients have been discharged on Home First pathway
- Hillingdon Home First started on 8 May 2017. **372** have been discharged on Home First pathway
- Ealing Home First started 5 June 2017. **273** patients have been discharged on Home First pathway
- Harrow Home First commenced on 12 June 2017. **141** patients have been discharged on Home First pathway
- Tri-borough Home First started 10 July across both Imperial and Chelwest Trusts. **253** patients have been discharged on Home First pathway
- Hounslow Home First started on 10 August 2017. **56** have been discharged on Home First pathway

[3] NHS England Publications Gateway Reference 05871

[4] Figures correct as at 23 February 2018

4. Conclusion

North West London continues to achieve A&E performance in line with or better than both London and England. While North West London is not yet consistently meeting the 95% national standards during 2017/18, performance is improving, and we are close to meeting the 'key deliverable' goal of 90% as set out in the 2017 NHS England planning guidance.

Planning guidance for 2018/19 continues to target an improvement in our A&E performance with the aim for each A&E delivery system to improve or deliver 90% all type performance by September 2018. Our Health and Care Plan does set out the ways in which we expect to manage demand effectively and improve services. Our A&E performance across the winter months demonstrates the resilience we have built into the system.

NW London STP – cover paper for the Joint Health and Oversight Committee (JHOSC)

In October 2016 we published our Sustainability and Transformation Plan (STP) for NW London. The plan, developed across health and local government, aimed to change the model of care from a reactive system which waited for people to fall ill and attend a hospital, to a proactive one focussed on prevention and giving people the right care in the right place at the right time, with a real integration between health and social care.

The Plan was originally organised into five delivery areas:

1. Improving your health and wellbeing
2. Better care for people with long term conditions
3. Better care for older people
4. Improving mental health services
5. Safe, high quality sustainable hospital services

Within those five delivery areas we identified the following priority areas:

- Investment and support for GPs and their
- Saving lives through improved cancer
- Long term conditions and mental
- Providing the right care every time to prevent serious illness
- Supporting people to take control of their own health
- Getting the whole health and care system working together for older people
- Home from hospital
- Last phase of life
- Supporting adults with serious and long-term mental health
- Targeted support for specific groups of people
- Crisis care
- Children and young people
- Commissioning high-quality and effective care for older people
- Improving commissioning of specialised services
- Getting hospital patients better, quicker
- Organising hospital
- Hospital productivity programme

To make this a success we focussed in on what is at the heart of the challenge facing us in North West London – supporting our urgent care system.

As a result we identified a number of key programmes based on the STP which could help us make real, sustainable progress to improving the quality of urgent care – taking the pressure off some of our most challenged acute hospitals.

We are doing this through three key (interdependent) programmes. Work streams across these programmes are working together to improve care across the whole spectrum of non-elective activity:

- Our **keeping people well** programme proactively supports people with long-term conditions to prevent exacerbation and crisis which could lead to hospitalisation.

- When people are in crisis, our **support in times of crisis** programme ensures people receive a swift and effective package of care and out of hospital support so that they can be cared for in the home or a community setting.
- If people do need acute hospital care, our **appropriate time in hospital** programme makes sure that they see the right experts at the right time in the right place, so that they can be discharged – or as quickly as possible.

Within these three programmes are nine specific work streams (and the relevant STP delivery area they fall under):

Keeping People Well
- Long term condition management: Diabetes transformation (DA2)
- Integrated community teams

Support in times of crisis
- Frailty services (DA3)
- Mental health support (DA4)
- Referral to rapid response
- Supporting care homes & People in last phase of life (DA4)

Appropriate time in hospital
- Acute patient flow improvements (DA5)
- Home First (DA5)
- Hospital transfer (DA5)

All of these interdependent programmes and work streams are focussed on managing our non-elective (NEL) admissions, which is the cornerstone of our STP. While we in NW London have been fully focussed on this task we haven't always communicated as well as we should about how we can achieve this and so the paper which follows sets out how these key parts of our STP are being taken forward to reduce the amount of NEL admissions.

The paper that follows sets out very clearly how these three programmes are set up, how they interrelate with each other, highlights some of the evidence base for the work we have done – in particular where pilots have been run successfully either elsewhere or within NW London – and most importantly showcase where we have made real progress.

NHS
North West London
Collaboration of
Clinical Commissioning Groups

Delivering the North West London STP urgent and emergency care priorities

Reducing the need for non-elective hospital care

This paper outlines how we will work across our STP to manage non-elective demand, mitigating growth in the system

These priorities form part of our Sustainability and Transformation Plan (STP), building on our system-wide agreed local services strategy for primary and out-of-hospital care. It focusses on high-impact changes to manage patients' needs more proactively and where possible, and clinically appropriate, to do this without being admitted to hospital.

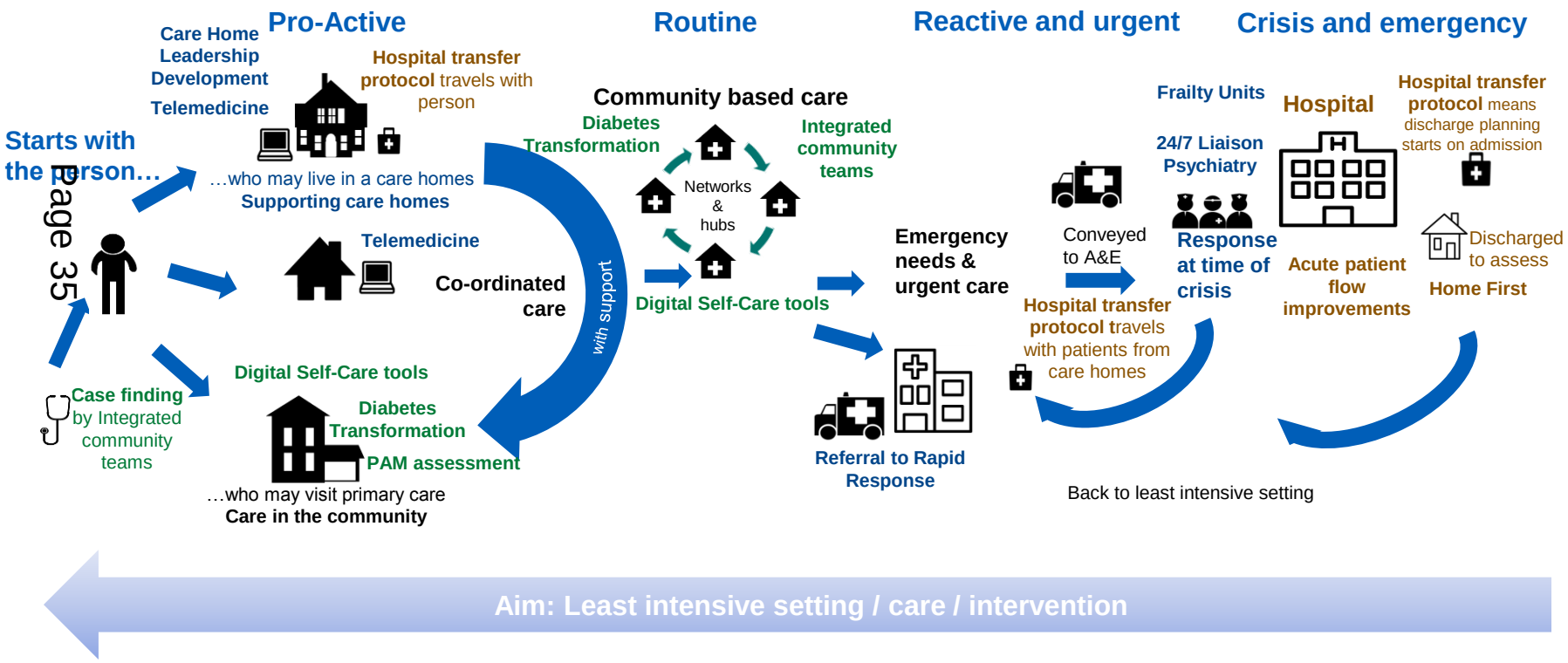
The overall aim is to reduce the need for non-elective hospital care. Improving health and care for our population, as well as the sustainability of our health and care system.

We are doing this through three key (interdependent) programmes. Work streams across these programmes are working together to improve care across the whole spectrum of non-elective activity :

- Our **keeping people well** programme proactively supports people with long-term conditions to prevent exacerbation and crisis which could lead to hospitalisation.
- When people are in crisis, our **support in times of crisis** programme ensures people receive a swift and effective package of care and out of hospital support so that they can be cared for in the home or a community setting.
- If people do need acute hospital care, our **appropriate time in hospital** programme makes sure that they see the right experts at the right time in the right place, so that they can be admitted, treated and discharged as quickly as possible.

Each of our work streams fits within the overall model of care as set out in our Local Services Strategy. It aims to meet people's needs in the most appropriate setting

Keeping People Well | **Support in Times of Crisis** | **Appropriate Time in Hospital**



In order to achieve our model of care, each of the strategy's three programmes contains a number of work streams. These form the basis for implementing the strategy and realising its benefits.

Keeping people well

- Long Term Condition management: Diabetes Transformation
- Integrated Community Teams

Support in Times of Crisis

- Frailty services
- Mental health support
- Referral to Rapid Response
- Supporting care homes & people in last phase of life

Appropriate Time in Hospital

- Acute patient flow improvements – including:
  - SAFER Patent Flow Bundle
  - Red and Green days
- Home First
- Hospital Transfer (Red Bag) protocols

Programme 1: Keeping people well

What does the programme include?

Our Diabetes Transformation Programme is the first of our comprehensive programmes aimed at keeping people with long-term conditions (LTCs) well and at home

Integrated community teams (ICT) are avoiding hospital admissions by supporting patients to self-care and to be cared for in the community

Why has this programme been included in the strategy?

Keeping people well – especially those with long-term conditions (LTCs) - will reduce demand on acute hospital services by:

- **Avoiding admissions** as patients actively managing their health and care will prevent ill health and therefore acute care needs.
- **Avoiding admissions** as integrated, holistic community-based service manage long-term conditions effectively, preventing exacerbation.
- **Reducing length of stay** as community-based support facilitates faster discharge and reduces risk of re-admission.
- **Reducing length of stay** through effective diabetes management in acute settings, reducing complications.

Keeping people well

Over 38%of people admitted to our hospitals for emergency treatment have diabetes; our **Diabetes Transformation Programme** is the first of our comprehensive programmes aimed at keeping people with long-term conditions well and at home

What are we doing?

- Our programmes of long term condition management, centred around the patient, provide comprehensive services aimed at keeping people with a wide range of LTCs well and at home.
- This strategy focuses on our work with diabetes as it is our most comprehensive programme to date, and so we are keen to maximise benefit and learning for other areas.
- 38.2% of people admitted to hospital for non-elective care in NW London have diabetes.
- Our diabetes transformation programme will allow us to achieve optimum diabetes outcomes, save patients from complications and reduce costs.
- We are focused on four main areas of work:
  - Self-care and structured education: supporting those with diabetes better self-manage through tools and information
  - Integrated diabetes care: reducing complications associated with diabetes by managing three clinical treatment targets and delivering an NW London single diabetes service specification
  - A re-designed diabetes foot pathway to prevent amputation and foot disease
  - Diabetes prevention: increasing referrals to the national diabetes prevention programme

What have we achieved so far?

- Our *Know Diabetes w*ebsite has been launched
- A shared record viewable to all clinicians involved in diabetes care.
- Clear improvements in a range of clinical indicators evidenced to reduce the risk of morbidity and mortality, e.g., 3,088 patients with the NICE 3 Treatment Target controlled since June 2016
- 55k patients with a collaborative care plan allowing more coordinated care for these patients

Who will benefit?

- Adults of all ages with diabetes across NW London, **who accounted for 35, 897 admissions and the equivalent of 852 beds in 2017/18.**
- For diabetes prevention, adults of all ages across NW London at risk of developing diabetes.

Evidence underpinning our approach

- 235 **NW London GP** practices have already transformed their diabetes care –with clear improvements in a range of clinical indicators.
- **RAMP-DM, Hong Kong:** In over 121k patients, 66% reduction in mortality, 41% reduction in emergency attendance and 59% reduction in admissions at 5 years.
- **Camden:** integrated unit covering the whole CCG area has led to decreases in numbers of emergency admissions due to diabetes and numbers of people developing complications.

Delivery area 2 - Better care for people with long term conditions.
Providing the right care every time to prevent serious illness

Keeping people well

Integrated community teams are avoiding hospital admissions by supporting patients to self-care and to be cared for in the community

What are we doing?

- Avoidable admissions for patients across NW London are being reduced through embedding an integrated model of care that enables patients with long term conditions (LTC) to plan and manage their own care by themselves, with carers and/or with community support.
- NW London is a pioneer for integrated care and each borough has its own care model for bringing together a multidisciplinary team to proactively meet the needs of patients with LTC. Whilst all CCGs have implemented this for three years, West London and Hillingdon CCGs demonstrate the most significant admission reductions. They are amongst 15 nationally that have reduced both total emergency admissions, and admissions per capita, over the last two years.
- Future work focuses on learning from key success factors and adapting care models across NW London to reflect best practice, including in areas such as: risk stratification and case finding, multi-disciplinary case management and use of the patient activation measure (PAM) assessment to support patients to set and achieve self-care goals, with appropriate monitoring.
- Implementing this model across NW London reduces hospital admissions, supports earlier discharges, and supports patients to self-care and be cared for in their own home for longer.

What have we achieved so far?

- All NW London CCGs and boroughs have integrated care models in place. We now need to learn from those which have had greatest success in improving outcomes – West London and Hillingdon.
- Hillingdon had seen the fourth biggest reduction nationally (13%) in total emergency admissions, and admissions per capita, over the last two years. West London had achieved nearly 10%.

Who will benefit?

- Patients of all ages across NW London who are eligible for integrated care in their boroughs.
- The initial focus will be on frail patients.
- **In 2017/18, patients who could be managed through primary care accounted for 36,033 admissions and the equivalent of 748 beds in 2017/18.**

Evidence underpinning our approach

- In **West London**, GPs report working more effectively and no patients enrolled had not had a health crisis since being case managed.
- Since 2014, **Hillingdon's** Care Connection Teams have delivered a 15% reduction in older people (65+) NEL admissions.
- **Islington** CCG PAM data suggest non-activated patients are 38% more likely to attend A&E than activated patients.

Delivery area 2 - Better care for people with long term conditions.
Supporting people to take control of their own health

Programme 2: Support in times of crisis

What does the programme include?

Proactive Frailty Services will avoid admissions by providing a holistic response for frail older people.

Mental health support is about building capacity in local mental health units and providing 24/7 access to specialists for people in crisis

Referral to rapid response will reduce admissions by providing immediate care assessment and brief care interventions in the community

Supporting care homes and people in last phase of life will help care home staff and carers to manage patient care in the community

Why has this programme been included in the strategy?

Supporting people in times crisis by providing them with care and advice in the community, without an admission to hospital, will reduce demand on acute hospital services by:

- **Avoiding admissions** as patients receive suitable interventions to manage crisis either in community settings, or more swiftly in acute settings (preventing acute attendances converting to admissions)
- **Reducing length of stay** as co-morbidities between mental and physical health are managed effectively in acute settings (liaison psychiatry).
- **Reducing length of stay** as patients with more effective community-based support can be discharged sooner.

Support in Times of Crisis

Proactive Frailty Services will avoid admissions by providing a holistic response for frail older people.

What are we doing?

Our new proactive frailty service model that is being implemented across NW London will reduce avoidable admissions of frail older people (65+) who present in A&E in crisis. The service is being developed in phases. Initial implementation has focused on acute-based frailty units but there are five elements in total to be developed:

1. **Acute-based frailty units:** frailty teams will operate in all A&E sites, reflecting peak hours of presentation.
2. **Acute ambulatory care:** to support the emerging acute frailty pathways in A&Es, this will create streamlined access to ambulatory care services.
3. **Community frailty teams:** this will shift the focus of the service away from an acute hospital setting, using MDTs to proactively manage care in the community.
4. **Community ambulatory care:** ambulatory care pathways will also shift focus into a community setting.
5. **GPs, practices and primary care:** the GP Forward View focuses proactive management of frailty through regular reviews and falls risk assessments. This works in parallel with other elements of the programme.

Taken together, these interventions will better enable frail patients to stay well and independent for longer by providing treatment and care that allows them to stay in their own home and avoid the clinical risks associated with hospitalisation.

What have we achieved so far?

- A small scale pilot initiative ran at Ealing hospital in 2017. This showed an opportunity to run a proof of concept pilot in Northwick Park.
- Frailty standards agreed with NW London geriatricians group, including standard frailty assessment tool.
- A pilot of the community frailty unit is in operation in West London.

Who will benefit?

- Acute based frailty units will benefit frail older people (65+) who present to in A&E in crisis.
- In future years, proactive management by community teams will benefit people with frailty of all ages.
- **These patients accounted for 45,519 admissions and the equivalent of 1,059 beds in 2017/18.**

Evidence underpinning our approach

- A small scale pilot initiative ran at **Ealing hospital** in 2017. Of the 29 patients who were seen during the pilot, 67% were able to go home on the same day and were not admitted. The baseline admission rate is around 70%, suggesting that this model presents a significant opportunity to deliver care in a different way.
- **Leicester:** NEL admissions reduced by 20-30% and LoS by 0.5 days.
- **Poole:** 42% reduction in the number of care of older people bed days.
- **Royal Free Hospital:** same day discharge increased from 12% to 16% and LoS reduced by an average of three days per patient.

Delivery area 3 - Better care for older people.
Getting the whole health and care system working together for older people

NHS
North West London
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Clinical Commissioning Groups

Support in Times of Crisis

Mental health support is about building capacity in local mental health units and providing 24/7 access to mental health specialists for people in crisis through acute trusts and through direct referral

What are we doing?

Mental health support reduces avoidable admissions and length of stay for patients with mental health conditions by:

1. **Offering a 24/7 liaison psychiatry service (LPS):**

- In acute trusts a psychiatric liaison team is available 24/7 to provide a timely and responsive assessment and care to patients in mental health crisis**.** These teams assess patients in A&E within 1 hour of referral and patients on wards within 24 hours of referral.
- Wider work to reduce unnecessary A&E attendances of people in mental health crisis focuses on providing access to alternative support by Community Crisis Teams.

2. **Implementing Single Point of Access (SPA):**

- Single point of access (SPA) helplines provide 24/7 access to trained mental health advisors and clinicians who can offer help or advise to patients and carers in a crisis. GPs and police colleagues can also call the SPA for advice or to make referrals.

3. **Increasing capacity in mental health units:**

- Mental Health (MH) trusts are implementing Red to Green days to improve patient flow and increase bed capacity so patients in MH crisis are quickly transferred to the appropriate place of care. They are also working to reduce long stays (>50 days) to improve flow.

What have we achieved so far?

- Flow improvements at West London Mental Health Trust (WLMHT) has increased the average number of available mental health in-patient beds from 5 to 14.4 and there is a downward trend in patients staying over 50 days.
- Liaison Psychiatry Teams operate during normal hours in all acute trusts
- The 24/7 SPA helpline launched in 2016 has received over 5,000 calls for people managing a mental health crisis.

Who will benefit?

- Patients presenting at A&E or on acute wards who have an identified mental health need.
- **This group of pepole accounted for 23,863 admissions and the equivalent of 545 beds in 2017/18.**
- Our longer term changes will also benefit patients with mental health needs in the community.

Evidence underpinning our approach

- Analysis of **RAID in Birmingham** found reduced length of stay with 9,290 bed days saved over the 8-month study period, from a total of 2,497 referrals (equivalent to 13,935 bed-days in a full year).
- Implementing the RAID model across **four East London Hospitals** showed a decrease in length of stay for patients with mental health and drug and alcohol problems of approximately 2833 bed days in 2014/15, driven by a reduction in non-elective patient bed usage.

Delivery area 3 – Improving mental health services.
Crisis care

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Support in Times of Crisis

Referral to rapid response will reduce admissions by providing immediate care assessment and brief care interventions in the community

What are we doing?

- Rapid response is a highly responsive multidisciplinary community team providing assessment and short-term treatment for adult patients with urgent needs, available in all NW London boroughs. Patients access the services via a number of referral routes, with most referrals being from GPs.
- NW London started the redesign of its Rapid Response services in 2009 and this work has now taken place across all 8 CCGs. We now have Rapid Response services working 7 days per week for the whole population of NW London.
- Currently, NW London operates a rapid (within two hours) Multi Disciplinary Team assessment and care planning. Teams include nurses and therapists with access to medical and social care resource.
- We are now working to deliver consistent outcomes across the region through standardising our approach and sharing best practice across our Boroughs.
- The service will expand to serve more people via more access routes, providing a more comprehensive service. We will also extend rapid response teams to include mental health and social care expertise, in line with practice elsewhere, and ensure that services are integrated with pre-crisis patient care management in primary care, in particular for frailty syndromes.

What have we achieved so far?

- Rapid response services are in place in all eight NW London CCGs.
- A prevention of admission pathway has been in place with LAS since April 2017.

Who will benefit?

- Patients fulfilling the criteria for referral to the service (varies by Borough).
- **People who could use these services instead accounted for 666 admissions and the equivalent of 6 beds in 2017/18.**
- Wider rapid response impact is realised from delivery within integrated community teams (for which rapid response is a fundamental part).
- LAS referrals release ambulance resources to attend to other patients.

Evidence underpinning our approach

- Reporting of **Brent STARRS** indicates 2,325 admissions avoided in 2014/15, and 2,539 in 2015/16. Conversion rates from referral to avoided admission are consistently 80-90% per month.
- Other NW London boroughs are also avoiding significant numbers of admissions, including 1.546 in **Ealing** and 1,981 in **Hounslow** in 2016/17.
- The **South Manchester Rapid Response Service** resulted in 293 non elective admissions being avoided, from 319 referrals.
- In **Kent,** of 342 referrals recorded as being made to avoid admission, 94.4% of patients were discharged to their usual place of residence, avoiding admission.

Delivery area 3 - Better care for older people.
Getting the whole health and care system working together for older people

NHS
North West London
Collaboration of
Clinical Commissioning Groups

Support in Times of Crisis

Supporting care homes and people in last phase of life will avoid admissions by helping care home staff and carers to feel manage patient care in the community

What are we doing?

Avoidable admissions from care home and last phase of life patients will be supported in two ways:

1. **Through a leadership development programme and acuity and dependency tool:**

- Funding for the Care Home Manager Leadership Programme has been secured for up to 100 out of 140 care homes.
- The acuity and dependency tool informs care home staff about dependency needs of residents so that they identify those at risk of admission and manage their care pro-actively before they reach crisis.

2. **Through supporting care homes, and patients in the community, through telemedicine:**

- By April 2018, all care homes in NW London will have a telemedicine service staffed by a specially trained nursing team who have access to patients' primary care records. This involves 111 calls being re-routed or through the use of video technology.
- Admission avoidance targets from telemedicine in care homes have been agreed and a dashboard is in place to monitor these targets.
- Following successful implementation and evaluation of telemedicine for care homes, phase two will be implemented to provide telemedicine support to people in the last phase of life in the community.

What have we achieved so far?

- A pilot providing care homes with 24/7 access to clinical advice pan-London showed a 6.5% monthly decrease in care home 999 calls. Some providers also had access to video-conferencing facilities.
- Service design and planning for telemedicine implementation in care homes has been completed.
- Video conferencing procurement has commenced.

Who will benefit?

- All care home residents across NW London will benefit from improved care home leadership.
- All patients in their last phase of life will also benefit from telemedicine, both those in care homes and those in their own homes. **This group of people accounted for 27,197 admissions and the equivalent 674 beds in 2017/18.**

Evidence underpinning our approach

- Across **NW London**, care homes patients account for 4% of A&E attendances and 8% of NEL admissions.
- The **Airedale** Vanguard tele-health hub has shown a 37% reduction in NEL admissions from care homes.
- **Ealing CCG** has an enhanced primary care service for care homes. Since 2013, NEL admissions from care homes have decreased by 7% year on year despite rising acuity. Length of stay is decreasing.

Delivery area 3 - Better care for older people.
Last phase of life

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Programme 3: Appropriate time in hospital

What does the programme include?

Acute patient flow improvements are reducing length of stay at NW London acute hospitals.

Home First will support timely discharge from hospital by assessing patients in their home environment to make informed choices about long term care.

Hospital transfer (Red Bag) protocols will support patients to have a swift journey through our hospitals by providing documentation that can speed up care decisions.

Why has this programme been included in the strategy?

Ensuring that patients receive care in an efficient and effective manner in hospital - and that they are discharged as soon as they no longer need acute care - will reduce demand on acute services:

- **Reducing length of stay** by progressing patients from admission to discharge as efficiently as possible.
- **Reducing length of stay** by discharging patients into the community as soon as they no longer need acute treatment.

Appropriate Time in Hospital

Acute patient flow improvements are reducing length of stay at NW London acute hospitals.

What are we doing?

- We are reducing length of stay for patients in hospital through a wide range of patient flow programmes across our acute trusts.
- To develop a seven-day model of care that prevents unnecessary waits for patients, pilot projects to improve patient flow have been implemented and evaluated.
- Those showing clear benefits will then be rolled out more widely. Two flow programmes are being implemented by all Trusts across the region:
  - SAFER Patient Flow Bundle
  - Red and Green Days
- Each Trust also has a wide range of initiatives in place designed to improve flow throughout the non-elective pathway.
- These programmes will ensure that patients stay in hospital for no longer than clinically required.
- Patients will receive value adding care only and can progress towards discharge in the timeliest manner, improving patient experience and avoiding risks of increased length of stay including muscle deterioration, infection and pressure ulcers.

What have we achieved in this area so far?

- A number of initiatives have been piloted and analysed. Those showing a clear positive impact are now being rolled out.
- All of our acute Trust have programmes in place to improve non-elective flow. These will be developed in future as new initiatives come on-stream.
- The pilots implemented across NW London, along with trust-level flow initiatives, have had a combined impact of a 10% LoS reduction for patients (65+) across NW London providers.

Who will benefit from this change?

- All patients accessing acute care.

Evidence underpinning our approach

Pilots have shown a LoS reduction of:

- 1.0 days from weekend therapies
- 1.4 days from weekend pharmacy TTAs
- 0.6 days from increased weekend downstream medical cover.

Delivery area 5 – Safe, high quality and sustainable hospital services.
Getting hospital patients better, quicker

Appropriate Time in Hospital

Home First will support timely discharge from NW London's hospitals by assessing patients in their home environment to make informed choices about long term care.

What are we doing?

- Home First is a model of care where the assessment of a patient's ability to successfully function and carry out their normal daily activities is performed in their own home and not in a hospital bed.
- All acute Trusts in NW London have been piloting a Home First service. A core deliverable of the workstream has been the consolidation and simplification of existing discharge pathways**.**
- By 2020/21 all acute trusts in NW London will be moving away from piloting Home First to operating a Home First service as 'business as usual'.
- The Home First pathway provides significant opportunity to reduce length of stay and reduce the need for longer-term care packages.
- However, following successful implementation and service evaluation of Home First, increased length of stay reductions will be gained through piloting and implementing the approach with patients with more complex needs that need step-down or long term care packages.

What have we achieved in this area so far?

- All 8 boroughs across NW London have designed and tested a new Home First pathway, and are now focused on implementation and sustainability.
- Over **1500 patients** have been discharged successfully in the initial six months of project delivery (as of Feb 2018).
- Work on discharge pathway and capacity mapping has been completed.

Who will benefit?

- Patients who are medically fit to be discharged form acute hospitals, but who require further support at home or in the community (other than those in care homes).
- **This group of patients accounted for the equivalent of 656 beds in 2017/18.**

Evidence underpinning our approach

- **NW London:** Hillingdon Hospital's 8 week Home First pilot in mid 2017 found a 2.2 day reduction in average length of stay. This represents 158 bed days saved over pilot period.
- **Medway**: 25% reduction in 'Delayed Transfer of Care' rates after initial 3 months.
- **South Warwickshire:** reduced average LoS for over 75s by 19.4% (7.7 to 6.2 days) in 4 years, and by 24% for whole population (12.6 to 9.5 days).

Delivery area 3 - Better care for older people.
Home from hospital

Appropriate Time in Hospital

Hospital transfer (Red Bag) protocols will support patients to have a swift journey through our hospitals by providing documentation that can speed up care decisions.

What are we doing?

- **Hospital transfer (Red Bag) protocol –** a 'Red Bag' contains standardised documentation about a care home patient to facilitate quick clinical decisions in a hospital environment.
- It impacts on length of stay by:
  - Providing A&E assessors with the information they need to make decisions about the best pathway for the patient – limiting time spent in A&E
  - Providing ward staff with information they need to speed up care decisions
  - Facilitating direct liaison between ward and care home staff about discharge planning, so that discharge planning can start as soon as possible.
- The hospital transfer protocol is supported by in-reach training for care home staff about how to maintain high-quality information in the red bags.
- Local plans for roll out are being scoped and developed. Implementation will be complete by April 2018.
- Following implementation, further process changes in acute settings will be identified, as well as linking red bag contents with care planning.

What have we achieved in this area so far?

- Plans are being finalised for the roll out hospital transfer protocols across care homes for older people (65+).
- The current scope is older people in care homes, however, Hillingdon and Hounslow have plans to extend the use of Red Bags to mental health, physical disability, learning disability and sheltered housing services.

Who will benefit?

- All care home residents in NW London who access acute care. Patients who could benefit from this **accounted for the equivalent of 235 beds in 2017/18.**
- Later phases will further benefit care home residents by linking with care planning and other public services.

Evidence underpinning our approach

- Early monitoring of the impact and outcomes of the **Sutton CCG Red Bag Vanguard** has show that length of stay is 3 to 4 days shorter for care home residents who have had a Red Bag than those without a Red bag.

Delivery area 3 - Better care for older people.
Getting the whole health and care system working together for older people

NHS
North West London
Collaboration of
Clinical Commissioning Groups

Version 1.0

Being well, living well: a sustainability and transformation plan for North West London

EQUALITY ANALYSIS

(Equality Impact Assessment screening)

Contents

Date of next review

During the life of the STP programme (2016-2021) equality analyses will be completed for NWL-wide STP initiatives. Where known, dates for each are shown in Section 6. Please note these are works in progress so the dates are subject to change.

Section 1: Introduction

Policy being assessed

North West London Sustainability and Transformation Plan (NWL STP)

This is an overarching plan. It brings together some existing plans which have been previously assessed for their impact.

Senior Responsible Officer for the policy/function and lead person responsible for conducting the equality analysis

Clare Parker; Lead for the North West London Sustainability and Transformation Plan (NWL STP)

This screening has been conducted under the authority of Christian Cubitt, Director of Communication, NHS North West London Collaboration of CCGs.

Scope of the equality screening

The proposals in the STP programme need to pay due regard to the Public Sector Equality Duty (s.149, Equality Act 2010) to: ***'advance equality of opportunity between those who share a "protected characteristic" and those who do not share that protected characteristic'***. The STP proposals need to be analysed to how they will be advancing this equality aim including the need to:

- *remove or minimise disadvantages experienced by people due to their protected characteristic*
- *ensure that opportunities that reduce the equality gap are identified and built into plans*
- *take steps to meet the needs of people from protected groups where these are different from the needs of other people.*

Approach to the screening

The following equality screening sets out:

- an overall consideration of the effect that the STP proposals will have on equality groups based on each of the five delivery plans.
- at which level equality analyses should be undertaken e.g. London-wide, NWL STP, an area of NWL (e.g. two or three CCGs) or CCG/borough level with an indication of the timescales that these may be completed.

Each NWL-wide initiative will have an identified lead who will:

- work to the principles in the STP communications and engagement plan to ensure direct engagement with the communities most affected by the proposals
- be responsible for ensuring that any required equality assessment is carried out
- consider any HR implications for staff arising from the STP proposals
- ensure that any actions resulting from the equality analysis are implemented

Any equality assessments required of borough and local level initiatives are led by the relevant local programme leads.

Section 2: Description of the Sustainability and Transformation Plan

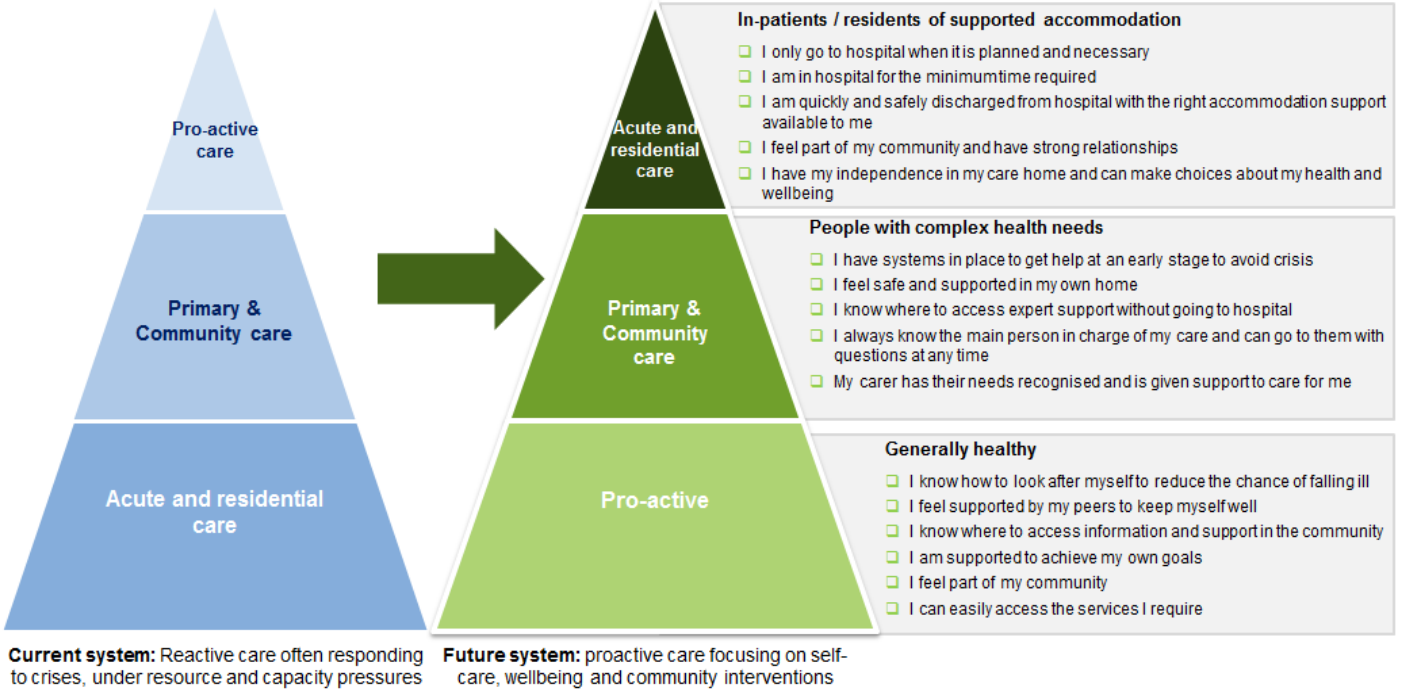
This equality screening considers the potential equality impacts of the proposals set out in the North West London Sustainability and Transformation Plan (NWL STP) draft submitted to NHS England on 21 October 2016.

The STP is the new national planning framework for NHS services, which supports the delivery of a transformed health service set out in the Five Year Forward View (5YFV). During 2016, 30 organisations across North West London (which covers eight CCGs and eight local authority areas[1]) have worked together to develop the STP.

The NWL STP has adopted the following joint vision.

Vision
Everyone living, working and visiting North West (NW) London should have the opportunity **to be well and live well** – to be able to enjoy being part of our capital city and the cultural and economic benefits it offers. For this to happen, the health service needs to turn the current model, which directs most resources into caring for people when they become ill, on its head. The new model must support patients to stay well and take more control of their own health and wellbeing, as close to home as possible.

Our vision of how the system will change and how patients will experience care by 2020/21



If we are to address the challenges to improve health and well-being, improve care and quality, improve productivity and close the financial gap (the triple aim), we must fundamentally transform our system. In order to achieve our vision we have developed a set of nine priorities which have drawn on local place-based planning, sub-regional strategies and plans and the views of the sub-regional health and local government Strategic Planning Group.

[1] Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea, and Westminster.

Having mapped existing local and NW London activity, we can see that existing planned activity goes a long way towards addressing the triple aim. But we must go further to completely close these gaps. At a NW London level we have agreed five delivery areas that we need to focus on to deliver at scale and pace. The five areas are designed to reflect our vision:

NWL STP priorities
1. Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves 2. Improve children's mental and physical health and well-being 3. Reduce health inequalities and unequal outcomes for the top three killers: cancer, heart diseases and respiratory illness 4. Reduce social isolation 5. Reduce unfair variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease 6. Ensure people access the right care in the right place at the right time 7. Improve the overall quality of care for people in their last phase of life, enabling them to die in their place of choice 8. Reduce the gap in life expectancy between adults with serious and long-term mental health needs and the rest of the population 9. Ensure services and experiences are of a high quality every day of the week.

- Delivery area (DA) 1 focuses on improving health and wellbeing, prevention and addressing the wider determinants of health
- DA 2 focuses on preventing the escalation of illnesses through better management of long term conditions
- DA 3 focuses on a better model of care for older people, keeping them out of hospital where appropriate and enabling them to die in the place of their choice
- DA 4 focus on improving outcomes for children and adults with mental health needs
- DA 5 aims to ensure we have safe, high quality, sustainable acute services.

Delivery plans have been developed for each of our workstreams; they are live documents which will continue to be updated as the programme develops.

Section 3: Public health profile for North West London

Public health profile for North West London

The following information is taken from the Shaping a Healthier Future strategic outline case carried out in December 2016 and various sources including the London Poverty Profile.

Overall

- The total population in NW London has increased from 1,953,500 in 2011/12 to 2,086,000 in 2015/16.7 This figure is forecast to increase by 141,000 (7%) over the period to 2018/19 and will is likely to increase at a similar rate to 2025/26.
- Only half of the population is physically active, with 13-24% of adults obese
- Over 80% of people want to die at home, but only 22% do so.
- There is a marked variation in the outcomes for patients across NW London, driven by variation in the quality and delivery of services in both primary and secondary care.
- Life expectancy is highest in Kensington and Chelsea and lowest in Hounslow
- Six of the eight boroughs have higher rates of increasing risk alcohol drinkers than the rest of London (although London rates are lower than the rest of the UK). In NW London, there are an estimated 317,000 'increasing risk drinkers' (drinkers over the threshold of 22 units/week for men and 15 units/week for women) with binge drinking and high risk drinking concentrated in centrally located boroughs.
- c.14% of the population smoke

Age

- There is a forecast rise of 13% in the number of people aged over 65 in NW London from 2015 to 2020. Between 2020 and 2030, this number is forecast to rise again by 32%.
    - The number of people aged over 85 is expected to increase by 20.7% by 2020/21 and 43.8% by 2025/26. These people are likely to have increasingly complex, long term conditions. There is an anticipated increase of 6,280 based on the 2014 baseline from 31,400 to 37,680 in 2020 that are currently, and forecast, to be living with a long term condition.
    - Half of over-65s live alone and over 60% of adult social care users want more social contact
    - 24% of people over 65 in NW London live in poverty, and this is expected to increase by 40% by 2030
    - 11,688 of our over-65 population have dementia, and the numbers are increasing
    - People aged over 65 form 15% of the population, but between April 2014 and September 2016, 46% of admissions and 68% of hospital bed days were attributed to people over 65. This disproportionate use of hospital capacity is even more marked for over 85s who, despite being only 2% of the population, used almost a quarter of the bed days in NW London in the last two and a half years.
- 1 in 5 children have conduct disorder
    - 10-28% of children are living in households with no adults in employment
    - 1.5% of children under 5 have tooth decay, compared to 0.9% nationally
    - Mental health needs are prevalent in children and young people with 3 in 4 of lifetime mental health disorders starting before the age of 18
    - Eating disorders account for nearly a quarter of all psychiatric child and adolescent inpatient admissions –with the longest stay of any psychiatric disorder, averaging 18 weeks

Disability (including long term limiting illness and mental illness)

- There are 338,000 people living in NW London with one or more long term condition, and a further 121,680 mostly healthy adults are at risk of developing a long term condition before 2030

- 1,500 people under 75 die each year from cancer, heart diseases and respiratory illness. If we were to reach the national average, we would save 200 people a year
- 21% of the population is classed as having complex health needs.
- 300,000 people, nearly one in six of all ages, have one of the following five long-term conditions: diabetes, asthma, coronary heart disease (CHD), chronic obstructive pulmonary disease (COPD), and congestive heart failure.
    - There are 20,000 patients diagnosed with COPD in NW London, but evidence suggests that this could be up to 55,000 due to the potential for under-diagnosis
    - 512 strokes per year could be avoided by detecting and diagnosing atrial fibrillation and providing effective anti-coagulation to prevent the formation of clots in the heart
    - 198,691 people have hypertension which is diagnosed and controlled. This is around 40% of the estimated total number of people with hypertension in NW London, but ranges from 29.1% in Westminster to 45.4% in Harrow.
- People with serious long-term mental health needs live 20 years less than those without. The number of people in this group in NW London is double the national average.
    - Around 23,000 people in NW London have been diagnosed with schizophrenia, bipolar and/or psychosis, which is double the national average
    - The population with mental illness have 3.2 times more A&E attendances, 4.9 times emergency admissions
    - There is a strong correlation between long term conditions and mental health problems. 317,000 people have a common mental illness, with 46% of these estimated to have a long term condition.
    - People with mental ill health use more emergency hospital care then those without, with 3.2 times more A&E attendances and 4.9 times emergency admissions.
    - 25% of people with depression and anxiety never access treatment

Gender reassignment

Data on gender re-assignment is not available at a NW London level, but a Home Office funded study for the Gender Identity Research and Education Society, estimated there were 300,000 – 500,000 transgender people in the UK[2].The study quotes from a 2007 report which estimates that 20 people per 100,000 of the UK population had sought medical care for gender variance – this would equate to around 400 people in NW London.

Pregnancy & Maternity

- In 2016 there were 30,000 births in NW london
- ONS data from 2015 suggests around 1.5%-7.7% of mothers in North West London smoke in the month of delivering their baby.
- 90% of mothers in NW London initiate breast feeding (2015)

Race and Religion

- North West London is ethnically very diverse with demographics varying across and within boroughs. Brent's Black and Minority Ethnic (BAME) residents make up 65% of the population, the figure is 30% in Kensington and Chelsea. The largest migrant populations are from India, Poland and Kenya.
- Some BAME groups (e.g. south Asians and black groups) have higher risks of major, potentially preventable, health conditions. South Asian groups have 50% higher risk of ischemic heart disease than white groups, while black groups have lower risks of heart disease than the general population. black groups have double the risk of stroke than the general population, and south Asian groups have rates 50% higher than the general population
- BAME Londoners are more likely to be unemployed, workless or low paid.

[2] Gender Identity Research and Education Society, The Number of Gender-Variant People in the UK, 2011

Sexual orientation

- Based on estimates for London 2.6% of the population identify themselves as lesbian, gay or bisexual, 0.3% describe themselves as ‘other’, a further 6.9% ‘don’t know’ or ‘refuse to say’ and 2% did not respond to this question. Nearly 90% of Londoners describe themselves as straight or heterosexual.
- Syphilis is an important public health issue amongst men who have sex with men, among whom incidence has increased over the past decade.

Socio-economic groups

- A third of children under 16 live in poverty according to official definitions.
- NW London’s 16-64 employment rate of 71.5% was lower than the London or England average.
- There are significant health inequalities across NWL and within boroughs, in terms of life expectancy and years of life lived with poor health. In one borough, men experience a 16 year difference in life expectancy between most and least deprived.
- The gap in life expectancy between the most and least deprived 10% of the population is 11.3 years for men and 7.9 for women
- People in the poorest fifth of incomes have are far more likely to have mental health problems that those in the richest fifth
- Death rates for cancer and heart disease are about twice as high for people from manual rather than non-manual backgrounds.

Section 4: Consultation, engagement and contribution

Between April and July 2016, in order to shape the direction of the STP we:

- Hosted two co-production workshops with lay partners, Healthwatch and providers
- Hosted two workshops with communications leads to help develop the engagement strategy and co-designed the strategy with Healthwatch chairs
- Hosted sessions with clinicians
- Ran a market stall event for core partners to showcase the range of work happening across the area
- Held 22 events across the eight boroughs. In Brent around 100 people discussed emerging priorities in table discussions, whilst in Hillingdon, over 100 more people attended an STP focused workshop
- Attended Health and Wellbeing Boards and CCG Governing Body meetings.

The feedback we received was addressed and incorporated into the STP submitted to NHS England in July 2016.

From July to October we organised a programme of 'town hall' style meetings and other face to face events across the eight boroughs, working closely with Healthwatch and other patient groups and residents' associations. The events were a mixture of presentation, question and answer sessions and table workshops to allow as many attendees as possible to participate. The events were led a senior clinician and a senior councillor from the borough.

We contacted over 500 groups (e.g. faith groups, community organisations and charities). We launched an online engagement tool targeting those residents who were unable to attend a public meeting; we surveyed residents and held pop up stalls in libraries, and visited community meetings. 1500 members of the public visited the online site leaving 400 comments. This activity was supported with Facebook advertising which reached more than 18,000 residents.

We ran a series of workshops with clinicians and local government officers and provided updates through internal newsletters, bulletins and updates, and online through intranets.

Feedback can be categorised into two distinct areas. First, there was a clear demand from those we most regularly engage with (for example stakeholders like Healthwatch, established patient groups and 'more informed' individuals) for greater clarity on 'technical' issues relating to the STP. These included its background, scope, legal standing, governance, timelines, implementation plans and likely impact on future funding for the NHS and local authorities. Other issues raised included requested clarity on engagement and consultation plans and how the STP related to future NHS organisational forms, such as accountable care partnerships. The second area was more about content , and related to the five STP delivery areas in the NW London draft document. All comments can be viewed online[3]

Going forward, where specific programmes or projects require consultations, as set out under section 14Z2 of the NHS Act 2006, we will carry those out.

[3] www.healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/nwl_stp_october_submission_appendices_v01.pdf

Section 5: Equality screening for the NWL STP

Delivery Plan 1: Improving health and wellbeing, prevention and addressing the wider determinants of health

The plan focuses on supporting people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves. It prioritises children's mental and physical health; aims to reduce social isolation and reduce inequalities in the outcomes of the three top killers: cancer, heart disease and respiratory illness. Establishing a People's Health and Wellbeing Charter, co-designed with patient and community representatives will focus attention on protected groups.

Protected groups	Impact (high, medium, low, none)	Nature of potential impact (positive/negative/ unknown)	Evidence of impact (describe how the policy will impact on each protected group)	Recommendations/mitigating actions (actions to be taken to tackle inequality and advance equality of opportunity)
Age	High	Positive	• Promoting prevention and improving wellbeing will help people of all ages • Older people in general experience greater health problems than the rest of the population and are more likely to develop long-term conditions which can be alleviated by changes in lifestyle • Older people in particular suffer from social isolation that this delivery plan addresses • There is a higher incidence of the top killers (cancer, heart disease and respiratory illness) in older people • Reducing the number of socially isolated people will be particularly advantageous to older groups • Implementing a programme for overweight children will be beneficial as will increasing immunisation rates, and the introduction of a pilot to prevent conduct disorder. • The *Future in Mind* strategy particularly targets children in schools • The Healthy Workplace Charter is less likely to benefit older and younger people (as they are less likely to be in work)	• Delivery of the plan will advance equality • The potential reduction in equality from the introduction of the Healthy Workplace Charter is more than counterbalanced by other schemes.
Disability	High	Positive	• Promoting prevention and improving wellbeing will help disabled people • Disabled people in general experience greater health problems than the rest of the population and are more likely to develop long-term conditions which can be alleviated by changes in lifestyle • The new Work and Health programme will provide	• Delivery of the plan will advance equality • The potential reduction in equality from the introduction of the Healthy Workplace Charter is more than counterbalanced by other schemes

Protected groups	Impact (high, medium, low, none)	Nature of potential impact (positive/negative/ unknown)	Evidence of impact (describe how the policy will impact on each protected group)	Recommendations/mitigating actions (actions to be taken to tackle inequality and advance equality of opportunity)
			effective employment support for people with learning disabilities and people with mental health problems • The *Like Minded* programme will support people with mental health problems • Targeting smoking cessation activities at people with mental health illness will reduce the equality gap for this group of people • Implementing annual health checks for people with learning disabilities will reduce the equalities gap • The Healthy Workplace Charter is less likely to benefit older and younger people (as they are less likely to be in work)	
Gender reassignment	Medium	Positive	Likely to be affected the same as the rest of the population	Monitor to ensure there are no unintended consequences
Marriage and civil partnership	Medium	Positive	Likely to be affected the same as the rest of the population	Monitor to ensure there are no unintended consequences
Pregnancy and maternity	Medium	Positive	Likely to be affected the same as the rest of the population	Monitor to ensure there are no unintended consequences
Race	High	Positive	• Some ethnic groups tend to have poorer general health outcomes and higher rates of illness than others. • Promoting prevention and improving wellbeing will help people of all races. • For those who do not speak fluent English, who are accustomed to accessing services they need in a familiar location and way, they may experience some difficulties.	• Delivery of the plan will advance equality • Ensure prevention programmes are relevant and targeted to local black and minority ethnic group communities. • Need to build on existing good practice working with local community groups and interpreters where necessary and seek to recruit a workforce that reflects the community.
Religion or belief	Medium	Positive	Likely to be affected the same as the rest of the population	Monitor to ensure there are no unintended consequences
Sex	Medium/ high	Positive	• Initiatives that prevent suicide and encourage better self-care/seeking early advice etc. are more likely to benefit men.	Check details of plan when developed to ensure it will advance equality

Protected groups	Impact (high, medium, low, none)	Nature of potential impact (positive/negative/ unknown)	Evidence of impact (describe how the policy will impact on each protected group)	Recommendations/mitigating actions (actions to be taken to tackle inequality and advance equality of opportunity)
			• Widespread availability of long acting reversible contraception in GP services, maternity and abortion services and early services for early pregnancy loss will benefit women.	
Sexual orientation	Medium/ high	Positive	Initiatives that prevent suicides will have a greater positive effect on the lesbian, gay, bisexual and trans (LGBT) community.	Monitor to ensure there are no unintended consequences
Socio-economic and other vulnerable groups	High	Positive	• People in lower socio-economic groups, homeless people and people unregistered with a GP are more likely to be benefit from prevention activities, however it is likely that they will not be able to afford to live healthily as easily as those with higher incomes and they may not be included in activities unless efforts are made to particularly target them in initiatives. • Providing supported housing for vulnerable people at risk of homelessness will reduce the equality gap • The Healthy Workplace Charter is less likely to benefit older and younger people (as they are less likely to be in work)	• Delivery of the plan will advance equality • Ensure prevention programmes are relevant and targeted to people in lower socio-economic groups. • Encourage local uptake of national screening programmes through hospitals so that homeless people and those not registered with GPs can access services. • Consider those groups who are unable to, or don't access GP services (homeless people/those not registered) • The potential reduction in equality from the introduction of the Healthy Workplace Charter is more than counterbalanced by other schemes

Delivery Plan 2: Preventing the escalation of illnesses through better management of long term conditions

Prioritises reducing the variation in the management of long term conditions such as diabetes, cardio-vascular disease and respiratory disease; and ensures people access the right care in the right place at the right time. Plans focus on delivering the Strategic Commissioning Framework and Five Year Forward View for primary care; increasing early diagnosis and treatment of cancer; better outcomes and support for people with common mental health needs; reducing variation by focusing on Right Care priority areas; and improving self-management and 'patient activation'.

Protected groups	Impact (high, medium, low, none)	Nature of potential impact (positive/negative/ unknown)	Evidence of impact (describe how the policy will impact on each protected group)	Recommendations/mitigating actions (actions to be taken to tackle inequality and advance equality of opportunity)
Age	High	Positive	• Older people tend to need to have more long term conditions (LTCs) than the rest of the population, so integrated care, patient activation etc in this delivery plan will reduce inequality. • Older people are less likely to take advantage of new communication methods e.g. digital technology • Older people tend to rely more on public transport, so enabling these groups to receive more care in their local community will make access to health services easier for them and their carers.	• New access routes to primary care need to be in conjunction with existing access, not a replacement, in order to preserve choice until it is clear that traditional services are no longer needed. • Delivery of the plan will advance equality. • Develop transport solutions in partnership with TfL. • Use of Right Care commissioning which uses data and evidence to reduce unwarranted variations in services and health will reduce the equality gap.
Disability	High	Positive	• Promoting prevention and improving wellbeing will help people of all disabilities. • Online services are likely to be beneficial to some people with physical/mobility difficulties • Cross-device services e.g. on apps could enable services to be better presented to people with learning disabilities • There is a link between mental health and long term conditions. A focus on improving both management of LTCs and mental health will tend to close the equality gap • Increasing availability of, and access to, personal health budgets will tend to close the equality gap.	• New access routes to primary care need to be in conjunction with existing access, not a replacement; in order to preserve choice until it is clear that traditional services are no longer needed. • Delivery of the plan should sufficiently advance equality. • Develop transport solutions in partnership with e.g. TfL, to ensure there is adequate transport to enable people to easily receive care close to home. • Use of Right Care commissioning which uses data and evidence to reduce unwarranted variations in services and health will reduce the equality gap.
Gender reassignment	Low	None/minimal	Likely to be affected the same as the rest of the population	Monitor to ensure there are no unintended consequences

Protected groups	Impact (high, medium, low, none)	Nature of potential impact (positive/negative/ unknown)	Evidence of impact (describe how the policy will impact on each protected group)	Recommendations/mitigating actions (actions to be taken to tackle inequality and advance equality of opportunity)
Marriage and civil partnership	Low	None/minimal	Likely to be affected the same as the rest of the population	Monitor to ensure there are no unintended consequences
Pregnancy and maternity	Low	None/minimal	Likely to be affected the same as the rest of the population	Monitor to ensure there are no unintended consequences
Race	High	Positive	• Promoting prevention and improving wellbeing will help people of all races. • Some ethnic groups tend to have poorer general health outcomes than others and higher rates of long term conditions (e.g. diabetes) so these proposals will have the potential to have greater positive effect. • For those who do not speak fluent English, who are accustomed to accessing services they need in a familiar location and way, they may experience some difficulties.	• New access routes to primary care need to be in conjunction with existing access, not a replacement; in order to preserve choice until it is clear that traditional services are no longer needed. • Delivery of the plan should sufficiently advance equality. • Develop transport solutions in partnership with TfL. • Use of Right Care commissioning which uses data and evidence to reduce unwarranted variations in services and health will reduce the equality gap. • Ensure prevention programmes are relevant and particularly targeted to local black and ethnic group communities. • Need to build on existing good practice working with local community groups and interpreters where necessary and seek to recruit a workforce that reflects the community.
Religion or belief	Low	None/minimal	Likely to be affected the same as the rest of the population	Monitor to ensure there are no unintended consequences
Sex	Low	None/minimal	Likely to be affected the same as the rest of the population	Monitor to ensure there are no unintended consequences
Sexual orientation	Low	None/minimal	Likely to be affected the same as the rest of the population	Monitor to ensure there are no unintended consequences

Protected groups	Impact (high, medium, low, none)	Nature of potential impact (positive/negative/ unknown)	Evidence of impact (describe how the policy will impact on each protected group)	Recommendations/mitigating actions (actions to be taken to tackle inequality and advance equality of opportunity)
Socio-economic and other vulnerable groups	High	Positive	• People in lower socio-economic groups tend to need to have more long term conditions than the rest of the population, so integrated care, patient activation etc in this delivery plan will reduce inequality. • Some lower socio-economic groups (e.g. homeless people) will have less opportunity to take advantage of new communication methods e.g. digital technology and not be able to use public transport. • Lower socio-economic groups tend to rely more on public transport, so enabling these groups to receive more care in their local community will make access to health services easier for them and their carers.	• New access routes to primary care need to be in conjunction with existing access, not a replacement; in order to preserve choice until it is clear that traditional services are no longer needed. • Delivery of the plan should advance equality. • Develop transport solutions in partnership with e.g. TfL, to ensure there is adequate transport to enable people to easily receive care close to home. • Use of Right Care commissioning which uses data and evidence to reduce unwarranted variations in services and health will reduce the equality gap.

Delivery Plan 3: A better model of care for older people, keeping them out of hospital where appropriate and enabling them to die in the place of their choice

Delivery Plan 3 aims to improve the overall quality of care for people in their last phase of life and enable them to die in their place of choice. We plan to do this by improving market management of care and taking a whole systems approach to commissioning; implementing accountable care partnerships; upgrading rapid response and intermediate care services; creating an integrated and consistent transfer of care approach across NW London; and improving care in the last phase of life.

Protected groups	Impact (high, medium, low, none)	Nature of potential impact (positive/negative/ unknown)	Evidence of impact (describe how the policy will impact on each protected group)	Recommendations/mitigating actions (actions to be taken to tackle inequality and advance equality of opportunity)
Age	High	Positive	• Older people are the main focus of this delivery plan • Improved management of local services, including ensuring a sustainable nursing and care home sector will benefit older people • Joint commissioning, between health and local government, of the entirety of older people's out of hospital care should result in better care for older people • People of all ages will benefit from high quality local acute services, improved referral times, reduced avoidable admissions etc, but older people are high users of these services • Improved transfer of care processes will benefit older people • It is possible that some older people will be discharged from hospital without the necessary support at home • Advanced care plans and improvements in end of life care (e.g. more people enabled to die at home) will benefit older people.	• Delivery of the plan will advance equality • Ensure strong links between health and social care services. • Ensure that safeguards are in place to ensure appropriate services for people who wish to die at home
Disability	High	Positive	• Disabled people tend to be high users of these services, so improvements will tend to impact more on this group • Improved management of local services, including ensuring a sustainable nursing and care home sector will benefit disabled people • Joint commissioning, between health and local government, of the entirety of older people's out of hospital care should result in better care for some disabled people • Disabled people will benefit from high quality local acute services, improved referral times, reduced avoidable admissions etc • Improved transfer of care processes will benefit disabled	• Delivery of the plan will advance equality • Ensure strong links between health and social care services.

			people • It is possible that some disabled people will be discharged from hospital without the necessary support at home.	
Gender reassignment	Low	Neutral/ positive	Likely to be affected the same as the rest of the population	Monitor to ensure there are no unintended consequences
Marriage and civil partnership	Low	Neutral/ positive	Likely to be affected the same as the rest of the population	Monitor to ensure there are no unintended consequences
Pregnancy and maternity	Low	Neutral/ positive	Likely to be affected the same as the rest of the population	Monitor to ensure there are no unintended consequences
Race	Low	Neutral/ positive	Likely to be affected the same as the rest of the population	Monitor to ensure there are no unintended consequences
Religion or belief	Low	Neutral/ positive	Likely to be affected the same as the rest of the population	Monitor to ensure there are no unintended consequences
Sex	Low	Neutral/ positive	Likely to be affected the same as the rest of the population	Monitor to ensure there are no unintended consequences
Sexual orientation	Low	Neutral/ positive	Likely to be affected the same as the rest of the population	Monitor to ensure there are no unintended consequences
Socio-economic and other vulnerable groups	Low	Neutral/ positive	Likely to be affected the same as the rest of the population	Monitor to ensure there are no unintended consequences

Delivery Plan 4: Improving outcomes for children and adults with mental health needs

Delivery Plan 4 aims to reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population. We will implement a new model of care for people with serious and long term mental health needs, to improve physical and mental health and increase life expectancy. We will focus interventions on target populations and provide crisis support services, including delivering the 'Crisis Care Concordat'. We also aim to implement 'Future in Mind' to improve children's mental health and wellbeing.

Protected groups	Impact (high, medium, low, none)	Nature of potential impact (positive/negative/ unknown)	Evidence of impact (describe how the policy will impact on each protected group)	Recommendations/mitigating actions (actions to be taken to tackle inequality and advance equality of opportunity)
Age	Medium/ High	Positive	• Older and younger people are more at risk of mental health problems • More support in primary care, increased training in mental health care, greater support and coordination between different support organisations will reduce the equality gap • Aim to support 2,600 more children through the *Future in Mind* programme • Provision of community eating disorder service • There is a risk in moving people out of institutions into the community	• The proposed actions are likely to reduce the equality gap • Ensure strong links between health and social care services • Ensure travel issues are considered when moving the location of care
Disability	High	Positive	• This group is the key group targeted by the proposed interventions and care in delivery plan 4 • Tailored support for specific populations with high needs – people with learning disabilities/Autism, those with dual diagnosis • Crisis support • New model of care	• Delivery of the plan will advance equality • Ensure travel issues are considered when moving the location of care
Gender reassignment	High	Unknown	Unknown	More information required to determine the effect
Marriage and civil partnership	Low	Positive	Likely to be affected the same as the rest of the population	Monitor to ensure there are no unintended consequences
Pregnancy and maternity	Medium	Positive	Increased provision of specialist perinatal treatment	Delivery of the plan will advance equality
Race	High	Positive	• Due to the increased incidence of mental health problems in some ethnic groups, improving mental	• Delivery of the plan will advance equality • Need to build on existing good practice

			health services will have a beneficial effect on this group. • For those who do not speak fluent English, who are accustomed to accessing services they need (emergency and local) in a familiar location, they may experience some difficulties.	working with local community groups and interpreters where necessary.
Religion or belief	Low	Positive	Likely to be affected the same as the rest of the population	Monitor to ensure there are no unintended consequences
Sex	Medium	Positive	Initiatives that prevent suicide and encourage better self-care/seeking early advice etc are more likely to benefit men	• Delivery of the plan will advance equality
Sexual orientation	High	Positive	Initiatives that prevent suicides will have a greater positive effect on the lesbian, gay, bisexual and trans (LGBT) community.	• Delivery of the plan will advance equality
Socio-economic and other vulnerable groups	High	Positive	• Those in poverty, out of work or homeless are particularly vulnerable to mental health conditions, so these initiatives will reduce the equality gap • Targeted employment services and support through the *Work and Health Programme* will support people with mental health problems having difficulty in finding work	• Delivery of the plan will advance equality • Ensure all programmes of work are positively offered to this group (or they may not benefit)

Delivery Plan 5: Ensuring safe, high quality, sustainable acute services

This plan aims to improve the consistency in patient outcomes and experience, regardless of the day of the week that services are accessed. We plan to use specialised commissioning to improve pathways from primary care and support the consolidation of specialised services; deliver the seven day services standards; support reconfiguration of acute services; and deliver the NW London Productivity Programme.

Protected groups	Impact (high, medium, low, none)	Nature of potential impact (positive/negative/ unknown)	Evidence of impact (describe how the policy will impact on each protected group)	Recommendations/mitigating actions (actions to be taken to tackle inequality and advance equality of opportunity)
Age	High	Positive	• People of all ages will benefit from high quality local acute services, improved assessments by a consultant, easy access to diagnosis etc, but older people will benefit differentially as they are high users of hospital services • New frailty services will benefit older people • Some older people could be discharged from hospital without the necessary support at home. • The introduction of Paediatric Assessment Units and recruitment of c72 paediatric nurses will improve care for children • Consolidation of some orthopaedic services focused on improving quality will differentially advantage older people	• Ensure achievement of clinical standard to transfer to community, primary and social care • Need to consider transport issues in any consolidation of services • Delivery of the plan will advance equality
Disability	High	Positive	The delivery plan aims to achieve the clinical standard on mental health services	• Ensure achievement of clinical standard to transfer to community, primary and social care • Need to consider transport issues in any consolidation of services • Delivery of the plan will advance equality
Gender reassignment	Medium/ Low	Positive/ None	Likely to be affected the same as the rest of the population	Monitor to ensure there are no unintended consequences
Marriage and civil partnership	Medium/ Low	Positive/ None	Likely to be affected the same as the rest of the population	Monitor to ensure there are no unintended consequences
Pregnancy and maternity	High	Positive	Delivery of the maternity vision set out in Better Births will improve care.	Need to ensure women giving birth at hospitals or in environments which are unfamiliar can familiarise themselves with the birthing environment

Race	Medium	Positive	For those who do not speak fluent English, who are accustomed to accessing services they need (emergency and local) in a familiar location, they may experience some difficulties.	• Need to consider transport issues in any consolidation of services • Need to build on existing good practice working with local community groups and interpreters where necessary.
Religion or belief	Low	Positive	Likely to be affected the same as the rest of the population	Monitor to ensure there are no unintended consequences
Sex	Low	Positive	Likely to be affected the same as the rest of the population	Monitor to ensure there are no unintended consequences
Sexual orientation	Low	Positive	Likely to be affected the same as the rest of the population	Monitor to ensure there are no unintended consequences
Socio-economic and other vulnerable groups	Low	Positive	Likely to be affected the same as the rest of the population	Monitor to ensure there are no unintended consequences

Section 6: Governance

The NW London STP is separated into five delivery areas and 22 workstreams. Projects undertaken within the 22 workstreams will be subject to appropriate equality impact assessments (EIAs) as they progress whenever the screening suggests this is necessary. Some projects will have already had EIAs conducted that may need review. This will be the case for some ongoing borough level projects and those that were consulted on as part of Shaping a Healthier Future.

Necessary EIAs will be conducted at :

- Borough level – one CCG
- Area level – two or more boroughs and CCGs working together
- North West London (NWL) level – assessment most appropriately carried out across all eight CCGs.
- London-wide level

Section 7: Conclusions

The scale and scope of the STP programme means that there are potentially many equalities impacts, relevant to all groups sharing protected characteristics, and people living in deprivation. The STP programme will need to ensure that these are considered in a proportionate and timely manner to inform service design.

This screening indicates that most equality groups and people living in deprivation will benefit from the STP proposals and the focus of the STP is likely to close the equality gap in most areas. There is a possibility that some groups will not benefit from changes unless positive action is taken to target them (e.g. homeless people and people not registered with a GP may not benefit from GP improvements without new ideas of how they will be encouraged to attend a GP practice).

The overarching framework proposed by the NWL STP programme will have a positive effect on the residents of North West London. Some initiatives should continue as planned, others need to consider and implement mitigations as they proceed, and others require more work to understand the implications and their likely effect on equality groups.

It is particularly important that the STP programme ensures representatives of equality groups are engaged in planning and decision-making. The programme will need to consider how to engage with:

- groups and communities most affected by the proposals
- people who are not in touch with patient representatives and community groups or organisations but who will nevertheless be impacted by potential changes to services

This equality screening will be used to identify where more work needs to take place and where resources need to be targeted to ensure all protected groups gain maximum benefit from the improvements.

Actions	Lead(s)	Timescale
1. Identify NWL-wide initiatives requiring a full equality analysis	STP Senior Responsible Officer (SRO)	End of Jun 2017
2. Officers responsible for equality analysis to be identified for each NWL-wide equality analysis	STP Executive Lead	End of Jun2017

3. Consider how to incorporate equality analysis and monitoring into the STP programme and service specifications e.g. whether there is a need to monitor borough-based equality analysis; how dependencies across workstreams are managed; whether staff training is required to support them meet the needs of equality groups	STP SRO	Jun 2017 onwards
4. Carry out any equality analyses necessary for each NWL-wide initiative including: • working with Directors of Public Health to undertake further population needs analysis when the RightCare STP level analysis becomes available • taking account of equality analyses already undertaken on local transformation programmes	Equality analyses leads	Jun 2017 onwards
5. Work with CCGs and councils to embed engagement with the equality groups and communities most affected by the proposals	STP Director of Comms	Jun 2017 onwards

ENDS

healthwatch
Central West London

Healthwatch Central West London

Charing Cross Hospital: Experiences of Today, Questions for Tomorrow

February 2018

Contents

1. Introduction

The continued uncertainty around the future of Charing Cross Hospital has been raised repeatedly by residents to Healthwatch Central West London.

Discussions about future models of healthcare and what this means for Charing Cross Hospital have been dominant in the London Borough of Hammersmith and Fulham and more widely for many years both on the ground and on a strategic level.

This report provides patient views on the future of Charing Cross Hospital and their experiences of using the hospital. We heard very strongly that residents want to be at the heart of the way health and care services are being shaped and delivered.

It is not the purpose of this report to either record or analyse the history of this debate, nor to explore its socio-political manifestations and implications but we hope that our findings will be used to inform these discussions.

Healthwatch CWL carried out specific work around Charing Cross during October and November 2017 that included:

- Submission of questions to Hammersmith & Fulham Clinical Commissioning Group; Imperial College Healthcare NHS Trust; and North West London Collaboration of Clinical Commissioning Groups. A joint response to these questions was received on 9th November 2017.
- Outreach survey work to collect outpatients' experiences of using Charing Cross Hospital and their views on its future. In total, 218 surveys were collected over four full days, morning and afternoons: Friday 17th, Tuesday 21st, Wednesday 22nd and Thursday 23rd November 2017.

The report focuses on analysing the joint response from Imperial College Healthcare NHS Trust (ICHT) and North West London Collaboration of Clinical Commissioning Groups (CCGs), and the survey responses.

The report aims to:

- Build a comprehensive picture of the current situation at Charing Cross Hospital, captured within the timeframes that our project work took place.
- Provide patients' views and experiences for key decision makers, responsible bodies, as well as residents and groups to inform their position and future actions.

Main themes explored are:

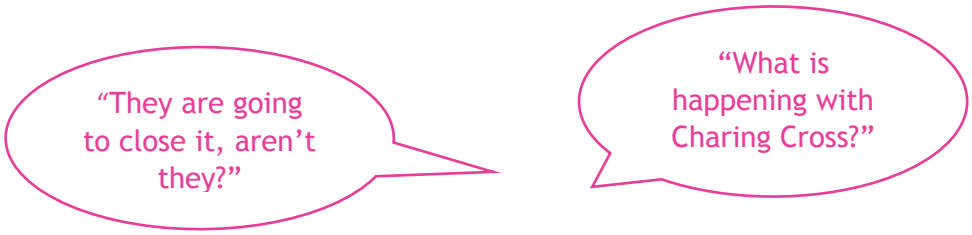
- Patient involvement in the future provision of Charing Cross Hospital.
- Patient experience of the hospital in terms of
    - a) treatment,
    - b) communications with staff,
    - c) waiting times, and
    - d) travel distance.
- Evaluating the importance of Charing Cross Hospital for patients.

- Exploring patients' perceptions of ‘local hospital’ definition.
- Testing patient preference of using ‘out of hospital’ services.

This report was presented as a draft to the Hammersmith and Fulham Health, Adult Social Care and Social Inclusion Policy and Accountability Committee (PAC) meeting on the 30th January. Slight amendments have been made to this final version to include this and reflect comments received. The Committee welcomed the report and recommended that it should be presented to the Board Meetings of Imperial College NHS Healthcare Trust Board and Hammersmith and Fulham CCG and at the Joint Health and Social Care Scrutiny Committee.

2. Methodology

A key aspect of Healthwatch Central West London's work is to provide information to the public about healthcare and changes in local provision. We also listen to people's experiences of accessing healthcare and whilst doing this we have heard concerns about the future provision of Charing Cross Hospital from residents on a number of different occasions.



To help local people get the answers they need, we put forward questions regarding the future of Charing Cross Hospital to the relevant responsible bodies.

The questions were formulated in collaboration with the Healthwatch Local Committee in Hammersmith and Fulham. Local Committee members submitted their questions by e-mail and in a special meeting held on Friday 4th August 2017. Further changes to questions occurred through e-mail communications in which Healthwatch representatives at Imperial College Healthcare Trust were also included.

The questions covered the following themes:

- Communications and Involvement
- A&E and Wider Services
- Beds, community services and accessibility
- Charing Cross in the national context
- Funding
- Technical infrastructure

The questions were submitted directly in writing to Hammersmith and Fulham Clinical Commissioning Group; Imperial College Healthcare NHS Trust; and North West London

Collaboration of Clinical Commissioning Groups on the 5th October 2017. By law organisations who plan, run, and regulate health and social care services must listen to our comments and respond within 20 working days.

On 6th November 2017 we received a joint response addressing most of the questions signed by Imperial College Healthcare Trust and North West London Collaborative of Clinical Commissioning Groups. We received the outstanding responses on Thursday 9th November 2017.[1]

Along with their response, Imperial College Healthcare Trust informed us that it was organising a public event on 27th November 2017 with special focus on Charing Cross Hospital. We believe that this was an immediate outcome of Healthwatch pointing out local concerns and uncertainty of the future of Charing Cross.

Following this, we designed a survey to collect people's experiences of using Charing Cross Hospital and their views on its future.[2] As a main reference point for the design of the survey we used the joint response received. We asked people to complete the survey during outreach at Charing Cross Hospital where we held a stall on the 1st floor for four full days: Friday 17th, Tuesday 21st, Wednesday 22nd and Thursday 23rd November 2017.

We collected a total number of 218 responses from outpatients, with an average of 50 each day.

The survey focused on the following themes:

- Identifying patients geographical spread.
- Capturing patient experience of the hospital in terms of
    - a) treatment,

[1] To read the questions and the joint response go to Appendix a, p. 27
[2] To read the survey questionnaire go to Appendix b, p. 45

    - b) communications with staff,
    - c) waiting times, and
    - d) travel distance.
- Evaluating whether and why Charing Cross is important for patients.
- Testing patient preference of using “out of hospital” services.
- Exploring what turning Charing Cross into a “local hospital” means for patients.
- Identifying if patients want opportunities to be involved in shaping the future of the Charing Cross Hospital.

The survey statistics include “no answer” data, as in some cases patients chose not to respond to all the questions. When appropriate, this information has been included in the data, as it helps to build the picture of how patients currently view and experience Charing cross Hospital.

Most of the people we surveyed identified themselves as patients (85.4%), although a small percentage identified themselves as carers (6.85%) and visitors (7.3%). For the purposes of this report, when we refer to patients, we refer to everyone surveyed.

We have also collected demographics and these are available on request.

3. Summary and Key Findings

As outlined in the introduction, this report aims to build a comprehensive picture of the current situation for Charing Cross Hospital that will provide stakeholders with evidence about patients' views and experiences to help them inform their future decisions and actions.

The main findings that this report focuses on analysing in the following chapters are:

- **Patient Involvement:** Patients want more opportunities to be involved in shaping the future of Charing Cross Hospital.
- **Patient Experience of Charing Cross on the Day:** Patients are extremely satisfied overall with their experience, especially in terms of satisfaction of treatment and staff communication.
- **Patient Information:** Patients are confused about the definition of what a ‘local hospital’ might be and want more information to help them inform their position.
- **Patient Perception of Charing Cross:** Patients value Charing Cross Hospital for both its services and its role in the community.
- **Patient Preference on Out of Hospital Services:** Patients would prefer to continue using Charing Cross Hospital instead of their GP practice.

Our analysis also takes into consideration patient flow. It shows, where appropriate and possible, distinctions between all patients, those living in the STP North West London area and Hammersmith and Fulham residents.

When we refer to patients in this report, we are referring to outpatients. We acknowledge in both the introduction and methodology chapters that surveying inpatients or patients waiting for A&E treatment could provide different results.

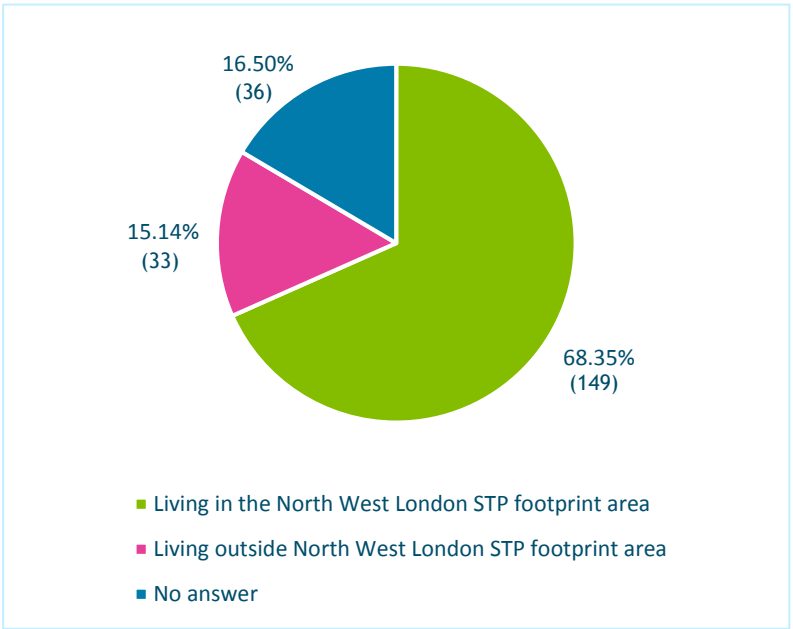
The main finding of this report is the high number of people indicating that they would like opportunities to be involved in the future of Charing Cross Hospital and what type of provision it might be after 2021.

Further findings on a) positive patient experience, b) the importance that Charing Cross Hospital has for patients, c) the need to clarify what is meant by “local hospital”, and d) further work on understanding patients' preference for out of hospital services provide useful information that stakeholders can explore to ensure patient involvement can happen at an early stage.

4. Patient Flow

Healthwatch Central West London’s role is to capture patient experience of people using services in Royal Borough of Kensington and Chelsea, City of Westminster and Hammersmith and Fulham. This includes all patients that are using health or social care services that are based within these Boroughs, regardless of whether they are local residents.

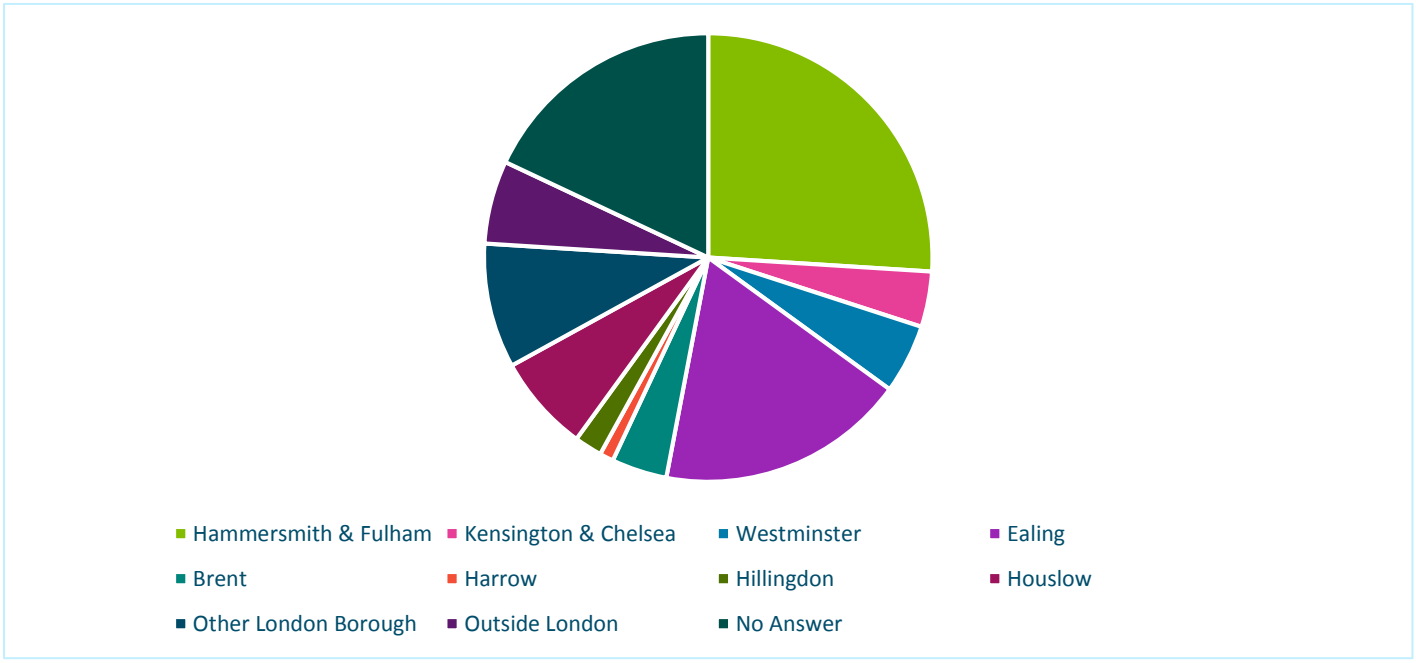
To get a better understanding of who uses Charing Cross Hospital, we asked the patients we spoke to provide us with their home postcode where possible.

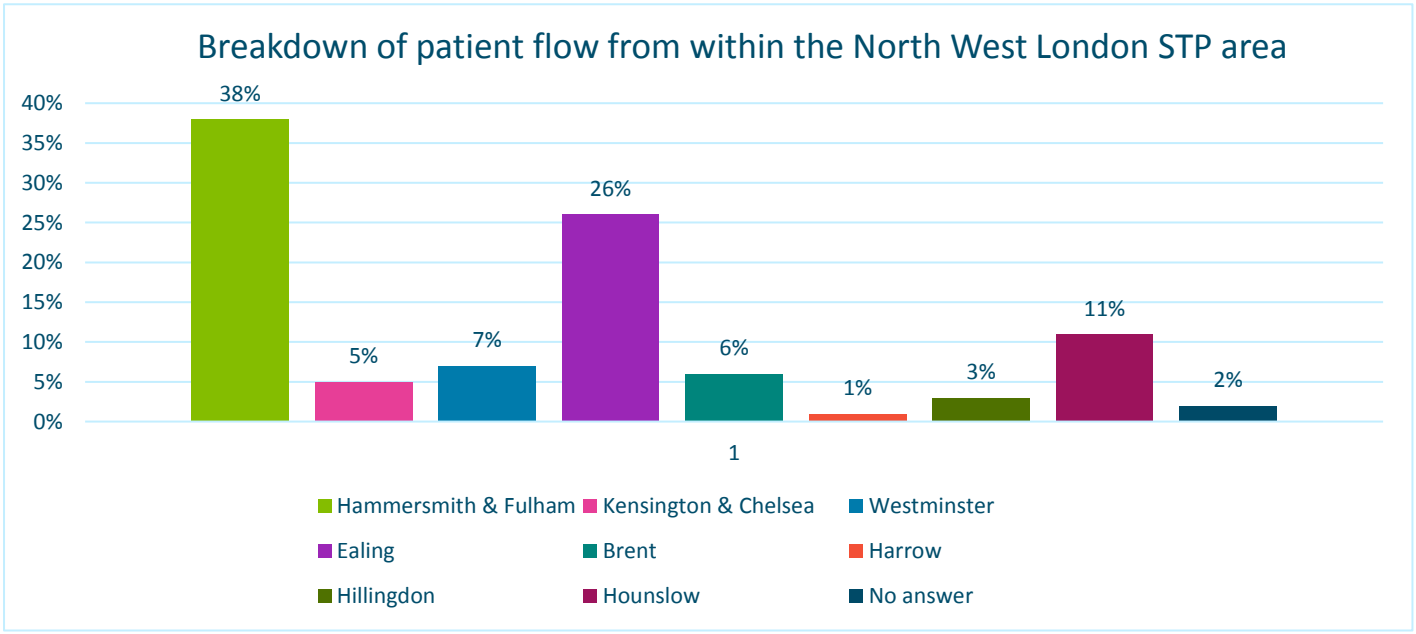


As we can see in the pie chart, although most patients lived within the STP North West London area (68.35%), a significant number visiting Charing Cross Hospital on the days we were there, live either in other parts of London or across the country (15.14%).

This could indicate that the future of Charing Cross Hospital will be of wider interest than local and North West London stakeholders.

The pie chart below provides a better sense of the geographical distribution of patients.





This diagram, focused on patients from within the North West London STP area, shows that patients came mainly from Hammersmith and Fulham (37%), followed by Ealing (26%) and then Hounslow (11%).

The results of the survey do not change dramatically when we look at patient experience according to a breakdown of areas (Hammersmith & Fulham, North West London STP area and all patients surveyed). However, where appropriate the report breaks our findings down to different areas for comparison.

5. Analysis of findings

A) Patients ask for involvement

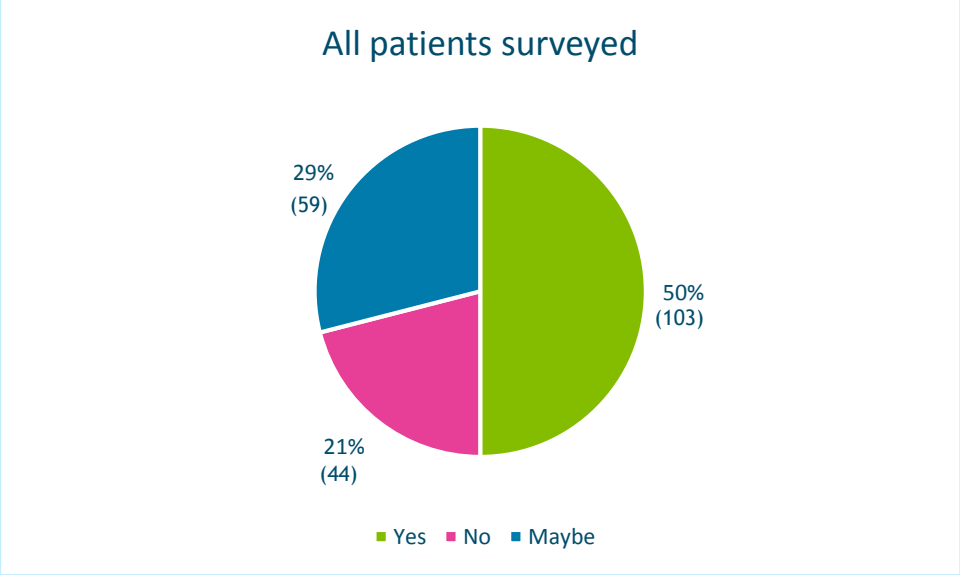
Our survey highlighted Imperial College Healthcare NHS Trust (ICHT)'s position that no changes are going to happen until 2021 and asked patients if they would like to be involved in shaping the future of Charing Cross Hospital. The main finding of this report is that a high number of patients responded yes and requested involvement opportunities.[3]

What did patients tell us about involvement in the future of Charing Cross Hospital?

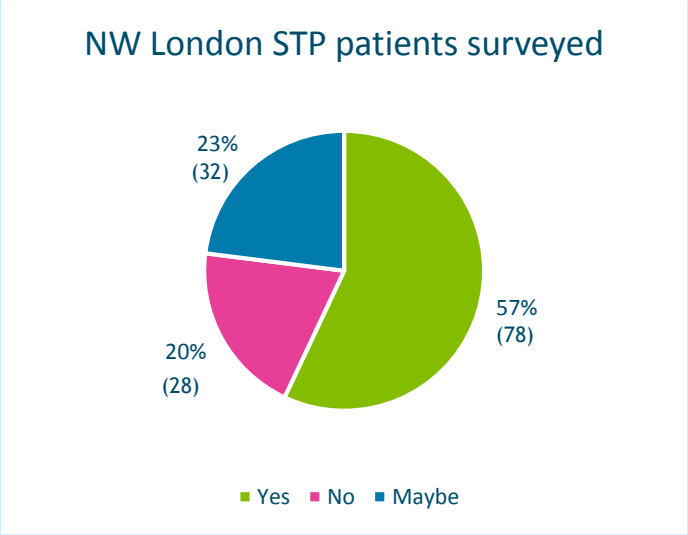
From the 218 people surveyed, of those who answered the question on whether they would like opportunities to be involved in the future of Charing Cross Hospital (206), 50% said they would like opportunities to be involved; 29% said maybe and 21% said no.

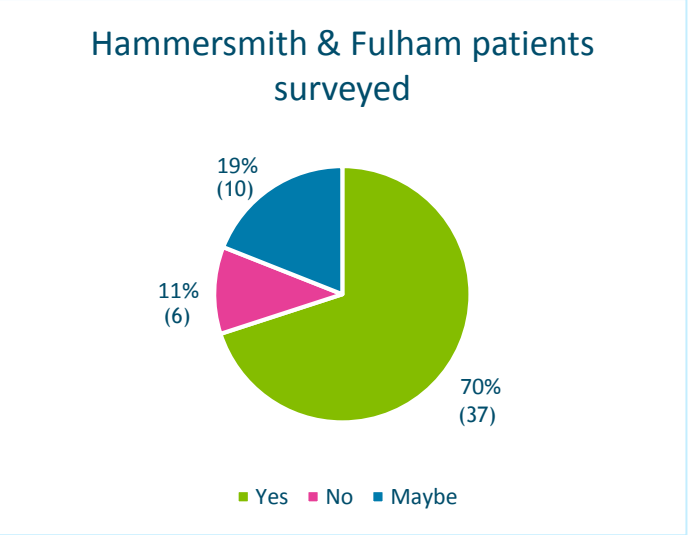
The numbers rise slightly when the question is applied to patients living in the STP North West London footprint area; 57% yes, 23% maybe and 20% no.

Looking specifically at the data from Hammersmith & Fulham, the request for involvement rises, with 70 % saying that they would like opportunities to be involved, 19% maybe, and 11% replying no.



[3] Appendix b, Question 8, p. 46





In addition, from the 218 people surveyed, 16% (35) said that they would be happy to be contacted by Healthwatch for a face-to-face or phone interview to talk more about their experiences of Charing Cross and share their views on its future.

What did ICHT and North West London Collaborative tell us about plans for public involvement in the future of Charing Cross Hospital?

In their joint response, ICHT and North West London Collaborative clearly stated that they want to engage and involve patients for future developments. ICHT organised an event on Monday 27th November 2017 to inform patients about their current position on Charing Cross and they said that a series of events will take place in 2018 to mark 200 years since the birth of Charing Cross Hospital.

The joint response emphasised a need for public engagement and referred to the communications and engagement plan that has been put forward by Hammersmith and Fulham CCG (Appendix a., p. 29). However, the response also pointed out that engagement with patients specifically around Charing Cross has been put on hold until plans are unveiled (Appendix a., p. 34).

In addition, Imperial is part of a collaboration of organisations – the Hammersmith and Fulham Integrated Care Partnership – that is working together to develop "a radically better way of providing care for the population of Hammersmith and Fulham through an integrated/accountable care approach" (Appendix a., p. 38). Healthwatch CWL is also represented part of this collaboration. Based on the data gathered through our survey, we suggest that more information is required to ensure that residents can be fully aware of this partnership, how it works and how people can be involved. In addition, patients from different sectors of the community should be invited to participate and help shape this partnership. The results from our outreach should encourage stakeholders to involve patients at this very early stage in the future of Charing Cross Hospital.

The following chapters provide more information on the elements that could be considered in a new patient involvement plan for the future of Charing Cross Hospital.

B) Patient Experience

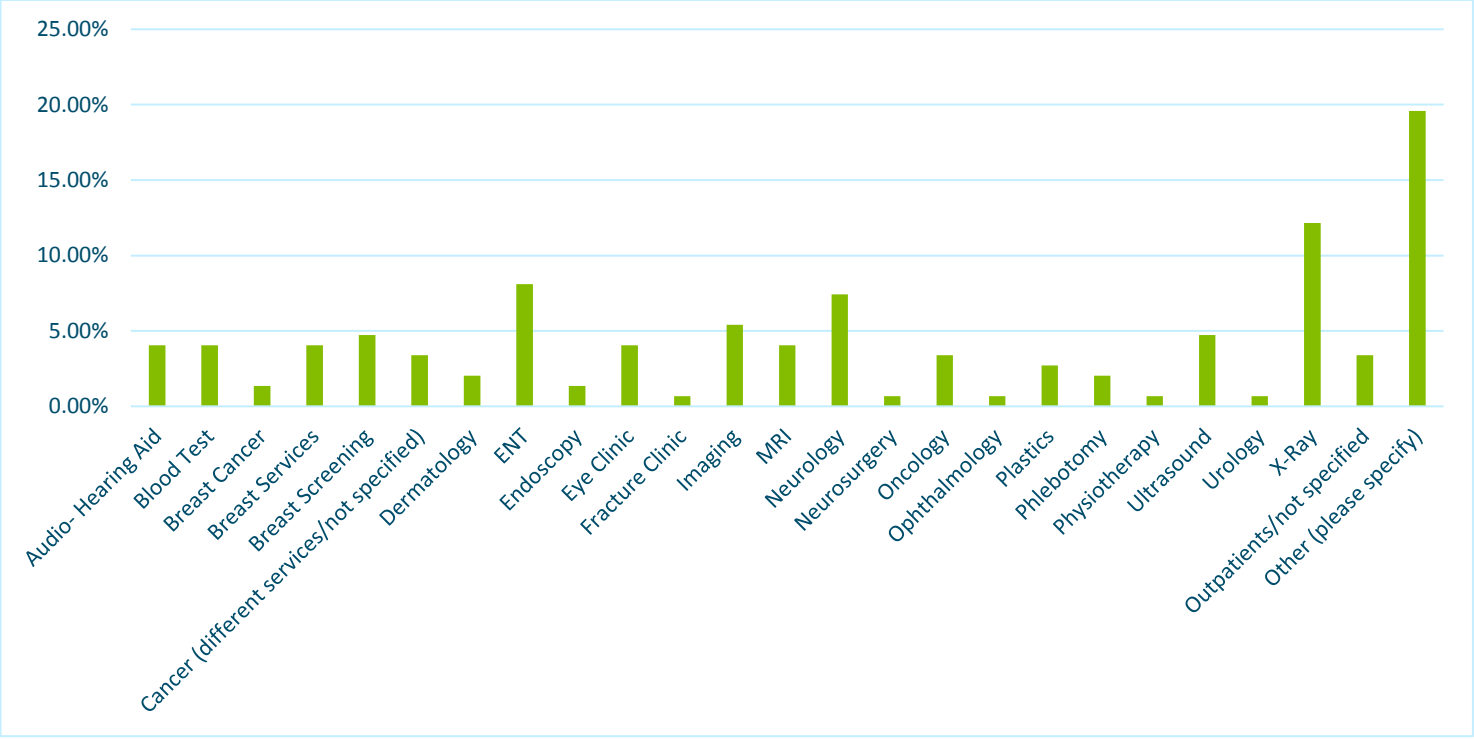
We asked patients to share their experiences of using services in Charing Cross Hospital on the specific day that they visited the Hospital[4].

Patients were invited to tell us how satisfied they were with their experience of using the hospital in four different categories:

- the time they waited to be seen,
- the distance they had to travel to get to the Hospital,
- the treatment they received,
- the communication from staff members.

Most patients said they were “extremely satisfied” with their experience overall. This was followed by high levels of “very satisfied” or “satisfied”. Very few people chose “not satisfied” or “not satisfied at all” in all cases.

The patients we met on the days of the survey were at the Hospital to use a variety of different services and specialist support, such as ENT, breast screening, neurology, audio-hearing, attending mainly regular or pre-scheduled appointments with different referrals times, varying from one day to more than 6 months.



[4] Appendix B, Question 4, p. 45

Treatment and communication from staff

As is evident from the data shown in the table on page 13, the two areas that scored particularly highly in the "extremely satisfied" option are communication from staff (58%) and treatment received (59.36%).

Nearly 90% of patients said they were satisfied with their treatment and the communication they had with staff; whilst no patient chose the "not satisfied at all" option with regards to their treatment.

The results complement the Care Quality Commission (CQC)'s recent report that found outstanding practices in Charing Cross Hospital: "*Without exception, patients told us they were treated with kindness, dignity, respect and compassion. There was a high standard of care provided for patients on the medical wards, and we saw that staff went to great lengths to respect and accommodate the wishes of patients and their loved ones. There was a strong, caring and visible-centred culture, which was fully rooted on all the medical wards visited*".[5]

The quantitative data is complemented by comments made by patients, some of which are listed below.

Comments made by patients on treatment and staff:

"Very efficient, friendly staff and was seen immediately even though I was early."

"The staff and doctors are always kind, courteous and helpful. Couldn't ask for more!"

"Friendly, professional, approachable staff."

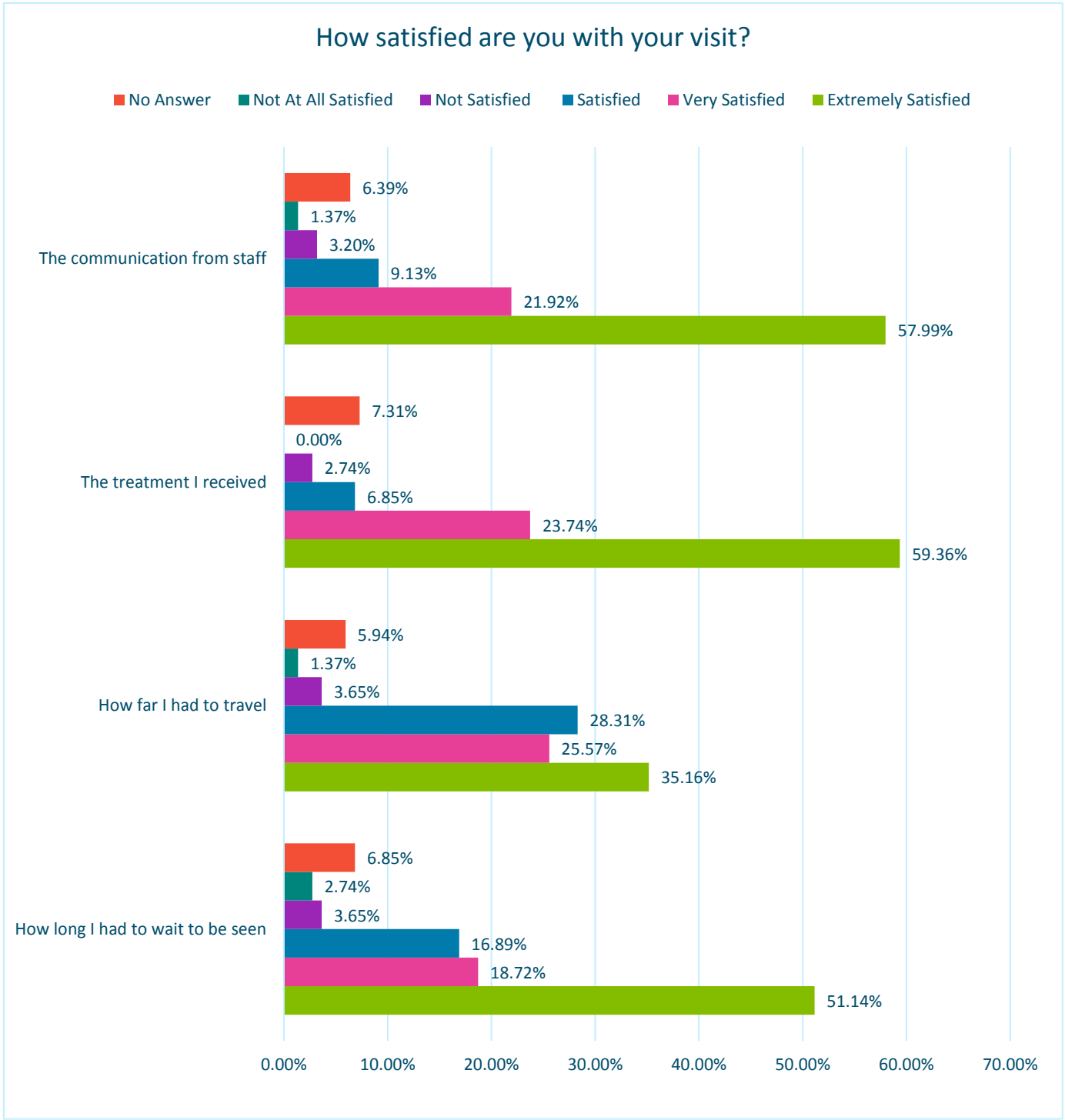
"The atmosphere at Charing Cross is very nice, comforting."

"The treatment care and expertise I have received through a really difficult time by the Neurology and stroke teams has been excellent."

"The professionalism of the specialist nurse is superb."

"Impressive and consistently high standard, well done Charing Cross."

[5] Charing Cross Hospital Quality Report, Date of inspection visit: 7th-9th March 2017, Date of publication: 19/10/2017, p. 4



Waiting times

In this report, patient satisfaction about the time waiting to be seen refers to the time from the moment they arrived at the hospital to when they were seen. As shown in the table on page 12, the levels of satisfaction are high, with 75% of patients saying that they were extremely, very or just satisfied. However, as we saw from our question on treatment received, most appointments were regular appointments or pre-scheduled, and this will have a bearing on responses. Further work and analysis on patient referrals could be done by ICHT to look at the waiting times for outpatients.

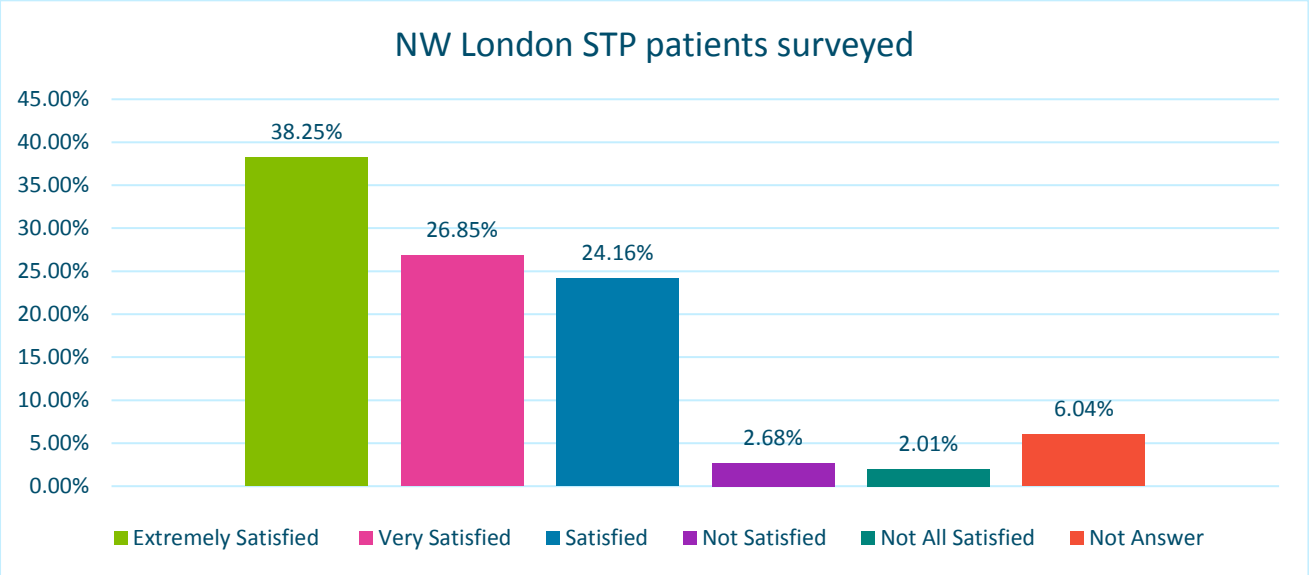
The only question for which the “extremely satisfied” option scores below 50%, at 35.16%, was about patients' feelings regarding the time they had to travel. Even for this question it was the highest scoring choice. The overall levels of satisfaction reach nearly 90%.

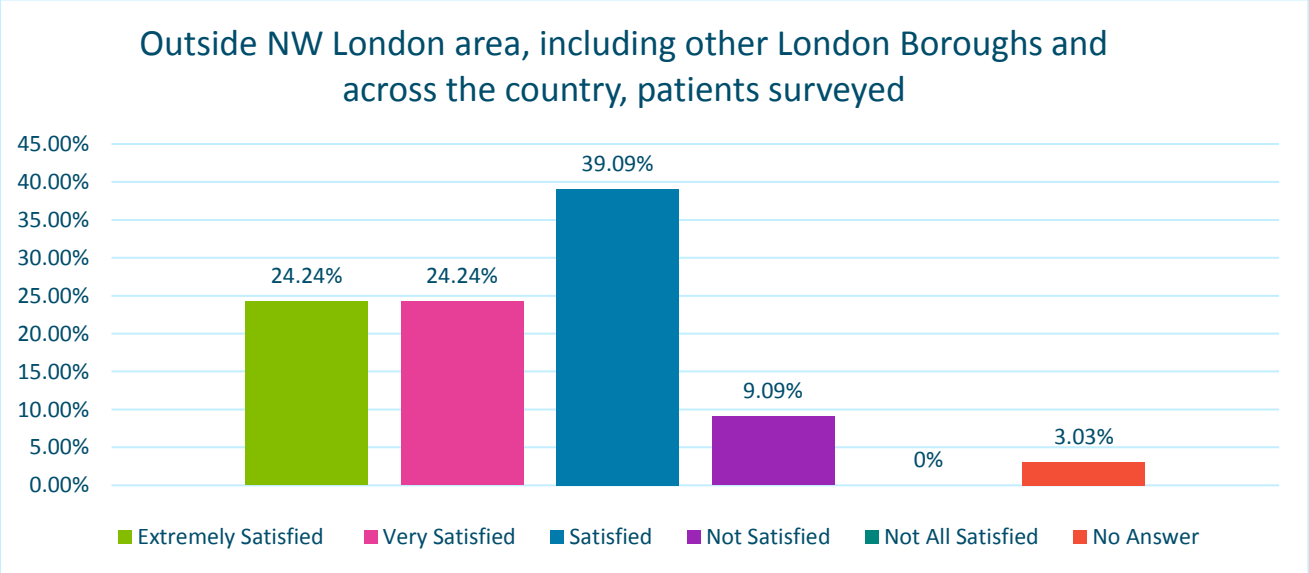
Travel distance

Looking at the data gathered for this question for within the North West London STP area and residents outside that area (other London Boroughs and across the country) separately, there is a slight difference but not as high as might be expected. This may imply that travel distance is not necessarily experienced according to miles, but rather is open to personal interpretation and may also be related to the quality of the experience.

As one patient put it:

“It's so good. Oncology. Moved out of London and come 30 miles-that's how important it is.”





However, there will always be room for improvement. Despite the high levels of patient satisfaction outlined in this chapter, we identified the following two areas that ICHT could look at more closely.

- **Concerns about levels of cleanliness in the inpatient units**

As we have already highlighted the survey was done with outpatients. However, we received a few comments and concerns from people who were either visiting a family member in the inpatient unit or have recently used the inpatient units about the levels of cleanliness.

- **Lack of appropriate signage for outpatients**

During our outreach, a high number of patients who completed our survey were people who had initially asked us for directions to the Clinic where their appointment was. This was due to a lack of proper signage on the 1st floor for outpatients.

C) Importance of Charing Cross Hospital for Patients

The picture of positive patient experience demonstrated in the previous chapter is complemented by comments received by patients about their general experience of Charing Cross Hospital.

> *"Charing X is one of the best hospitals in the world. Expertise and the care was outstanding. It works to prevent and tackle the illness. Brilliant at coordinating treatment in the hospital"*

Patients were asked to indicate what was important for them about Charing Cross Hospital.[6] The could select as many options as they liked from the following categories:

- A&E Department
- Urgent Care Centre
- Outpatient services
- Impatient Services
- Charing Cross Hospital is an important part of my community
- Charing Cross Hospital is not important to me

The combination of quantitative and qualitative results from the survey show high appreciation of specialist care, the variety of services offered, and a strong recognition of its importance for the community.

[6] Appendix b, Question 6, p. 46

Comments reveal an attachment to Charing Cross Hospital that is based on previous treatment received, the continuity of care, and recalling memories of significant moments in their lives when they were patients.

Below, we have separated some of the comments received into different categories, giving an indication of where the patient lives for each, to build a full picture of Charing Cross Hospital and its importance for patients. It seems to have a historic significance that goes beyond geographical boundaries.

Part of the community and beyond:

"CXH is and have always been an important part of the community." (H&F resident)

"I am 76 years old and I have lived in Hammersmith for 45 years. This Hospital has always been very good for me and my husband" (H&F resident)

"Charing Cross not important to me -unthinkable. The spirit of ethos of Charing Cross Hospital was carried to this site by staff from the strand location -always the best." (H&F resident)

"This hospital is very important to my community, Definitely" (Hounslow resident)

"I have been coming to this hospital for many years, it is my hospital." (H&F resident)

A&E:

"It is important (vital for my condition) that there are good fast communications between A&E and my hospital consultant. This why I chose to come to A&E here." (Kingston resident)

"Visited A&E and was an in-patient when I had pneumonia. Diagnosis saved my life and have used the resources here a lot!" (Ealing resident)

"I attend regularly to see various consultants and have had bad asthma and lungs, so I need A&E and all the consultants in one Hospital." (Hounslow resident)

"Hammersmith Hospital doesn't have an A&E only UCC but it isn't well equipped for emergencies such as asthma attack. When I had one I was sent to Charing X A&E." (H&F Resident)

General and specialist services:

"I have used this hospital a lot for many services and it's brilliant" (Ealing resident)

"There is a high stand of specialised multidisciplinary care at Charing X" (Hounslow resident)

"My experience is (related) to my mum's treatment for cancer. I think the hospital does a good deal for the patient and its care and the staff and nurses go above and beyond." (Westminster resident)

"Everything is well planned. I feel that everything is focused on me. I feel special!!" (no postcode provided)

Specialist services such as cancer services, the stroke unit, as well as the A&E department and the value people give to the hospital as an important part of the local community and its historical significance, are key elements of the patient experience that should inform any future changes.

D) A Local Hospital?

The plans for Charing Cross to become a local hospital were set out in *Shaping a Healthier Future* service reconfiguration for North West London document which was published in 2012.[7] This document is a key marking point in the debate around Charing Cross Hospital.

Imperial College Healthcare NHS Trust (ICHT) and the North West London Collaborative of CCGs (NW London Collaborative CCGs) have repeatedly said, including in their answers to Healthwatch CWL, that Charing Cross will continue to provide A&E and wider services for at least the lifetime of the Sustainability and Transformation Plan (STP) for North West London which runs until 2021.[8]

STPs are part of governmental plans for changes to the healthcare system; their aim is to change the way healthcare is being designed and delivered, moving from a reactive approach to a more proactive model. They promote a increased focus on prevention and primary care to keep people healthy closer to where they live (i.e. GPs, community services and the voluntary sector) with the aim of reducing pressure on secondary care (i.e. inpatient units at hospitals). Consequently, future changes to Charing Cross Hospital's provision will be influenced by the way that the STP is delivered in North West London.

[7] Shaping a Healthier Future: https://www.healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/Shaping%20a%20Healthier%20Future%20Consultation%20Document%20Updated%20August%202012.pdf

[8] The STPs, part of governmental plans, were published in 2016 aiming to provide a strategic framework of how healthcare is going to be designed across a big geographical area and they are planned to run until 2021. The STP for NW London footprint area: https://www.healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/stp_june_submission_draft.pdf

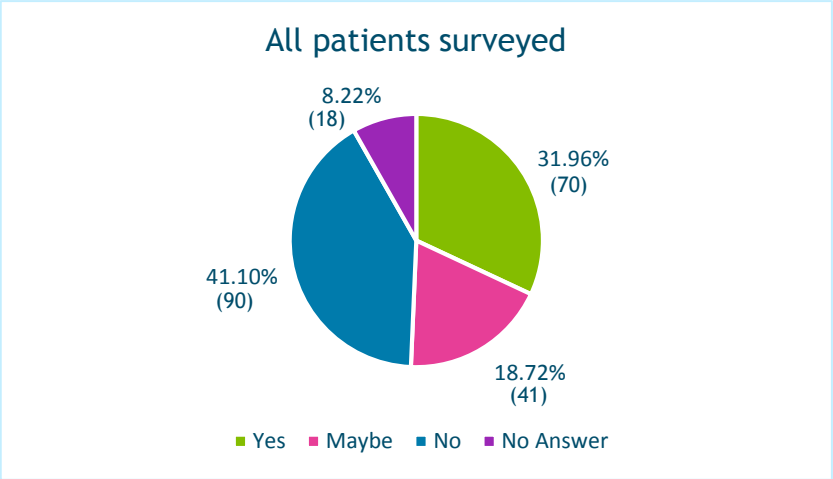
The definition of a "local hospital" which was set out in *Shaping a Healthier Future* (and repeated by ICHT and North West London Collaborative of CCGs in their response to Healtwatch CWL) is as follows:

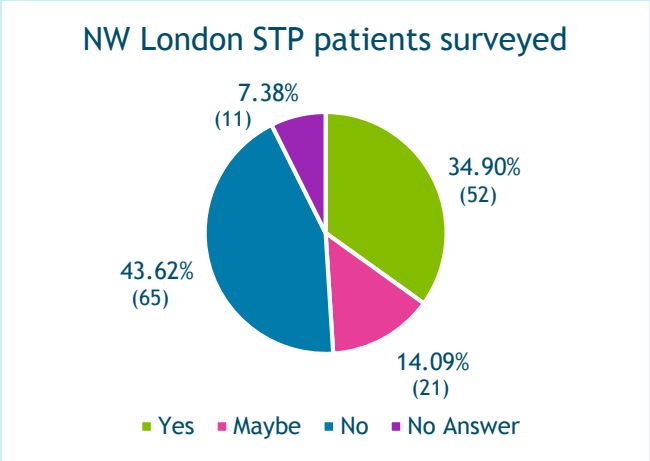
"A type of hospital that provides all the most common things people need hospitals for, such as less severe injuries and less severe urgent care, nonlife threatening illnesses, care for most long-term conditions such as diabetes and asthma, and diagnostic services. It basically provides the kinds of services that most people going to hospital in NW London currently go there for."

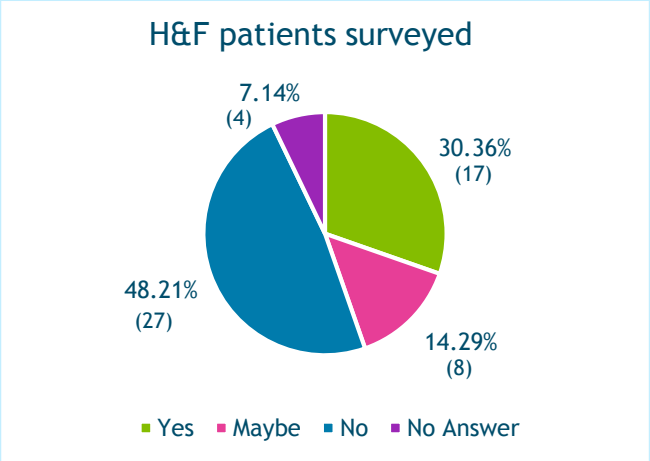
What did patients tell us about turning Charing Cross into a "Local Hospital"?

Our survey asked patients if they feel that their health needs and those of others in their local area, will be fully met by Charing Cross becoming a local hospital (after 2021) as described above.[9]

As the three pie charts below show, there was no clear consensus about whether people felt that their health needs would be met by Charing Cross becoming a local hospital. When looking at all patients surveyed, **just over 40%** said that their health needs **would not** be met, **just over 30%** said that their health needs **would** be met and nearly 19% saying maybe, while around 8% did not answer this question.







[9] See Appendix b, Survey, Question 7, p. 46

The number of patients who do not think that their health needs will be fully met by Charing Cross becoming a local hospital gets slightly higher if we look at patients living in the STP North West London area, at just over 43% and slightly higher still when examining the data from Hammersmith and Fulham patients only, at about 48%.

Examining the comments received to this question gives us a fuller picture of the concerns that people have regarding changes to Charing Cross Hospital. Most show that people do not understand what a local hospital means and how this is going to affect the services they currently receive.

"I do not know, if I don't know what local hospital is."

"It is a very vague statement. We need A&E, we need a cardiovascular ward, breast screening. As we live longer and develop more illness in later life we need a hospital to care for us."

"They want to change it into a clinic. That's how it sounds. What are they going to do with emergencies?"

"The explanation is rubbish: not accurate, not informative."

"I will decide when plans are ratified. Things will change to meet changing needs and funding."

"It's not really clear what local hospital means; could be a bad or good thing."

There were a number of comments from people that did not support Charing Cross becoming a "Local Hospital", expressing concerns about which services are going to be kept, raising doubts about the need for change and stating that Charing Cross should stay as it is.

" 'Local' suggest routine problems. Most people recognise Charing Cross as a centre of excellence."

"It should stay exactly like it is because it is an asset to this neighbourhood and other boroughs."

"The history and the medical standards and training at Charing X would not support this."

"Very big NO. Keep it like it is and A&E."

"Absolute rubbish. They should not be allowed. It is a major hospital for the community. Leave it alone. Disgraceful! I paid for 45 years. It's a government plan to privatize NHS-leave it alone!"

There were a few comments where patients stated that they would support a change under specific circumstances and for different reasons.

"Yes, As long as they don't turn it into hotels/flats."

"Yes, but I have a more local A&E at St Georges."

The combination of our quantitative and qualitative data indicates that the "local hospital" definition is open to interpretation.

All the comments received in this question can be found at Appendix 3.

What did ICHT and North West London Collaborative tell us about the future of Charing Cross Hospital?

At the ICHT event on Charing Cross on the 27th November 2017 the Trust representatives stated that they did not know what a local hospital is. However, they made it very clear that no changes will happen to the acute and inpatient units of Charing Cross until and unless there is evidence of reduced clinical need.[10] At the time of writing this report it was unclear what this evidence would include.

With 2021 only four years away, patients are confused as to **why** these changes are taking place and **what** is going to change exactly. This reflects gaps identified in the joint response we received by Imperial and North West London Collaborative.[11] Although the aim of making changes to future provision of Charing Cross has been set, a series of steps towards its implementation are yet to be taken. These include:

- **The Outline Business Case and Financial Business Care.** As stated in the response: "As we progress from the SOC (Strategic Outline Case) to Outline Business Case and Financial Business Case, all details will be refined including the equality impacts and the actions required to mitigate these. Full equality impact assessments will be undertaken in line with best practice for all relevant programmes and projects as part of their development" (Appendix a. p. 28).
- **Engagement work with residents.** As stated in the response: "The subsequent work to engage patients and the public in the development of detailed plans for Charing Cross Hospital was paused as increasing demand for acute hospital services highlighted the need to focus first on the development of new models of care to help people stay healthy and avoid unnecessary and lengthy inpatient admissions. Our approach of actively not progressing plans to reduce acute capacity at Charing Cross Hospital unless and until we could achieve a reduction in acute demand was formalised in the North West London STP published in 2016. The plan made a firm commitment that Charing Cross Hospital will continue to provide its current A&E for at least the lifetime of the plan, which runs until April 2021. We also made the commitment to work jointly with staff, communities and councils on the design and implementation of new models of care. At this stage, therefore, before the engagement process with the residents of Hammersmith & Fulham, it is too early

[10] The presentation and a video from the event can be seen here: https://www.imperial.nhs.uk/about-us/events/charing-cross-hospital-open-door-event
[11] See Appendix a, p.27

to specify the details of services Charing Cross Hospital would offer in the future." (Appendix a. p. 34)

- **Staffing.** As stated in the response: "Nothing has been 'set in stone' with regard to overall staff levels across the five years of the STP. Any changes in workforce will be part of the detailed service plans that are developed at a local level". (Appendix a. p. 41)
- **Out-of-hospital provision and reduction of demand on hospital services.** The joint response says that nationally there is evidence that supports the case for reduction in demand on hospital services through out of hospital provision. However, it states that: "Locally, we have yet to secure the capital required for the majority of the hub developments. Of the hubs which we have developed the evidence is just emerging. We are in the process of compiling this and anticipate having this available later this year. We have a full strategy for this work". (Appendix a. p. 33)

The lack of documentation along with the results of the survey and the comments people made about the lack of information provided to them raise inevitably questions regarding the future of Charing Cross provision, as the pieces that could reveal how it could look like after 2021 in the "Local Hospital" puzzle have not been revealed yet.

E) Testing Preference of Out of Hospital Services

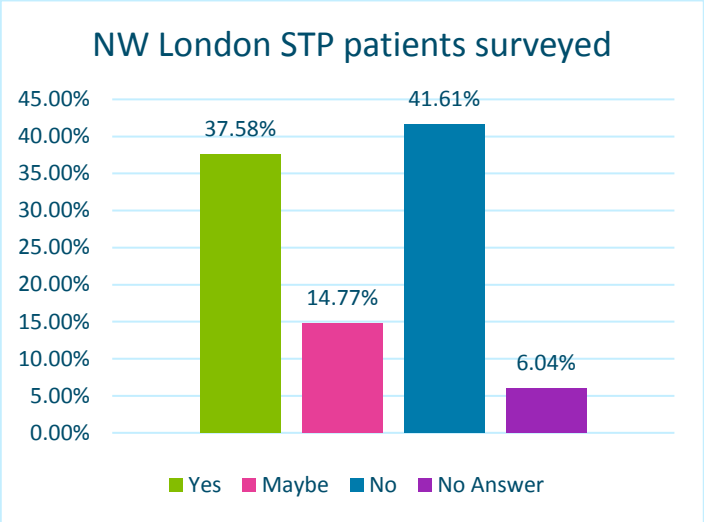
It is clear from the joint response and Imperial College Healthcare NHS Trust (ICHT) position at the event on the 27th November 2017 that no changes will be made to Charing Cross Hospital unless and until clinical need is reduced. A key component to this, as we saw at the end of the previous chapter, will be the evaluation of the out of hospital services. At the time of writing this report, there is no local evidence that the out of hospital services are decreasing hospital demand.

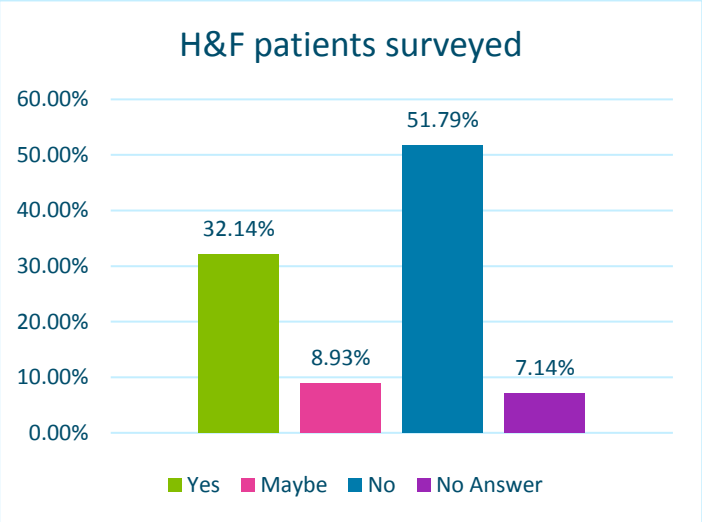
Taking into consideration the importance of out of hospital services for the future provision of healthcare and the implications this might have for Charing Cross Hospital, we thought it would be useful to test people's preferences. To get an understanding of how people feel about of hospital services, we asked patients if they would be happy to receive the service they used at Charing Cross Hospital at a different setting close to their home, for example at their GP surgery.[12]

As shown in the following two diagrams, a slightly higher number of patients from the North West London STP area would prefer to continue receiving treatment at Charing Cross Hospital than would be happy to receive treatment somewhere else, with 41.6% choosing "no" and just over 37% choosing "yes". A greater number of patients from Hammersmith and Fulham would prefer to continue receiving treatment at Charing Cross

[12] See Appendix b, Survey, Question 5, p. 45

Hospital than to receive treatment in a setting closer to their home, with just over half choosing “no” as a response and about 32% choosing “yes”.





The results are similar to the ones discussed in the previous chapter, with patients’ answers indicating mixed feelings regarding a transfer of services from hospital to their GP surgery.

The people that supported delivery of the service they used at Charing Cross Hospital in primary care, stated travel distance as main reason. However, a lot of people stated that Charing Cross is close to them.

“If the service would be closer to home, I would prefer it.”

“I live nearby the hospital. The hospital staff had always been a great help.”

For those that would not support it, the main reasons stated are:

- The lack of expertise at GP surgeries.
- The lack of equipment at GP surgeries.
- GPs are already overcrowded.
- The value of specialists at Charing Cross Hospital.
- The relationship built with staff over their time of care and treatment.

This is shown by the comments below:

“Hermodialysis is very specialised and must be done in hospital setting.”

“I have confidence in the multidisciplinary offer at Charing Cross and I am under the rheumatology department.”

“GP not specialist.”

"I prefer to visit Charing X, as I feel safe that the treatment I will get will be the best."

"Impossible for GP services, which I use and value to equal London teaching hospital standards."

"GP does not provide the same service a hospital can provide. For example dealing with emergencies."

"As long as people are qualified."

"I would rather have it here because I like the hospital."

"I have faith in CCH. They saved my life 9 years ago and have looked after me extremely well since then."

"I prefer to have it here because they are more efficient and they know what they are doing."

"Charing Cross hospital is my hospital. I am happy coming here."

"The choice is not mine. I am here for breast cancer yearly check-up."

"Can I pick up hearing aids batteries at my GP? I don't know."

"I think the complexity of my case means hospital setting needed."

"Treatment is specialised. The GP is oversubscribed and although uncertain I am sure the hospital is the best choice."

"Don't believe the GP could provide that level of service."

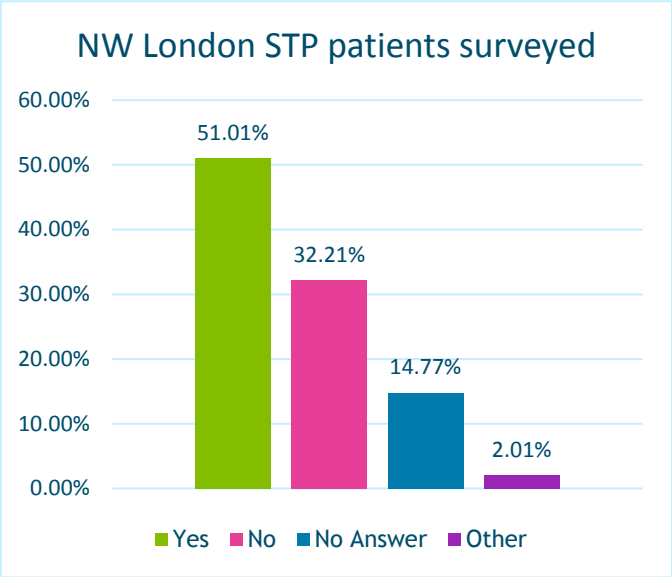
"It makes sense to separate GP clinics from hospitals. Providing citizens with options is a sign of civilisation. GPs often get it wrong."

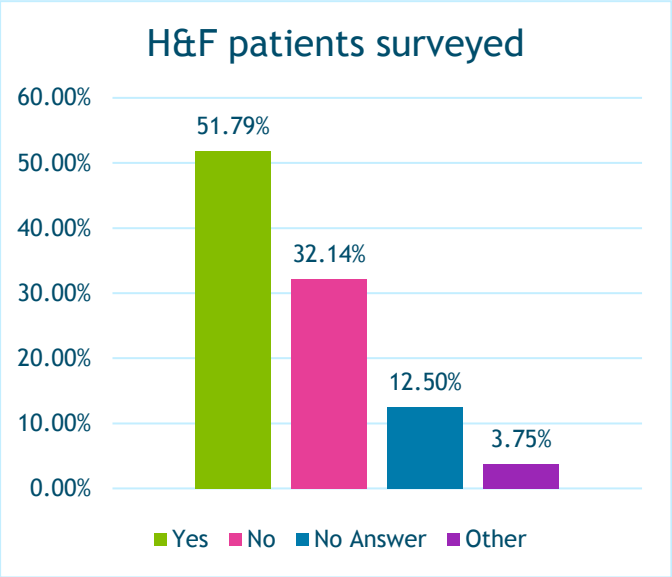
The hospital is actually closer to my home than my GP Practice. Also, I am more comfortable in a hospital setting, more expertise etc."

Hospital services are more specialized and staff have more experience of range issues as they see more patients."

For further analysis, the above results could be looked alongside the tables below that indicate that the majority of patients surveyed identified themselves as having a long term health condition. As we saw at chapter 5.b on patient experience, patients were at Charing Cross Hospital to use a variety of different services. We asked patients to tell us about their preference of using out of hospital services based on the service the visited the hospital on the day of the survey. However, we are unable to tell if they were thinking of support and treatment needed for their long term health condition or the specific service they used on the day we met them when answering the survey.

Do you consider yourself to have a long-term health condition?





Current and future plans for healthcare changes could benefit by looking more closely into patient's sentiments of out-of-hospital services to inform future work.

6. Conclusion & Recommendations

This report provides a picture of the experiences of patients using Charing Cross Hospital and their views on its future.

Patients told us very clearly that Charing Cross Hospital is an important part of their local community and for some, it brought back memories of previous visits to the hospital for them and family members. We heard that patients want opportunities to be involved in shaping the future of Charing Cross Hospital and that they need more information so that they can understand plans for future service provision.

The report also takes into account the position of the North West London Collaborative CCGs, Hammersmith and Fulham CCG and Imperial College Healthcare Trust and we have included their position on patient information and involvement as outlined in their joint response to the questions we asked them.

We believe that this report provides stakeholders with an opportunity to look at how they are communicating with local people and others who use Charing Cross Hospital and to plan how they will involve people in any decisions that are made about the hospital's future.

Conclusion

Charing Cross Hospital is very important part of the community for local people and others who use the hospital. They value the continuity of care that they have received

from the hospital at different stages in their lives, recalling memories of significant moments when they were patients.

Local people and others who use the hospital are concerned about its future and want opportunities to be involved in decision making process.

Recommendations

To ensure that everyone who values Charing Cross Hospital as an important part of their community, or who has used, or may use, it in the future is able to have their say on its future, we recommend that:

1. A clear and robust communications and engagement strategy should be developed and implemented. This should clearly set out:
    a. The process by which decisions about the future of Charing Cross Hospital will be made
    b. How this will be communicated to local people and others that use the hospital
    c. How local people and others who use the hospital will be involved in the decision-making process
    d. Clear routes for patients to have their say
    e. A timeframe for engagement.

At the time of writing this report, changes are taking place in the governance structure across the North West London STP area. Some decisions about local health provision that will be implemented by Hammersmith and Fulham CCG are now taken by North West London Collaborative CCGs.[13] Healthwatch CWL has raised concerns and questions regarding the new governance structures and routes of accountability for local people with regards to decisions made at NW London Collaborative CCG level.[14] The lack of clarity about decision making structures and lines of responsibility and accountability adds to the confusion surrounding the future of Charing Cross Hospital.

Therefore, our second recommendation is:

2. North West London Collaborative CCGs, Imperial College Healthcare NHS Trust and Hammersmith and Fulham CCG should provide clear information about how, by what criteria and by whom decisions about the future of Charing Cross Hospital will be made and who is responsible for local communication and engagement on its future.

Due to the lack of information about the timeline of changes in governance we are not able to suggest a specific deadline. Therefore, we suggest that North West London

[13] North West London CCGs' Governing Body Paper: Developing further collaborative working across North West London CGGs: http://www.hammersmithfulhamccg.nhs.uk/media/116666/GB-26-Sept-North-West-London-Draft-Governing-Body-Paper-Final_v2.pdf

[14] Visit our website for our questions: https://healthwatchcwl.co.uk

Collaborative CCGs, Imperial College Healthcare NHS Trust and Hammersmith and Fulham CCG should indicate by when they will be able to implement Healthwatch CWL recommendations.

7. Appendices

Appendix a

The joint response signed by Imperial College Healthcare Trust and North West London Collaborative of Clinical Commissioning Groups to Healthwatch Central West London questions.

Dear Olivia

Thank you for your letter setting out a range of questions around the future of Charing Cross Hospital.

Before we get to the questions themselves, we think it useful to note the overall aim of the work we are doing here in Hammersmith & Fulham and across North West London. We want to flip the model of care from a reactive one, where we wait for people to get sick and then attend A&E, to a proactive one, which focuses on keeping people well and out of hospital, providing care in settings much closer to home wherever possible.

The *Shaping a healthier future* service reconfiguration for north west London, and the Trust's clinical strategy, set out plans for Charing Cross to evolve to become a new type of local hospital, offering a wide range of specialist, same-day, planned care, as well as integrated care and rehabilitation services, particularly for older people and those with long-term conditions. It would retain a 24/7 A&E appropriate to a local hospital.

However, we have been clear that we will not reduce acute capacity at the hospital, including within its A&E, unless and until we can achieve a sufficient reduction in acute demand. The Sustainability and Transformation Plan published in 2016 made a firm commitment that Charing Cross will continue to provide its current A&E and wider services for ***at least*** the lifetime of the plan, which runs until April 2021.

We have also made the commitment to engage with our local community, including with Healthwatch, as we start to develop the detail around the plans at Charing Cross. Your involvement in that process is essential and we look forward to continuing to work with you.

It's also worth highlighting that you raise a number of questions around the use of digital services within healthcare. Most people use health services in a local community setting where there has already been significant developments in the use of digital technology to improve patient benefits. Through the 'Care Information Exchange' Imperial College Healthcare is also leading a major initiative to build an online care record for patients and those providing their care across North West London.

Turning then to the questions themselves, please find detailed answers set out on the following pages. If you would like any further detail please let us know.

Clare Parker, Chief Officer – CWHHE, SRO – Shaping a Healthier Future

Ian Dalton CBE, Chief Executive, Imperial College Healthcare NHS Trust

A) COMMUNICATIONS AND INVOLVEMENT

Q1) What negative impacts for patients have been captured as part of your planning for this major change for example during an options appraisals?

A) The Strategic Outline Case (SOC) as the enabler for the North West London Sustainability and Transformation Plan (STP) offers an excellent opportunity to further address health inequalities and ensure a positive impact of any proposed service changes for our protected groups. We have a thorough understanding of the demographics and particular health challenges of our residents to support our inequalities work, and are of course working closely with our local authority colleagues to share and update our knowledge of specific groups and any emerging issues.

To date two Equality Impact Reviews have been completed. The first was undertaken when the Shaping a Healthier Future (SaHF) strategy was produced. This included, based on the available evidence to date, how the SaHF programme meets with the aims of the Public Sector Equality Duty.

The second was an STP-wide health inequalities impact screening analysis, which provides a framework for the detailed equalities impact assessments likely to be needed. This approach is in line with other STP regions.

The Equality Impact Reviews identify potential adverse impacts. These are all stated within the documents attached with indications of how these are or will be addressed. As we progress from the SOC to Outline Business Case and Financial Business Case, all details will be refined including the equality impacts and the actions required to mitigate these.

Full equality impact assessments will be undertaken in line with best practice for all relevant programmes and projects as part of their development.

It's also worth making the point here that there have been some really positive steps forward in the way we have transformed care across NW London as a part of the SaHF and STP plans – for example the maternity and paediatric transitions which have taken place have seen real benefits to our patients and residents. We continue to monitor and evaluate both of these transformations to ensure they remain successful. We are committed to ensuring that all service developments have effective and thorough monitoring and evaluation going forward.

Q2) Do you have evidence to demonstrate that patients and communities can be assured that possible negative impacts from future changes will be mitigated? If yes, please provide a copy of your evidence. If not, please provide us with information regarding how you are going to test and measure possible negative impacts.

A) As set out in the previous answer we have conducted Equality Impact Reviews which are available online at:

SaHF EIA
https://www.healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/Equalities%20Impact%20-%20Strategic%20Review%20%20vf.pdf

STP EIA
https://www.healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/stp_equality_impact_analysis_april_2017.pdf

Q3) What steps have you taken to communicate with the local population, your plans for Charing Cross hospital in a clear, accessible and easy to understand manner and how are you monitoring the progress? Please provide a breakdown of steps and monitoring mechanisms.

A) As indicated above, we have been very explicit about the fact that no major changes will take place at Charing Cross during the lifetime of the STP. This is a commitment that has been made publically and has not changed. At the 'town hall' style meeting held in October 2016, the CCG also committed to improving engagement with local residents more generally. To this end the CCG approved a new communications and engagement strategy at its meeting in September which sets out very clear objectives for future engagement with local people.

Additionally, the Trust uses its website and social media channels (eg Facebook and Twitter) to communicate with audiences about developments and issues regarding Charing Cross Hospital. We also use the Trust's electronic newsletters which are tailored to specific audiences: stakeholders; GPs; and patients and the public. Commissioners use the Healthier NW London website as well as the CCG twitter feeds to help keep people updated.

The Trust chief executive has regular meetings with local MPs and with Hammersmith & Fulham Council's Cabinet Member for Health and Health Scrutiny Committee Chair. The Trust chief executive also meets formally with representatives of the Save our Hospitals group. Similarly, senior officers from both Hammersmith & Fulham CCG and NW London routinely meet with the local MP, councillors and representatives from patients' groups to talk through our plans.

In addition, the Trust is planning a public event at Charing Cross Hospital at the end of November 2017 to set out the current position on Charing Cross and to share updates on recent and planned investments.

Q4) Will you be able to produce a briefing, for wide circulation, that explains what your plans are and what they mean for local people? The briefing should refer to policies from different documents to inform local people, but also provide them with the opportunity to track down the progress you are making moving forward.

A) We are happy to discuss an update which brings together all the plans (SaHF, Trust strategies and plans, STP etc) and explains where we are and the current position on Charing Cross. We would welcome involvement from Healthwatch in developing that update to ensure we make it as user friendly as possible for local people.

We will produce a concise briefing on the current position on Charing Cross and its future as part of the Trust's public event at Charing Cross being planned for November 2017.

Again, we also make the point that major change at Charing Cross is not planned until there has been sufficient reduction in acute demand, which will not be within the lifetime of the STP, that is not before April 2021. Any proposed changes will also include equalities impact assessments and opportunities for local people to be informed and involved.

Q5) How are you going to involve members of the public, as well as health professionals in the development of the plans for Charing Cross hospital? Healthwatch Central West London would like to be fully involved in the planning and consultation process and work with the Trust to ensure that any changes result in an enhanced level of healthcare provision for the local population.

A) As our plans for Charing Cross progress, we have been clear that we are committed to involving patients and the public in their development. We envisage that Healthwatch, as well as our own lay partners, will be integral to that process.

B) A&E AND WIDER SERVICES

Q1) What is the evidence that suggests that Charing Cross should become a local hospital and what is the definition of a local hospital? Please provide us with any supporting documents.

A) The case for Charing Cross to become a local hospital was set out in the SaHF consultation document. We believe that this will help us deliver services which are right for the people of Hammersmith & Fulham, matching their needs.

The consultation document (August 2012) for the plans to improve local NHS services in North West London as part of the SaHF programme, identified eight different settings for care. Section 10 of the consultation described a 'Local hospital' as follows:

"Local hospital – this type of hospital provides all the most common things people need hospitals for, such as less severe injuries and less severe urgent care, nonlife threatening illnesses, care for most long-term conditions such as diabetes and asthma, and diagnostic services. It basically provides the kinds of services that most people going to hospital in NW London currently go there for."

There is also further reference to this case within the SOC – Part 1. The strategic case in the SOC sets out a list of factors which point in the same direction:

1. Our current system is unsustainable. We cannot achieve our vision without major changes to how we deliver care, given the population health trends, coupled with our current model of care and health infrastructure. This is therefore an opportunity for us to do something different and better for our residents.
2. We have a strategy to meet our residents clinical and social care needs in the right place at the right time. We will reconfigure health services so they are: localised where possible; centralised where necessary and in all settings integrated across health and social care providers to improve patient care.

3. We are confident that based on our experience of successfully delivering change and identified opportunities; our new model of care will address the key issues. Our strategy is to focus resources to keeping the population well through management of long term conditions, rapid access and treatment via local services with high quality acute specialist care when it matters most. This will achieve financial and clinical effectiveness.
4. Our new model of care requires major changes. Our SaHF proposals deliver much of this vision. Approved by the Secretary of State in 2013, SaHF is an inter-connected model of care which:
    - Retains activity in the community, enabled by out of hospital hubs where services are co-located and primary care is delivered at scale
    - Reconfigures our acute services to deliver high quality care and provide clinical and financial sustainability. This is principally achieved by concentrating valuable clinical capability across fewer sites

It is also important to recognise that in Hammersmith & Fulham, as well as across North West London as a whole, we face the following major challenges:

- An ageing population with increasingly complex and resource intensive health needs, with an increase in the overall population.

- Over 30 per cent of inpatient beds in acute hospitals are occupied by patients whose care would be better provided elsewhere in their own home or community. Clinical audits regularly show that over 30 per cent of patients in an acute hospital bed do not need acute care.[15] It is best for patients if they are able to return home at the optimal time for them, to be subsequently cared for in the most appropriate setting, preferably their own homes.

- Unacceptable variation in the quality and delivery of all services. There are variations in the quality of care and the proportion of patients who need to be readmitted after receiving a number of procedures varies considerably from one hospital to another. Senior doctors' availability in acute medicine and emergency general surgery at the weekends is more than halved at many sites compared to cover during the week.

- A reactive health service where resources are still focused on getting patients better rather than keeping people well to start with.

- Workforce capacity with shortages in supply expected in many professions and expected increases in demand, combined with the need for a skilled workforce to deliver a 7-day service under the current model across multiple sites. The lack of skilled workforce to deliver a seven-day service under the current model across multiple sites is an issue in North West London. Workforce shortages are expected in many professions under current supply assumptions and expected increases in demand making the provision of services more fragile.

[15] NW London Sustainability and Transformation Plan v01 21 October 2016.

- We have more A&E departments per head of population than other parts of the country and insufficient capacity to meet demand as senior staff and resources are spread too thinly across multiple sites.[16]

- Poor quality estate in our hospitals and primary care which is increasingly costly to maintain, does not meet modern standards and is not fit for purpose for delivery of care. NW London has more poor quality estate and a higher level of backlog maintenance across its hospital and primary care sites than any other sector in London. For example, a detailed survey and compliance audit (called a six-facet survey) undertaken in 2015, suggested total investment / project costs of £1.3 billion to bring all the Imperial College Helathcare Trust estate to an acceptable condition (Source: Imperial College Healthcare NHS Trust Annual Report 2016/17, p49)

- Too many small hospitals resulting in a compromise of clinical productivity for the residents of North West London, with valuable clinical resources being spread too thinly and the inability to drive high quality specialist care which can be achieved by concentrating care into fewer large hospitals:

    - The total population in North West London is 2,086,000 as of 2015/16.[17] With a growing population in North West London it is increasingly hard to provide a broad range of appropriate specialist services at the existing nine acute hospital sites to the standards our patients expect and deserve.

    - This is because specialist teams gain skills as a result of the numbers of people they diagnose and treat. There is evidence that the more specialised doctors and other professional staff become, the better the results for patients.[18] If treated by a specialist, patients are at a lower risk of death, are likely to have fewer complications and are likely to benefit from shorter stays in hospital.[19]

    - Units therefore need to serve a sufficiently large population so they are busy enough for clinical staff in a variety of specialities and subspecialties to maintain their clinical skills for the best outcomes for patients.

    - For example, guidance from the Royal College of Surgeons[20] recommends that for emergency surgery to be of high quality, activity from a population of 500,000 needs to be undertaken on one site. Even with the current configuration of A&E services nationally, the seven A&E departments in North West London hospitals each have a catchment population smaller than average.

[16] "Delivering High-quality Surgical Services for the Future", a consultation document from the Royal College of Surgeons reconfiguration working party, March 2006.
[17] Office for National Statistics (ONS) population estimates.
[18] Hall, Hsiao, Majercik, Hirbe, Hamilton, The impact of Surgeon Specialization on Patient Mortality; Annals of Surgery 2000.
[19] Chowdhury, Dagash, Pierro. A systematic review of the impact of volume of surgery and specialisation on patient outcome; British Journal of Surgery, 2007.
[20] "Delivering High-quality Surgical Services for the Future", Royal College of Surgeons, March 2007.

- And clinical evidence has highlighted that for emergency care services, early involvement of senior medical personnel in the assessment and subsequent management of many acutely ill patients improves outcomes.

- It is known that in North West London, our hospitals are only sometimes meeting the seven-day services standards guidelines of emergency general surgery admissions seeing a consultant within 14 hours.

Q2) What evidence is there that GP hubs and other out-of-hospital provision are reducing demand on hospital services?

A) There is national evidence from the work being undertaken by Vanguards which supports the case for reduction in demand. I attach an NHS presentation from the national new models of care team which is presenting early evaluation of vanguards. Slide 5 quotes 30% reduction in NEL admissions. Locally, we have yet to secure the capital required for the majority of the hub developments. Of the hubs which we have developed the evidence is just emerging. We are in the process of compiling this and anticipate having this available later this year. We have a full strategy for this work in enclosed in these two documents.

NW London Local Services Strategy Ful

NW London Local Services Strategy Pre

Q3) "No reduction of A&E and wider services" – this term has been used in the Trust's responses to concerns regarding a closure plan for Charing Cross Hospital. Please provide a breakdown of all services with clarification what is included and what is not in "wider services".

A) Charing Cross Hospital provides a range of acute and specialist care services, it also hosts the hyper acute stroke unit for the North West London region and is a growing hub for integrated care in partnership with local GPs and community providers. Information on all the services at Charing Cross Hospital is provided on the Trust website.

Our approach of actively not progressing plans to reduce acute capacity at Charing Cross Hospital unless and until we could achieve a reduction in acute demand was formalised in the North West London STP published in 2016. The plan made a firm commitment that Charing Cross Hospital will continue to provide its current A&E for at least the lifetime of the plan, which runs until April 2021. We also made the commitment to work jointly with staff, communities and councils on the design and implementation of new models of care.

The Trust does consider specific proposals for service changes from time to time in response to quality, safety and/or efficiency issues. On these occasions we are very mindful of our duty to engage with patients, the public, their elected representatives and our other partners in order to develop the best proposals and reach the right decisions for patients. We followed this approach with the successful move of the stroke unit at St Mary's Hospital to Charing Cross Hospital in 2015.

We will continue to engage with people on specific service proposals and we will also undertake equality impact assessment related work for any such proposals.

Q4) If the Shaping a Healthier Future plans go through, please clarify: a) Will there be A&E and consultants on site at Charing Cross? And b) Will there be a blue light ambulance service at Charing Cross?

A) In 2012, the NHS published plans for a reconfiguration of health services across North West London to respond to rapidly changing health and care needs. A full public consultation set out plans for a more integrated approach to care, with the consolidation of specialist services onto fewer sites, where this would improve quality and efficiency, and the expansion of care for routine and on-going conditions, especially in the community, to improve access.

Charing Cross Hospital was envisaged as a local hospital within this network of services, building on its role as a growing hub for integrated care offered in partnership between hospital specialists, local GPs and community providers..

In October 2013, the Secretary of State for Health supported the proposals in full, adding that Charing Cross Hospital should continue to offer an A&E service, even if it was a different shape or size to that currently offered. He also made clear that there would need to be further engagement to develop detailed proposals for Charing Cross Hospital.

The subsequent work to engage patients and the public in the development of detailed plans for Charing Cross Hospital was paused as increasing demand for acute hospital services highlighted the need to focus first on the development of new models of care to help people stay healthy and avoid unnecessary and lengthy inpatient admissions.

Our approach of actively not progressing plans to reduce acute capacity at Charing Cross Hospital unless and until we could achieve a reduction in acute demand was formalised in the North West London STP published in 2016. The plan made a firm commitment that Charing Cross Hospital will continue to provide its current A&E for at least the lifetime of the plan, which runs until April 2021. We also made the commitment to work jointly with staff, communities and councils on the design and implementation of new models of care.

At this stage, therefore, before the engagement process with the residents of Hammersmith & Fulham, it is too early to specify the details of services Charing Cross Hospital would offer in the future.

C) BEDS, COMMUNITY SERVICES AND ACCESSIBILITY

Q1) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: a) How many beds will there be and what type will they be when compared to now?

A) As indicated previously it is too early to specify the details of services Charing Cross Hospital would offer in the future.

Charing Cross Hospital currently has just over 400 inpatient and day-case beds.

Successful programmes have shown that high-quality interventions that support patients before they become acutely unwell can reduce non-elective admissions and slow progression of a disease. This can contribute to a reduction in overall care costs through the removal of acute beds when out-of-hospital solutions are in place. It does not necessarily mean planning to treat fewer people – it means treating people in a different way or different place.

The NHS is already working closely with local residents and patients at CCG level as we implement new services that help people stay as healthy as possible, avoid unnecessary stays in hospital (especially older patients) and support patients to return home as quickly with the support they need. We will build on this engagement activity to engage further with stakeholders specifically about the services Charing Cross Hospital should offer in the future.

The Trust's current clinical strategy was published three years ago in 2014. We see each of our three main hospitals developing their own distinctive and interconnecting character: with Hammersmith continuing on its path as a specialist hospital with a strong focus on research; St Mary's being the acute/emergency hospital for North West London; and Charing Cross as a pioneering local hospital with planned/elective surgical innovation and integrated care services. All the Trust's main hospital sites will continue to provide local services as well as their particular unique function.

At the time of the clinical strategy being published the proposed number of beds at our main hospital sites by 2020 was shown (with the July 2014 numbers in brackets) shown in the table below:

Hospital	**Total**	**Inpatient beds**	**Day-case beds**
Charing Cross	150*	24 (360)	86 (41)
Hammersmith	466	427 (406)	39 (39)
St Mary's	540	507 (401)	33 (40)
Total	1,156*	958 (1,167)	158 (120)

* In the space requirements and costings for Charing Cross Hospital, we also allowed for a further approximately 40 beds to support a new integrated care offering.

Since then, the work to engage patients and the public in the development of detailed plans for Charing Cross Hospital has been paused as increasing demand for acute hospital services at the site highlighted the need to focus first on the development of new models of care to help people stay healthy and avoid unnecessary and lengthy inpatient admissions.

Our approach of actively not progressing plans to reduce acute capacity at Charing Cross Hospital unless and until we could achieve a reduction in acute demand was formalised in the North West London STP published in 2016.

Q) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: b) If there is a reduction of beds, how will demand be met and managed?

A) Demand will be met and managed through a combination of increased capacity at other local trusts, reduced demand for services through better management of long term conditions such as diabetes, earlier intervention when people become ill and new ambulatory models in hospitals so that less people are conveyed or admitted, and discharging people home at the right time with full community support becomes the norm.

Q) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: c) If there is a reduction of beds, how are you measuring safety issues given the high bed occupancy figures at ICHT hospitals?

A) NHS England Chief Executive Simon Stevens announced earlier this year that hospital bed closures arising from proposed major service reconfigurations will in future only be supported where a new test is met that ensures patients will continue to receive high quality care.

From 1 April 2017, local NHS organisations have to show that significant hospital bed closures subject to the current formal public consultation tests can meet one of three new conditions before NHS England will approve them to go ahead:

- Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
- Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
- Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme)

All bed reduction proposals will, therefore, be subject to being evaluated against these conditions. The assessments made against these conditions will form part of any documentation that is put forward to NHS England and will be included in documents considered at Trust Board and CCG Governing Body meetings in public.

Q) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: d) Are there any estimates as to how many in-hospital patient visits that requiring bed and clinic capacity will be replaced by community based services?

A). We have made estimates in the past, for example during the 2012 consultation, and we will be updating all figures once we have implemented and evaluated the out of hospital services so that they reflect real activity and demand in the future.

Q) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: e) How many of these community based services depend on the enhanced digital capabilities and interoperability strands referred to in Local Digital Roadmap – STP January 2017?

A) Full realisation of the integrated health and care services envisaged in the local area will require a shared digital patient record, which allows transfers of care between different settings to be automated. Where these settings use different clinical IT systems, the shared digital record is dependent on interoperability between those systems.

Community based services in the area are currently supported by TPP's SystmOne Community clinical IT system, which is a common platform with the GPs in the three local CCGs, all of which use SystmOne; so the shared record is already available between primary and community healthcare.

Between primary and acute care, there are some existing interfaces between SystmOne in primary care and the Cerner acute clinical IT system in use at Imperial College Healthcare (and due to be implemented at Chelsea & Westminster): referrals can be transmitted electronically from SystmOne using the NHS E-Referrals Service (e-RS) and discharge information at the end of acute episodes of care is sent electronically from Cerner to SystmOne.

However, full realisation of the shared digital patient record will require more comprehensive interfaces between community and acute services, either directly or via the NW London Care Information Exchange currently under development. These interfaces do not yet exist in SystmOne, but fortunately TPP has recently announced that it will develop an open interface capability, and we would expect links to Cerner to be developed and in place well before 2021.

Q) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: f) In Shaping a Healthier Future 2012, there were plans to develop a separate elective orthopaedic hospital on the lines of the one in Epsom. Is this still planned and how will it affect Charing Cross?

A) There are no plans in place to develop a separate elective orthopaedic hospital. The Provider Board considered the benefits of an orthopaedic centre(s) in April 2017 and made two recommendations. Firstly to approach the Elective Orthopaedic Centres (EOC) in two phases and not assess the feasibility of an EOC in 2017/18. The first phase will be to drive up productivity and quality within each Trust and to measure performance against a sector score card, informed by existing measures that Trusts use. It was noted that the MSK clinical network will be key to supporting delivery. Secondly it was agreed to review the data in April 2018 to assess the need for a NW London EOC. This two-part approach is driven in part by the need for capital funding for an EOC.

Q) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: g) How will Charing Cross, as a local hospital be complemented by integrated care and an Accountable Care Partnership

A) NHS commissioners across North West London have agreed that Accountable Care Partnerships are the preferred model for delivering an integrated care system. Accountable care approaches are a potential way of overcoming dispersed responsibility for the commissioning and provision of care.

Imperial College Healthcare is part of a collaboration of organisations - the Hammersmith & Fulham Integrated Care Partnership - working to develop a radically better way of providing care for the population of Hammersmith & Fulham through an integrated/accountable care approach.

The programme also involves lay partners in the co-design of all aspects of the emerging care model. Healthwatch representation in the programme structure is provided by Olivia Freeman, who is a member of the steering group and a valued lay partner.

During 2017/18, the partnership plans to test its shared principles in practice by redesigning a number of care pathways for a sample of the population. The partnership is also working closely with Hammersmith & Fulham social care services.

Q2) Given that we have a growing, ageing population who live longer with periods of chronic illness and disability how can you in practice reduce planned admissions without rationing access to operations such as cataract removal, knee and hip replacements? Isn't there now an additional pressure on the STP to limit access to these procedures given their inclusion on the list of areas whose finances are deemed to require increased control through the Capped Expenditure Process?

A. The Capped Expenditure Programme (CEP) is not about cutting services - but making sure we balance our books across the NHS in North West London. We have to reduce waste and cut inefficiency across North West London and it is important we do that in a sensible, planned way, so as to avoid any unplanned cuts at a later date. By taking this approach we can ensure that we continue to deliver high quality healthcare services. The overall approach we are taking to healthcare in NW London is all about better management of long term conditions and earlier interventions to ensure that we can deal sensibly with the growing and ageing population.

D) CHARING CROSS IN THE NATIONAL CONTEXT

164,000 disabled people this year in England have had some or all of their Personal Independence Payments withdrawn and Employment Support Allowances have been cut by 33.3%. Between 2010 & 2015 there was a 31% cut, i.e. £4.6bn in English social care budgets and 400,000 fewer people receive social care in 2015 compared to 2009-10 (Association of Directors of Social Services Budget Survey 2015).

Q) Given this context and how it is reflected in the areas served by Charing Cross Hospital please answer the following: a) Have you measured how these changes on a national level have impacted residents across North West London?

A) The planning work around the SOC has not addressed this in detail as the nature of the SOC is to focus on high level growth based on historic trends and the individual plans from each Trust and each provider. If this is addressed it would be in the detail of those plans rather than in the SOC. Plans for specific service change will be influenced by the analysis of local needs and services designed in ways that meet those needs.

Q) Given this context and how it is reflected in the areas served by Charing Cross Hospital please answer the following: b) How this national landscape has been taken into account to inform your plans for the future of Charing Cross hospital services?

A). Our planning is based on actual data and the use of past trends to influence future planning. The impact of social care cuts is reflected in our planning. Also its important to point out that integrated care gives us an opportunity to mitigate the impact.

Q) Given this context and how it is reflected in the areas served by Charing Cross Hospital please answer the following: c) Given this collapse in funding, how can you ensure that STP plans are realistic

A) It is not clear what impact, if any, the changes in national policy for Personal Independence Payments (PIP) and Employment Support Allowances (ESA) will have on health needs. As the STP is very much a high level document it is the detailed planning of individual services that will need to take account of the specific needs highlighted during the service design phase.

Q) Given this context and how it is reflected in the areas served by Charing Cross Hospital please answer the following: d) How have you tested the assumptions that integrating community health and social care can generate enough extra capacity to compensate for potential loss of services?

A) The integration of community health and social care involves changing the model of care from a reactive one, where we wait for people to get sick and then attend A&E, to a proactive one, which focuses on keeping people well and out of hospital, providing care in settings much closer to home wherever possible. This will require new funding and evaluation approaches which will require modelling and testing prior to rolling out. We have made real inroads in reducing our non elective admissions across NW London – which bucks both the London and the national trend – see the graph at Appendix II for more detail.

We are continuing to work with our social care partners to develop better integrated services. The joint strategic needs assessment outputs will support the decisions made about what services are provided and how best they can be delivered to ensure that those most in need receive the level of care and support that they require.

As mentioned earlier, through the Hammersmith & Fulham Integrated Care Partnership, in addition to social care and community services Imperial College Healthcare is working with other healthcare providers - West London Mental Health Trust, the Hammersmith and Fulham GP Federation and Chelsea and Westminster Hospital - on new models of care.

Q) Given this context and how it is reflected in the areas served by Charing Cross Hospital please answer the following: e) Have you measured the impact these changes at the national level will have in the local context regarding Charing Cross provision for people that are not in employment?

A) The planning around Charing Cross is in the very early stages. We are not planning on making any changes to Charing Cross within the lifetime of the STP.

E) FUNDING

Q1) According to this article *http://www.nationalhealthexecutive.com/Health-Care-News/go-ahead-given-to-support-15-stp-areas-with-325m-capital-investment?dorewrite=false/Page-1345* ***from 19.07.2017, NW London STP is not going to participate in a share of the £325m, funding which NHS England has targeted to "strongest and most advanced schemes in STPs" How will losing out on this bid affect the delivery of the STP and, in particular, Charing Cross hospital provision? What are the current steps taken to face the financial challenge?***

A) The £325 million was the first cohort of STP capital funding which was for schemes due to be completed within the next twelve months. We are still progressing our bid for funding and understand further funds will be available. Our bid is following an approval process requiring regulator (NHS England and NHS Improvement approval) and Department of Health approval prior to being considered by the Treasury. This is still progressing. We are still anticipating our plans being funded in due course.

Q2) On page 42, Local Digital Roadmap January 2017 states in the last sentence: "Funding for the programme is still under discussion within NHSE, and full details of programme costs and the associated funding will be published in due course." Please clarify "due course" and inform us when you will be able to provide a timeline related to the funding. Which systems will be prioritised? What are the clinical and demand implications of not providing the technology systems that cannot be funded?

A) NHSE has clarified that there will be no funding for the Local Digital Roadmap (LDR) in 2017/18. It is expected that the funding for 2018/19 will be announced at some point after the Autumn Budget and that the bidding process will be clarified in February 2018. The North West London Digital Portfolio Board will be responsible for agreeing a list of prioritised projects within the context of the national investment levels available. The implication is that aspiration to be paperless by 2020 will not be realised.

Q3) Local residents are concerned that saving £1.3bn from NW London's budget over the next 5 years could lead to job redundancies or downgrading of skills. How are you going to measure labour cost against the budget and what are the steps you are taking to show that you mitigate possible negative impacts on the quality of healthcare?

A) In 2016/17, the Trust invested £600 million in staff benefits (pay and pension contributions) from a total annual expenditure of £1,091.5 million. Appendix 1 shows the annual growth in Trust staff benefits over the past three years.

The Trust's clinical staff (including consultants, doctors and senior nurses) often work across more than one of our hospital sites and so the Trust does not hold information for the number of clinical staff by specific hospital site.

The Trust currently employs nearly 11,000 staff in total, of which around 2,500 are doctors including consultants. Five years ago the Trust had a total headcount of nearly 10,000, of which around 2,000 were doctors including consultants.

As healthcare changes so the roles our staff perform will change and people will do their jobs in different ways. However while we expect the ways of working to change we would always ensure that we had the right numbers of staff to deliver safe care.

While the savings target is challenging, it is also recognised that changing the way services are delivered should achieve economies of scale that will enable significant savings to be made. North West London is looking at the experiences in other places where efficiencies have been achieved and service quality and levels maintained. Part of service reconfiguration does involve reviewing how services are delivered and the skill mix required. This will also happen across North West London in order to ensure that the right staff at the right level and in the right quantity are available. Some staff will almost certainly be doing things in different ways in the future which could mean that certain services require fewer people. Nothing has been 'set in stone' with regard to overall staff levels across the five years of the STP. Any changes in workforce will be part of the detailed service plans that are developed at a local level.

F) TECHNICAL INFRASTRUCTURE

Q1) How robust is the technical infrastructure being put in place, which the move to the community model of service provision relies upon. How can assurance be demonstrated to the community?

A) The NHS network (N3) provides a secure and robust means to enable teams working in community locations access to the Trust's full range of clinical systems. This is demonstrated through the existing community and acute services already provided across North West London.

Q1a) How many systems that need to, can share data now and how many will be able to by 2021?

A) Community healthcare services in the three boroughs covered by Healthwatch Central West London are currently delivered by Central London Community Healthcare (CLCH) and Imperial College Healthcare, mainly using TPP's SystmOne clinical system. Other care settings which will be relevant are Urgent & Emergency Care and federated primary care services; most of these settings are also served by SystmOne, including all practices in the tri borough

Cerner is the electronic patient records system in use at Imperial College Healthcare and being implemented at Chelsea and Westminster sites. It has an interoperability tool to enable sharing of data with other clinical systems. The providers of SystmOne, which is widely used in primary care, have recently announced that they will be enabling information sharing. This will allow us to build on the work already done to develop the Care Information Exchange to create an information sharing platform that incorporates clinical information from systems across all care settings in North West London.

Q1b) What are the implication for the STP if the underlying systems cannot share data? What will be the effect of removing the productivity tools required to provide to healthcare remotely?

A) Communication between care settings is less effective and efficient if it relies on manual processes to effect transfers of care. More effective working is dependent on the ability of systems to share data between acute (Cerner), community (mainly SystmOne) and primary care (SystmOne). This capability already exists between community and primary care. SystmOne does not currently share data with acute systems, but the supplier TPP has recently announced a commitment to develop open interfaces to SystmOne and we would expect interoperability to be developed in the next one or two years.

We are not entirely clear what is meant by the second part of the question. Clinicians in primary and community care are already able to work remotely via mobile devices such as laptops and tablets – this is what is normally meant by 'productivity tools'. These are not being removed.

Q1c) What is the state of cyber security across all systems?

A) Imperial College Healthcare remained free from virus infection during the global cyber-attack on 12 May 2017. The Trust continues to maintain and strengthen its ability to protect our systems against cyber security threats.

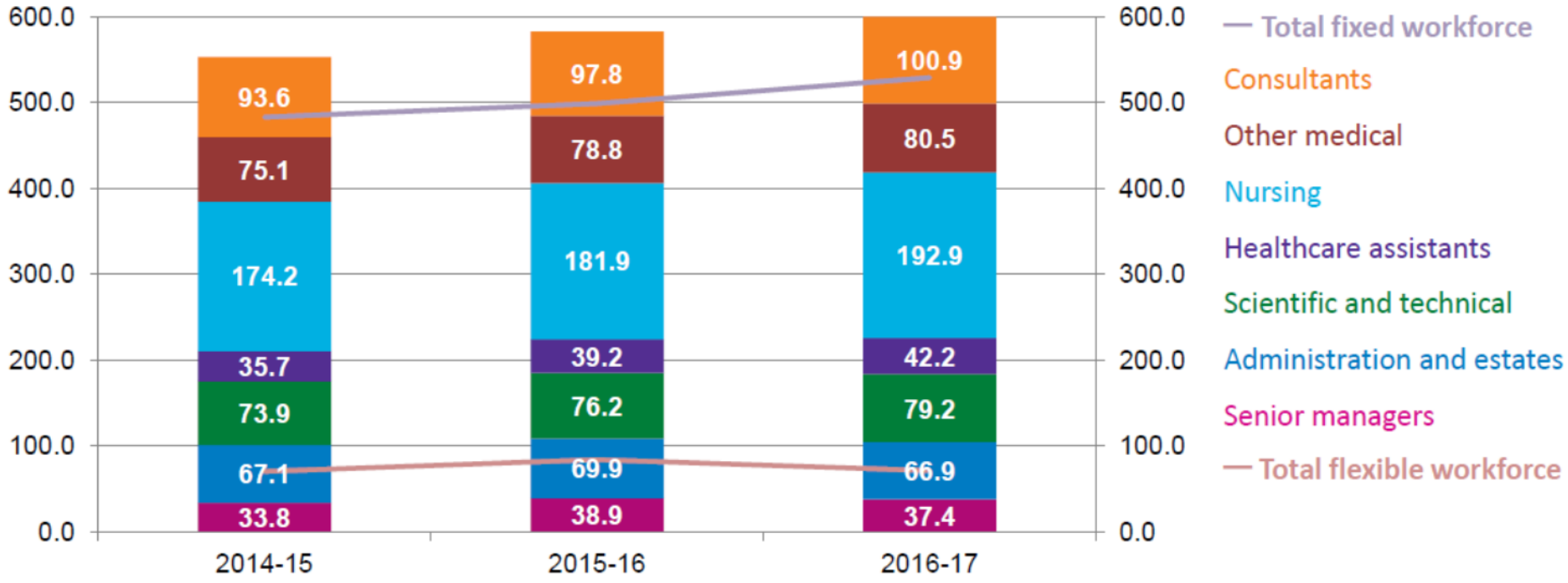
Q1d) What is the timeline for improving or rendering obsolete technology that can be economically improved?

A) During 2016/17, Imperial College Healthcare invested a total of £6.1 million in Information, Communications & Technology (ICT) infrastructure. We are one of 16 acute Trusts that have been nominated Global Digital Exemplars with a commitment to drive digital innovation for our patients

Q1e) What are your plans for raising data standards to improve interoperability of the IT infrastructure?

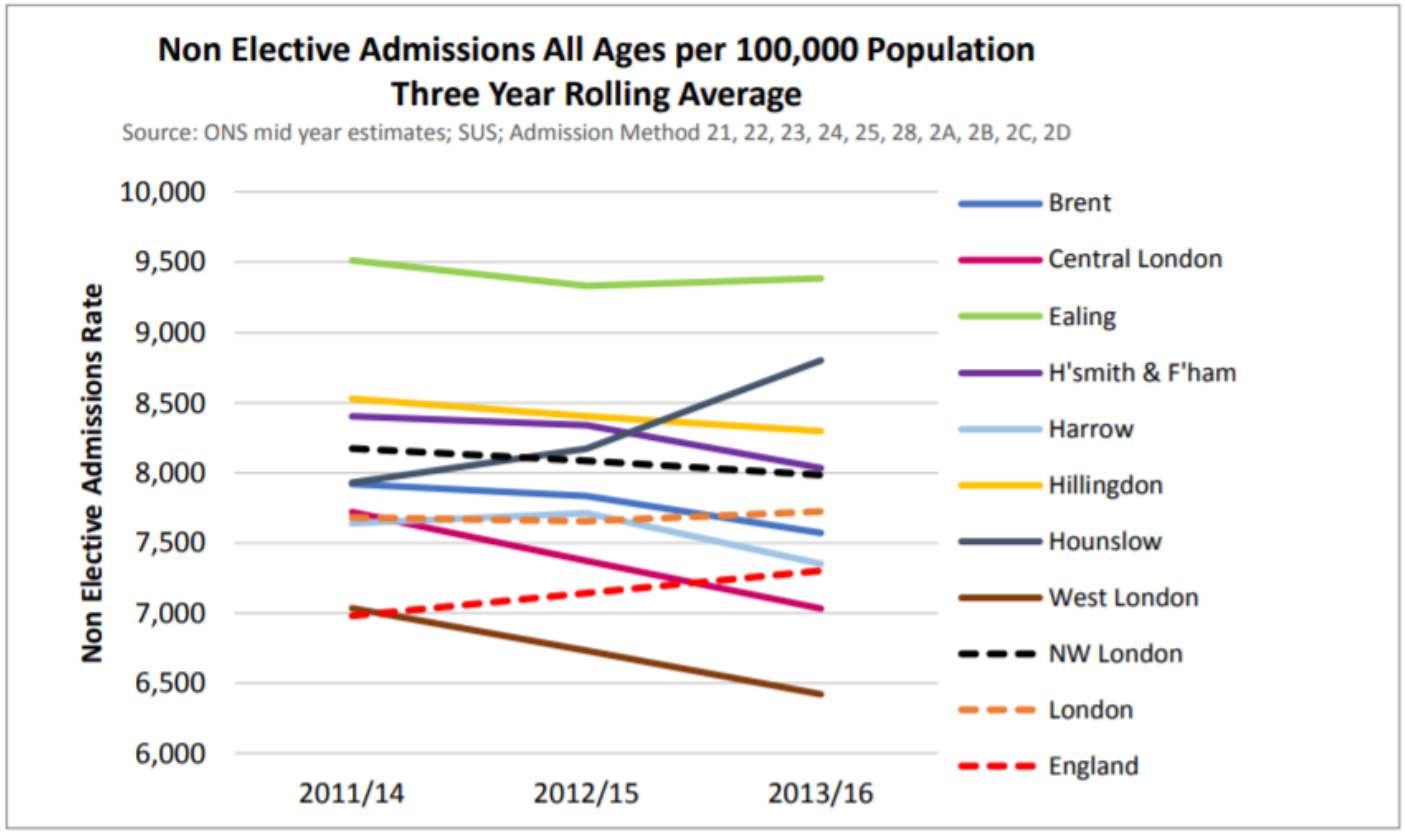
A) To most effectively share information between systems the data must be recorded in a structured way that is common to all systems. Snomed is the coding standard that is being adopted across the NHS to facilitate this and is being implemented across North West London.

2016/17 investing in staff (£m)



Appendix II

Figure 15: Non-elective admissions all ages per 100,000 population three year rolling average 2011/12 to 2015/16



Source: Strategic Outline Case (SOC) Part 1 – p.4

Appendix b – Survey

Questionnaire used to gather patients views and experiences, including demographics questions.

Tell us your experience to help shape the future of Charing

healthwatch Central West London

Healthwatch wants to learn more about your experience of using Charing Cross hospital and your views on the future on the hospital.

Your Postcode:

1. Why are you at the hospital today? Please tick ONE option or tell us more by writing in 'other'.

Patient ☐ Visitor ☐ Carer ☐

Other, please specify:

2. Which service are you visiting today?

Name of service:

3. How long did you have to wait to get a hospital appointment?

4. How satisfied are you with your visit? Please select the option that applies most by ticking the box in each line.

	Extremely satisfied	Very satisfied	Satisfied	Not satisfied	Not at all satisfied
How long I had to wait to be seen					
How far I had to travel					
The treatment I received					
The communication from staff					

Tell us more

Comment:

5. If the service you used today was available closer to your home in a different setting (for example at your GP practice) would you be happy to receive it there instead of Charing Cross Hospital? Please tick.

Yes ☐ Maybe ☐ No ☐

Please tell us more about why you made this choice:

6. Please tell us what is important about Charing Cross Hospital for you? Please select all that apply and use the comment box if you wish to tell us more.

A&E Department ☐ Urgent Care Centre ☐

Inpatient services (this is when you have to say in the hospital for a night or more) ☐

Outpatient services (this is when you visit a service but don't have to spend the night in) ☐

Charing Cross Hospital is an important part of my local community ☐

Charing Cross Hospital is not important to me ☐

Please tell us more about your choice/s

7. The NHS and Imperial Trust that run Charing Cross Hospital said that there are no plans to make any major changes at least until 2021. Plans are for "Charing Cross to evolve to become a new type of local hospital". They described a 'local hospital' as: ***"a type of hospital that provides all the most common things people need hospitals for, such as less severe injuries and less severe urgent care, nonlife threatening illnesses, care for most long-term conditions such as diabetes and asthma, and diagnostic services. It basically provides the kinds of services that more people going to hospital in North West London currently go there for."***

Do you feel that your health needs, and those of others in your local area, will be fully met by Charing Cross becoming a local hospital as described above?

Yes ☐ Maybe ☐ No ☐

Comment:

8. Would you like there to be opportunities for you to be involved in future plans for Charing Cross Hospital?

Yes ☐ Maybe ☐ No ☐

Demographics Monitoring

This section asks questions about you. The data you share with us will not be used to personally identify you, and will not be passed on to anyone else. **It is optional to complete this page.**

What is your age? (please circle)

0-15 16-25 26-45 46-59 60-74 75+

To which gender do you most identify with?

- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ Other: _____
- ☐ Prefer not to say

What is your sexual orientation?

- ☐ Bisexual
- ☐ Gay
- ☐ Lesbian
- ☐ Heterosexual
- ☐ Other: _____
- ☐ Prefer not to say

To which ethnicity do you most identify with?

- ☐ White British
- ☐ Black British
- ☐ Asian British
- ☐ Other non-white British
- ☐ Irish
- ☐ Gypsy or Irish Traveller
- ☐ White & Asian
- ☐ White & Black African
- ☐ White & Black Caribbean
- ☐ Any other mixed/multiple ethnic background, please describe
- ☐ African
- ☐ Caribbean
- ☐ Indian
- ☐ Pakistan
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Any other Asian background, please describe
- ☐ Arab

Please describe: _____

Do you consider yourself to have a disability? (please circle) Yes / No

Do you consider yourself to have a long term health condition? (please circle) Yes / No

Do you look after someone? (please circle) Yes / No

If you wish to be kept up to date from Healthwatch please leave us your contact details and we will add you to our mailing list. Your details will be kept separate from your answers. We can also arrange a face to face or phone call interview with you if you wish to tell us more about your Charing Cross views and experiences. Please tick all that apply.

I would like to be added to the Healthwatch Central West London mailing list ☐

I would like to tell you more about my views and experience of Charing Cross Hospital ☐

Name:

Email:

Telephone:

Address:

Postcode:

Borough:

Appendix c – All patient's comments on "Local Hospital"

All comments received by patients in response to question 7 (See Appendix b).

- The explanation is rubbish: not accurate, not informative
- We need all facilitates under one roof
- We need this hospital as it is with all it's services and especially A&E
- It should stay exactly like it is because it is an asset to this neighbourhood and other boroughs.
- Very vague, don't know
- I will decide when plans are ratified. Things will change to meet changing needs and funding.
- I am not sufficiently qualified to know if this is a good description/plan.
- This is an excellent hospital. Keep it that way.
- The hospital should remain as it is.
- We need this Hospital, as I need most my consultants in one hospital.
- Charing Cross is a fine hospital. However, this is not our local hospital, so we don't feel qualified to comment on future needs.
- This hospital has major units to treat specific things and its saves so many people lives a day
- I live nearby and I used this hospital on many occasions. I want this hospital to carry on serving people of the UK
- I do not know if I do not know what local hospital is
- very close by, it meets our requirements as family
- Very important to keep services at Charing Cross Hospital and excellent staff
- A question in the future. It's a manufactured expression of cottage hospitals.
- Yes, As long as they don't turn it into hotels/flats
- Not sure I like the idea of a local hospital in general
- Yes, but I have a more local A&E at ST Georges
- We need more help
- I do not know what 'local hospital' services entail/include.
- Very vague

- I'm happy with the services I receive here and prefer it to stay as it is.
- What about cancer? What about operations?
- It is a very vague statement. We need A&E, we need a cardiovascular ward, breast screening. As we live longer and develop more illness in later life we need a hospital to care for us.
- Charing Cross should stay the way it is currently. There is a huge influx of people coming to live in the Borough. I personally umbellic tied to dialysis unit there.
- I am happy with my hospital and the service I get from.
- I had oncology and breast reconstruction at Charing Cross. I benefited from having experienced specialist plastic surgeons here.
- The facilities of the hospital is essential for the local communities.
- The history and the medical standards and training at Charing X would not support this
- It's not really clear what local hospital means; could be a bad or good thing.
- As we get older we may need more specific treatment and therefore travelling far from home will become difficult and expensive.
- "Local" suggests routine problems. Most people recognise Charing Cross as a centre of excellence.
- It has specialist departments which will be a shame to lose
- A cottage hospital by another name is inadequate to the current needs of the catchment area, people get really sick and need expert care. As if they would pay any attention (for involvement)
- IF what they say comes to fruition then it would be great.
- Please do not close vital services like A&E and the specialist cancer services
- I don't understand.
- They want to change it into a clinic. That's how it sounds. What are they going to do with emergencies?
- Leave it as it is.
- The halfway house described above is no good to patients and staff. This hospital should remain as a fully functional unit.
- It would be a shame to lose the excellent full service.
- As long as it stays as it is.
- Why would they do that/

- Concerned about A&E/more serious incidents.
- This area need a full hospital. Number of people in hospital is growing. We need hospital in this area.
- When something is successful don't change it.
- Will they do the screening? If yes, it will be ok. It is longer to go to Hammersmith.
- That would be useless for me. I use it for urgent health needs
- Every hospital needs A&E
- Leave things as they are!
- I had knee surgery and it was good. Every service is very good. I would like to keep it as it is. 12/4/2017 11:34 AM
- Leave the hospital the way it is. All my family coming here, it has good reputation. Why change?
- Are they keeping A&E?
- We need A&E, it is very important for this area
- I have kidney condition which requires a center with specialists
- Being leaders in the field in a specialist capacity must also be important?
- Less is WORSE for patients
- We need to have maternity, hart, strokes
- Where all the specialist can move to?
- It would be a real shame to be without the hospital, it would be greatly missed.
- They should continue to do operations, always seem brilliant. I don't quite understand. That could be a gray area.
- It is not clear if this new hospital will have my specialists
- The proposal to change to a local hospital is very disappointing. It is our local hospital and we need urgent care including A&E.
- I am happy if they add services. It's very important to keep the facilities that they have, because I already need to come from Harrow.
- It is important to have all the services
- We need more information
- I want present facilities to continue

- Absolute rubbish. They should not be allowed. It is a major hospital for the community. Leave it alone. Disgraceful! I paid for 45 years. It's a government plan to privatize NHS-leave it alone!
- I like it as it is now. We need urgent care places.
- No, it will not be a good idea becoming a local hospital. This hospital should stay as it is.
- What about cancer?
- It depends if other hospitals gave these services. We need all the facilities here.
- I don't really know
- What about Maggie and the treatment for cancer that people come all over the country for? Where are they supposed to go?!
- Need specialized input at times. Links with others need to result in a smooth transition.
- I cannot answer this question because my "local" A&E is at Kensington and Chelsea Hospital.
- I need Charing Cross Hospital to provide all the services of a big hospital.
- Better to keep it the way it is now.
- They should take care of the building and the staff because they work hard.
- This is an important hospital in the area which is very busy and big population, and close to transport links that is more accessible.
- If there are alternatives nearby for the services that are going to be moved then it's fine. But if those services are too far then it's not fine.
- With respect, don't trust what I have heard to date. Cost Cutting thinly veiled as transformation.
- This is my first referral to CXH ENT (recommended by A&E Register at CWH), so I don't have enough experience/exposure to CXH to comment further.
- I think the oncology department is vital.
- Don't know enough about the proposed changes.
- This is a general hospital and the only other nearest hospital is St Mary's (Paddington).
- I would expect to visit whichever Imperial hospital has a neurology clinic.
- We cannot tell what re-arrangements of services across the Trust may happen. Thereby keeping urgent care etc accessible in the area.
- More focus on elderly care

- Services such as cancer diagnosis and treatment will apparently no longer be available
- The statement above appears to imply a scaling down of service to exclude the most services of most urgent conditions.
- Urgent care and A&E must be local! The world being urgent.
- I have no idea what the blurb cited above actually means in real terms. Generally, I think the hospital should serve the needs of the community and there's no need to get clever about it.
- This Would mean travelling to St Marys or Charing Cross on a more regular basis, which is not always possible or practical for all.
- There are very few A&E units in the area. Long queues at Chelsea and Westminster. It has world class cancer care and is a vital teaching hospital.
- Stop cutting hospital services in West London.
- Read it, says no-urgent. It should have an A&E at all times. Sounds like the care is going to be reduced.

8. Contact Us

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This report is going to be published on the 20th February and has been shared with Hammersmith & Fulham Health, Adult Social Care and Social Inclusion Policy and Accountability Committee (PAC), North West London Collaborative of Clinical Commissioning Groups, Hammersmith & Fulham Clinical Commissioning Group, Imperial College Healthcare NHS Trust, the London Borough of Hammersmith & Fulham Council, Save Our Hospitals, the Care Quality Commission, local Healthwatchs in North West London, and Healthwatch England.

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