Independent Healthcare Commission for North West London

Submissions of Written Evidence

Volume 1

Contents:

Royal College of Nursing
London

RCN London response to the review led by Michael Mansfield QC into the impact of the Shaping a Healthier Future programme of hospital reorganisation in North West London

With a membership of over 415,000 registered nurses, midwives, health visitors, nursing students and health care assistants, including 53,000 working in London, The Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. The RCN promotes patient and nursing interests on a wide range of issues by working closely with Government and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

Summary:

The Shaping a Healthier Future programme was launched in 2012 to reorganise hospital services in North West London, with a reduction in acute provision balanced by a boost to out of hospital services. Giving the project the go ahead in the House of Commons in November 2013 Health Secretary Jeremy Hunt said the plans would give North West London "probably the best out-of-hospital care anywhere in the country".

It is increasingly clear that the promised investment in out of hospital care has not been delivered on the scale needed to account for the hospital closures. RCN members have told us that the changes have damaged patient care in the past year and that further changes should not go ahead without guarantees of investment in community services at a level necessary to keep patients safe. The RCN supports the suspension of the closure programme, including the proposed downgrades of Ealing and Charing Cross hospitals, until further guarantees can be given about increases to funding for out of hospital care.

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1. Background: Shaping a Healthier Future

"Shaping a Healthier Future" was initially launched in 2012 and involved the downgrading of several hospitals across North West London to "local" hospitals without A&E provision, closure of acute provision and reduction or downgrading of specific services. It also promised commitments to investment in capacity of out-of-hospital and community services in order to offset reductions in acute provision.

The final plans involved the closure of Central Middlesex and Hammersmith A&E units, the downgrade of A&E services at Ealing and Charing Cross and the closure of Ealing maternity services. The impact of the reorganisation for patients is now being reviewed by Michael Mansfield QC, commissioned by four local authorities in the area, following a winter in which waiting times at the remaining A&E units have been among the worst in the country. The RCN has been asked to respond to the review. The RCN has around fifteen thousand members in our two north west London branches covering the area affected by the changes and we invited those members to contribute to this response.

2. The impact of the closure of Central Middlesex and Hammersmith A&E units

As the process has gone on serious questions have been raised about the impact of the Shaping a Healthier Future changes for patient care. In the week before Christmas 2014, London North West Healthcare Trust saw just 53.7 per cent of the most seriously ill A&E patients within four hours. Imperial College Healthcare Trust that week treated 70.2 per cent of A&E patients within four hours against a national target of 95%.

Capacity at the remaining units has been overstretched. Prior to Christmas West Middlesex University Hospital stated it could not take more patients. Sites at the London North West Healthcare NHS Trust (Northwick Park site) have reportedly been "on divert" numerous times over the past 6 weeks. With the closure of Ealing A&E department, a hospital in a borough with a rising population, pressure on Northwick Park will increase further. There have been repeated concerns throughout the process that the practical travel options for communities affected by the closures have not been properly thought through.

The effect on nursing staff working in the area has been devastating. One said she was "appalled, overwhelmed and horrified" by the impact of the changes. Complaint rates are increasing, as are staff sickness rates with a knock on effect for patient care.

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3. A confusing time for patients

Several members raised the near simultaneous closure of Barnet A&E. There is little capacity anywhere in the system to take the slack. Ambulance diverts have had limited effect over recent weeks as there just isn't anywhere with capacity to divert to. Ambulance waits have gone up at neighbouring units due to the increased number of attendances. One member said the "travel to further A&E departments and increased waiting times were highly likely to be fatal for some patients." One member described the travel routes to the remaining alternatives as "like rolling a dice".

Another repeated concern has been how the changes have been explained to the local population, and a perceived lack of understanding by patients about the status of the new units. This is despite a local publicity campaign. One member said "patients and particularly their carers are frightened and confused about the A&E service closures." Another said: "Patients won't know whether their condition can be treated at their local Urgent Care Centre or if they should travel further to a hospital that has an A&E department. Vital time will be wasted if they choose an Urgent Care or Walk-in-Centre to be assessed and discover they need to be transferred to an A&E department."

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4. A more disjointed system

We were told of increased difficulty in transferring patients between services which have been differently arranged. The example was given of living kidney donors who were previously seen at the Renal Rapid Assessment Unit at Hammersmith, with the A&E available to deal with any serious complications. These patients now have to be booked and referred elsewhere, increasing disruption for the patient and creating an administrative impact for the staff.

There are also reports of delayed transfers for cancer patients. Patients requiring hospice placements are often not getting them so patients are not always getting the specialist symptom control and support they may require, and their preferred place of death is not always met.

5. The impact for the wider health economy

"Shaping a Healthier Future" has had a direct impact on hundreds of health staff working at the hospitals involved, but it has also had knock on effects for those working in community services in the area and in the private sector. The effects of the closure programme have been felt by health workers across North West London:

- Community Care

In primary care one member said their workload had increased fourfold, while nurses were being de-skilled by the pressure to see so many patients. Importantly, members made clear that the pressure on GP services was damaging their ability to carry out preventative health interventions – a clear driver over time of the increase in sick people presenting to A&E who should have been kept well earlier in the system. We were also told there is evidence of an increase in "grade 4" community acquired pressure ulcers, and continuing care teams being asked to pay towards care in the community.

Cuts to district nursing numbers have placed an "unsafe and unmanageable" strain on remaining staff. They are under further pressure from families whose expectations of the service are no longer being met. Patients are not always getting the support they require from their community services because of the high, unmanageable, workload. Patients are, therefore, arriving at A&E due to increase in symptoms which could have been avoided.

Practice nurses report longer delays for their patients in the urgent care centres, and more difficulty getting patients seen for routine dressings over weekends. Suggested solutions included more community beds with direct referral, more triage of minors to urgent care centres, or a dedicated children's urgent care centre to create more capacity in the A&Es

- Mental health

Some mental health patients who require medical intervention now have to be transferred to Northwick Park, where before they were seen at Central Middlesex. The transfers and attendant delays impact on patients, on families, and on the ambulance service. Mental health patients already in A&E are often delayed there awaiting assessment from nurses not based there. The whole problem is exacerbated by the acute shortage of mental health beds meaning patients are discharged too soon only to re-present in A&E a few days later.

- Students

One member running continuing learning courses for qualified nurses at a local university told us that her students were "burnt out, tired and frequently unable to get their time for the study days because of shortages at their departments." Students are reportedly concerned about the safety and quality of care they are able to provide. In addition funding pressures mean many are having to self-fund what is meant to be a core clinical requirement.

6. Investment in out of hospital services

The benefit for patients of the Shaping a Healthier Future programme was based on an increase in out of hospital care to enable more patients to be kept well or treated at home to reduce hospital admissions. In November 2013 Jeremy Hunt promised seven-day access to GP surgeries throughout north-west London and the creation of over 800 additional posts to improve out-of-hospital care. In practice, though, little seems to have been done to boost capacity elsewhere in the system to make up for the closures.

We always hear a lot about how we can reconfigure, improve care and save cash yet with both the current situation with mental health and A&E services it is clear that alternative services have not adequately been put in place. Proper replacement services, transition arrangements, funding and a workforce plan should have been in place before the existing units were cut.

What is clear is that frontline staff do not feel they are being given the support they need to safely deliver services. Cuts to hospital care have been made first, before the increase in capacity has been delivered.

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7. Next steps: The proposed downgrade of A&E services at Ealing and Charing Cross & the planned closure of Ealing maternity services

The RCN will always support service reorganisation which delivers improvements in the quality of patient care. Difficult decisions have to be confronted and the public persuaded of the case for change. We are acutely aware of the scale of the task facing those planning future health services in London where the demand from patients continues to grow while budgets continue to be cut and where political scrutiny can be intense. However it is just not clear that benefits for patients have been delivered in this case.

There have been growing calls for the remainder of the Shaping a Healthier Future closures to be suspended until out of hospital capacity is properly expanded. The RCN has little choice but to support those calls based on feedback from members working in North West London. The cuts to hospital settings have been made before the extra capacity in out of hospital care was delivered. This is self-evidently the wrong way round and has had a predictable and negative impact for patients.

Royal College of Nursing London, 27 January 2015

For further information please contact Ewan Russell, London Regional Communications Officer, ewan.russell@rcn.org.uk or 020 7841 3337

Smith Peter

From: Jonathan Ramsay [redacted]
Sent: 25 February 2015 02:14
To: Smith Peter
Subject: North West London healthcare commission.

Dear Mr.Smith,

Thank you for the invitation to submit evidence. I have represented The Royal College of Surgeons of England, as an invited member of the ShaHF Clinical Reconfiguration Board.Contemporaneously, I was a member of Healthcare for London's Emergency Surgery Standards Group, and acted as a member of the Emergency Services Review Team for NHS London.

It was clear that none of the Trusts in North West London were able to achieve the proposed emergency standards, and that a possible solution to this serious(pan London) problem might be effected by reconfiguration.

That reconfiguration, with emergency surgical services located to provide comprehensive care for catchment populations much larger than is the case for any Trust Site in north West Thames (with the exception of Northwick Park) was also consistent with the RCS view as expressed in their publication on Emergency Surgery 2013.

Reconfiguration as proposed, would be expected to improve the quality of emergency surgical provision, and this was my advice, on behalf of the RCS, to the Clinical Board.

The Reconfiguration board considered sites, but then assumed that the Trust responsible for the 'reconfigured' site would manage the diverted cases on their remaining facilities.

The specific effects of the removal of acute in patient facilities from the Charing Cross Site were not regarded as of overall concern by the board because the representatives of ICHT were clear that redevelopment of the St. Mary's site would allow all cases to be accommodated safely.A discussion about the effects of effective closure of emergency on site surgery at Charing Cross ahead of developments at St Mary's did not take place,but the inference was clearly that ICHT could cope with extra demand.

Since that time it has become clear that 1. Emergency surgical volumes have increased 2. Complexity and Co morbidity have increased.

3. Capacity elsewhere in the region is saturated(C W and NWP) Currently therefore provision of satisfactory emergency surgical services alongside increased surgical activity in general seems to require the capacity currently only available on all of the Imperial Sites.

Jonathan Ramsay, Director of professional affairs, RCS Eng.

Sent from my iPhone

Submission to the Independent Healthcare Commission for North West London by Cllr Rory Vaughan, Chair of the Health, Adult Social Care and Social Inclusion Policy and Accountability Committee, Hammersmith & Fulham Council

24 February 2015

Table of contents

1 Position

1.1 Hammersmith & Fulham Council (the Council) opposes the cuts in acute hospital services, especially the planned rundown and eventual closure of the A&E unit at Charing Cross Hospital, which will severely impact on the quality of healthcare in our borough. There is no mandate for these changes – indeed, the vast majority of residents have made it very clear that they reject them – nor is there any clinical or business reason for these closures.

1.2 The Council believes that the closure of the A&E unit at Hammersmith Hospital and the planned rundown of that at Charing Cross hospital, and the planned closure of 336 acute beds at Charing Cross, would:

- Substantially reduce the amount of locally responsive emergency care available to Hammersmith and Fulham residents;
- Significantly increase pressure on other hospitals in a way that is dangerous and puts lives at risk;
- Increase ambulance journey times, impacting on the quality of care during the crucial transfer period to A&E, and;
- Increase the burden on GPs and primary healthcare without proven plans in place to absorb demand.

1.3 Furthermore, the Council believes:

- Decisions are not being taken for clinical reasons;
- There has been inadequate consultation with residents living in H&F, and;
- There has been a lack of robust challenge to the plans from hospital providers, notably Imperial College Healthcare NHS Trust (ICHT)

2 Context

2.1 The Council understands that change is needed within the NHS and supports investment in specialist emergency facilities to improve critical care, particularly in areas around cardiology, major trauma and stroke.

2.2 Furthermore, the Council supports and is helping to implement proposals to treat more patients in their own communities, improving the patient experience by improving accessibility to community healthcare.

2.3 However, the Council believes that the original changes set out by North West London NHS (superseded by the North West London Collaboration of Clinical Commissioning Groups) in Shaping a Healthier Future (SaHF) and subsequently modified in business cases, make unrealistic assumptions about the number of people who can be treated without the need for hospital admission.

2.4 We also believe that the plans have not been properly tested to the depth required. The real experience of the NHS is one where demand for hospital care is not reducing (see Table 2 further below). Taking away emergency care and hospital beds at a time when demand is not reducing will severely impact on patient care in Hammersmith & Fulham.

3 Our concerns

The reduction in emergency care (A&Es)

- Closure of Hammersmith Hospital's A&E unit has led to a severe impact on emergency care, which will be made far worse if the A&E unit at Charing Cross is also closed
- Replacing the units with GP-led Urgent Care Centres (UCCs) is woefully inadequate
- Calling the UCCs 'A&Es' will confuse patients and potentially risk lives
- Residents face a significant increase in ambulance journey times

3.1 The proposals in SaHF were, in part, based on the assumption that with nine Type 1 (major) A&Es there was an 'over provision' of A&E departments in North West London.

3.2 Nationally there were, on average, 267,107 people per Type 1 A&E[1], while the configuration in north-west London, prior to the closure of Central Middlesex and Hammersmith A&Es, amounted to 223,722, which is 16% less than the national figure. With their closure, there are 287,643 people per Type 1 A&E in north-west London, 8% more than the national average. Reducing the number of Type 1 A&Es further, to 5 as set out under SaHF, would mean that there would be 402,700 people per A&E in north-west London, 51% more than the national average.

3.3 The plans would therefore result in residents having insufficient access to emergency care services. For residents in Hammersmith & Fulham, who have lost one and face the loss of the other A&E unit, this would be amplified and result in lengthy ambulance journeys, potential delays in treatment and worsening standards of emergency care for patients.

3.4 The loss of those A&E units may also have a detrimental effect on the care of those suffering from mental health traumas. Police called, out-of-hours, to public disturbances resulting from an individual experiencing a mental health breakdown have the option of using an A&E service rather than a police cell. Where these options are reduced it is more likely that an arrested suspect suffering from a mental health trauma may not get the care they need and end up in a police cell. Individuals suffering from mental health problems will also lose the option of self-referral to A&E units if they experience a breakdown out-of-hours. This is likely to increase the chances that their condition may deteriorate and that they may pose a danger to themselves and/or to others.

3.5 The executed and planned reduction in emergency care comes at a time when (a) demand is constant and (b) population growth in Hammersmith & Fulham has been substantially underestimated.

[1] Based on ONS 2013 mid-year estimates of population

Table 1: Demand on A&E (Type 1 emergencies)

	2011/12	2012/13	2013/14
Charing Cross	33,549	34,025	35,211
Hammersmith	19,002	21,237	22,347
St Mary's	81,190	79,297	73,345
Total	**133,741**	**134,559**	**130,903**

Table 2 Demand on A&E (Type 1, Type 2 and Type 3 emergencies)

	2011/12	2012/13	2013/14
Charing Cross	82,277	81,979	78,674
Hammersmith	47,950	51,944	51,088
St Mary's	149,957	146,094	152,228
Total	**280,184**	**280,017**	**281,990**

3.6 While demand data for the whole of 2014/15 are not yet available, the closure of the A&E unit at Hammersmith Hospital on 10 September 2014 precipitated a sharp decline in performance across the A&Es operated by ICHT, of which Charing Cross is a constituent. The percentage of patients at Type 1 A&Es waiting less than four hours from arrival to admission, transfer or discharge, which prior to this was around 90%, plummeted to 70% in mid-December 2014. While it has recovered slightly, performance is still well below target. This highlights the weakness inherent in the closure programme, a position that would only worsen with the removal of more Type 1 A&E capacity.

3.7 This is compounded by tactical errors in plans to further rationalise A&E capacity under SaHF. The Care Quality Commission's Quality Report of ICHT, published in December 2014, gave an "inadequate" overall rating to the St. Mary's A&E, which is planned for retention, but a "good" overall rating to the A&E at Charing Cross, which ICHT intends to downgrade. While the CQC's reinspection of St. Mary's A&E in January 2015 yielded an improvement, we contend that this merely papers over the cracks and does nothing to address the declining standards of A&E care across north-west London.

Population growth in H&F

3.8 SaHF relies on ONS (Office of National Statistics) population projections, which forecast a 0.3-0.4% per annum increase in H&F and a 1.1% per annum increase across North West London. Cost weighting has been applied to this to reflect the higher cost of different age groups, assuming an activity growth of 2.8% per annum.

3.9 We are concerned that relying on ONS data greatly underestimates the longer-term population growth that is likely to occur in H&F. It does not take into account the fact that H&F has three nationally significant regeneration areas with 31,000 new homes planned in the next 20 years, when including cross-border development in Ealing and Brent.

3.10 We believe that the GLA's Strategic Housing Land Availability Assessment is a much more reliable model than ONS data. This takes into account planned redevelopment

and predicts that by 2034 the borough's population will be 224,260, an increase of 22,961 on ONS projections.

3.11 Even the GLA's own projections do not take into account the 24,000 (7,000 within H&F's borders) new homes likely to be built between 2030 and 2040 as a result of the planned HS2 interchange at Old Oak.

Table 3 Potential discrepancies on population projections

	H&F population by 2034	H&F population by 2039	Pop'n by 2039 incl. cross border development at Old Oak (Ealing/Brent)
SaHF projection (based on current ONS projections of 0.4% per annum)	194,649	198,570	
GLA	224,620	231,329	
Including planned regeneration at Old Oak		246,029	271,229

3.12 This shows that the increase in population has been underestimated by 29,971 by 2034, rising to potentially 47,459 in 2039, or 72,659 when taking into account cross-border development. Based on the current UK average of 2.4 acute beds per 1,000 population, this amounts to an under provision of 72 acute beds by 2034 and potentially 172 by 2039.

Inadequacy of Urgent Care Centres

> "Segregation of this group of patients from patients requiring more acute or specialist emergency care has not been beneficial to all patients in the pathway."
> - **Royal College of Emergency Medicine**

3.13 The Council believes that replacing A&E units with consultant cover with GP-led Urgent Care Centres is wholly inadequate. It (a) risks confusion from patients on the type of care available and (b) risks delay and confusion within patient pathways.

3.14 It has been reported that up to 40% of current A&E patients could be treated within a primary care setting. Yet the College of Emergency Medicine's own survey reveals that only 15% of A&E admissions could be safely treated by GPs without an emergency department assessment. Once an assessment is carried out, this rises to 37%.

3.15 Patients arriving at Urgent Care Centres will not have access to an assessment by a trained emergency care professional. This risks causing a substantial delay in treatment should emergency care be required. In some cases that delay could be fatal.

3.16 The College of Emergency Medicine supports the idea of Urgent Care Centres but insists that they should be co-located alongside full A&E units. This would ensure that patients with lower care needs could be treated by a GP while patients with higher care needs could be quickly and safely transferred to emergency care specialists.

3.17 The establishment of UCCs outside of an acute setting risks confusion in the type of care offered. It is questionable whether GPs will have the necessary skills and experience to determine quickly whether a patient needs to be referred on to an emergency care setting.

3.18 Further, the long-term trend of retiring GPs not being replaced by newly-qualified or younger doctors will place more pressure on the sector to fill the gap in A&E provision at the very time when core GP services are themselves under threat as a consequence. With a GP vacancy rate in Hammersmith & Fulham of 9% (July 2014), we believe that any move to extend UCC provision at the expense of capacity or capability of the borough's sole remaining A&E unit will undoubtedly place patients' lives at risk.

Confusion between A&Es and UCCs

3.19 Such risk is compounded by the lack of clarity and standards in labelling and service provision between A&Es and UCCs. Confusion could be exacerbated by the desire to label Urgent Care Centres as A&Es, even though they will not be delivering A&E services. Patients cannot be expected to understand the differences between services offered at different A&E units, with people at risk of turning up at hospital believing that they will be treated for a significant emergency when the hospital will not have the facilities or trained staff to deal with this.

3.20 Even within the NHS there is considerable confusion, with many trusts refusing to refer to Urgent Care Centres as A&Es. For example, Oxleas NHS Foundation Trust's website defines an Accident & Emergency Unit as treating 'serious' injuries or illness, such as:

- Loss of consciousness
- Acute confused state and fits that are not stopping
- Persistent, severe chest pain
- Breathing difficulties
- Severe bleeding that cannot be stopped

3.21 On a local level, senior management at ICHT recognise the lack of distinction between A&Es and UCCs. The CEO of ICHT, appearing at the Council's Health, Adult Social Care and Social Inclusion Policy and Accountability Committee on 7 October 2014 noted that ICHT would await the outcome of the Keogh urgent and emergency care review before committing to a definition of a UCC.

Increase in ambulance journey times

3.22 It is estimated that 170 patients a day will be redirected to other hospitals following the closure of A&E units at Hammersmith and Charing Cross. With the closure of

Hammersmith A&E it is estimated that, on average, patients face an increase in average journey times of 3.3 minutes. The business case sets out that loss of a major hospital at Charing Cross would see an increase in ambulance journey times of between 48-57%.

3.23 This will have a detrimental impact for stroke patients given that Charing Cross's Hyper Acute Stroke Unit (HASU) would also transfer to St. Mary's. Healthcare for London's stroke strategy says that all Londoners should have access to a HASU within a 30-minute ambulance journey time. The Council is concerned that, with increased ambulance times, there could be an increasing number of occasions when that 30-minute target is not met.

Unsustainable pressure on acute beds

> "The business case refers to a significant number of beds lost – but we would strongly advise maintaining the current bed stock until the community care and length of stay benefits are realised. Members' experience of bed reduction before social and community care is mature has resulted in extreme pressure on Emergency departments as the incomplete community care system collapses at times of increased demand. The Emergency departments and acute hospital bed base will be unable to provide a safety net for failures in community care. Investment in the infrastructure must be a priority and three years for realisation is very short."
> - **Royal College of Emergency Medicine**

3.24 The Council believes that the planned reduction of 336 acute beds at Charing Cross will place an unsustainable burden on neighbouring hospitals, particularly during mid-summer and mid-winter when demand increases because of weather-related problems. When taking into account new beds that are planned at St Mary's and Chelsea & Westminster, the total number of planned acute beds available to H&F residents from local hospitals will fall from 1793 to 1437, a reduction of 23%.

3.25 In 2013/14 both St Mary's and Chelsea and Westminster hospitals reported no spare capacity, particularly during periods around the summer heat-wave. It is inevitable that, if the changes go ahead, there will be a significant under-provision of acute beds, leading to lengthy transfers and/or increased waiting times for hospital admission.

Decisions not being taken for clinical reasons

3.26 Decisions taken within the SaHF programme have been a moving feast, constantly changing without proper public consultation. The Council is concerned that many of the decisions are being made without a sound clinical evidence base but rather on the desire to see short-term fixes.

3.27 There is, for example, significant clinical concern about new proposals to create an elective surgery hub at Charing Cross hospital. While the Council supports as many services as possible being delivered from the hospital, we are concerned about the safe delivery of elective surgery without it being co-located with emergency facilities.

3.28 Furthermore, we believe that the planned reconfiguration of services is not based on demand for services but on the need to satisfy complex commissioner-provider financial arrangements, which includes underwriting expensive PFI arrangements at Central Middlesex Hospital, an under-utilised facility with low patient demand. This is evidenced by an alarming drop in anticipated extra patient day cases (from 18,000 to 2,500). ICHT's own board has noted that the scope of SaHF is clearly influenced by problems at Central Middlesex Hospital. The Council believes that this is to the detriment of residents of Hammersmith & Fulham.

3.29 Had the plans been developed for clinical reasons, Charing Cross hospital would have been retained as a Major Hospital given the high demand for services compared to neighbouring hospitals.

Table 4 Baseline bed numbers in 2012/13

	Total available beds	Total occupied beds
St.Mary's	418	418
Hammersmith	373	373
Charing Cross	443	443
Chelsea & Westminster	559	498
Ealing	373	312
Central Middlesex	235	197

Increased pressure on primary health care

> "The pressures on general practice to deliver effective care are mounting, as is the need to deliver continuity of care and accessible services. The crisis of demand versus capacity in the health service is not new; it has not arisen overnight and neither can it be solved quickly. Sustainable solutions must be found to increase workforce capacity and enable general practices to continue to deliver the level of service that their patients expect now, as well as taking on the challenge of providing more complex care, spending longer with their patients and communities and taking on new roles and responsibilities."
> - **The Royal College of General Practioners**

3.30 The reduction in acute provision relies, in part, on the successful delivery of the Out of Hospital strategy and improvements in community care. The Council very much supports this and is working hard with the NHS to improve access to community care by bringing health and social care pathways closer together.

3.31 However we are concerned that the strategy is not sufficiently mature to reduce demand in the acute sector. Reductions in the acute sector should only be considered once the strategy has been successfully developed and delivered and there has been a proven reduction in demand.

3.32 The Out of Hospital Strategy relies, in part, on the creation of 'Virtual Wards' to create a team of healthcare professionals around vulnerable patients more likely to be at risk of requiring hospital care. Yet healthcare professionals tell the Council that infrastructure to make this happen is weak with few, if any, Service Level Agreements (SLAs) in place to oversee performance. Virtual Wards are more reliant

on goodwill than organisational rigour, which opens the strategy to inconsistencies in delivery and ultimately failure.

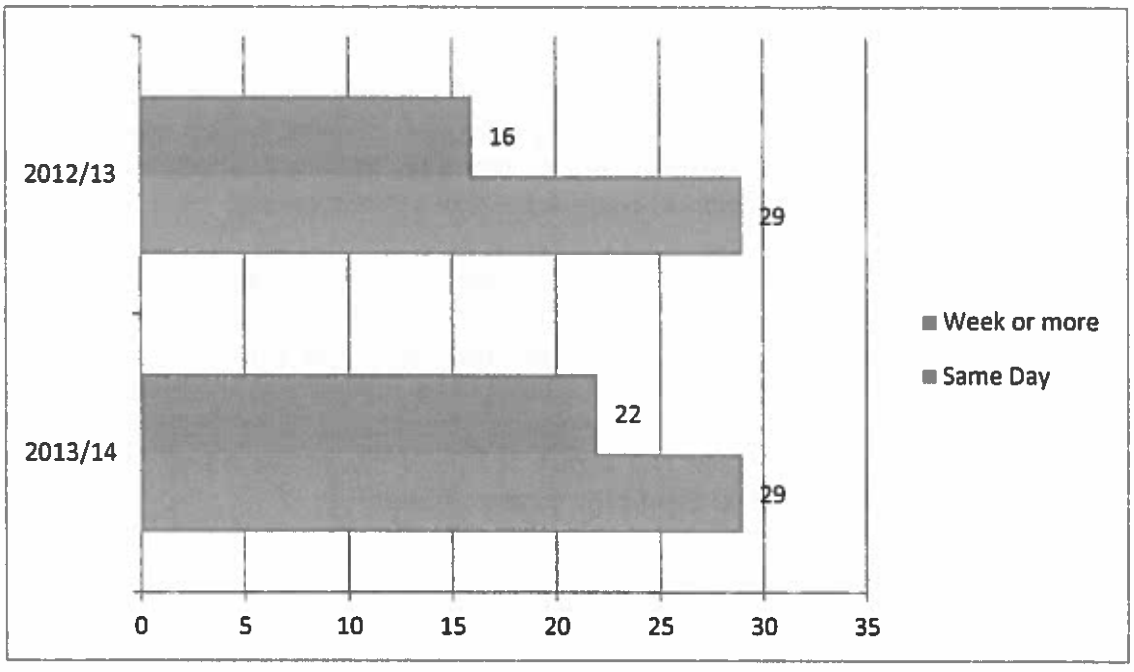
3.33 Furthermore the Council is concerned about the lack of a wider plan to improve community care. In reality the Council is only one partner amongst a number with relationships centred on part of the Council's work in areas around Adult Social Care. There is little or no discussion with Housing about the necessary investment needed in sheltered housing in supporting the long-term needs of a rising elderly population. This underlines the lack of a holistic approach and the failure to involve local government properly in conceptual stages in long-term health strategies. This is exacerbated by the weakness of current governance arrangements.

3.34 Local GPs in H&F anecdotally talk of a 'broken system' where demand is rising beyond the level of resources that are available. Many practices are struggling to cope with the bureaucracy of having to manage multiple contracts from different providers.

3.35 The business case points out that 79% of GP practices in North West London have satisfaction scores below the national average, stating: "The effectiveness of the delivery of GP services is highly variable and often below national averages. The variation means we are not consistently delivering the kind of high quality primary care we should be.

3.36 In Hammersmith & Fulham the number of residents having to wait more than a week for an appointment is rising, as shown by the national GP Patient Survey, which analysed 2496 responses in 2013/14 and 2939 in 2012/13.

Figure 1 How long did you have to wait for an appointment? (%)



3.37 This is backed up by national data which shows that morale amongst GPs is at an historic low. According to the British Medical Association:

- Six out of 10 GPs are considering early retirement and more than a third are actively planning for this decision
- Almost all GPs reported that their workload was too heavy some of the time, with more than half saying their workload was unmanageable or unsustainable at all times
- More than a quarter of GPs had said they were considering leaving the profession
- Only 50% of GP practices plan to bid for more resources to extend patient opening hours

3.38 The planned investment in primary care of between £6-8 million, as set out in the business case, should not be dependent on hospital reconfiguration and is required to bring the quality of primary health care up to modern standards. It is not sufficient to accommodate the diminution of service entailed by the reduction in acute provision laid out in the ICHT Clinical Strategy.

Lack of challenge by Imperial College Healthcare NHS Trust

3.39 ICHT is the main provider of hospital services for residents living in Hammersmith & Fulham. As such we would have expected a far more robust challenge to the proposals by the Trust's board.

3.40 Our research shows that there have been 19 Board meetings in public since the start of 2012 with public records available for 18 of these meetings. Of the 18, SaHF has been discussed 11 times. Of these three meetings received process updates and two meetings expressed support for SaHF and Option A.

3.41 The SaHF business case was discussed on 25 September 2013 and a challenge was made regarding the provision of medical training under the plans. A reference was made to consultation with patients "and other interested parties" but not with the wider public.

3.42 Plans for Charing Cross were discussed on 29 January 2014 and set in the context of cutting costs by using out-of-hospital pathways. While it was mentioned that a purpose-built facility would be provided at the site, the clear implication is that this would be a significant reduction in scale from the current facility.

3.43 The need to cut costs was underlined in the discussions at the 26 March 2014 meeting, where a further write-off for estates in 2014/15, on top of that in the "current accounts", was reported. On top of this challenge, the precarious nature of the finances at Central Middlesex Hospital (CMH) was highlighted in reference to a large drop in anticipated extra patient day cases (from 18,000 to 2500) resulting from changes to SaHF plans. While not a part of ICHT, the problems at CMH will clearly have a knock-on effect due to the wider scope of SaHF.

3.44 The closure of Hammersmith Hospital A&E was discussed and agreed at the 28 May 2014 meeting. The proposals were challenged by the Board and also by members of the public, who were directed to the consultations carried out for SAHF and also more recently as part of the application process for Foundation Trust status. Following this, the Board approved plans for closure to take place on 10 September and for a formal staff consultation process. The 30 July 2014 and 24 September

2014 Board meetings received updates on the closure plans, the latter mentioning the "nationwide confusion over what services [an Urgent Care Centre] provided".

3.45 It is a matter of concern that a programme with such wide-ranging implications for the health economy in north-west London has had such limited challenge by ICHT Board. Of the eleven times for which records are in the public domain, the minutes of the 28 January 2015 meeting not yet being available, only three challenges of any substance to SaHF or proposals relating to it were issued.

3.46 We contend, therefore, that the public scrutiny of the specific proposals affecting ICHT by its Board is insufficient, unfit for purpose and has in consequence led to poor decision-making. We urge that in future, therefore, decisions by ICHT Board affecting healthcare provision are made openly, in public and only after a full programme of public consultation and engagement that relates to the proposals as they exist at the time.

4 A future model for acute care

4.1 The Council supports the move towards creating more specialist care. The Hyper Acute Stroke Unit at Charing Cross and the specialist cardiology unit at Hammersmith Hospital have undoubtedly saved lives.

4.2 The Council supports the creation of the Major Trauma Centre at St. Mary's Hospital in Paddington and specialist paediatric facilities at Chelsea and Westminster Hospital. However, we do not believe that the creation of specialist units should be at the expense of local A&E units providing everyday high quality emergency care.

4.3 There should be greater investment in community care so that more people can be treated closer to their home. Only when appropriate plans and strategies have been put in place and, crucially, proven to be working should we consider any further reductions in acute provision.

North-West London Healthcare Commission:

RESPONSE FROM LB HOUNSLOW

24 February 2015

OUR POSITION ON SHAPING A HEALTHIER FUTURE

The Council position towards Shaping a Healthier Future (SaHF) was set out in a report to Cabinet on 4 September 2012, where it was agreed that the Council:

- Supports the case for change proposed in the configuration of hospitals in North West London;
- Supports Option A which includes West Middlesex University Hospital as a 'major hospital' and Charing Cross Hospital as a local hospital;
- Requests assurances from the NHS that West Middlesex Hospital will be able to cope with increased numbers of patients using its accident and emergency, maternity and other services

The Health & Adult Care Scrutiny Panel provided a consultation response. This looked at the issues involved in greater depth and has fed into the consultation response from the Joint Health Overview and Scrutiny Committee (JHOSC) that was set up specifically to look into the SaHF proposals. This JHOSC in its response raised a number of concerns including:

- The readiness and capacity of the out of hospital services
- How A&Es and Urgent Care Centres will work together
- The financial viability of the acute reconfiguration options
- The impact on emergency care in future hospitals not designated as major hospitals, including specialists services
- Impact of demand and population growth
- Impact of proposals upon transportation especially for disadvantaged populations

To a large extent these concerns have remained and have been the focus of the JHOSC since and reflected in the current year's workplan. The Health & Adult Care Scrutiny Panel have retained a watching brief with regular updates from the borough's representatives on the JHOSC, plus receiving presentations on related local issues from Hounslow CCG.

On 2 December 2014, a Single Member Decision confirmed the Council's intention to join and actively participate in the Healthcare Commission. The reasoning was to understand the impact that SaHF implementation to date has had upon West Middlesex University Hospital (WMUH) and other hospitals serving the population of

the borough, and to understand the likely impact of other proposed future changes within SaHF, and proposals relying upon the implementation of SaHF.

We wish to make clear that we remain fully supportive of the proposals to upgrade WMUH to a major hospital. Furthermore we are also supportive of the proposed acquisition of WMUH by Chelsea & Westminster Hospital NHS Foundation Trust (ChelWest), which is itself in part predicated upon SaHF proposals. We believe that both should improve the provision of health services at a time when the borough is experiencing huge growth in population and births.

However we also sought assurances from the outset that WMUH will be able to cope with increased numbers of patients using its accident and emergency, maternity and other services. Recent local trends would suggest that in the case of A&E there are causes for concern, not least the increase in waiting times beyond the four-hour benchmark which is greater than national and regional trends and would seem to coincide with the closure of A&E services elsewhere in North West London.

Our intention in supporting the Healthcare Commission is to ensure that the anticipated benefits to our residents is realised and that the risks and concerns around the SaHF programme are being actively managed and minimised. We believe this is an opportune time to review the progress of Shaping a Healthier Future; to look at trends and impacts following the closure of A&E services at Hammersmith and Central Middlesex Hospital; to understand how the risks highlighted and assurances sought have been managed and mitigated; and to incorporate any lessons in moving forward.

In the following paragraphs we set out local issues that we would like to see addressed by the Commission.

A&E Waiting Times

Traditionally, the performance against Type 1 A&E waiting times at WMUH has been better than the North West London, London and England averages. In recent months this picture has changed markedly.

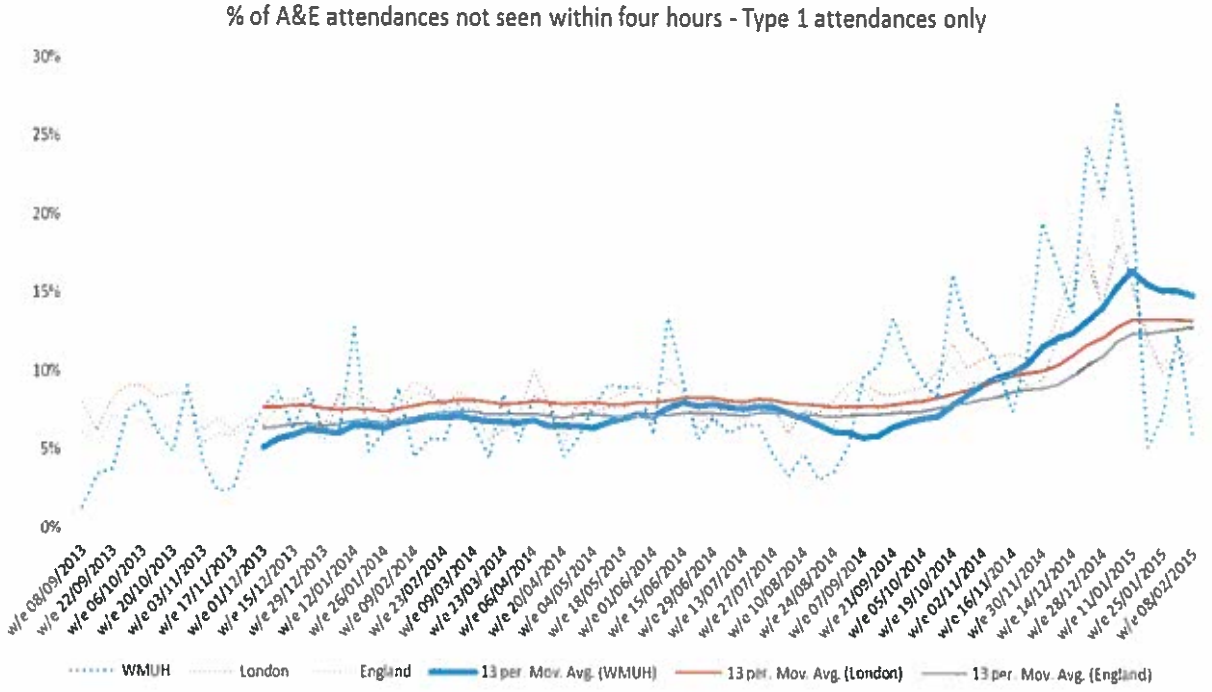


Figure 1: Percentage of all A&E attendances not seen within four hours, week-by-week, with 13-week moving average also shown

The 13 week moving average trends show that since September 2014 the percentage of Type 1 A&E attendances not seen within 4 hours has overtaken the averages for London and England. At the end of August 5.3% of Type 1 attendances at WMUH were seen outside of the 4-hour period, compared to 9.4% in London and 8.7% in England. By the second week of January the rate at WMUH has risen to 21%, overtaking by some margin the regional and national averages at 16% and 15.7% respectively. Whilst there has been some improvement during February, the WMUH trend remains above London and England averages.

Whilst increases waiting times at A&E have been a national issue, the trends since September suggest that there are local factors impacting on provision at WMUH over and above these wider trends. The timing of this change in trend suggests a link to the closure of A&E capacity elsewhere in North West London. At this time we do not know the underlying reasons but we would be interested to see where in North West London any additional demand may be coming from, and whether this would have previously been met through the closed A&E departments.

Impact of demand and population growth/change

Even before the closure of the A&Es at Hammersmith and Central Middlesex Hospitals, A&E services at WMUH were experiencing substantial growth in demand. The total number of A&E attendances at WMUH increased by 30% between Q1 2011/2 and Q4 2013/4, much greater than the North West London (NWL) rate of

8.4%. This is at a time when rest of London and England have seen total attendances fall over the same period.

One of the reasons we are supportive of increasing the provision of health services at WMUH is the recent growth in the local population. Between 2001 and 2011 the borough experienced a 19.6% increase (or 41,616) to 253,957. This was the 5th highest in London and was over 10,000 more than the GLA projection for that time. Local analysis of GP registrations suggests this may under-estimate the population by 10,000 even after taking account of error, duplication and the evening out of cross-borough practice populations.

The increase in population has been driven by young families. A breakdown by age shows that the biggest increases are in the 0-4 (38.5%) and 25-34 (27.5%) age brackets. Birth rates in the borough have been higher than the regional and national averages for some time. There has also been a significant rise in the 55-64 age bracket (29%). This has been a reliable predictor of rises in demand for services such as school places, and this will apply to health services too.

Population growth is forecast to continue and by 2030 current projections are forecasting a total population of 314,101. A breakdown is as follows:

Age Group	2011	2015	%	2020	%	2025	%	2030	%
0-4	20,249	22,011	*8.7%*	22,001	*8.7%*	21,449	*5.9%*	21,178	*4.6%*
5-9	15,064	18,162	*17.1%*	20,003	*32.8%*	19,867	*31.9%*	19,384	*28.7%*
10-14	13,922	14,065	*1.0%*	17,301	*24.3%*	18,874	*35.6%*	18,738	*34.6%*
15-19	14,684	14,486	*-1.4%*	14,426	*-1.8%*	17,277	*17.7%*	18,652	*27.0%*
20-24	18,396	18,950	*2.9%*	18,563	*0.9%*	18,258	*-0.8%*	20,359	*10.7%*
25-29	26,214	26,935	*2.7%*	27,289	*4.1%*	26,519	*1.2%*	26,162	*-0.2%*
30-34	25,783	27,360	*5.8%*	28,111	*9.0%*	28,084	*8.9%*	27,299	*5.9%*
35-39	21,297	23,564	*9.6%*	25,200	*18.3%*	25,790	*21.1%*	25,725	*20.8%*
40-44	18,159	19,743	*8.0%*	21,571	*18.8%*	22,906	*26.1%*	23,500	*29.4%*
45-49	16,818	17,584	*4.4%*	18,705	*11.2%*	20,000	*18.9%*	21,245	*26.3%*
50-54	14,553	16,102	*9.6%*	17,084	*17.4%*	17,855	*22.7%*	18,889	*29.8%*
55-59	12,276	13,366	*8.2%*	15,142	*23.3%*	15,972	*30.1%*	16,554	*34.8%*

60-64	10,904	10,945	*0.4%*	12,097	*10.9%*	13,681	*25.5%*	14,411	*32.2%*
65-69	8,033	9,542	*15.8%*	9,719	*21.0%*	10,729	*33.6%*	12,159	*51.4%*
70-74	6,619	6,906	*4.2%*	8,502	*28.4%*	8,665	*30.9%*	9,599	*45.0%*
75-79	5,311	5,670	*6.3%*	5,910	*11.3%*	7,326	*37.9%*	7,500	*41.2%*
80-84	3,726	4,099	*9.1%*	4,518	*21.3%*	4,803	*28.9%*	6,006	*61.2%*
85-89	2,217	2,391	*7.3%*	2,881	*30.0%*	3,325	*50.0%*	3,625	*63.5%*
90+	1,109	1,407	*21.2%*	1,768	*59.4%*	2,376	*114.2%*	3,113	*180.7%*

Demand for health services within the borough is therefore only likely to grow further, which is why as a borough we are keen to secure the status of WMUH as a major hospital.

Reliance on Out of Hospital (OOH) Strategy and Transfer of Funds from Acute to Community Settings

At the very outset we at Hounslow (and many other stakeholders) highlighted the reliance on OOH strategies as a key risk. We stated that the progress of the Out of Hospital Strategies needed to be monitored and their success verified before the closure of acute settings. Again we want to be clear that we support the shift from acute to community settings. At the local level we have work very closely with Hounslow CCG through our Joint Commissioning team and the Health & Wellbeing Board to develop these services and there is good progress. At a recent Health & Adult Care Scrutiny Panel, Hounslow CCG provided an update on the development of OOH services and this is attached as Appendix 1.

The question is whether this is sufficiently embedded and whether it is happening at a scale that allows reconfiguration to take place without a detrimental impact upon local health services. We believe the transfer of funds from acute to community settings needs to be at a greater scale before reconfiguration can take place. The fear is that by prematurely closing acute services, the wider strategy is put at risk as funding and resources is diverted back into acute settings to address the resulting deterioration in performance.

At a programme level, there does not seem to be a set of agreed metrics against which to judge the success of the OOH Strategies that would allow an objective view as to when reconfiguration was appropriate. The IPR report[1] is unequivocal that the success of Out of Hospital services must be proven prior to the closure of A&E

[1] Advice on Shaping a Healthier Future Proposals for Changes to NHS Services in North West London (Independent Reconfiguration Panel, September 2013)

services at Charing Cross and Ealing. The impact on A&E services at WMUH after the closures at Hammersmith and Central Middlesex would seem to reinforce that point. Greater clarity over how this is measured and who monitors this is required.

Financial Viability & Outline Business Cases

Over the past year the JHOSC has received a number of approximate dates for the publication of the Outline Business Cases for SaHF. Each time these dates have passed without publication of those business cases, with little explanation as to why this is the case. Still today these have not been published and there is uncertainty as to when these will be available, or even what stage they are at.

That reconfiguration has commenced without their publication is a concern. This concern is heightened in Hounslow because of the proposed acquisition of WMUH by ChelWest. This acquisition relies upon SaHF proposals being taken forward. If the outline business case are not yet ready, and if this were to affect the acquisition, it would impact both upon WMUH move to foundation status and its ability to address its ongoing deficit position. Such a scenario is of significant local concern.

Governance and Oversight

At the local level we have strong relationships with Hounslow CCG and are actively taking forward local health agendas. However in many ways we feel unsighted about the SaHF programme. At the North West London level, the only local authority input has been through the JHOSC. The JHOSC was set up as a consultative body and its remit is to scrutinise the implementation plans for SaHF and make any resulting recommendations to the appropriate body. Its ability to question and contribute to the SaHF more widely is limited.

We would welcome the Commission's view as to whether there should be other involvement mechanism for local authorities at the North West London level given our community leadership role and the potential impact on the future of our social care services and budgets. We would be interested to learn what involvement mechanisms have been used in other parts of the country, and whether the lack of oversight has contributed to significant slippage and a lack of transparency outside of health.

Concluding Remarks

LB Hounslow remains supportive of the proposals within the SaHF to upgrade WMUH to major hospital status. We believe this, and the related acquisition by ChelWest will result in improved access to services for local residents at a time when the borough is experiencing unprecedented levels of population growth.

We do not support the closure of further acute provision across North West London. The experience of local A&E waiting times suggests that the conditions are not yet in place as to enable closure without a detrimental impact on the services received by local people. We believe this is an opportune time to look again at the strategies to develop the right conditions at the sub-regional level, and ensure there is sufficient transfer of resources from acute to community settings.

We will continue our successful local working, but are looking for greater local authority input at the sub-regional level. In our view this will improve oversight and transparency, and help local authorities to increase their contribution to achieving our shared goals to improve health and care services for local residents.

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Delivery of Hounslow CCG's Out of Hospital (OOH) Strategy

January 2015

Sue Jeffers, Managing Director, Hounslow CCG

Clare Parker, Chief Officer, Hounslow CCG

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Out of Hospital strategy

- In order to meet the demands of a growing population with more long term conditions within the resources available, we need to improve prevention, early intervention and care at home.
- We need to transform primary, community, hospital and social care and the way they work together to improve access, quality and capacity.
- The vision for care in Hounslow is shared with our neighbouring CCGs in NW London - people, their carers and families will be empowered to exercise choice and control; GPs will be at the centre of organising and co-ordinating people's care; systems will not hinder the provision of integrated care.
- There are a number of interdependent programmes underway across North West London to deliver this:
  - Primary care transformation
  - Whole systems integrated care, including the Better Care Fund
  - Shaping a Healthier Future
- The diagram below shows the relationships between these programmes.
- Hounslow CCG is making significant investments in out of hospital services to enable the reductions in activity in the acute sector that underpin the acute reconfiguration assumptions in Shaping a Healthier Future.

The relationship between the programmes is shown below

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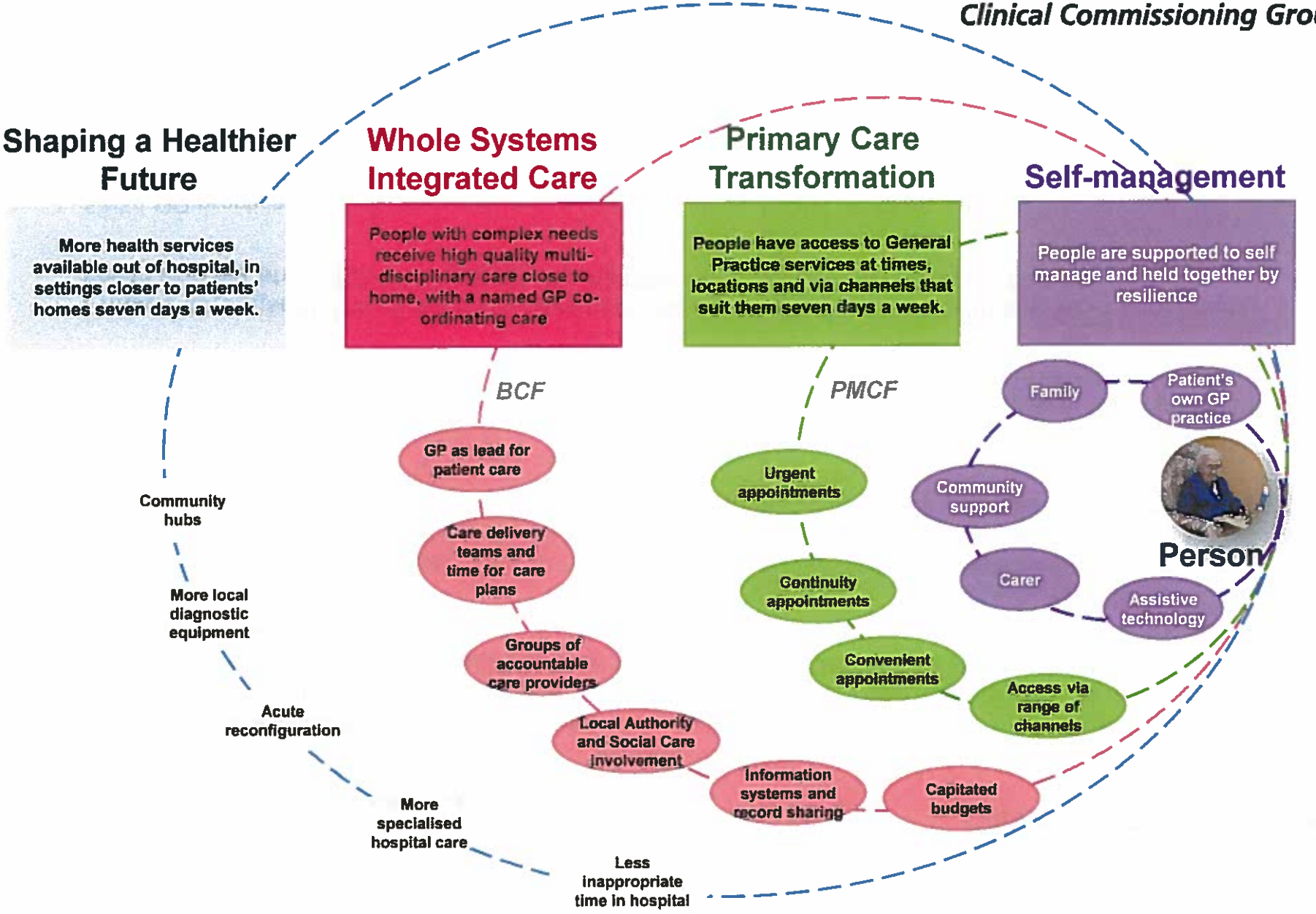

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Transforming primary care

- 53 out of 54 practices in Hounslow taking part in **Prime Minister's Challenge Fund** - covering a population of over 285,000 patients. Around £780,000 is available to Hounslow's five networks to help deliver outcomes against urgent, continuity and convenient care. PMCF is helping GPs extend online access, for e.g. through rolling out electronic prescribing.

- **GP weekend opening** is now available in Hounslow - with one practice open each weekend in each of its 5 localities, open for 6 hours on Saturday and 4 hours on Sunday, all linked to 111. Five practices in Hounslow were open on Christmas Day, Boxing Day and New Year's Day 2014. PMCF provides further opportunity to build on this.

- **44 practices are already offering telephone consultations** as an alternative to face to face appointments and **4 practices are offering email consultations** alongside conventional channels of patient access.

- **Primary care mental health services** have been enhanced with the introduction of primary care mental health workers who support GP practices to manage more complex mental health patients.

- 52/54 GP practices and all newly-commissioned community health services, such as the diabetes and heart failure services, now using **one IT system, SystmOne**, which standardises clinical records and in turn will aid integration between services.

- Along with Ealing CCG, we commissioned London Central and West Unscheduled Care Collaborative (LCWUCC) as the new **provider of GP out of hours services** across both boroughs. LCWUCC has been delivering the out of hours service on behalf of GP practices who have 'opted out' (15 GP practices in Hounslow) from providing this service directly since November 2014. The remaining 'opted in' practices will continue with their current arrangements.

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Transforming primary care: out of hospital services portfolio

- Hounslow CCG, along with other CCGs in the Central London, West London, Hammersmith and Fulham, Hounslow and Ealing Collaborative agreed to commission a common **out of hospital services (OOHS) portfolio**, with standardised specifications and prices, to replace the previous Local Enhanced Services. This will ensure that all patients within CWHHE are able to access the same range of services.

- For Hounslow CCG, the total investment of £4.4m represents an increase of £2.3m on the 2013/14 LES budget.

- OOHS are being commissioned at a GP network level, with these new GP provider organisations or networks taking responsibility for ensuring that all patients within the network are able to access all the services.

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Transforming primary care: out of hospital services portfolio

- Chiswick Locality is the first locality in Hounslow which has gone live with the following eight OOH services on a pilot basis:
  - Ambulatory Blood Pressure Monitoring
  - Anti-coagulation (levels 1 & 2)
  - Case finding, care planning and care monitoring
  - Wound care (simple and complex)
  - Near patient monitoring
  - Phlebotomy
  - Spirometry testing

- When fully implemented, the full range of services will include:
  - Diabetes (Level 1, High Risk & Level 2)
  - ECG
  - Homeless services
  - Mental Health services (Complex Common; Severe and Enduring)
  - Ring Pessary

- We expect to all services in place and 100% population coverage by 31 March 2016.

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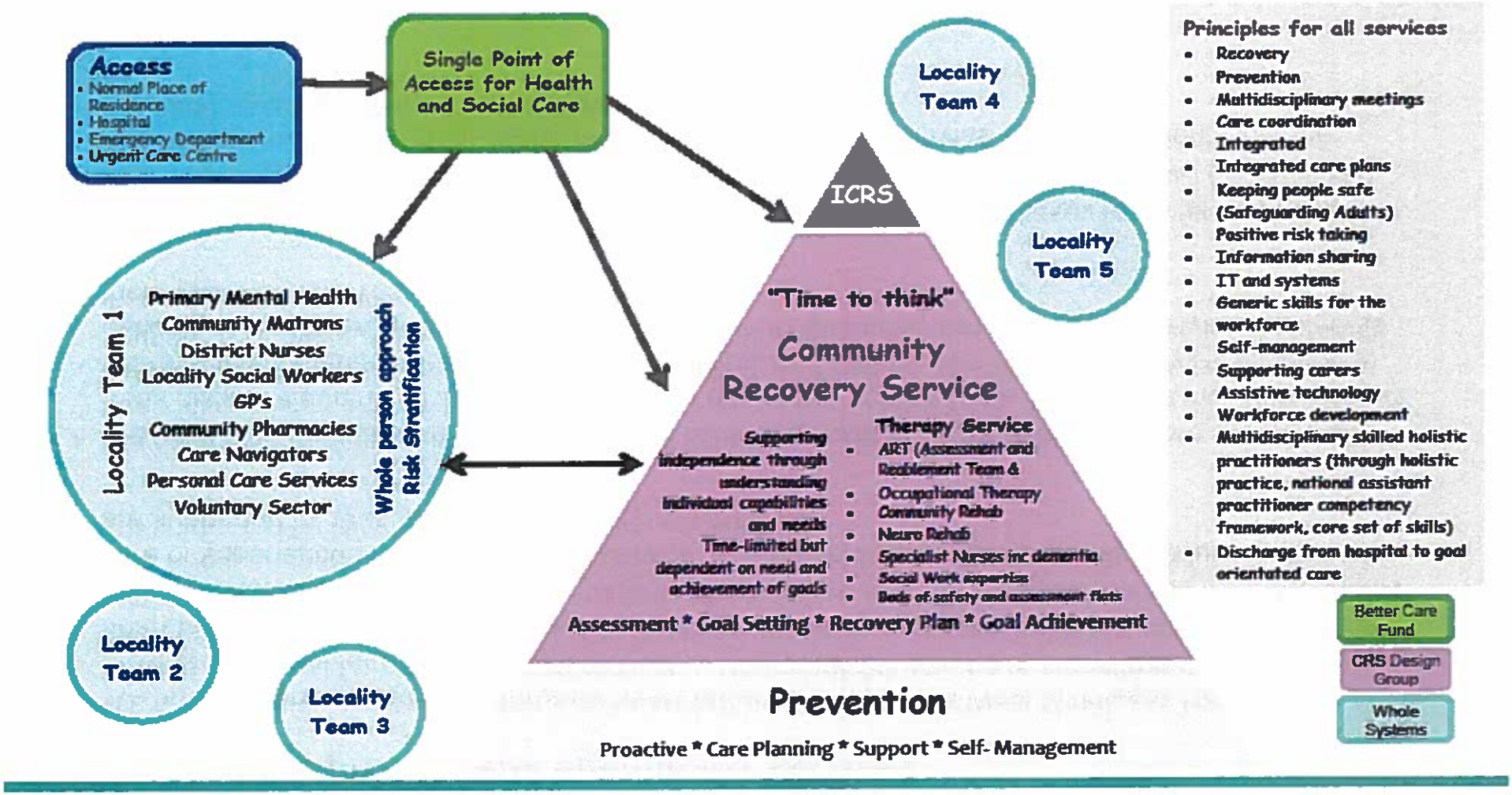
Transforming primary and community services

- We have commissioned a **community heart failure service** from West Middlesex Hospital to provide treatment for patients registered with a Hounslow GP who have a confirmed diagnosis of heart failure. The aim of the service is to increase access to specialist heart failure team advice for primary care colleagues and to support patients who have recently been discharged from secondary care or experienced heart failure. The service is delivered by two specialist heart failure nurses who are supported by West Middlesex Hospital consultants.

- We have also recently commissioned a new community **diabetes intermediate care service** with three distinct elements of service delivery that will go live in May 2015. The service includes care for intermediate patients with diabetes, foot protection, and patient education. The service will provide patients in Hounslow with a robust, safe and reliable community based diabetes service that meets their needs & improves their diabetic outcomes.

- A new **ambulatory emergency care service** is available at West Middlesex Hospital for patients who need urgent hospital care but which doesn't require a UCC or A&E. Patients will be assessed, diagnosed and treated on the same day where possible. The service can refer patients into the weekend opening service if appropriate.

Transforming primary care



Resources for all teams to draw on:

- Specialist Palliative Care
- Marie Curie
- SALT (Speech and Language Therapist)
- Continence
- Carers – paid and unpaid
- Dietetics
- ICRS (Integrated Community Response Service)
- Tissue Viability
- Phlebotomy
- PCF (Personal Care Framework)
- Community Heart Failure/ Cardiac Rehab
- Day Resource Centres
- Community Equipment
- Exercise programmes
- Community Dental Care
- Opticians
- Podiatry
- Stroke Association
- Assessment flats
- COPD Rehabilitation
- Rehabilitation beds
- Dementia services
- Sandbanks
- Falls Prevention
- Assistive Technology
- Housing
- Adult Education
- Employment support
- Transport for Patients and Carers

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Integrating health and social care – Whole Systems Integrated Care

- The CCG is working with partners including London Borough of Hounslow, 5 GP Networks, WMUH, HRCH, WLMHT, voluntary organisations and patients, service users and carers as an Early Adopter of the NW London **Whole system Integrated Care** programme.

- Hounslow' s programme will target people with **one or more long term conditions and people with dementia and other organic brain diseases** over 16 years of age. This covers over 60,000 people.

- At the end of 2014, **whole systems integration simulation events** were held, which brought together health and social care workers, lay partners, patients, carers, and third sector representatives, to discuss current system works, co-design how a new system could look and how theirs and other professional's roles would align in it.

- Work is in progress across most of the milestones for delivery of WSIC, including data sharing capability, shared care planning and GP locality network development.

- Delivery of WSIC is co-dependent on delivery of primary care transformation, out of hospital services portfolio and the Better Care Fund.

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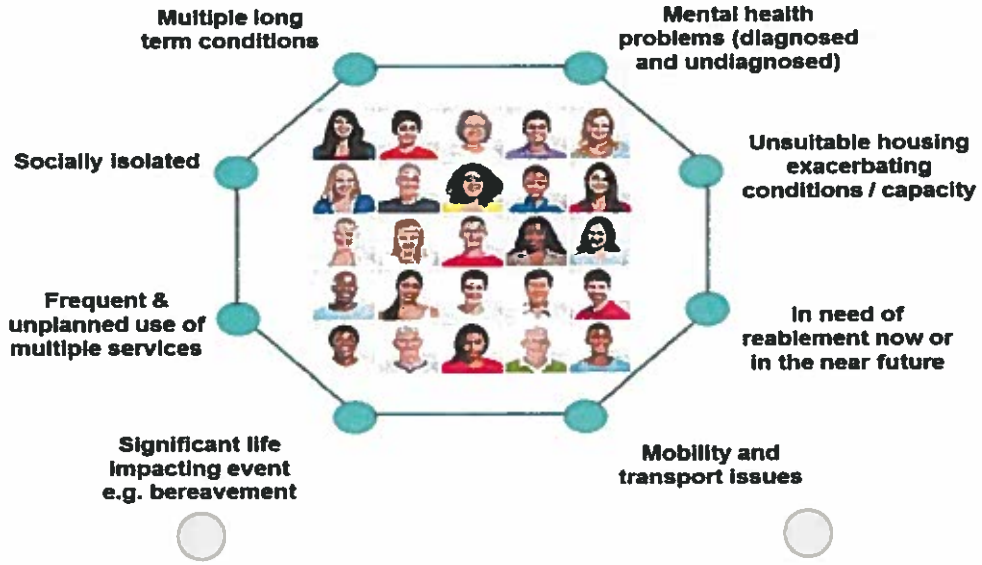
Better Care Fund

- Better Care Fund available for Hounslow Council and CCG in 2015/16 is £16,898,000. This is not new money and requires significant changes in health and social care economy, to a more preventative agenda with less reliance on statutory services.

- As our work and engagement in this area has evolved, we have been able to identify a number of common challenges for those in greatest need, which if addressed, would genuinely transform their quality of life and wellbeing. The illustration below highlights some of these challenges

- We will work with WMUH to understand the positive impact of the BCF on preventing unnecessary admissions to hospital.



Better Care Fund

- There are a number of overarching themes to the Better Care Fund plan:
  - Help people self-manage and provide care navigation
  - Invest in reablement and rehabilitation through an Integrated Community Recovery model
  - Invest in locality based social work
  - Universal Information, advice and signposting
  - Integrate NHS and social care systems around the NHS Number and through a single point of access across health and social care
  - Integrated dementia services
  - Seven day working in localities for GP services and hospital social work teams supporting community provision
  - Personal Care Framework commissioned to replace existing traditional homecare services
  - Implementation of the Care Act, supporting the additional costs of implementing the act for local authorities is a requirement of the BCF.
  - Protection Adult Social Care, including the need to support carers
  - Care homes, both in relation to GP cover and support and quality monitoring.
  - Care Plans for over 75s through primary care and co-ordinated care

Integrating health and social care – Better Care Fund

- We have introduced the **Integrated Community Response Service (ICRS)** - a team of GPs, nurses, a mental health nurse, a handyman and a social worker is available from 7am to 7pm seven days a week. It provides patients over the age of 18 with help within two hours of the service being called. The team works to prevent people going into hospital or a care home when they could be looked after in their own home. The team also provides support at home to allow people to return home from hospital more quickly.

- We are redesigning our rehabilitation and reablement service model and pathway to provide, alongside the Integrated Community Response Service, a **Community Recovery service**: a combination of reablement and community rehabilitation, which will work with individuals who have lost their independence through illness or accident and support them to build confidence, regain skills and to self-manage their health conditions and medication. The service will introduce patients to assistive technologies such as Telecare and Telehealth.

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Integrating health and social care – Better Care Fund

- **Social workers and GPs are working together in pathfinder localities.** Two localities (Feltham and Great West Road) are piloting this initiative with the existing locality multi-disciplinary groups. From April 2015 this will be rolled out across all five localities. Our multi-disciplinary teams work with the voluntary, community and independent sector to support highest risk patients to ensure they can access all the services they need, self-manage their conditions and proactively ask for help, so they remain healthy, independent and well.

- The evaluation of the **Care Navigator Service** has highlighted the benefits of the scheme and shown areas for future development. These scheme is being developed by bringing together learning from the pilot scheme and learning from simulation events and whole systems planning. The scheme will be co-designed and have full engagement with members of the Patient and Carer Reference Group throughout the procurement process.

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Integrating health and social care – Better Care Fund

- GPs are undertaking **clinical sessions in care homes** at weekends reducing admissions to hospitals from care homes at weekends.

- The Council and the CCG have jointly procured an **integrated recovery-focused Personal Care Framework** to provide people with effective, quality and appropriate health and social personal care at home as an alternative to traditional homecare.

- Additional social work capacity, including presence in Emergency Departments, is an integral part of BCF plans to support the acute sector. Additional hospital social work capacity will ensure that more section 2s are dealt with within 48 hours which will significantly reduce the number of delayed transfers of care. We are have **remodelled the hospital service to extend social care to 7 days per week,** and ensure that weekend discharges are enabled and that homecare packages under the new Personal Care Framework are able to be set out of normal office hours. This will be initially funded through systems resilience funding from November 2014, and will be funded through the Better Care Fund from April.

Next steps – 2015/16

- We will be developing plans to commission a non-emergency patient transport service to support the shift of services from hospital to community setting. This will help patients access new community and primary care services, and in turn reduce non-attendance rates.

- We will be developing the **integrated community paediatric hubs** to reduce outpatient paediatric referrals and improve access to paediatrics in the community. Core elements of the hubs will be: regular joint clinics (GP and consultant) at GP practices, regular multi-disciplinary team meetings, improved access to acute paediatric advice, and parental support.

- Work will be done on **clarifying the urgent care pathway** across 111, UCC and GP access including weekend opening.

- We will also be looking at the **further development of the GP weekend opening** initiative.

Brent	London Borough of Brent 24th February 2015

Independent Healthcare Commission for North West London Evidence Submission

1.0. Introduction

1.1. This paper outlines Brent Council's concerns with regard to the implementation of the Shaping a Healthier Future (SaHF) proposals and the impact the recent closures of A&E facilities are having on the quality of health care available to residents of Brent. It is our view that further planned reconfiguration of hospital care is likely to only increase the pressure on the remaining acute provision in the absence of clear, timetabled plans to provide the necessary additional capacity within out of hospital services as envisaged by the original SaHF model.

1.2. Brent Council accepts the case for reconfiguration of acute hospital services across West London, where there is clear clinical evidence of better outcomes for patients being achieved as a result. The Council notes the approach of creating specialist centres of excellence for the treatment of strokes, cardiology and paediatric care and acknowledges there is evidence that patient care in specialist centres has improved as a result of these changes. However we are concerned that the population assumptions underpinning the case for a reduction in A&E Units from nine to five across west London have significantly underestimated both current and projected future demand. This is evidenced by the steady increase in the length of patient waiting times at Northwick Park Hospital since the closure in September of the A&E units at Central Middlesex and Hammersmith and Fulham Hospitals. Furthermore the capacity available within out of hospital and GP services to respond to the reduction in acute provision has been considerably overestimated resulting in increased and unsustainable pressure on both primary care services and the remaining A&E Units.

1.3. Any reduction in acute provision, both in terms of A&E and bed capacity, is reliant on successful delivery of the Out of Hospital Strategy and improvements in community care. The Council broadly supports the approach to providing enhanced primary care services in local setting. We are working closely with our local health partners to develop networks of out of hospital support, whether provided by Urgent Care Centres, GP surgeries, community nursing or integrated health social and community care.

1.4. However these aspects of SaHF, particularly local investment in the out of hospital Strategy, have not been progressed by the NHS at the same pace as the reduction in acute provision. Currently there has been no proven reduction in patient demand for hospital services as a result of investment in primary care to warrant continued implementation of the planned closures under the proposed SaHF model.

1.5. The Council does not believe that the evidence available confirms planning for or implementation of the SaHF proposals, specifically the reconfiguration of A&E services in the North West London Healthcare NHS Trust, has delivered the promised improvement in healthcare services for our residents. For week ending 30th November 2014, Northwick Park Hospital was only able to meet the 4 hour wait standard for 62.95% of patients attending the A&E department, this figure had decreased further to an all-time low of 53.7% of patients for the week prior to Christmas 2014.

1.6. A detailed analysis of the current position has been carried out. In reviewing a wide range of evidence, a number of areas of concern have emerged. The Council's key concerns are:

- The accuracy of population assumptions underpinning the model
- Poor performance of A&E services
- Under use of Urgent Care Centres
- The shortage of acute hospital beds
- Delay in implementation of the out of hospital strategy
- Delay in developing GP capacity
- Delayed transfer of care from hospital and increasing readmission rates.
- Governance arrangements

1.7. As a result of these concerns the Council considers that the implementation of SaHF's to date has failed to:

- ensure that facilities to provide A&E and acute bed capacity are sufficient to meet the current and future demands of the West London population.
- Invest in sufficient capacity within the out of hospital strategy to meet displaced demand from hospital reconfiguration.
- develop services from a strategic and holistic perspective to ensure continuity of care following the decommissioning or downgrading of services.
- deliver services which are relevant to and meet the needs of the people of the borough

We believe that these are the key issues which need to be considered by the North West London Independent Healthcare Commission, to which this evidence is submitted.

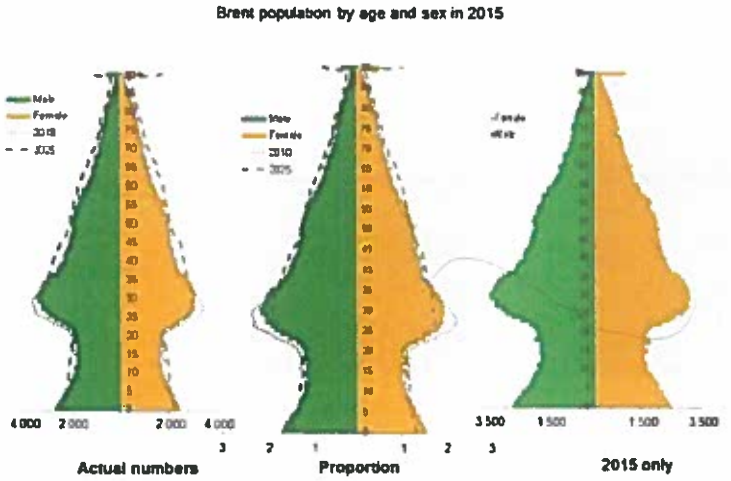
2.0. The accuracy of population assumptions

2.1. Brent is the most densely populated borough in outer London with a density of 74:1 people/hectare. The population is growing and it is ethnically diverse – 65% of Brent's residents are from black, Asian or minority ethnic backgrounds. Population

projections for Brent suggest an ongoing and significant increase in resident numbers. Projections also show significant changes in the age profile of residents, with, in particular, an increase in the number of older residents whose specific health issues may necessitate urgent acute care if they are not appropriately supported in the community over the long term.

2.2. In 2015 there are 320,781[1] people living in Brent. Over the last five years the population has grown by 4.1% from 308,267[1] in 2010. It is projected to increase by a further 3.3% to 331,237[1] by 2020 and to 341,368[1] by 2025. The number of people aged 65 and over has increased from 32,593 in 2010 to 36,045 in 2015. This cohort is projected to increase by 9,081 to 45,127 in 2025, a percentage increase of 25.2%. Looking more closely at the older population, those aged between 85 and 89 are projected to increase by 48.5% from 2,905 in 2015 to 4,313 in 2025 and those aged 90 and over, by 90.3%, from 1,607 to 3,057.

Figure 1: Population by age and gender



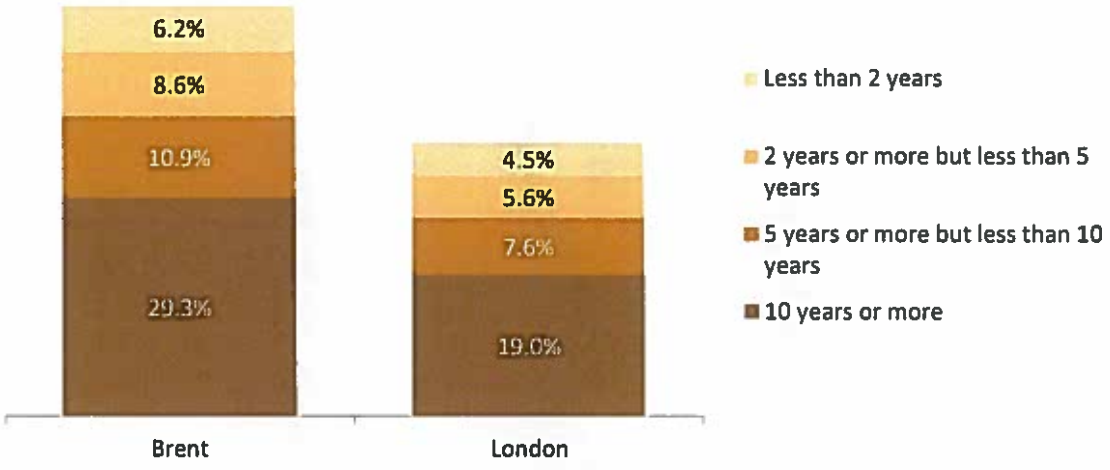
2.3. In December last year, the Mayor of London announced his decision to designate a Mayoral development area at Old Oak Common and to put in place a new Development Corporation. This is of huge significance for the NW London boroughs and is acutely relevant for the capacity of health provision and SaHF[2]. The Development Corporation will take the leading role in planning for development and regeneration in the area, to deliver 24,000 homes and 55,000 jobs. The Corporation covers a 950 hectare site that straddles the boroughs of Hammersmith & Fulham, Brent and Ealing. Whilst the increase in homes and employment opportunities are welcome, if the NW London Healthcare Trust is currently struggling to deliver emergency health care to residents, it is difficult to see how the SaHF changes will enable local health care services in the area to address the potentially significant population increase the developments at Old Oak Common and Park Royal will precipitate.

[1] GLA SHLAA based population projections from ONS 2013 mid-year estimates
[2] 'Old Oak and Park Royal Development Corporation Greater London Authority 2014

2.4. The publication of population figures by the Greater London Authority[3] in early February, which confirm London's population at a record high, would further suggest that the stresses now being experienced by London health services are unlikely to diminish. The specific figures for NW London further confirm the continuing trend for population movements from inner to outer London.

2.5. We would also propose that the diversity and transience of our population may also suggest that A&E becomes the initial source of health care for some groups who are unfamiliar with the existence of other pathways, such as urgent care centres or who do not remain in the borough long enough to register with a GP in order to access health care. Figures below confirm this potential, showing that almost a quarter of Brent residents born abroad have lived here for less than five years.

Figure 2: Length of residence in the UK for those born abroad



2.6. The council believes that the strategy to replace A&E units with consultant led Urgent Care Centres does not provide an adequate alternative. The communications strategy has not successfully made clear to patients the type of care or injury that can be dealt with by UCC's and this risks confusion and delay in treating patients with more complex conditions.

2.7. It has been reported that up to 40% of current A&E patients could be treated within a primary care setting. However the College of Emergency Medicine's own survey results reveal that only 15% of A&E admissions could be safely treated by a GP without an emergency department assessment.

3.0. Poor performance of A&E services

3.1. A key concern following the implementation of SaHF is the dramatic decline in the performance of A&E services at Northwick Park Hospital. In August 2014, the Care Quality Commission published the results of its quality inspection of services

[3] London population estimate confirmed at record high Mayors Press release 2.2.15

provided by North West London Hospitals NHS Trust. With specific regard to Northwick Park Hospital, the Commission rated the hospital as 'Requiring Improvement'. The A&E department at the hospital was singled out as 'Requiring Improvement':

> *"The A&E department at Northwick Park hospital required improvement in order to protect people from avoidable harm. There were inadequate staffing levels to provide safe care to patients within the major treatment area. The escalation protocol was inadequate and did not provide a sufficient or measurably safe response.*
>
> *Northwick Park hospital was consistently not meeting the 4-hour A&E waiting time target. The leadership within the A&E department did not ensure that patient experience and flow through the department was assured."* [4]

This independent assessment of the performance of A&E services gives the council significant cause for concern: if the service was performing poorly in August 2014, prior to the implementation of the changes and the closure of Central Middlesex A&E, this must call into question capacity to deliver the expanded services anticipated in SaHF. It also raises questions regarding the capacity to expand services at the same time as delivering the improvement plan associated with the CQC inspection.

3.2. One of the major issues identified during consultation on the SaHF proposals was the capacity of A&E at Northwick Park Hospital in the context of the closure of A&E services at NW London Heathcare Trust partner hospital, Central Middlesex. Despite assurances that no closure would be implemented prior to additional resources being operational, the closure of Central Middlesex Hospital A&E went ahead in September 2014. The associated expansion and modernisation of A&E facilities at Northwick Park was not implemented until December 2014. Northwick Park A&E continued to not meet the national standards for patient waiting times. Table 3 below indicates the percentage of patients attending Northwick Park hospital A&E who are being seen within the target 4 hours.

3.3. Whilst there was a slight improvement in month on month performance between December and January (since reversed) comparison of the quarterly figures in table 4 below, which mitigates seasonal variations, further demonstrates the continuing decline.

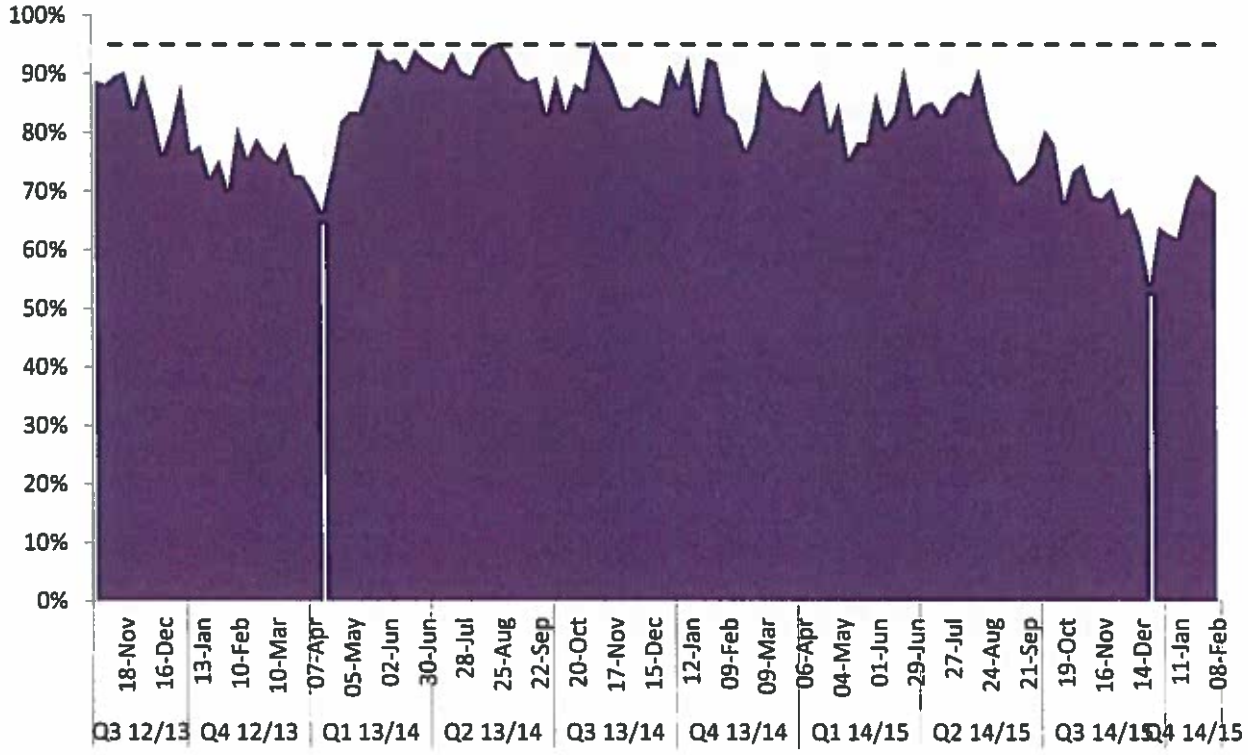
3.4. In the week ending 01/02/2015, eight people waited for 12 hours or more in A&E before they were seen. Since quarter two in 2012/13 only two people had to wait that long, on separate occasions. Waiting times in the urgent care centre are much lower than in A&E. Only once, since quarter two 2012/13 has the percentage of patients waiting longer than four hours exceeded 2%.

3.5 These figures clearly demonstrate that the hospital is unable to respond within national standards to attendances at A&E following the closure of Central Middlesex in September 2014. This highlights that, even with the enhancement of facilities and capacity at Northwick Park, the health infrastructure designed to support the SaHF remains inadequate. Since September 2012 the NW London Hospital Trust A&E service has not been able to perform above the target of 95% of attendees being

[4] Care Quality Commission report of inspection of Northwick Park Hospital August 2014

seen within 4 hours. In the light of these figures, the question must be put as to how A&E services can be expected to deliver the improvements envisaged by SaHF.

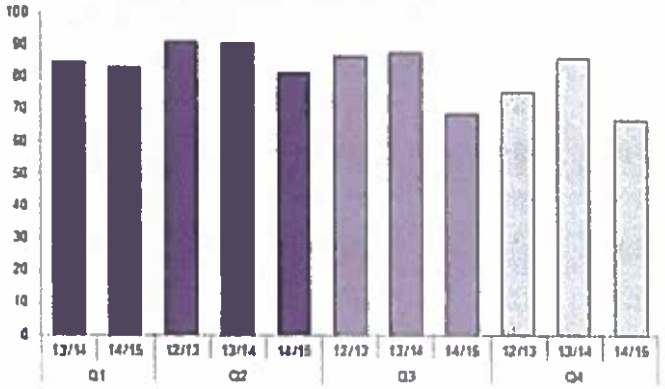
Figure 3: Percentage of patients seen within four hours in major A&E departments of North West London Hospitals NHS Trust5 from week ending 23/09/2012 to 08/02/20156



[5] From Q3 2014/15 London North West Healthcare NHS Trust
[6] NHS England A&E attendances and emergency admissions

Figure 4: Percentage of patients being seen within 4 hours, quarterly figures

Percentage of patients seen within four hours at major A&E departments of North West London Hospitals NHS Trust* comparing quarters



*from Q3 2014/15 London North West Healthcare NHS Trust

Source: NHS England A&E attendances and emergency admissions

4.0. Under use of urgent care centres

4.1. A well-integrated health system would expect to demonstrate a shift in the flow of patients and the nature of the issues being presented to the various care settings following closure of major A&E facilities. The original intention of the care model in Shaping a Healthier Future was to provide the most responsive care in the most appropriate environment, with an emphasis on patients receiving primary care in local settings wherever possible. As such, it might be expected that usage of the urgent care network would be increasing as residents use the service which can most appropriately and efficiently meet their needs.

4.2. The figures in Table 5 below suggest that there has not been any significant increase in the usage of the urgent care centres or any associated decrease in the use of the A&E service despite the reduction in the number of units in North West London. This would seem to suggest that either residents are not aware of the alternative facilities, are unclear on the treatment available from them or have not confident to use them where they believe they may need emergency assessment.

Table 5: Numbers attending London North West Hospitals NHS Trust type one (major) and type three A&E departments (UCC) Q3 and Q4 2014/15[6]

Week ending	Type 1 Departments - Major A&E	Type 3 Departments - Other A&E/Minor Injury Unit	Total	Type 3 as % of total
08/02/2015	2326	3845	6171	62%
01/02/2015	2288	3720	6236	52%
25/01/2015	2264	3474	5738	61%
18/01/2015	2269	3378	5647	60%
11/01/2015	2264	3391	5655	60%
04/01/2015	2412	3811	6223	61%
28/12/2014	2440	3981	6421	62%
21/12/2014	2626	4216	6842	62%
14/12/2014	2540	4140	6680	62%
07/12/2014	2623	4087	6710	61%
30/11/2014	2616	4103	6719	61%
23/11/2014	2583	3975	6558	61%
16/11/2014	2599	3939	6538	60%
09/11/2014	2453	3705	6158	60%
02/11/2014	2374	3847	6221	62%

5.0. The shortage of acute hospital beds.

5.1. A further area of concern for the council is the continuing reduction in the number of acute beds available within the NW London Healthcare Trust. The shortage of acute beds at Northwick Park is acknowledged by the Trust and while reassurance has been given that bed capacity will be expanded in the future, the current shortage is significantly impacting on the waiting times within A&E services. The council is not convinced that the planned expansion of acute beds at Northwick Park is sufficient to fully meet future demand and is concerned by the continued delay to increasing bed numbers which are clearly required immediately. As a result there is on ongoing negative impact on the quality of health care available to our residents, as admissions are delayed and waiting times in A&E increase.

5.2. The proposed reduction across west London in acute beds as a result SaHF was predicated on the assumption that improved out of hospital care would reduce admissions and demand for acute services, through better management of conditions within primary care settings. This change in patterns of care and patient demand has

not materialised. The paper from Sean Boyle and Roger Steer[7] submitted as evidence to this commission states:

> *"The net effect of the SaHF proposals..... would be a reduction of approximately 25% in total beds in North West London as resources are shifted from the acute sector to out of hospital settings..... Over half of this reduction is based on the assumption that average length of stay in hospital will be reduced by 15%...."*

However the Director of Operations at the North West London Hospitals NHS Trust has during attendance at Brent Scrutiny Committee accepted the need for at least a further 80 acute beds at Northwick Park to meet demand. It is of concern that at such an early stage of implementation, the modelling assumptions of Shaping a Healthier Future with regard to acute bed capacity are already under pressure.

5.3. The changes to bed capacity are shown below in Figure 6 including numbers as well as occupancy. There has been a steady increase in the number of occupied general and acute beds between quarter 2 2012-13 and quarter 2 2014-15. Continued pressure on the number of available beds in 2014-15 will continue to impact on the successful functioning of A&E and performance on waiting times as patients requiring admission are unable to move through from A&E.

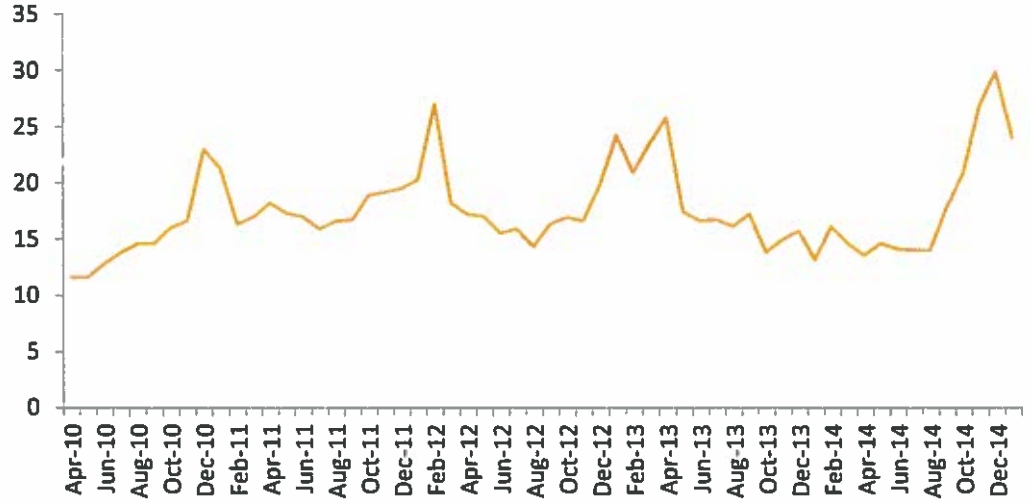
Figure 6 Overnight beds North West London Hospitals NHS trust[8], availability and occupancy

5.4. A further indicator of the lack of capacity to escalate at Northwick Park Hospital is the time taken for ambulances to transfer patients to the care of the hospital – if patients cannot be moved on from A&E their transfer from the ambulance service is also delayed. The table below indicates the average time taken to transfer patients from the London Ambulance Service to the A&E at Northwick Park and suggests a sharp increase in this average between August and December 2014. Despite a reduction in the average transfer time since December this is still significantly higher than previous average transfer times.

[7] Evidence submission – Sean Sean Boyle and Roger Steer

[8] North West London Hospitals NHS Trust:Northwick Park, St Marks and Central Middlesex hospitals

Figure 7 average time between arrival and hospital to trolley for Northwick Park Hospitals.[9] (minutes)



6.0. Delay in implementation of the overall out of hospitals strategy

6.1. The document from Brent Clinical Commissioning Group 'Final Commissioning Intentions for 2015 – 16' clearly states that:

> *"The acute reconfiguration is dependent on significant take up of existing and new out of hospital services being delivered locally by all CCGs to ensure that patients only go to hospital when they need to"*

6.2 However the process and timeline for delivering this objective is not being managed in alignment with the changes that have taken place in the acute sector. The document also comments:

> *"Outline Business Cases for all sites and an Implementation Business Case will be developed, aligned with clinical vision and centrally reviewed to ensure the solution for North West London remains affordable. Outline Business Cases for all hospitals are expected to be approved by NHSE, NTDA, DH and HMT in 2015/16. Following approval a full business case is to be developed to allow the redevelopment of sites to continue"*

6.3 The commissioning intentions clearly set out the imperative to provide effective of out of hospital care as central to the successful implementation of SaHF. These include:-

- Increased available bed capacity
- Reduced numbers of delayed transfer of care cases
- Reduction of inappropriate attendances/admissions
- Reducing demand on local acute services
- Ensuring that there is a responsive, timely and accessible service that responds to different patient preferences and access needs

[9] London ambulance service (LAS)

6.2. One of the key issues identified by both health care providers and the public during the consultation period for SaHF was the absolute imperative of out of hospital services being in place prior to the closure of any emergency facilities. Without this it was widely agreed that the remaining A&E facilities would be overwhelmed by additional demand as a consequence of the closures. The Decision Making Business Case from SaHF acknowledged these concerns and specified that:

> *"Acute changes must be synchronised with Out of Hospital changes to deliver full benefit... where possible, Out of Hospital changes must be delivered prior to acute changes".*

6.3 Plans put forward by Brent CCG have clearly demonstrated their intention to deliver enhanced out of hospital services. In Brent's Better Care Fund Plan[10] submission, it is specified that:

> *"In simple terms, there are two broad objectives that we are working towards which neatly summarise our ambitions for health and social care integration –*
>
> - *To reduce the use of residential care and enable people to remain healthy and independent in the community.*
> - *To reduce hospital admissions and the length of time people stay in hospital.*
>
> *Three of the schemes in this plan contribute directly to these objectives and form a whole system response aimed at reducing hospital admission, the length of time a patient has to stay in hospital if they are admitted, and more planned and proactive care, based in the community. Those schemes are:*
>
> - *Keeping the most vulnerable well in the community*
> - *Avoiding unnecessary hospital admissions*
> - *Effective multi agency hospital discharge"*

6.4 The CCG's Out of Hospital Strategy 'Better Care Closer to Home' [11]further emphasises this ambition:

> *"We have a clear vision for delivering better care, closer to home in Brent and have started to commission new services that are allowing people to receive the care they need in their homes. At the heart of our vision is providing the right care, in the right place, at the right time to reduce reactive, unscheduled care and do more planned care earlier."*

The recognition of the importance of the continuing development of out of hospital services and a commitment to their delivery is clear and one that the council supports and welcomes. However, an examination of the extent to which these intentions have been realised suggests progress has been considerably behind the pace of change within the hospitals reconfiguration. The Out of Hospital Strategy was published as a draft in 2012 and a final version of the strategy does not appear to have been considered and endorsed by NHS Brent CCG.

6.5 This suggests that the *implementation* of SaHF is inevitably flawed as the other components upon which its success is dependent are incomplete with little evidence of tangible and ongoing progress to align the two elements.

6.6 It is our view that the development of co-ordinated and enhanced out of hospital provision is behind the reductions in emergency and in-patient provision. Despite the

[10] Brent Better Care Fund Submission Brent CCG September 2014
[11] Brent Better Care Closer to Home Brent CCG July 2012

acceptance that the two element of the programme where interdependent there appears to have been weak co-ordination of the necessary work streams cross the entirety of the SaHF model.

7.0. Delays in developing GP Capacity.

7.1. Our key concern in the context of the overall out of hospital strategy is General Practice. The development of hub networks for GP surgeries in Brent can make a significant contribution to enabling more local people to access GP services in a location they prefer and at a time that best meets their needs. In so doing it will also support the implementation of SaHF. However, in a survey undertaken by Brent Healthwatch in May 2013, 63% of respondents did not know what a GP hub appointment was and in a further survey in November 2014, 30% of respondents felt they still wait too long for an appointment to see their GP.

7.2 A number of concerns have been raised regarding the sustainability of current GP services and their capacity to deliver their intended role within the SaHF model. These concerns include the following:-

- The property base of many GP practices is unsuitable and unsustainable in the long term.
- Many local GP's are approaching retirement age.
- It is financially unsustainable for every GP practice in NW London to operate 8 -8 7 days per week to meet increases in demand.
- There are not enough GPs and nurses in NW London for every GP practice to operate 8-8 7 days a week
- It is likely that increasing the number of appointments would cater for unmet need instead of redistributing existing demand
- Use of the GP Hub model to redistribute demand to available appointments is not suitable for all patients and patients with complex or long-term conditions wish to be seen by their specific GP.

7.3 The figures below demonstrate some of the access issues in relation to GP services.

- In 2012 there were 69 GP practices in Brent, 15 of which have all male practitioners and 16 with all female practitioners. In November 2014 the number of practices had reduced to 67.[12]

- In 2012 there were 339,381 patients registered with NHS Brent CCG, with an average of 4,919 patients per practice. This equates to 1,694 patients per GP or 66.9 GPs per 100,000 population. This is similar to London (66.4 GPs per 100,000 population) and the same as England. In January 2015, Brent CCG had 363,071 registered patients[13] and 216 GPs registered with

[12] HSCIC: General medical practices
[13] HSCIC: General medical practices

Brent CCG practices[14]. This equates to 1,680 per GP or 59.5 patients per 100,000 population.

- However, of the 67 Brent GP practices, only 37 (55%) open after 6pm, including 15 (22%) that open until after 7pm. Only 37 (55%) practices open at 8.30am or before. Of these, three (4%) open at 7:30am and ten (15%)at 8am[15].

- Patient satisfaction varies considerably between GP practices to GP. Despite an average satisfaction score of 75.6%[16] in 2013/14 for opening hours, individual practice scores for opening hours ranged from a low od 39.7% to 91.3%. The average satisfaction with practice opening hours in Brent had increased slightly from the previous year 2012/13, when 74.2% of patients were satisfied with their practice opening hours.

- Similarly, although on average, 74.9%[16] of patients were satisfied with phone access to their practice, this varied from 41.7% to 99.3%.

- The percentage of patients that knew how to contact out of hours GP services when their practice was closed was 44.1%[16], ranging from 29.1% to 61.4%.

- In 2013/14, 46.7%[16] Brent patients saw or spoke to a GP or nurse on the same or following day they contacted the practice. This varied by practice ranging from 17.9% to 83.1%. The average increased from 2012/13 when 44.2% of patients saw or spoke to a GP or nurse on the same or following day.

- Although less than half the patients received an appointment within 48 hours, the overall experience of making an appointment was reported as positive by 71.1%[16] of Brent patients. This ranged by practice from 48.4% to 96.6%.

7.4 The responsibility for commissioning of GP practices currently sits with NHS England through nationally set contracts. This arrangement impedes flexibility to respond to local need and more effective integration of GP services into commissioning strategies for joint health and social care services envisaged under the Health and Social Care Act.

8.0. Delayed transfer of care from hospital and increasing readmission rates.

8.1. A further measure of the success of out of hospital care is the speed with which residents can be discharged from hospital and the success of their rehabilitation in the community. The council is working closely with health partners to provide the alternative accommodation and GP support necessary to enable prompt discharge from hospitals.

[14] NHS Choices: GPs' staff downloaded 05/02/2015 .
[15] NHS Choices: GP opening times, downloaded 05/02/2015
[16] Median percentage for all NHS Brent CCG practices

8.2. In 2013/14 the rate of patients ready to leave a hospital bed, but not moved due to delays by the NHS or social services was 9.8 per 100,000 population[17]. This is higher than both the London and England average, 6.8 and 9.6 per 100,000 population respectively[17]. The rate of people delayed due to social care services in Brent is 3.0 per 100,000 population, which is near the England average (3.1 per 100,000 population) but higher than London (2.3 per 100,000 population)[17]

Table 8 Emergency readmissions occurring within 30 days of discharge from hospital, Brent residents 18

Year	Percentage
2011/12	12.06
2010/11	11.90
2009/10	11.13
2008/09	11.18
2007/08	10.48
2006/07	10.52
2005/06	9.63
2004/05	9.07
2003/04	8.41
2002/03	7.56

Although not significant numbers, figures demonstrate a steady increase since 2002/03 in the numbers of residents being readmitted to hospital as emergencies within 30 days of their discharge from hospital. This could suggest weaknesses in out of hospital health care provision or potentially early discharge due to pressure on available bed capacity.

8.3. Patients of the NW London Healthcare Trust are supported in their rehabilitation by the STARRS service. This community service provides support to residents, in conjunction with services at Willesden Hospital, to support successful rehabilitation and thus prevent readmission to hospital. The STARRS team is highly regarded in its interaction and integration with the emergency services at the Trust. The CQC inspection report [19] commented positively on its reputation within A&E. The STARRS service is a key element within the overall approach to reducing demand and should be a central to the future success of the out of hospitals strategy.

9. Governance

9.1 The governance arrangements for decision taking on and implementation of SaFH have not been clear and appear to have mitigated against effective local authority engagement and participation.

[17] HSCIC: Adult Social Care Outcomes 2C delayed transfers of care
[18] Health and Social Care Information Centre (HSCIC): NHS outcomes framework – indicator 3b
[19] CQC Inspection – Northwick Park Hospital August 2014.

9.2 In establishing Brent CCG and its predecessor, the PCT, the NHS recognised the importance of health commissioning arrangements being coterminous with local authorities. Brent Council welcomes coterminosity as an aid to joint working, particularly between health and social care. However SaFH is a North West London strategy.

9.3 While the NHS recognises North West London as a geographic basis on which to plan, this does not correspond to any existing local government structure(s). We would suggest that the North West London orientation of SaHF hampered local government's ability to influence and contribute to the development of health care either within each local authority area or across the wider footprint of NWL. It is the case that a JHOSC has been established. However scrutiny is only one means by which local government should be involved in the development of health care.

9.4 The processes of NHS decision making, in particular the development of and agreement of business cases, can seem opaque to local government with its systems of open and democratic decision making. The account by the JHOSC of their difficulties obtaining information illustrates how difficult it has been for local government to participate and contribute to NHS decision making.

9.5 SaHF is being implemented in the aftermath of the Health and Social Care Act. SaHF is predicated upon a whole systems response – at its heart are shifts of activity from hospitals to the community. Amongst other things this relies upon a shift of clinical responsibility from hospitals to GPs. However the Health and Social Care Act separated responsibility for the commissioning of most hospital services, which rests with CCGs, from responsibility for commissioning GP services which now rests with NHS England. This fragmentation of responsibility seems to be a barrier to the whole system change which the effective implementation of SaHF demands.

10.0 Conclusion

10.1 The 'Shaping a Healthier Future' proposals are far-reaching in their intentions to remodel health services across west London. While the intention to provide more and improved health services in primary care settings is positive the evidence to date does not indicate that this is the experience of local people using our hospitals and GP surgeries. The evidence suggests that financial consideration rather than clinical priorities are determining the pace of implementation of hospital reconfigurations.

10.1 This is further undermined by the lack of transparent governance and key planning documents not being available to add joint planning of community health and social care services to support the implementation of the SaHF proposals. The lack of alignment with the primary care and out of hospital strategy is placing unsustainable pressures on a system which requires additional investment and capacity to meet the needs of our residents. It is the council's view that the population and planning assumptions on which Shaping a Healthier Future were based requires fundamental review to ensure a health care system in West London which is fit for purpose now and in the future.

Introduction

1.1 I am Mary Daly I have represented the Sudbury Ward of the London Borough of Brent since 2010 as an elected Councillor. I have been a member of the Brent Partnership Overview and scrutiny Committee until May 2014. I currently sit on Brent Scrutiny Committee. Brent Scrutiny Committee is responsible for Scrutiny of the NHS as it affects residents of the London Borough of Brent.

1.2 I have worked as a Nurse, Midwife and since 1976 as a Health Visitor in London retiring in 2013.

1.3 Whilst all of the cuts impact Brent residents and have a knock on effect on each other. SaHF proposed major cuts in services sited in Brent and widely used by Brent People. They proposed the Closure of A&E at Central Middlesex Hospital (CMH) and the downgrading of the hospital and the closure of 187 beds at Northwick Park Hospital (NPH).

1.4 In 2012 (SaHF) was published by the NHS in London. It emphasized the requirement to make "*unprecedented*" cuts to the NHS in North West London.

1.5 My submission addresses the impact of those cuts on Brent Services since the publication of SaHF.

1.6 It advised that the £3.5billion is to be spent in North West London health economy and that there must be savings of at least 4% per year up until 2015.

1.7 Savings of £381M is to be made 60% from the acute sector half of those acute sector savings is to be made in the non elective activity including outpatient activity, A&E service, and Elective services.

1.8 SaHF advised that NWLHT was required to make the largest savings in percentage terms at 15%

Winter Pressures

introduction

2.0 in November 2013 NWLHT closed A&E at Central Middlesex Hospital (CMH) citing safety. This action was undertaken suddenly and without consultation.

2.1 The NHS Brent was under pressure especially during the winter period of 2013/4. A paper was presented to the Brent Partnership Health Overview and Scrutiny Committee in November 2013 acknowledging that pressure and outlining measures to deal with the pressures.

2.2 The NHS Brent acknowledged that there would be a need to be a plan for additional capacity for the winter of 2013/4. A £6.452M package which included additional acute and non acute bed capacity,

2.1 funding of £400,000 to London Ambulance service to redirect patients from NPH A&E to CMH A&E. Although CMH was only open 15 hours per day by this time none the less LAS conveyed 2397 patients to CMH between January and May 2013. This information was presented in a paper to

Brent Partnership Health Overview and Scrutiny Committee in November 2013 LAS reported to the committee that their instruction was to pick up patients from HA0, HA9, NW9 and convey them to CMH seven days a week.

2.2 In February 2014 during the winter pressures the Care Quality Commission (CQC) inspected CMH and in May published its report) . It found that Urgent and Emergency Services (A&E) and medical care was good. There was no reference in the CQC report to the proposed closure of CMH A&E or the vital role being paid by CMH A&E and Medical beds at the time of the inspection in relieving pressure on NPH.

2.3 In May 2014 the CQC inspected NPH the report was published in August 2014. NPH was found to require improvement in six of the eight departments inspected including A&E. There was no reference to the impending closure of A&E at CMH the month after the publication of the CQC report and the impact of that on NPH's ability to cope during the winter of 2014/5

2.4 In August 2014 a paper was presented to the Brent Scrutiny Committee outlining the rationale for proceeding with the closure CMH A&E. It was suggested that CMH A&E was clinically unsafe because of staff shortage. There was much use of the word "assurance". All agencies including NWLHT, UCC at CMH, UCCat NPH, LAS, Imperial,Ealing HealthcareTrust, Royal Free , were reported to have confirmed their readiness to support the planned closure. The benefits to NPH A&E was much emphasised

2.5 The paper presented to the committee stated in its closing paragraphs in relation to CMH that " *the risk of delay was noted in particular NWLHT's inability to maintain a safe service at CMH through winter*" and that Brent CCG was *assured* of this.

2.6 There appears to have been no published indication that the risks of the closure of CMH A&E on the population in Brent considered. Reference is made to assurances given to various NHS bodies based on desk top modelling.

2.7 On a visit to NPH in late 2014 the Scrutiny Committee was assured that the poor performance of NPH A&E would be halted when the new A&E at NPH opened and members of the committee was assured that all of the staffing concerns raised in the CQC report had been addressed.

2.8 Neither the NHS nor the CQC nor officers of the council inform Scrutiny Committees of inspections to Health Facilities in their area. Members of committees usually hear about such inspections from the media. In September 2014 a paper was presented to by the NHS at the request of the Scrutiny committee about the CQC inspection of NPH published a month earlier. The theme of the paper was that the problems identified during the CQC inspection were resolved by the closure of CMH A&E and that the inspection was not a matter of great concern. One NHS representative claimed to be a CQC Inspector and that all hospitals will be inspected in this way and similar outcomes found. Member's efforts to invite the CQC Inspectors to the Committee to give evidence was not successful the reason is not entirely clear.

2.9 In January 2015 London Ambulance Service (LAS) attended a subcommittee of Brent Council Scrutiny Committee. It advised that it was required to make £53M of cuts in the preceding 3-4 years and it had done so by not filling 240 vacancies. Brent CCG was aware of this fact as it is the lead Commissioner of ambulance services in London on behalf of the rest of London.

2.10 LAS described 411 front line vacancies in London in January 2015. Brent was reported as having the highest number of Para Medic vacancies at 112 front line vacancies. This contrasts with the assurance accepted by NHS Brent in July 2014 when it was stated to them that there would be additional LAS front line staff and that they would be in place by September 2014 as part of the assurance process supporting the closure in A&E CMH. NHS Brent is the lead agency commissioning ambulance services on behalf of the rest of London and not only should have known the crisis in ambulance services but had contributed to it in its commissioning actions.

2.11 In February 2015 the NHS presented a paper to Brent Scrutiny Committee at its request. The paper failed to answer the questions put to it on behalf of the committee instead it described the current status of the Systems resilience Group, a group of senior managers addressing winter pressures.

2.12 It seemed to imply but not to state explicitly that the cause of the failings at NPH A&E was Delayed Transfer of Care (DTOC) the graph providing the details of DTOC was so small as to be unreadable.

2.14 The Managers from the NHS seemed to imply that NPH's performance was one of the better in London.

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The proposal to close 1005 beds across North West London.

Central Middlesex Hospital

3.0 The principal focus of concern about the proposed cuts in Service in North West London has been on A&E closures. However the proposed closure of hospital beds by approximately 25% has been subject to less scrutiny.

3.1 In 2012 The Pre Business case (SaHF) suggested that there was a surplus of 1099 beds in North West London including 104 beds at Ealing Hospital, 71 beds at CMH and 186 beds at NPH. They advised that *"taking account of changes in demand and commissioner strategy"* there will be a reduction of 979 beds across the sector.

3.2 CMH has 227 beds , at the time of publication of SaHF. SaHF advised that in 2012 there was reported to be 204 beds in use at CMH

3.3 Roundwood Suite at CMH was described by the CQC in February 2014 as four general inpatient wards. The CQC described the Medical services as good during the inspection that month

3.4 Documents published by the NHS indicate that it is a 40 bed suite of wards. Ward 1 of Roundwood closed in February 2013. The remaining ward of 30 beds closed at the time of the closure of the A&E.

3.5 In November 2014 North West London Hospital Trust confirmed that the number of beds at CMH had reduced to 122 beds, including Gladstone Ward 90 beds, intensive care and high intensity 8 beds, elective beds 24 beds. The beds at the time of the closure of A&E in September 2014 were s CCU 8 beds Roundwood 40 beds and A&E observation 10 beds.

3.5 In February 2015 NWLHT reported that 119 beds only were in use at CMH

Northwick Park Hospital (NPH)

3.6 SaHF advised that in 2012 there was 576 beds at NPH of which 533 was open at that time of the publication of SaHF. The report advised that due to demand and commissioning strategy 76 fewer beds would be needed with a further 67 not needed because of LOS2??. It was stated in SaHF that there was a surplice Of 187 beds at NPH.

3.7 In December 2013 a report was presented to Brent Partnership Health Overview and Scrutiny Committee at the committee's request. The Committee was advised that in February 2013 it was discovered that NWLHT 2,700 surgical patients on the waiting list and that half of them had waited for more than 18 weeks with 12 patients waiting more than a year for treatment.

3.8 The cause of the incident was reported to be a failure of systems and processes. Capacity and demand was reported to be a key factor. The report stated that *"insufficient care was commissioned "as a result "demand for particular services had built up but without the necessary capacity"*

3.9 The committee was advised that the Trust (NWLHT) was working towards increasing elective capacity at CMH and emergency capacity at NPH. It is unclear if that commitment was honoured.

3.10 Capacity was purchased from neighbouring NHS and Private hospital to address the needs of the thousands of patients whose surgery had breached the 18 week Referral to Treatment (RTT) target. It is unclear if all of those patients have now been treated

3.11 In December 2013 a paper was presented to Brent Health Partnership Overview and Scrutiny Committee advising of concern about A&E waiting times. It was reported that Bed capacity had been increased at NPH from 629 in 2012/3 to 699 in 2013/4 additional capacity was also planned of 28 acute beds. It is unclear if this capacity included the facilities at CMH which at that time included the A&E 15 hours per day and the Roundwood acute Medical Unit.

3.12 In February 2015 NPH reported that there were no closed beds at NPH and a total of 604 beds were in use this excluded a further 67 maternity beds. Taking into account the 90 beds at CMH and 32 beds at Willesden Health and Care Centre a total of 726 beds are available to meet the demand for health care presenting at NWLHT

3.13 In 2014 the NHS was advised by CAPITA that the *"Capita demand and capacity model identified a further capacity gap of 89 beds"* even allowing for the additional beds purchased in that year to meet the winter pressures. it is not clear if Capita factored in the beds at CMH. NWLHT is currently committed to building a 100 bed unit to meet need at the NPH site.

3.14 It seems clear that the NHS knew in the summer of 2014 when they decided to close the A&E and Roundwood Medical Suite at CMH that there was a serious shortage of beds. There is no evidence that the risks associated with closure been addressed instead the closure was presented as a positive action for NPH in that the A&E would enjoy additional staff and extra beds.

3.15 in November 2014 Brent CCG highlighted the risk for patients in failing to invest in sufficient hospital care in its Governing Body meeting of 26th November 2014. The following targets have been missed. M6 cancer standard was missed at NPH, Referral to

treatment 18 week targets are still being missed, cancelled operations did not meet the standard. It is unclear how often operations are cancelled as local residents report it is commonplace. A&E at NWLHT has now failed to achieve the A&E standard set out in M6 throughout the winter. Significant patients were reported to have waited in ambulances for more than 30 minutes at NWLHT.
3.16 in February 2015 Brent NHS presented a paper to Brent Scrutiny Committee at the request of the committee who requested an update from Brent NHS in the light of widespread concern about capacity within the system. The paper failed to address the request for information and instead described in detail the work of a group known as the Systems Resilience Group. it reported that a further £4,2M was spent to meet winter pressures including reopening 12 beds in Willow Ward at Willesden Health and Care Centre as well as £419,000 to McKinsey Consulting for unspecified purposes. Managers at NHS Brent described NPH as performing well despite the evidence to the contrary.

Willesden Health and Care Centre.

3.17 Willesden Health and Care Centre is a PFI hospital run by a private company from whom health service organisations rent space. The wards are the responsibility of NWLHT since its recent merger with Ealing Hospital.
3.18 It has not been inspected by CQC since 2011 but was inspected by Brent LINK in December 2011. At that time the hospital was described as having three inpatient Wards, Menzler and Fifoot Wards had a total of 40 beds. The wards were described as providing rehabilitation services to patients who have been inpatient in an acute hospital and who need extra care and support to help them to become more independent following a period of illness. Robertson Ward a 12 bed Specialist Neurological Rehabilitation Ward. In addition there are two wards Willow and Furness wards they appear they appear to have been closed at the time of the LINK inspection.
3.19 In 2012 there were significant cuts in the service when it was managed by Ealing Hospital.
3.20 In 2012 This author received a complaint about poor care of residents at Willesden Health and Care Centre. The complaint was investigated by Managers from Ealing Hospital but there was a lack of transparency with regard to the learning as a result of the complaint because the resident died after the complaint was made
3.21 The Hospital appears to be used in recent years to relieve pressure on NPH and wards appear to have been opened when the hospital is under pressure and closed when the pressure is relieved on the acute hospital.
3.22 In December 2013 the Brent Partnership Health Overview and Scrutiny Committee was advised that 20 additional beds was to be opened at Willesden Health and Social Care Centre costing £1,065,000
3.23 In October 2014 the Executive of Brent CCG was advised that that Furness ward was in continual use as "*Winter Beds*" since 2013 and that a further £1.4M was required to make a further 12 beds available on Willow Ward. Brent CCG complained about the cost pressure of funding the beds into 2015/6.
3.24 In November 2014 Brent Partnership Overview and Scrutiny Committee was advised by the NHS in a paper presented to the committee that the 40 beds in Menzler AND Fifoot wards would be moved to CMH.
3.25 Willesden Health and Care Centre seems to play an important part in meeting the needs of some of Brent's most vulnerable and frail residents. Especially when other areas of the NHS is under pressure. It is an NHS facility with a potential 70 beds but was not included in the SaHF cuts proposals.

Out of Hospital Care

4.00 SaHF is predicated on providing out of hospital for some of the vulnerable groups in our community in Brent, Frail elderly people and people with complex chronic illnesses. It was he trailed as providing more suitable care close to resident's homes. Commissioners are required to make 4% Quality, Innovation, Productivity and Prevention (QIPP) savings on existing services to fund the new services required to meet the needs of local people in an environment of less access to hospital care.
4.1 There appears to have been little progress in delivering the *Out of Hospital* services upon which the cuts proposed in SaHF is predicated
4.2 This proposal to replace hospital based services with *Out of Hospital* services appears to be driven by Brent CCG in the borough of Brent although Commissioners increasingly talk about Brent and Harrow as one entity.
4.3 One of the first actions of Brent CCG was to decommission and decommission a range of community outpatient clinics. the service specification for clinics the first two Community clinics, Cardiology and Ophthalmology was published in 2012. The existing services had been provided by NWLHT.

4.4 The Ophthalmology clinic was commissioned from BMI Healthcare. The numbers of contacts commissioned by this service was reduced from 9,000 first time appointments to 8,300 and follow-up appointments from 28,500 to 24,900 appointments. The service is competing with an identical service provided by NWLHT.

4.5 The Cardiac Service eventually commissioned from Royal Free Hospital has not yet commenced although its commencement is reported to be imminent. The procurement process has been tortuous including threats of legal action and complaints to Monitor by NWLHT. In 2011/2012 NWLHT saw 10,500 first time patients and 12, 100 patients. The new contractor (Royal Free Hospital) is commissioned to see only 9,900 first time patients and 10, 100 follow-up patients. NWLHT is operating as a competitor service. it is unclear if there is sufficient demand for two competing community outpatient clinics.

4.6 Concern has been expressed that NHS Brent who has issued press releases promoting the new services, one of which has not yet started may pressurise GPs to refer to the newly commissioned services.

4.7 The process of commissioning the service has been unseemly and there is concern that patient choice could be undermined.

4.8 A second wave of community services are also now commissioned and are also behind schedule. In the meantime the Musculoskeletal Physiotherapy service vital to rehabilitation is in a state of worrying neglect.

4.9 The process appears to be as confrontational as the first wave.

4.10 there is concern about chronic neglect of community services in Brent NHS The service specification for the Musculoskeletal Service expired in September 2013. The understanding of staff working in the service is that they are commissioned to undertake 8000 contacts with Brent residents. There was reported to be 15,000 referrals to the service last year and other Health Professionals have reported long waiting times of up to two months to see a physiotherapist in the

community in Brent. This is reported by them to be impacting the ability of the community to receive patients from Hospital who are ready for discharge. The service

4.11 The District Nursing service is reported to be understaffed and to have difficulty recruiting. There are reported to be particular difficulty in Wembley and Kilburn Districts.

4.12 A whole systems integrated care pilot is operating in Brent. The pilot is funded by Commissioners and others. The pilot is intended to address the problem of meeting the health needs of 3% (approximately 9,000) of the population of Brent who are frail elderly and or have two or more chronic illnesses whilst avoiding A&E and Hospital admission.

4.13 the pilot requires all patients in the target group to have a care plan and for care coordinators to coordinate the plan.

4.14 The funding has paid for five care coordinators in Brent although there is currently only three. The care coordinators in post look after the patients in 13, 20 and 16 GP practices respectively. The care co-ordinators are employed by the mental health Trust on NHS and are paid grade four (£18,000pa) and are not clinicians.

4.15 Care Co-Coordinators reported barriers to their planning of care include delays in other services e.g. the musculoskeletal service needed 2 months notice. It was acknowledged that the service was modelled on the American Managed Care model and the principal driver of the model was to control health costs in the target group of patients. in this case to avoid A&E use and hospital admission.

4.16 It was acknowledged to the Scrutiny Committee in January 2015 there are a number of obstacles in relation to the pilot it is underfunded in relation to the huge demand on the service, there is a risk the workers will be exploited and diluted, there is a multiagency employer, there has been no major investment in primary social or community care and although the care co-ordinators are employed by the Mental Health Trust Mental illness is not within their remit.

4.16 Managed care has been controversial in the United States in that it has been driven by a cost cutting agenda to the benefit of health providers. The pilot in Brent is also driven by saving money in that success is measured by the number of patients in the target group kept out of A&E and not admitted to hospital.

4.17 There appears to be little debate about the risks to vulnerable patients of such a scheme in an environment where primary and community services are declining and hospital services are scheduled for closure on an unprecedented scale.

4.18 The Better Care fund is an initiative promoted by NHS England. It is proposed that existing Local Authority and Health Funding is pooled, this is in reference to existing funding and is intended to meet the needs of the same population group as the Whole Systems Integrated Pilot. It also seems to have the same objective of keeping the target population out of hospital.

4.19 in order to address concern about long waiting times to see GPs in Brent NHS opened GP surgeries during evenings and weekends five in total The project was to be funded by a contribution, unspecified from the Prime Ministers challenge fund a sum from Health Education North west London and £4M from NHS Brent. The project is reported to be a pilot and to run until 2017 but

members of Brent Scrutiny Committee have been unable to establish how the pilot is being evaluated.

4.20 A number of concerns have been expressed to members of the Scrutiny Committee about this project. They include the fact that the hubs are poorly marketed to patients, Patients understand the care they are likely to receive in an Urgent care Centres or A&E versus prospect of finding and attending a strange surgery when they feel ill to see a doctor is unknown to them is unappealing.

4.21 There is a concern that the CCG is transferring funding all be it small but increasing sums from its intended purpose to of commissioning community and Hospital care to primary care, a service the CCG is currently not responsible for funding without the proper structures in place to ensure that value for money is being obtained.

4.22 Brent Scrutiny Committee is currently looking at access to Primary Care and that will be made available to the commission when it is published.

4.23 in a paper to Brent Health Overview and Scrutiny Committee in January 2014 NHS Brent outlined its statuary remit *"as commissioning of community and secondary healthcare services"* However the paper described disinvestment on the most vulnerable services such as Mental Health and investment in GP services of£4.7M.

4.24 Of the commitment to invest in community services in Brent in January 2014 it has decommissioned the Breast Feeding Team the target for £200,000 investment in 2014, there appears to be no MSK enhanced pathway which was to receive £82,000, as outlined above the service is stretched, it is unclear what happened to the investment of £148,000 in IAPT but NHS Brent but in November 2014 Brent CCG reported to its Governing Body that its *" performance against potential funding of £1.8M is being monitored monthly. Current assessment indicates a potential deduction of £1M due to underachievement of IAPT access rates measured against CCG plans submitted to NHSE".*

4.25 In the January 2014 paper NHS Brent outlined significant investment in Primary Care (GP's) including Primary Care Network Development £1,134M Better GP performance outcome £576,000 and Primary Care Hub Access ££813,000

4.26 investment by NHS Brent has continued for example between September and December 2014 one practice received just under £700,000 for enhanced medical services.

4.27 The paper also advised members that NHS Brent enjoyed a surplus of £26M in 2013/4 and was forecasting a surplice of £29.2M for the coming year.

4.28 The issue of conflict of interest has been raised about commissioning in Brent. It is unclear if value for money has been obtained for the services purchased from GP practices and just how much money has been diverted to GPs in Brent. It is also unclear which practices have benefitted most.

The Effectiveness of Scrutiny

5.0 Local authorities have a statuary duty to scrutinise the NHS on behalf of residents. The Scrutiny Committee is a committee of the council held in public and it is the only opportunity for the public to hear the NHS held to account for their actions.

5.1 Draconian cuts in local government funding has seen health scrutiny in Brent cut by about 50% in common with other services. There is approximately 6 hours per year available to scrutinise the NHS in Brent as opposed to 12 hours prior to the cuts. Investment in training has also been cut.

5.2 Scrutiny has the potential to contribute to Public Safety and its failures have been highlighted in recent years. The Mid Staffordshire inquiry and the Rotherham Inquiry are examples of learning from inadequate scrutiny.

5.3 Members of Scrutiny Committees should be independent of the work of the Council. This should be protected in the constitutions of their local authorities.

5.3 in Brent the NHS actively lobbies to influence the work of the scrutiny committee It has been reported that the NHS have lobbied to have limited scrutiny of the NHS in Brent. It is understood that it is their belief that scrutiny should be limiting to providers of service only. NHS Managers have reported that they consider role as that of liaison with the committee, members of the committee who have sought information has been complained about by the NHS and the NHS consider it appropriate to complain to officers of Brent Council about members for the act of actively scrutinizing.

Communication

5.4 There is concern that NHS Brent fails to communicate with its GP members in a worrying way. In 2013 it was revealed that NHS Brent had not consulted or even informed its GP members that it had decommissioned its Pathology Contract and awarded the contract to a new provider. The fact came to light when the service started to fail. Although the Better Care Fund is based on the GP being at the centre of the service as late as January 2015 local GPs were unaware of the changes about to happen and did not appear to have participated in them.

5.5 It is difficult to identify an occasion when public engagement has changed a proposal in NHS Brent. It must therefore be concluded that the conversation is in one direction and that such events are to inform rather than consult the people of Brent.

The impact of NHS pressures

6.00 The author, as an elected representative, has increasingly made representation on behalf of residents when complaining about NHS care. examples of complaints include poor end of life care with patients discharged from hospital with no care plan and passing away before the plan is in place. vulnerable patients with great medical need denied treatment in A&E because the staff in A&E did not have the competencies, patient dying following surgery, patient dying after admission to hospital with no explanation offered, patient placed in an apparent storage cupboard after surgery because of bed shortages, There has also been examples of good efficient care including NPH urgent care centre and treatment following surgery at CMH.

Conclusion

7.00 SaHF suggests that £319M can be removed from the NHS in North West London whilst delivering a better local NHS. The demand on the NHS since the publication of SaHF challenges the assertion that the NHS can lose over 900 beds.

7.1 in Brent there is little evidence that the out of hospital services needed to replace the closed beds in hospital to meet the needs of local people is being put in place. On the contrary services vital to keeping residents healthy in their homes are starved of investment with long waiting lists for some of the most vital meanwhile services vital to deliver the NHS has been cut.

7.2 NHS Brent appears to operate differing levels of oversight in relation to the moneys it allocates. Hospital and Community Services are being are challenged in a way GP Practices appear not to be.

7.3 The changes in the NHS are complex but growing concern in the community is widespread that the local NHS which is universally supported is at risk of being unable to deliver care.

Ealing

Dear Mr Smith,

In response to your request for submissions of written evidence to the Independent North West London Healthcare Commission, I am making this submission in my capacity as Portfolio Holder for Health and Adults Services, and on the behalf of the Ealing Council administration.

Our administration is opposed to the cuts in acute hospital services, especially the rundown and cessation of acute hospital services in the North West London area, which we believe will severely impact on the quality of healthcare of residents in London.

A significant number of Ealing residents have made it very clear that they reject the proposed changes set out in the "Shaping a Healthier Future" (SAHF) programme, as demonstrated by very large numbers signing petitions and participating in public rallies and protests against the changes. The SAHF programme therefore has no democratic mandate.

In the view of Ealing Council's administration, the changes to acute provision will:

- Substantially reduce the amount of locally responsive emergency care available to residents;
- Significantly increase pressure on other hospitals in a way that is dangerous and puts lives at risk;
- Increase ambulance journey times, detrimentally impacting on the quality of care during the crucial transfer period to A&E, and;
- Increase the burden on GPs and primary healthcare without proven plans or facilities in place to handle increased demand effectively.

With regard to the proposed and actual changes associated with the SAHF programme, Ealing Council's Cabinet are unanimously of the view that:

- The proposals are not underpinned by a sound clinical case;
- The business case underpinning the programme is not robust;
- There has been inadequate consultation, communication and engagement with residents and service users throughout the programme.

Background and Context

My colleagues and I understand that change is needed within the NHS. Proposals to invest in specialist emergency facilities to improve critical care are supported, particularly in areas relating to cardiology, major trauma and stroke care.

The principle of enabling more patients to be treated out of hospital and in their local communities is also something we support. Ealing Council's administration understands that effective community based health provision is key to delivery of better health outcomes, and it is playing an active role in helping to achieve this goal, for example through its work relating to integrated health and social care commissioning, and through its management of and engagement with the Ealing Health and Well-Being Board.

However, the administration is also of the view that the assumptions made in the business case underpinning Shaping a Healthier Future about the numbers of people who can be

treated out of hospital in community settings are unrealistic, especially when these assumptions form such an apparently critical component of the case put forward for reductions in acute services.

In our view, proposals to shift patients from acute to community provision on the scale suggested are unrealistic. It is certainly completely untested; there are no examples of any such significant changes to healthcare provision having been successfully implemented before, a fact which heightens my concerns and those of my colleagues on the council's Cabinet.

Specific concerns

Ealing Council's administration has consistently expressed a number of specific concerns with proposals set out under the heading of "Shaping a Healthier Future". Attached to this document are a number of appendixes, which set these out in greater detail. These appendixes are as follows:

- **Appendix 1:** a summary of relevant Council motions relating to changes to healthcare provision in the North West London area
- **Appendix 2:** Relevant documents relating to the referral of the Shaping a Healthier Future programme to the Secretary of State by Ealing Scrutiny, on 19th March 2013, including a copy of the independent review of Shaping a Healthier Future proposals commissioned by Ealing Council authored by Tim Rideout, delivered September 2012
- **Appendix 3:** a summary of relevant communications, press releases and references to public response to Shaping a Healthier Future

A summary of some of our key concerns is as follows:

1. **The proposed reductions in emergency care (A&E) services in North-West London will put residents' health and lives at risk.**

The independent review of the Shaping a Healthier Future proposals commissioned by the Council during the consultation period (please see Appendix 2) found proposed reductions in emergency provision to be based on erroneous assumptions about levels of demand and travel times (see Appendix 2, sections 7 and 8). Our administration believes that the poor health outcomes arising from reductions in emergency provision within individual hospitals in the North-West London area will be compounded by the cumulative effect of these closures across North West London.

The independent review attached as Appendix 2 shows that, taking North West London as a whole, SAHF has the biggest impact on Ealing's residents. The "preferred option" in the SAHF business case estimates that the percentage of Ealing's patient activity impacted by the proposed reconfiguration is as follows:

- 53.9% of all inpatient admissions
- 9.6% of all outpatient attendances
- 30.0% of all A&E attendances

The council's administration believes that proposals to replace A&Es with Urgent Care Centres (UCCs) will not sufficiently address demand for emergency care, but will be

confusing to professionals and to patients. It is our view that this approach will put lives at risk, for example through increases in journey times to facilities where patients can be treated effectively.

Our administration notes that the College of Emergency Medicine supports the idea of Urgent Care Centres but insists that they should be co-located alongside full A&E units; as this would ensure that patients with lower care needs could be treated by a GP while patients with higher care needs could be quickly and safely transferred to emergency care specialists.

Patients arriving at Urgent Care Centres will not have access to an assessment by a trained emergency care professional. This risks causing a substantial delay in treatment should emergency care be required. In some cases that delay could be fatal.

Reductions in emergency care which have been made so far as part of SAHF have undoubtedly had a detrimental effect: Recent figures (January 2015) show that London North-West Healthcare NHS Trust, responsible for Central Middlesex Hospital, Ealing Hospital, Northwick Park and St. Mark's Hospital is the worst performing in England for type 1 major A&E department waiting time targets. The most recent NHS England figures showed that in the last 13 weeks 68 per cent of 'type 1' patients were seen within the four hour target, falling significantly short of the 95 per cent national target.

Furthermore, reductions in emergency care also create problems for a range of other healthcare service. For example, the strain placed on NWL Hospitals following closure of A&E facilities in North West London is certain to impact on capacity to provide effective maternity services, at a time when it is proposed that maternity services at Ealing Hospital are closed, and insufficient alternative provision is in place.

The administration also believes that substantial reductions in A&E provision will have a detrimental effect on the care of those suffering from mental health disorders and traumas, and create a substantial burden for other public services such as the Police. Police called out-of-hours to public disturbances resulting from an individual experiencing a mental health breakdown currently have the option of referring to an A&E service rather than a police cell to ensure the individual's needs are appropriately assessed and addressed.

Individuals suffering from mental health problems will also lose the option of self-referral to A&E units if they experience a breakdown out-of-hours. This is likely to increase the chances that their condition may deteriorate and that they may pose a danger to themselves and/or to others.

The Council's administration is also struck by the findings of recent CQC inspections which demonstrate clear issues with and pressures on emergency care services in North West London. An inspection carried out by the Care Quality Commission (CQC) of services at Chelsea and Westminster Hospital NHS Foundation Trust, reported on October 28th last year, found an increased demand for services at the trust, including in its accident and emergency (A&E) service. It also found that the A&E did not have the recommended levels of medical staff working there and that this service was 'experiencing difficulties' in meeting the extra demand.

On the 20th August, the chief inspector of hospitals found the A&E service at Northwick Park to be an inferior alternative to A&E provision at (now downgraded) Central Middlesex hospital. Since the announcement of plans to downgrade hospitals within the North West London area to "local" hospitals without adequate emergency care provision, Ealing Council's administration has expressed concerns about the ability of the remaining A&E services to cope with extra demand in patient numbers. The damning reports issued by the CQC in recent months have served only to increase the fears of our administration.

2. Proposals to reduce healthcare provision in North West London are based on inaccurate picture of demand for services.

As set out in the section of the independent review of the SAHF proposals dealing with demand for services and population growth (please see Appendix 2, section 7), Ealing Council has repeatedly made the point that assumptions about demand for services have been made on the basis of erroneous data relating to Ealing's population.

Ealing's population, as per the latest official statistics (ONS 2013 mid-year estimate), is estimated at 342,500. The borough's population is forecast to grow to over 400,000 by 2031. These figures are significantly higher than those referenced in the SAHF business case (318,500).

Furthermore, some other local sources of information suggest that Ealing's population may be higher than the official estimates. For instance, as of January 2015 the total Ealing population registered with a GP was 406,500. At the time of the 2011 Census, Ealing was one of the key boroughs with a high level of "hard to count" population, given its diverse population and a high number of houses in multiple occupation (HMOs). Recent research carried out by the London borough of Southwark suggests diverse boroughs with a sizeable proportion of recent immigrants may have substantial proportions of "hidden" populations who may not have participated in the 2011 Census and therefore remain uncounted. The GLA estimates also project Ealing's population figure for 2015 to be 352,500, similar to ONS projections of 351,100.

Over the next decade Ealing's population is projected to grow by 9% or 30,000 people (GLA, 2013). However, the over 75+ population is expected to grow at a significantly higher rate of 30% over the same period.

The planned and executed reduction in emergency care therefore comes at a time when demand is rising and population growth in Ealing has been substantially underestimated.

Ealing Council's administration believes that the planned reduction of acute beds at hospitals across North West London will render those hospitals incapable of addressing the health needs of the local population, particularly during mid-summer and mid-winter when demand increases because of weather-related problems.

Whilst efforts are being made by the Council and partners on the Health and Well-Being Board to help keep residents out of hospital and reduce the burden on A&E departments, the fact remains that A&E episodes across London have increased year-on-year since 2008. The increase is driven largely by population growth and comorbidity amongst older people (a relatively faster growing segment of the population). Despite this, it is assumed in the SAHF business case that 1,005 fewer hospital beds are needed in North West London.

3. **There is insufficient capacity in primary care and community based services to deal effectively with the reductions in acute provision, and there are insufficient alternatives to services which have closed, or for which closure is planned.**

Just as demand pressure for services has been underestimated, the capacity of community and primary care is overestimated in the SAHF business case.

Successful delivery of improvements in community healthcare provision is something the Council supports. The Council is working hard with NHS partners to improve access to community care by better integrating health and social care pathways, for example. However the council's administration is concerned that the local out-of-hospital strategy is not sufficient to enable reductions in acute provision.

It had been stated previously by representatives from the SAHF programme that reductions in the acute sector should only be considered once the out-of-hospital strategy has been successfully developed and delivered, and there has been a proven reduction in demand. The council's administration is struck by the following quote from the Royal College of Emergency Medicine:

"The [SAHF] business case refers to a significant number of beds lost – but we would strongly advise maintaining the current bed stock until the community care and length of stay benefits are realised. Members' experience of bed reduction before social and community care is mature has resulted in extreme pressure on Emergency departments as the incomplete community care system collapses at times of increased demand. The Emergency departments and acute hospital bed base will be unable to provide a safety net for failures in community care. Investment in the infrastructure must be a priority and three years for realisation is very short."

In the view of the Ealing Council's administration, there is no apparent indication of reduction in local demand for healthcare provision, and yet reductions in acute capacity (e.g. closures of A&E facilities) are being expedited. This approach is something we oppose strongly.

It has been reported that up to 40% of current A&E patients could be treated within a primary care setting. Yet the College of Emergency Medicine's own survey reveals that only 15% of A&E admissions could be safely treated by GPs without an emergency department assessment. Once an assessment is carried out, this rises to 37%.

The establishment of UCCs outside of an acute setting risks confusion in the type of care offered. It is questionable whether GPs will have the necessary skills and experience to determine quickly whether a patient needs to be referred on to an emergency care setting.

Furthermore, the long-term trend of retiring GPs not being replaced by newly-qualified or younger doctors will place more pressure on the sector to fill the gap in A&E provision at the very time when core GP services are themselves under threat as a consequence. Ealing Council's administration believes that any move to extend UCC provision at the expense of capacity or capability of A&E units will undoubtedly place patients' lives at risk.

The Royal College of General Practitioners is quoted as saying, "The pressures on general practice to deliver effective care are mounting, as is the need to deliver continuity of care and accessible services. The crisis of demand versus capacity in the health service is not new; it has not arisen overnight and neither can it be solved quickly. Sustainable solutions must be found to increase workforce capacity and enable general practices to continue to deliver the level of service that their patients expect now, as well as taking on the challenge of providing more complex care, spending longer with their patients and communities and taking on new roles and responsibilities."

Ealing Council's administration is concerned about the lack of a wider plan and holistic approach to improve community care. The failure to involve local government properly in conceptual stages in long-term health strategies is to the detriment of local residents.

The SAHF business case points out that 79% of GP practices in North West London have satisfaction scores below the national average, stating: "The effectiveness of the delivery of GP services is highly variable and often below national averages. The variation means we are not consistently delivering the kind of high quality primary care we should be."

The planned investment in primary care of between £6-8 million, as set out in the business case, is badly needed to help bring the quality of primary health care up to modern standards. However, it is not a sufficient substitute for acute healthcare provision, and should not therefore be predicated on reduction in acute provision.

Additionally, Ealing Council's administration has significant concerns about the lack of viable alternative maternity services to those currently provided through Ealing Hospital. Ealing Clinical Commissioning Group had been expected to confirm that Ealing's maternity unit would close in March 2015; a decision is now not due until the CCG Board meeting on 18th March. As officials are currently unable to specify how long the unit may remain open, and as a direct result of confused and delayed decision-making, it has been reported that midwives are already starting to leave Ealing hospital, which is creating significant distress and uncertainty for a large number of expectant mothers as to where they will give birth. In the light of recent criticisms made by the CQC of maternity services at alternative hospitals to Ealing (e.g. Hillingdon judged to have inadequate numbers of midwives; Northwick Park's maternity services judged "inadequate") the Ealing Council administration is deeply concerned that there is a critical lack of viable alternative maternity provision to that provided in Ealing hospital.

These concerns have been voiced by midwives at Ealing Hospital via a letter to the Secretary of State, more details of which are set out below as part of our concerns about lack of clinical case and support for reductions in North West London healthcare.

4. The changes set out in SAHF are not based on a sound clinical case.

Ealing Council's administration is concerned that decisions relating to the implementation of SAHF are being made without a sound clinical evidence base.

In some cases, for example the temporary stall in changes to maternity services at Ealing Hospital, the "implementation" of SAHF amounts to nothing more than short-term, unsustainable solutions to substantial problems with the original proposals.

In other examples, the council's administration believes that the planned reconfiguration of services is based to a large extent on the requirement to satisfy complex commissioner-provider financial arrangements, which includes underwriting poor value for money PFI arrangements at Central Middlesex Hospital, an under-utilised facility with low patient demand. The administration believes that the proposed reductions put the need to fulfil complex and expensive financial arrangements ahead of patient health outcomes. This approach is not supported.

Furthermore, the SAHF proposals cannot be said to have the support of local clinicians. As shown in the independent review of SAHF commissioned by the Council (Appendix 2, section 6), support by front-line clinicians across NW London for the changes is highly dubious. There are a significant number of local clinicians (GPs and hospital clinicians) that have serious concerns about the changes to North West London healthcare provision, and that consequently do not support them. For example, recently 90 of the 120 midwives based at Ealing Hospital have written to the Secretary of State to express concerns relating to proposed cessation of maternity services at the hospital.

Appendix 2 sets out specific examples, for example statements of opposition to the proposals from consultants working at Ealing Hospital, and the lack of a clear mandate for the proposals from local GPs.

5. The changes set out in SAHF do not have the support of local people.

There has been wholly insufficient public and patient engagement in the formulation of proposals to reduce healthcare provision in North West London. Public participation has been largely confined to SAHF "engagement events" which were attended by, in total, approximately 360 members of the public (about one in five thousand of the population of NW London). There have been no specific attempts to engage with local people since, particularly the most vulnerable groups hit hardest by the proposals.

Appendix 3 includes summaries of numerous public demonstrations of opposition to proposals to reduce healthcare provision in North West London.

Neither has there been any proper attempt to engage the Council at a senior level on a sufficiently detailed basis as changes to healthcare in North West London have been implemented. All concerns and issues raised by the Council and by its scrutiny panels with responsibility for health appear to have been roundly ignored. The Council has taken great care to support its concerns with detailed evidence; but no responses from decision-makers have been similarly detailed.

Going forward

Ealing Council's administration is committed to improving health and well-being outcomes for Ealing residents. The Council is actively engaged in the business of working with partners to improve outcomes and deliver sustainable, effective healthcare provision. A major focus for the authority going forward is how to improve prevention and public health, promote independence, and better integrate health and social care provision.

The administration is in favour of making every effort to keep residents out of hospital, and approves of the principle of investing in improvements to primary and community care.

However, these investments cannot be made on the basis of a flawed rationale, underestimations of demand, and over-estimations of the current capacity of primary and community care services to cope with reductions in acute provision.

Appendix 1 sets out that Ealing Council has been actively engaged in the debate around provision of local health services since the earliest announcements of proposals to change this provision, and has done what it can to ensure that concerns are communicated to the appropriate decision-making bodies and the Secretary of State.

The Ealing Council administration would like to express support for the Commission's mission to provide fresh, independent and evidence-led scrutiny of the proposed and actual changes to healthcare provision in North West London. If the Commission requires any further information on any aspect of this submission, or is following lines of enquiry relating to issues other than those covered here, please do not hesitate to make contact with myself, or with Matthew Booth who is our lead officer for this work. Matthew's contact details can be found below.

Yours faithfully,

Councillor Hitesh Tailor
Cabinet Member for Adults, Health and Well-Being
Ealing Council
Email: tailorh@ealing.gov.uk

Matthew Booth
Director of Policy and Performance
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Appendix 1: summary of Ealing Council motions relating to proposed changes to healthcare provision in North West London

19th July 2011

After amendment the following was **agreed**

"Council notes that Ealing Hospital Trust and the North West London Hospital Trust have discussed a possible merger and have released a Strategic Outline Case for such a merger.

Council notes that any proposals for a merger must go through a consultation process involving public and patient engagement, and be based on sound clinical evidence.

This Council is opposed to the loss of hospital services and in particular any potential closure of a 24 hour Accident and Emergency Department at Ealing Hospital."

It was also moved as an amendment by Councillor Stafford and duly seconded, that the motion be amended so that it reads,

"Council notes that Ealing Hospital Trust and the North West London Hospital Trust have discussed a possible merger and have released a Strategic Outline Case for such a merger.

Council notes that in answer to a question from Virendra Sharma MP the Prime Minister stated, "There are no plans to close [Ealing] Hospital."

However, this Council opposes any future proposal to close Ealing Hospital, whether this is done directly or by running down acute services until the hospital becomes unviable or simply a large polyclinic.

This Council further opposes a merger if it is means worse clinical outcomes for patients or less choice.

This Council is committed to keeping Ealing Hospital as a district general hospital, which serves the needs of its local community.

Therefore this Council resolves to participate fully in all consultations on the merger on a cross-party basis to achieve the best outcome for the residents of Ealing."

"Council notes its position on Ealing Hospital as agreed at the meeting of the Council held on 19th July 2011.

Council agrees to adopt the same principles for Central Middlesex Hospital. Therefore:

This Council opposes the closure of Central Middlesex Hospital, whether this is done directly or through running down acute services until the hospital becomes unviable or simply a large polyclinic.

This Council is committed to keeping Central Middlesex Hospital as a district general hospital, which serves the needs of its local community

Council notes that there have been significant proposals for changes at both Ealing Hospital and Central Middlesex Hospital.

Council notes that the preferred future service configurations proposed in the NHS document Stronger Together would mean that both hospitals were closed as district general hospitals.

Council notes that the primary stated driver for the merger is the need to improve clinical outcomes.

Council believes that clinical outcomes will not be improved through cuts and closures and that the only way to ensure clinical improvement is to invest in services at Ealing and Central Middlesex Hospitals.

Council resolves to ask the Leader of the Council and the portfolio holder for health to write to the Chief Executives of the hospital boards and the Secretary of State for Health to clearly state the Council's position on this issue and to demand that there is sufficient investment in both hospitals to allow them to remain district general hospitals."

The motion was **agreed**.

17 July 2012

After amendment the following was **agreed**

"This council reaffirms the position on Ealing Hospital agreed in a meeting of the Council in July 2011 as well as the position agreed regarding Central Middlesex Hospital in January 2012.

The council believes that the Healthier Futures consultation document is not currently compatible with these positions.

This council resolves to do everything it can to campaign against the proposals outlined in the consultation and in favour of the positions set out by the council in July 2011 and January 2012 and welcomes the all party support for the Save Our Hospitals campaign.

This council is also concerned about the potential loss of the A&E departments at Charing Cross and Hammersmith hospitals."

26 February 2013

After amendment the following was **agreed**

"This Council welcomes the decision of the cross-party Health and Adult Social Services Scrutiny Panel to refer the decision to shut A&E services at Ealing, Central Middlesex, Charing Cross and Hammersmith hospitals back to the Health Secretary Jeremy Hunt.

This Council does not believe the needs of Ealing residents will be met if the closures are allowed to go ahead and urge all parties to continue to work together for the benefit of our residents.

This council urges all local politicians to attend the save our hospitals march and rally on 27th April".

16 July 2013

After amendment the following was **agreed.**

"The council notes that the independent review of the decision to close 4 out of 9 A&Es in North west London is about to begin.

Council notes that there is currently a crisis in A&Es across the country. Council notes that in light of this current crisis it would be an extremely foolish decision to shut A&E services.

Council restates its opposition to these cuts and will seek to fully participate in the upcoming review that came about as a result of pressure from this council."

"The Council condemns the decision of the Conservative Secretary of State for Health Jeremy Hunt to close Hammersmith and Central Middlesex Hospitals' A&Es and to downgrade Ealing, Charing Cross, Central Middlesex and Hammersmith Hospitals to local hospitals".

"The council notes that whilst the Secretary of State said that there would be A&Es at Ealing and Charing Cross Hospitals he went on to state that these services would be of a "different shape or size" and despite repeated questioning by MPs he offered no details on what this meant other than to say that they would be "implemented by local commissioners following proper public engagement and in line with the emerging principles of the Keogh review of A&E services."

It has since been confirmed by SAHF Medical Director Dr Mark Spencer that Ealing and Charing Cross Hospitals will be smaller A&Es and are "unlikely to take blue flashing lights" ambulance cases. Also as local hospitals Ealing and Charing Cross will not have Intensive Care Units (ICUs) and other essential back up emergency services and it is clear that only patients with minor injuries will be able to be treated at these so called A&Es.

The council therefore condemns the Secretary of State's announcement as spin. The claim that these A&Es have been saved is simply dishonest and designed to deceive local residents.

The council also condemns the Secretary of State's decision to close paediatric inpatient services and maternity services at Ealing that will mean there will be nowhere in the borough for Ealing mothers to have their babies and they will have to travel much further to give birth with all the attendant safety concerns that this will bring.

The council thanks everyone who has taken part in the campaign to save our local hospitals to date and resolves to continue to campaign to save the A&Es at Ealing

and Charing Cross hospitals and believes that these A&Es should provide a full emergency service that accepts blue light cases as this is the only true meaning of an A&E.

Council calls on NHS NW London to engage in proper engagement and consultation with the public, service e users, staff and relevant Councils as recommended by the IRP in making decisions about future A&E services at Ealing and Charing Cross.

Council welcomes the IRP recommendation that A&E departments at Ealing and Charing Cross hospitals must be sustained until any new service is decided on and implemented.

Council also resolves to closely monitor the provision of primary care and out of hospital services promised by SAHF and notes the IRP recommendation that the "NHS's implementation programme must demonstrate that, before each substantial change, the capacity required will be available and safe transition will be assured".

Council further resolves to oppose the implementation of the Secretary of State's decisions if these services are not in place as the worrying precedent of Chase Farm in Enfield shows is likely to be the case.

The motion was **agreed**

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Councillor Dr. Abdullah Gulaid
Chair, Health and Adult Social Services Standing Scrutiny Panel

Councillor Anita Kapoor
Vice-Chair, Health and Adult Social Services Standing Scrutiny Panel

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19 March 2013

Dear Secretary of State,

'Shaping a Healthier Future' – Referral for Review

Following a meeting of the Health and Adult Social Services Standing Scrutiny Panel of London Borough of Ealing ("the Panel") on 4 March 2013, we write to refer for your consideration the decision of the North West London Joint Committee of Primary Care Trusts ("JCPCT"), reached on 19 February 2013, to make resolutions in connection with the Shaping a Healthier Future programme ("SAHF"). The JCPCT resolved that there should take place major downgrades of a number of hospitals serving Ealing residents: Ealing, Hammersmith, Central Middlesex and Charing Cross. These hospitals will lose accident and emergency services, emergency surgery services, non-elective medicine and surgery services, complex elective medicine and surgery services, a level 3 Intensive Care Unit, in-patient paediatric services, and obstetrics and maternity services.

The impact of the Panel's decision on Ealing's residents is severe. This has not, in the Panel's view, been sufficiently appreciated by the JCPCT. Indeed, whilst currently Ealing residents have the choice of a number of local hospitals to access the full range of healthcare services, this choice has practically been removed *altogether.* Not only does the JCPCT's decision result in the downgrading of the *only* hospital located in the London Borough of Ealing itself (Ealing Hospital), but it also downgrades three other hospitals that are proximate to the Borough and are used extensively by Ealing residents: Hammersmith, Central Middlesex and Charing Cross. The residents of no other borough are affected as severely as those living in Ealing.

The Panel has looked closely at the proposals, including with the benefit of a detailed expert report from a former NHS executive, and is firmly of the view that the proposal is not in the interests of the health service in Ealing. The proposal fails to satisfy the four tests that you have set for reconfiguration proposals to meet in your document *Revision to the Operating Framework for the NHS in England 2010/2011*. The Panel does not

believe that there has been adequate consultation or engagement with the public, clinicians or Ealing Council ("the Council"). The Panel therefore refers the matter to you under Regulation 4 of the Local Authority (Overview and Scrutiny Committees Health Scrutiny) Functions Regulations 2002.

We attach as Appendices to this letter comprehensive supporting evidence to support this request for referral. Titles of the Appendices are listed at the end of this letter for ease of reference.

The Appendices include documents sent by the Council to Anne Rainsberry, Chief Executive of NHS NW London in response to NHS NW London's purported consultation in connection with SAHF (Appendices 2, 4a and 4b, 5-7 inclusive, and 12a and 12b). These include a paper summarising the issues arising from SAHF from the Council's perspective, drawing substantially on the independent review of the proposals drafted by Tim Rideout ("the Rideout Report"); the Rideout Report itself; and the views of some key local stakeholders on the proposals, including Ealing Hospital and the Shadow Health and Well-Being Board, and the Panel's views expressed to NHS NW London during the consultation period.

Appendices 8, 12a, 12b and 13 contain the correspondence between NHS NW London and LBE in relation to Shaping a Healthier Future. Appendixes 1a and 1b comprise the main report to the Panel, and Appendix 14 is the resolution of the Panel to refer the matter to you. Appendix 11 is a document produced by a panel member detailing concerns with the nature of the data employed by SAHF in support of its proposals, produced for this referral subsequent to the Panel's 4 March meeting. Appendices 1a – 10 inclusive contain documentation formally submitted to the Panel before it made its decision to refer.

We note that Mr Rideout is a recognised specialist in change management, financial strategy and organisational turnaround and a former Chief Executive in the NHS. You will see that the Rideout Report, which followed a systematic review and testing of the business case for the proposals and discussions with key internal and external stakeholders, contains numerous criticisms both of the substance of the proposals and the way that the preferred option was identified, and the consultation which NHS NW London purported to undertake. It is not apparent that the JCPCT properly took into account the points made in the Council's consultation response through the Rideout Report at all.

We also draw your attention to the fact that there is very significant public opposition to the proposals across Ealing. Some 75% of Ealing residents have expressed opposition to the proposed changes. A greater proportion of respondents to the consultation disagree with concentrating fewer services on fewer sites than agree. Local elected leaders across all main political parties in Ealing, and key strategic partnerships such as the Shadow Ealing Health and Well-Being Board, do not support the proposals. The Panel has noted evidence from campaign groups that 80,000 residents across Ealing and Hammersmith and Fulham have signed petitions against the proposals.

The issues arising from the documentation attached are too numerous to set out fully in this letter, and we trust you will look carefully at all those issues and the proposals generally. We would, however, like to draw your particular attention to the following.

First, contrary to what NHS NW London has claimed, it is clear that your four reconfiguration tests have not been met so far as Ealing's health service is concerned. As the Rideout Report shows, the adverse impact on Ealing's residents is far greater than the impact on the residents of North West London as a whole, or of any other borough. This has not been properly acknowledged or catered for in the JCPCT's decision. Contrary to your stated requirement:

(i) there was **wholly insufficient public and patient engagement** at the stage when the proposals for consultation were being formulated. Public participation was largely confined to three pre-consultation engagement events that were attended by, in total, approximately 360 members of the public (about one in five thousand of the population of NW London). There were no specific attempts to engage with local people, and particularly the most vulnerable groups hit hardest by the proposals that emerged. Nor was there any proper attempt to engage the Council at a senior level on a sufficiently detailed basis. This is in circumstances where the proposals place a higher value on institutions than patients, and on finance than health.

(ii) there is plainly **insufficient GP support for the proposals** (see for example Appendixes 4a and 4b). In fact there is evidence of widespread local clinical opposition to the proposals. The Panel has reviewed a considerable body of evidence suggesting substantial opposition from local clinicians, and it is considered that NHS NW London has failed to secure a mandate in favour of the proposals from member practices of the local Clinical Commissioning Group (CCG), a significant majority of which voted **against** the "preferred option".

(iii) there is **insufficient clarity on the clinical evidence base**. This scale of change has never before been tested in the United Kingdom, and yet no proper consideration has been given to the effect of the proposals to downgrade hospitals on resulting standards of care. Moreover, no clear, let alone credible, plan has been developed which addresses the effect of moving activity out of acute settings into new, untested, care settings which are supposed to absorb it. As the Rideout Report (Appendix 2) makes clear, there is currently insufficient capacity and capability in primary and community services to support the proposed changes. In reality what is proposed is a huge experiment, putting the health of vulnerable individuals in Ealing at risk.

In this regard, we also note that should the decision of the JCPCT be upheld, changes to provision in all affected hospitals will mean that NW London will be served by 5 Type 1 emergency departments: equating to 395,440 per Accident &Emergency unit: 52% more than the national average. The Panel has no confidence that that will be sufficient; and it is Ealing residents who are affected the most.

(iv) the proposals are **not consistent with current and prospective patient choice**. Ealing residents are being deprived of practically *all* of their current choice of local hospitals for the full range of services. Not only will they be deprived of the opportunity to access the full range of services at a hospital located in the Borough; other hospitals used extensively by Ealing residents (e.g. Charing Cross, Central Middlesex and Hammersmith) are also being downgraded.

Secondly, there has been a failure properly to consider the effects that the downgrading will have on specific groups within Ealing's population.

The local population in Ealing has a relatively high burden of specific diseases and conditions. It is worse than the England average for obesity in children, physically inactive adults, hospital stays for alcohol related harm, drug use, diabetes, tuberculosis, acute sexually transmitted infections, and early death from heart disease and stroke. Notably high in Ealing is the prevalence of cardiovascular conditions, for which prompt urgent care in emergencies is critical.

Ealing also has a notably diverse community compared to the national average, with certain ethnic groups, for instance, constituting a greater part of the population than elsewhere, and which experience a far higher rate of particular diseases. Those hospitals regularly used by Ealing residents – and, in particular, Ealing Hospital – have developed impressive cultural competence. That will be lost, and there is no adequate plan for its replacement.

In spite of this, there has been no proper consideration of the impacts which the proposals would have on particular groups, and no proper consideration of what should be done to mitigate such impacts. As you will no doubt ascertain, the Equality Impact Assessments carried out are woefully inadequate, failing properly to engage with the specific needs of Ealing residents.

Thirdly, as the Rideout Report explains, there are also a number of general flaws with the underpinning approach adopted by NHS NW London including, importantly, insufficient exploration of alternatives to hospital reconfiguration caused largely by the failure properly to engage, referred to above. There were also fundamental problems with aspects of the methodology used by NHS NW London in further developing the proposals. The sequential nature of the methodology used by NHS NW London to identify the initial "long-list" of eight potential options has not provided the opportunity for all of the options to be tested on a truly comparable basis. It was not appropriate, for example, to use "location" as the primary driver for the development of these options, rather than other factors including the needs of local people and the relative quality of local hospital services.

Fourthly, there are further, compelling, reasons why the proposals should not have been approved at this particular time. No final decisions should be made about hospital reconfiguration until the "Out of Hospital" strategies have been implemented and their performance properly assessed as successful. Further, the decisions have been made by the local Primary Care Trusts on the eve of their abolition. This is highly inappropriate: decisions should not be made until the new Clinical Commissioning Groups are formally established and authorised and are working in partnership with the new Health & Wellbeing Boards. Further still, it is obviously sensible for the potential merger of Ealing Hospitals NHS Trust and North West London Hospitals NHS Trust (including its financial implications) to be addressed prior to deciding upon any reconfiguration.

Fifthly, the consultation conducted by NHS NW London in respect of the proposals was inadequate. The Panel is particularly concerned by the delays in the translation of consultation documents concerning the proposals, which it believes had a negative impact on engagement with the local community in view of the ethnically diverse nature of the Borough's population, because it unduly shortened the period of time during which proposals could be reviewed and discussed by those groups. It was also inappropriate that the consultation took place over the period of summer and school holidays and the London Olympic and Paralympic Games: one of the busiest summers for Londoners in living memory. In spite of the lack of pre-consultation engagement referred to above, the

consultation document was then structured to support the preferred option rather than providing a sufficiently open consideration of the alternatives.

We trust you will give anxious consideration to whether, in all the circumstances, the decision really is in the interests of the health service in the area of Ealing. As will be apparent from the above, the Panel firmly believes it is not.

Irrespective of the outcome of this referral, we would request that you direct NHS NW London to work closely with the new Health and Wellbeing Board (once formally established), and all relevant stakeholders, in the development of healthcare services and arrangements for Ealing residents.

We look forward to your response, and for any queries please contact Matthew Booth, Director of Policy and Performance using the details above.

Yours sincerely,

Councillor Abdullah Gulaid
(Chair of Ealing Health and Adult Social Services Standing Scrutiny Panel)

Councillor Anita Kapoor
(Vice-Chair of Ealing Health and Adult Social Services Standing Scrutiny Panel)

CC Members of the Health and Adult Social Services Standing Scrutiny Panel
Councillor Julian Bell, Leader, Ealing Council
Councillor Jasbir Anand, Cabinet Member for Health and Adult Services
Councillor David Millican, Leader, Conservative Group, Ealing Council
Councillor Gary Malcolm, Leader, Liberal Democrat Group, Ealing Council
Martin Smith, Chief Executive, Ealing Council

Jeff Zitron, Chair, NHS NW London
Dr Anne Rainsberry, Chief Executive, NHS NW London
Dr Mohini Parmar, Chair, Ealing Clinical Commissioning Group
Rob Larkman, Accountable Officer, Ealing Clinical Commissioning Group

Appendixes:

- **Appendix 1a:** Scrutiny Cover Report, 4th March Meeting
- **Appendix 1b:** Shaping a Healthier Future Progress Review (paper for 4th March Scrutiny meeting)
- **Appendix 2:** Rideout Report with colour-coded annotations
- **Appendix 3:** Shaping a Healthier Future Ealing Hospital Board consultation response
- **Appendix 4a:** Ealing CCG letter in response to the Shaping a Healthier Future consultation
- **Appendix 4b:** Ealing CCG ballot results in relation to Shaping a Healthier Future
- **Appendix 5:** Shaping a Healthier Future Health and Adult Social Services Standing Scrutiny Panel response to consultation
- **Appendix 6:** Summary of Full Council motions in relation to Shaping a Healthier Future
- **Appendix 7:** Summary of key points raised by the Shadow Health and Well-Being Board in relation to Shaping a Healthier Future
- **Appendix 8:** NHS NWL response to Ealing Council's Shaping a Healthier Future consultation submission
- **Appendix 9:** Joint Health Overview and Scrutiny Committee's Final Report on Shaping a Healthier Future
- **Appendix 10:** Recommendations to the Joint Committees of Primary Care Trusts with regard to Shaping a Healthier Future
- **Appendix 11:** Health and Adult Social Services Standing Scrutiny Panel member's submission on use of data in Shaping a Healthier Future business case
- **Appendix 12a:** Shaping a Healthier Future consultation response cover letter
- **Appendix 12b:** Shaping a Healthier Future Ealing Council consultation response
- **Appendix 13:** Letter from the Council to Anne Rainsberry, regarding lack of promised response to consultation submission
- **Appendix 14:** Health and Adults Scrutiny Decision Sheet

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Report to Scrutiny

Item Number:

Contains Confidential Or Exempt Information	*No*

Subject of Report: *Shaping a Healthier Future: progress review*
Meeting: *Health and Adult Social Services Standing Scrutiny Panel*

Service report author: *Matthew Booth, 020 8825 8556*
Scrutiny officer: *Kevin Unwin*

Cabinet Responsibility: *Health and Adults*
Director Responsibility: *Matthew Booth, Director of Policy and Performance*

Brief and Recommendations: It is recommended that the panel:

1. Review and discuss progress with Shaping a Healthier Future proposals, in the light of the papers attached and outcomes from the meeting of the Joint Committee of Primary Care Trusts on 19th February 2013;
2. Discuss and agree next steps in the light of the above, and in the context of statutory responsibilities and duties of the panel. This discussion should include whether or not to refer proposals to the Secretary of State on the basis that:

(a) *consultation on the proposals has been inadequate in relation to content or time allowed,* and/or

(b) *the proposals would not be in the interests of the health service in the area.*

3. If applicable, authorise the Director of Policy and Performance following consultation with the Chair and Vice Chair to submit any referral(s) and supporting documentation to the Secretary of State.

1. Introduction and Purpose of this Report

1.1 "Shaping a Healthier Future" (SAHF) is NHS North West London (NWL)'s proposed programme of reconfiguration of health services across an area which comprises 8 boroughs and a combined population of over 1.9m people.

1.2 If enacted, there will be significant changes to services offered by Hospitals in NWL, including Ealing Hospital.

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

1.4 The proposals have been subject to formal consultation which closed on 8th October 2012. In order to develop a credible and robust response, the Council has engaged with a range of local stakeholders, including members of the public, and commissioned an independent review of the SAHF proposals which was presented to the Council's Cabinet on 5th October 2012.

1.5 The proposals have been reviewed by the Joint Health Overview and Scrutiny Committee (JHOSC). The JHOSC was made up of representatives from London Boroughs of Hammersmith, Brent, Camden, Hounslow, Westminster, Harrow, Richmond, Wandsworth, Kensington and Chelsea and Ealing. The JHOSC's final report was published in October 2012, and is attached Appendix 9. The report is generally supportive of the case for change set out in Shaping A Healthier Future, although it raises a number of issues in relation to risk management of implementation of the changes and consultation process. The Chair of Ealing's Health and Adult Social Services Scrutiny Panel (HASSP), a member of the JHOSC, has raised with the JHOSC Chair a number of concerns in relation to the JHOSC final report, in particular the apparent acceptance of the feasibility of reduction of A&E services; approval of the Options Appraisal process, and process of editing and publication of the report itself. The issues raised have not resulted in any changes to the final published JHSOC report.

1.6 On February 19th the Joint Committee of Primary Care Trusts met to accept the recommendation to implement "Shaping a Healthier Future" and preferred Option ("A") set out within it. Details of the decision and implications are set out in Appendix 10.

1.7 Appendixes attached to this report are designed to enable the Panel to review and discuss progress with SAHF and agree next steps. In the light of the statutory duties of the panel, and the legal implications set out in this cover report, the Panel are asked specifically to consider whether or not to refer proposals to the Secretary of State. Referral can be made on one or both of these grounds:

1.7.1 *consultation on the proposals has been inadequate in relation to content or time allowed,* and/or

1.7.2 *the proposals would not be in the interests of the health service in the area.*

1.8 Appendixes attached to this cover report are as follows:

- Appendix 1: Shaping A Healthier Future: Progress Review ***(please note this is described as Appendix 1b in the Referral Cover Letter)***
- Appendix 2: Independent Review of Shaping a Healthier Future proposals, by Tim Rideout*
- Appendix 3: Shaping a Healthier Future – Ealing Hospital Board consultation response
- Appendix 4a: Shaping a Healthier Future Response letter from Ealing CCG to Jeff Zitron
- Appendix 4b: Ealing CCG ballot on Shaping A Healthier Future
- Appendix 5: Ealing Health and Adult Scrutiny Panel submission to the JHOSC in relation to Shaping a Healthier Future
- Appendix 6: Summary of Full Council motions relevant to Shaping a Healthier Future
- Appendix 7: Summary of key points raised by Shadow Health and Well-Being Board in relation to Shaping a Healthier Future
- Appendix 8: NHS NWL feedback to Ealing Council on its consultation response to Shaping a Healthier Future
- Appendix 9: NW London Joint OSC Final report October 2012
- Appendix 10: Recommendations to the Joint Committees of Primary Care Trusts in North West London, Feb 19th 2013

** Please note that the content of Appendix 2, the independent review report, has been colour coded according to particular themes, as follows:*

1) *Consultation process: turquoise;*
2) *Clinical case and clinical support: yellow;*
3) *SAHF methodology: pink*
4) *Feasibility of SAHF proposals: green*
5) *Substantial material used in the section in this paper relating to the "four tests": grey.*

2. Legal Implications

2.1 The key legislation relevant to this report is S21 Local Government Act 2000 and S244 and S245 National Health Service Act 2006. The relevant regulations are the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002/3048 (as amended) and Directions issued in 2003. The implications of this legislation follow below.

2.2 Where a local NHS body has under consideration any proposal for a substantial development of the health service in the area of a local authority, or for a substantial variation in the provision of such service, it must consult the overview and scrutiny committee of that authority.

2.3 In Ealing, the statutory scrutiny of proposals which impact on the health and wellbeing of the local population is carried out by the Health and Adult Social Services Scrutiny Committee.

2.4 Where a local NHS body consults more than one overview and scrutiny committee on any proposal it has under consideration the local authorities of those overview and scrutiny committees must appoint a joint overview and scrutiny committee for the purposes of the consultation and **only** that joint overview and scrutiny committee may:

(a) make comments on the proposal consulted on to the local NHS body

(b) require the local NHS body to provide information about the proposal

(c) require an officer of the local NHS body to attend before it to answer such questions as appear to it to be necessary for the discharge of its functions in connection with the consultation

2.5 A joint overview and scrutiny committee may make reports and recommendations to the NHS body by such date as may be specified by the NHS body. Where it does so it must include an explanation of the matter reviewed, a list of the participants in the review, and any recommendations on the matter.

2.6 Where a joint overview and scrutiny committee requests a response from the NHS body to whom it has made a report or recommendation the NHS Body must respond in writing to the committee within 28 days of the request.

2.7 Where a joint overview and scrutiny committee is not satisfied that consultation on any proposal has been adequate in relation to content or time allowed it may report to the Secretary of State in writing

2.8 In any case where the joint overview and scrutiny committee considers that the proposal would not be in the interests of the health service in the area it may report to the Secretary of State in writing.

2.9 The overview and scrutiny committees (e.g. the Ealing Health and Adult Social Services Standing Scrutiny Panel) originally consulted retain the right to refer the proposal to the Secretary of State on the grounds that

(a) consultation on a proposal has been inadequate in relation to content or time allowed and/ or

(b) the proposals would not be in the interests of the health service in the area

2.10 With regard to (a) the Secretary of State may require the NHS body to carry out further consultation, and having regard to the outcome of that consultation to reconsider any decision it has taken in relation to the proposal. With regard to (b) the Secretary of State may make a final decision on the proposal and require the NHS body to take such action as he may direct.

2.11 From 1 April 2013 the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 come in to force. The Regulations were published on 8 February 2013. The Regulations change the statutory framework for scrutiny of NHS reorganisation proposals and referrals to the Secretary of State and will require amendments to the Council's Constitution to ensure that functions have been properly delegated from 1 April. The implications of the Regulations are currently being considered prior to recommendations being made to full Council.

2.12 If the Panel considers on the evidence available to it that it is appropriate to make referral to the Secretary of State on one or both grounds it would make sense administratively to exercise its power to do so before 1 April 2013. This would avoid

the risk of delay arising from the fact that amendments to the Constitution would need to be agreed by full Council in order to give it the power to do so after 1 April 2013.

3. Financial Implications

3.1 In order to prepare a robust response to the Consultation, the Council has commissioned an independent review of the Shaping a Healthier Future proposals, and the business case which underpins them.

3.2 In order for the review to be independent and objective, and to reflect fine-grained technical analysis of the proposals as well as specialist insight into healthcare provision, the Council has engaged specialist consultants working in the field of health and social care. Costs associated with engagement of consultants to develop and co-ordinate the independent review; review the Decision-Making Business Case and recently published "alternative proposals" for hospitals in NWL; and provide editorial input into papers attached to this report, stand at **£69,882.**

3.3 In addition, a comprehensive range of material has been prepared to support the Save Our Hospitals campaign. This has included leaflets that have been delivered borough-wide and to GPs surgeries, advertising on bus shelters and buses, posters and banners, coverage in the Around Ealing residents' magazine and information on the web. In addition there has been support for key public engagement activities relating to the campaign. The total cost of this activity at this time is **£48,500.**

3.4 Costs associated with a stage for the rally at Ealing Common and two small stages at Southall and Acton Parks, traffic management and parking suspensions are estimated to be **£10,000.**

3.5 Total estimated costs incurred to date for activities associated with this report are therefore estimated at **£128,382.** These costs will be met from the Economic Incentive Reserve.

4. Other Implications

None.

5. Background papers

Link to the Shaping a Healthier Future Decision-Making Business Case (and alternative proposals for hospitals affected):

.http://www.northwestlondon.nhs.uk/publications/?category=5870-Decision+Making+Business+Case+-d.

Consultation

Name of consultee	Department	Date sent to consultee	Date response received from consultee	Comments appear in report para:

Internal		
Martin Smith	Chief Executive	12.02.13
Helen Harris	Director of Legal Services	12.02.13
Simon George	Director of Finance	12.02.13
Councillor A. Gulaid	Chair of Health and Adult Social Services Standing Scrutiny Panel	12.02.13
Councillor A. Kapoor	Vice-Chair, Health and Adult Social Services Scrutiny Panel	12.02.13

Report History

Decision type:	*I. Urgency item?*
Key Decision	No.

Authorised by Cabinet member:	Date report drafted:	Report deadline:	Date report sent:

Report no.:	Matthew Booth
	Director of Policy and Performance, Chief Exec's Department
	020 8825 8556

APPENDIX 1: Review of progress with "Shaping a Healthier Future"

For discussion by the Ealing Health and Adult Social Services Standing Scrutiny Panel, 4th March, 2013

1. Purpose of this paper

1.1 The Health and Social Care Act 2001, and subsequently the NHS Act 2006, give Councils with social care responsibilities the power to scrutinise matters relating to the health of local people.

1.2 In Ealing this function is carried out by the Ealing Health and Adult Social Services Standing Scrutiny Panel ('the Panel'). The Panel has a general monitoring role and must be consulted by local NHS bodies in relation to proposals for substantial developments or variations in services provided.

1.3 The Chair and Vice-Chair of the Panel have played an active role in the Joint Health Overview and Scrutiny Committee (JHOSC) which was convened to scrutinise proposals put forward by NHS North West London (NHS NWL) to radically re-organise healthcare services in North West London, set out under the heading "Shaping a Healthier Future". However, the Council has reserved its right to scrutinise the proposals separately through the Panel.

1.4 In order to inform its participation in the JHOSC and contribute to the Council's response to the public consultation on SAHF, the Panel has undertaken to hear evidence and develop its own position on the proposals.

1.5 In doing so, the Panel has considered key documents underpinning the programme such as the Pre-Consultation Business Case; the evidence gathered as part of the Council's response to the consultation; and information submitted to the JHOSC. The Panel has also held two meetings to discuss the proposals with representatives from NHS NWL, the first being in July 2012 during the consultation period, the second on the 4th March 2013, after the Joint Committee of PCT's final decision about whether to proceed with the SAHF proposals.

1.6 During its consideration of the SAHF proposals, Panel members have noted that the proposals have met with substantial criticism and opposition from Ealing residents, patients, clinicians, and technical experts operating locally in the field of health and social care. It has also been noted that the Shadow Ealing Health and Well-Being Board has failed to reach a consensus of support for the proposals.

1.7 In addition, whilst NHS NWL has reported general support for the principles and aims of the SAHF proposals as a whole for NW London from a number of national bodies (e.g. the Royal College of Midwives), they have not been able to demonstrate explicit support for the preferred option for Ealing. Furthermore both Ealing Hospital NHS Trust and Ealing Commissioning Group have confirmed that they do not support the preferred SAHF proposals for Ealing.

1.8 This widespread opposition to the SAHF proposals has been sufficient as to raise the question for the Panel to discuss, "Do the SAHF proposals meet the four key tests used by the Secretary of State used to test the efficacy of any proposed changes to a local health economy?" Specifically, these tests are:

- 1.8.1 Support from GP commissioners;
- 1.8.2 Strengthened patient and public engagement;
- 1.8.3 Clarity on the clinical evidence base;
- 1.8.4 Consistency with current and prospective patient choice.

1.9 The Panel has reviewed the SAHF proposals and discussed concerns with representatives from NHS North West London. Ealing's representatives on the JHOSC have also

expressed their disagreement with some elements of the Committee's final report, as raised with the Chair of the JHOSC, and noted in the minutes of the 1st October meeting.

1.10 The purpose of this paper is to set out a summary of the issues discussed so far, to enable the Chair of the Panel to discuss and agree next steps.

2. Basis of this paper

2.1 As part of its response to consultation on the proposed changes to healthcare in North West London, the London Borough of Ealing commissioned an independent review of the proposals. The review was carried out by Tim Rideout, an independent consultant with substantial experience in a variety of senior roles in the health service, including as a Chief Executive of a Primary Care Trust (PCT).

2.2 Outcomes from the independent review have also fed into meetings of the Panel, for the purposes of discussions with representatives from NHS NWL.

2.3 In the main, this summary paper is based on the key insights and conclusions set out in the independent review report (attached as Appendix 1), modified in the light of discussions during meetings of the Panel. A summary of the key points of the independent review, and details from relevant partnership meetings, committee meetings and public expressions of interest, follows below.

3. Headline summary of key points raised so far in relation to "Shaping a Healthier Future"

3.1 There have been profound flaws with the process of consultation on the proposals. For example:

- 3.1.1 There has been insufficient, inappropriate and ineffective engagement with the public;
- 3.1.2 There were significant delays to production and distribution of consultation materials, shortening the period of time during which proposals could be reviewed and discussed;
- 3.1.3 Contrary to good practice the consultation took place over the summer/school holiday period, during which time many residents will not have been present to engage with the process;
- 3.1.4 There has been insufficient and inappropriate engagement with residents for whom English is an additional language.

3.2 During the consultation, the clinical case has not been convincingly described or promoted and consequently there is evidence of widespread local clinical opposition to the proposals, for example:

- 3.2.1 The HASC has reviewed a considerable body of evidence suggesting substantial opposition from local clinicians;
- 3.2.2 NHS NWL have failed to secure a mandate in favour of the proposals from member practices of the local Clinical Commissioning Group (CCG), a significant majority of which have voted against the SAHF preferred option.

3.3 There is strong evidence of significant public opposition to the proposals. For example:

- 3.3.1 Campaign groups assert that 80,000 residents across Ealing and Hammersmith and Fulham have signed petitions against "Shaping a Healthier Future" proposals;
- 3.3.2 A greater proportion of respondents to the consultation disagree with concentrating fewer services on fewer sites than agree;
- 3.3.3 75% of Ealing respondents to the proposals say they are opposed to the proposed changes;

3.3.4 Local elected leaders across all main political parties in Ealing and key strategic partnerships such as the Shadow Ealing Health and Well-Being Board do not support the proposals.

3.4 There are significant concerns about the methodology used to identify and choose between the various reconfiguration options. The methodology is fundamentally flawed and therefore the conclusions are open to challenge. For example:

3.4.1 There is insufficient detail in the Equality Impact Assessment carried out on the pre-consultation business case, resulting in a failure in duties under the Equality Act 2010;

3.4.2 There are significant gaps and weaknesses in relation to financial modelling;

3.4.3 There is insufficient detail in relation to implementation, in particular project management and risk management thereof;

3.4.4 The modelling of future patient flows too readily assumes that patients can and will use services in a manner entirely consistent with proposed configuration of services;

3.4.5 The transport and travel-times analysis underpinning the proposals is limited and misleading.

3.5 Evidence of how the proposals will operate within and impact upon the local health economy is weak and there are concerns about the realism and deliverability of both the scale and pace of the proposed changes. For example:

3.5.1 There is a lack of detail in relation to development and implementation of the Out of Hospital Strategy;

3.5.2 Thee are significant concerns about the capacity of local primary care and community services to manage the impact of the proposals, especially in the light of increasing demand from a rapidly growing population with complex health needs.

3.6 Inadequate attention has been given to the responses during and after the consultation. For example:

3.6.1 The consultation feedback presentation given by IPSOS Mori and NHS N WL demonstrates that local public feeling has not been taken into account in shaping and developing the proposals;

3.6.2 NHS NWL have failed to address substantive concerns raised in Ealing Council's consultation response;

3.6.3 NHS NWL have failed to deliver on their promise to make the Decision-Making Business Case available for review and discussion ahead of decision being taken by Joint Committee of PCTs.

4. References to supporting detail

4.1 Table 1 on the following page sets out the points listed above with references to supporting evidence set out in the independent review report and Appendixes attached to this report, cross referenced with the "four tests" to be applied to any proposed reconfiguration of NHS services.

Table 1: Detail of specific issues with Shaping a Healthier Future, with references to the Ealing independent review and Secretary of State's "four tests"

Issue identified by the Panel and relevance to "Four Tests"	Specific points raised	References to supporting evidence (please note that numbers in brackets refer to sections in the Independent Review Report, attached as Appendix 1)
1. Profound flaws with the consultation process, including insufficient and inappropriate public engagement. Relevance to the Secretary of State's Four Tests: "Strengthened patient and public engagement" "Consistency with current and prospective patient choice."	Section 6 of the independent review report sets out in detail a number of issues with the consultation process. These include: • The pre-consultation engagement of key stakeholders – including patients, public, clinicians and the London Borough of Ealing has been inadequate. In particular, there has been insufficient and inappropriate engagement of vulnerable and disadvantaged groups; service users and carers; • Delays in the production of consultation materials appropriate for Ealing's diverse community, in which approximately 40% of households do not have English as a main language; • Timing of the consultation (i.e. over the summer period and during school holidays) was inappropriate and insufficient time was given for debate and consideration of immensely complex information; • The decision-making arrangements are inappropriate. Key decisions arising from the consultation process will be taken by organisations and bodies scheduled for abolition shortly after decisions have been taken. This will in effect result in a "break in accountability" with no agency responsible for the decision left responsible for implementation. Consideration should be given to amending decision making arrangements to ensure any decisions are made through new NHS and local government arrangements coming into effect in April	Section 6 of the independent review report, in particular: "Patient and public engagement are crucial elements of pre-consultation work. Pre-consultation engagement events took place on 15 February, 23 March and 15 May 2012. The business case states that these were "the main focus of [the] engagement with the wider public". This appears to indicate that approximately 360 members of the public (approximately 0.018% or 1 in 5,000 of the population of NW London) attended the events. It is not clear how many members of the public were actively engaged through other mechanisms pre-consultation. Given the significance of the proposals, greater engagement of the public should have taken place pre-consultation. In addition it is not clear how many residents of Ealing were actively engaged pre-consultation. Again, given the proposed impact of the proposals for Ealing, targeted local engagement should have taken place." (6.2.11) "In particular, the work done to engage with traditionally vulnerable groups is open to challenge." (6.2.12) "Going forward it is intended that more work will be done to engage the public and that "this will include work with local authority colleagues who support voluntary and community sector networks... who are able to access a large number of community members through the work they undertake". This engagement activity should have taken place before the development of the pre-consultation business case." (6.2.13)

Issue identified by the Panel and relevance to "Four Tests"	Specific points raised	References to supporting evidence (please note that numbers in brackets refer to sections in the Independent Review Report, attached as Appendix 1)
	2013	"The statements made in the business case relating to wider engagement and involvement in shaping the proposals are also open to challenge. The business case sets a number of stakeholder engagement principles. The principles are sound and should be supported. However, they do not address the apparent democratic deficit in the process. It is difficult to see how such proposals can be legitimised democratically without both the active engagement and support of local government. Currently, significant aspects of the proposals do not have the support of the London Borough of Ealing." (6.2.9) "As should be expected, explicit stakeholder mapping has been undertaken. The mapping makes reference to the "political" stakeholder grouping including various local government representatives (Health Overview & Scrutiny Committees, Borough Councillors, Borough cabinet members). Explicitly the business case states that "there has been significant engagement with political stakeholders throughout the pre-consultation period"7. This is contrary to the views of senior members and officers at LBE. There has been no attempt to engage LBE at a senior level on a sufficiently detailed basis. In particular LBE has confirmed that the Council has had only limited opportunity to influence the strategy and that a number of serious concerns and questions have been raised which have not yet been fully answered. Given the profound impact on local health services, this is a significant omission. (6.2.10)

Appendix 1b

Issue identified by the Panel and relevance to "Four Tests"	Specific points raised	References to supporting evidence (please note that numbers in brackets refer to sections in the Independent Review Report, attached as Appendix 1)
	The nature and structure of the consultation process and documents are divisive and are weighted in favour of the preferred option.	"The consultation document itself is very complicated and is structured to support the preferred option rather than provide a sufficiently open consideration of the alternatives, offering those consulted a very limited range of options." (6.5.3) "The overall nature of the SaHF consultation is potentially divisive. Many stakeholders interviewed during the course of this review expressed the view that the process (either inadvertently or deliberately) pitches clinician against clinician, hospital against hospital, and borough against borough." (6.5.4)

Issue identified by the Panel and relevance to "Four Tests"	Specific points raised	References to supporting evidence (please note that numbers in brackets refer to sections in the Independent Review Report, attached as Appendix 1)
2. The clinical case has not been convincingly described and there is clear evidence of widespread local clinical opposition. Relevance to the Secretary of State's Four Tests: "Support from GP commissioners" "Clarity on the clinical evidence base"	The independent review report set out in detail a range of flaws with the clinical case for change put forward in SAHF. It is also clear from the independent review report – and subsequent informal and formal meetings of local clinicians and partnership groups – that there is a lack of support for the proposals from local clinicians. This is partly because the clinical case for change is not sufficient to outweigh the potential risks of the proposed changes to the health of the local population. It is also partly because there has been inadequate focus on the health needs of the residents of Ealing as opposed to NW London as a whole.	See Sections 7 and 8 of the independent review report, attached as Appendix 1, and also: "Appropriately, great emphasis is placed on the need for extensive clinical engagement and leadership. The business case states that the programme has been clinically led and supported by GP commissioners and hospital clinicians. This is supported by signed statements from the four Medical Directors who have led the work and the eight CCG clinical chairs. However the extent to which this work has been influenced by McKinsey's own views and models is not clear. The extent to which the programme is genuinely supported by front-line clinicians across NW London and in particular Ealing is not clear. The evidence gathered during the course of this review indicates that there are a significant number of local clinicians (GPs and hospital clinicians) that have serious concerns about the proposals and that consequently do not support them." (6.2.3) "The SaHF programme team did include a public health specialist. He reviewed the information available from various Public Health Observatories, including the health profile for Ealing. This identified that although the overall mortality rate for Ealing is falling and is below the England average, the Borough is worse than the England average for obesity in children, physically inactive adults, hospital stays for alcohol related harm, drug use, diabetes, tuberculosis, acute sexually transmitted infections, and early deaths from heart disease and stroke. In line with the findings of the 2010 Marmot review into health inequalities SaHF's core response to these issues is the proposed development and improvement of out of hospital services (primary and community

Issue identified by the Panel and relevance to "Four Tests"	Specific points raised	References to supporting evidence (please note that numbers in brackets refer to sections in the Independent Review Report, attached as Appendix 1)
		care)." (6.2.7) "However, the impact of the proposed hospital reconfiguration on the health of people living and working in Ealing does not appear to have been assessed. This is a significant omission. It is clearly essential to understand the impact of the proposals on each of the borough's populations." (6.2.8)
	Although the majority of the member practices comprising Ealing Clinical Commissioning Group support the case for change, they do not support the proposals in their current form . The majority of practices supported Option C when asked to choose between options. **Consequently the preferred option is not supported by GP commissioners.** In addition, practices were not given the opportunity to consider other options for strengthening the configuration of local services. The proposals in their current form are not supported by the Ealing Hospital NHS Trust Board. It is important to note that in addition to standard acute health services, the Trust also provides (via an ICO) the community services previously managed by the local Primary Care Trust. SAHF's preferred option is critically dependent on the adequacy of such services to cope with the planned shift of care from hospital	The Independent Review report (Appendix 1), the formal consultation response from Ealing Hospital NHS Trust (Appendix 2) and the results of Ealing CCG's ballot of member practices (Appendix 3) set out some of the local clinicians' concerns about the proposals. Appendixes 3a and 3b attached to this paper set out the response to the consultation from the local Clinical Commissioning Group, which demonstrates that a minority of the Ealing CCG membership support the S HAF preferred Option. Ealing Hospital NHS Trust's formal response to the consultation is provided at Appendix 2. It sets out the concerns raised by the Trust's in relation to SHAF and preferred Option A, which include: "The Board meeting was attended by a number of senior consultants from Ealing who expressed real concerns about the

Issue identified by the Panel and relevance to "Four Tests"	Specific points raised	References to supporting evidence (please note that numbers in brackets refer to sections in the Independent Review Report, attached as Appendix 1)
	to community settings, making the Trust's view of the proposals even more important. In addition the Trust's response questions the relationship between the proposed merger with North West London Hospitals NHS Trust. SAHF completely fails to consider this potential merger despite the opportunity it may represent in achieving the objectives of SAHF (clinical and financial viability) in a more locally sensitive and responsive way.	impact of Option A on their patients." "Discussions with local clinicians including hospital staff, community staff and GPs suggest that the proposals in Option A are more radical for Ealing Hospital than is clinically necessary." "If Option A is backed in full the ICO (Integrated Care Organisation) and particularly the hospital's position, other than as part of a larger organisation is extremely precarious. Should the merger, or at least considerable joint working stall or stop, the Trust is likely to face considerable difficulties is attracting staff and patients. This could make financial and clinical viability questionable even in SAHF has not reached design or implementation phases." "Option A is heavily reliant on an effective out of hospital strategy and with this in mind the ICO's community services need to be supported to deliver high quality care closer to home"

Issue identified by the Panel and relevance to "Four Tests"	Specific points raised	References to supporting evidence (please note that numbers in brackets refer to sections in the Independent Review Report, attached as Appendix 1)
	The assessment of the impact of SAHF proposals on Equality Groups (and particularly those living and working in Ealing) carried out on the Pre-Consultation Business Case is insufficient. Consequently the extent to which this analysis meets the requirements of the Equality Act 2010 is questionable. What detail has been set out in relation to Equality Assessment shows that the proposed future location of hospital inpatient services will result in a worse service for groups with characteristics protected under the Equality Act 2010.	See section 6.4 of the independent review report, for example: "The business case makes reference to the equalities impact analysis (EIA), stating that one had been commissioned from Mott MacDonald in May 2012, with three reports produced, to ensure that the proposed reconfiguration of services complies with the PSED. The analysis looked at the impacts of the proposed options on populations with protected characteristics (plus an additional category of social deprivation) within NW London and does not provide a detailed disaggregation of data at borough level." (6.4.2) "For each issued raised, the EIA provides an impact appraisal and suggested mitigations and opportunities. However this has yet to be reflected in detailed SaHF proposals. It would clearly be appropriate for the EIA's conclusions to be systematically reflected in any detailed change proposals going forward." (6.4.6) "In particular, the work done to engage with traditionally vulnerable groups is open to challenge." (6.2.12.)

Issue identified by the Panel and relevance to "Four Tests"	Specific points raised	References to supporting evidence (please note that numbers in brackets refer to sections in the Independent Review Report, attached as Appendix 1)
	Over-provision of A&E departments in NWL is not as marked as claimed and Ealing Borough, as the third largest London borough with 339,300 residents, is of sufficient size to need/justify having its own hospital providing the full range of services proposed under the "major hospital" model.	"Furthermore, there is evidence that indicates the "over-provision" of A&E departments is not as marked as claimed. The whole UK population is served by 240 Type 1 emergency departments for a population of 62.3m people. That equates to 259,425 people per A&E. NW London currently has 8 Type 1 emergency departments, serving a population of just under 2m people. That equates to 247,150 people per A&E, 5% less than the national figure. Should the reconfiguration proposals proceed NW London will be served by 5 Type 1 emergency departments. That would equate to 395,440 per A&E, 52% more than the national average." (7.3.8)

Issue identified by the Panel and relevance to "Four Tests"	Specific points raised	References to supporting evidence (please note that numbers in brackets refer to sections in the Independent Review Report, attached as Appendix 1)
	The proposals and options are driven by financial rather than clinical concerns, and there is a lack of efficacy and transparency to the financial case underpinning the proposals. In addition other approaches to addressing the financial challenges faced by the NHS across NW London are not considered.	Section 7.4 of the independent review report sets out issues in relation to financial modelling in detail. Some points from this section include: "There are aspects of the financial model that are open to challenge." (7.4.1) "It is [...] asserted that there are "extreme financial pressures" facing the NHS in NW London and the need for unprecedented levels of efficiency savings (4% per annum). Consequently, the business case states that "a major part of any future configuration of health services in NW London is the degree to which it can help address the financial challenge and create a sustainable health economy". This drive to ensure financial sustainability is clearly appropriate. However the link between financial sustainability and reconfiguration is not unequivocally made. Other parts of the country are successfully addressing these financial challenges without the need for such radical reconfiguration." (7.4.3) "...there is recognition that further work will be required to complete a "Generic Economic Model" to support any capital business cases. This is necessary analysis that should have been completed before consultation began." (7.4.4) "...there are other options open to the NHS organisations in NW London. Locally, the potential merger of Ealing Hospitals NHS Trust and North West London Hospitals NHS Trust merger should be addressed first before reconfiguration. In addition there are other means of achieving financial sustainability not addressed within the business case, including:

Issue identified by the Panel and relevance to "Four Tests"	Specific points raised	References to supporting evidence (please note that numbers in brackets refer to sections in the Independent Review Report, attached as Appendix 1)
		• Renegotiation of Public Finance Initiative (PFI) contracts: The two North West London Trusts that are projected to be in deficit in 2014/15 under the "do nothing" scenario are subject to PFI contracts (West Middlesex and Central Middlesex). Clearly the terms of the PFI arrangements are contributing to the financial difficulty. Recently there has been a widespread call for PFIs to be re-examined and to take advantage of (a) the reduction in Bank of England interest rates to 0.5%, (b) the Government guarantee to borrow, and (c) the limited ability of PFI holders to borrow; • Patient pathway reconfiguration: An examination of the reconfiguration of services in South East London has shown that 'radial' (as opposed to 'concentric') reconfiguration involving specialist/tertiary hospitals, DGHs and community care providers could "do much more to drive up quality and drive down costs than reconfiguration across DGHs providing similar services"; and • Commissioner/provider agreement to modify Payment by Results (PbR): NHS Commissioners can agree to apply a modified version of PbR to reflect local needs and circumstances." (7.2.5)

Issue identified by the Panel and relevance to "Four Tests"	Specific points raised	References to supporting evidence (please note that numbers in brackets refer to sections in the Independent Review Report, attached as Appendix 1)
	There are concerns that Urgent Care Centre model proposed is untested and the proposed Centre serving Ealing's population will not have the capacity to handle demand for the type of emergency cases typically handed by A&E, and is therefore not a suitable substitute for A&E provision.	"The business case describes the "local hospital" as "a seamless part of the landscape of care delivery...networked with local A&Es". However the implication is that a percentage of patients attending the urgent care centre of a "local hospital" in the first instance will then have to be transferred to the A&E department of a "major hospital" with the consequent increase in inconvenience and risk. In effect Urgent Care Centres will face an undifferentiated "take" (cohort of patients). Insufficient information is provided on the detailed implications of this model. Other than a high level analysis it is not clear in sufficient detail which patients will require escalation to A&E from Urgent Care Centres and which current A&E patients will be treated at Urgent Care Centres. There is no current evidence that demonstrates that such "standalone" Urgent Care Centres can safely and appropriately handle the undifferentiated take that will in reality present, without co-location with a Type 1 A&E. The current A&E at Ealing Hospital serves a population with a relatively high burden of disease, exhibiting above average prevalence of tuberculosis, diabetes and cardiovascular disease. However there is only very limited evidence of how the Urgent Care Centre model will be developed in such a way as to successfully meet these needs. The business case assumes that "clinicians in Urgent Care Centres will develop strong working relationships with those in acute facilities". However, the basis for this assumption is not provided." (7.5.16) "Furthermore, there is not sufficient understanding amongst Ealing residents of the differences between A&E and urgent care, particularly since the services at UCCs vary from borough to borough." (7.8.14)

Issue identified by the Panel and relevance to "Four Tests"	Specific points raised	References to supporting evidence (please note that numbers in brackets refer to sections in the Independent Review Report, attached as Appendix 1)
	A greater number of patients will have to travel further, as will family or friends who wish to visit them. People will be compelled to make long and/or expensive journeys that may deter patients from attending and reduce the opportunities for visiting. The complexity and relative sparseness of relevant local public transport connections will result in a greater number being taken by ambulance for treatment. Emergency services will be too far away and very sick people will be put at risk by the time it will take to transport them - people may die as a result. Even if distance is not an absolute barrier, the ambulance service has not set out clear plans for increasing their capacity to cope with the extra demand and/or cannot be sure of journey times because of road congestion and/or will not have set out sufficient paramedics to cover all calls will be secured. The proposals are not consistent with Government policies about providing services nearer to patients. Insufficient thought and discussion has been given to how services could be retained locally.	"The travel analysis has been derived using Transport for London's HSTAT travel time database. HSTAT is the Health Service Travel Analysis Tool which can demonstrate changes in accessibility and journey time by public transport, car, cycling and walking resulting from proposed changes in location of health services. The analysis derives from TfL's accessibility model CAPITAL and combines these with key Socio-economic information based on the 2001 census data and health related datasets." (7.6.14)

Issue identified by the Panel and relevance to "Four Tests"	Specific points raised	References to supporting evidence (please note that numbers in brackets refer to sections in the Independent Review Report, attached as Appendix 1)
	The population forecasts used to develop the Options and approach are incorrect, invalidating the assumed impact of the proposals and assumptions of future demand. The proposed configuration is likely to leave NHS North West London unable to respond to increases in demand resulting from expected increases in population, because SAHF proposals are based on out-of-date population data which fails to recognise both the latest population estimate (over 339,000) and latest estimates of Ealing's projected population growth by 2021 (to 376,000). Recently released figures from the 2011 Census identify that Ealing's population increased by 12% between 2001 and 2011; the ONS official estimate of Ealing's current population is 4.4% higher than it was a year ago; ONS now predict further growth in Ealing's population of 11% over the next 10 years; the biggest changes will be in the older-age groups, the number of Ealing residents aged over 85 is projected to increase by 55% between 2011 and 2021.	"The core argument rests on the number of emergency surgeons available to support the rotas at each site, and the relatively low population catchment per current rota. However this should be tested further. The extent to which this takes account of the differential needs of local people and the significant population increases anticipated over the coming years is not clear. The theory is also based on sound but general supporting evidence developed by the Royal Colleges. Again, this should have been tested further against the current reality of service need in NW London." (7.6.10) "Up until recently analysis indicated that the London Borough of Ealing had a population of around 317,000 people which was expected to reach 334,700 by 2020, continuing to place greater demand on local health care services. The most recent ONS data however indicate that the Borough's current population is already around 339,300, suggesting a much larger population by 2020 than previously anticipated. Significantly, most of this population growth will be concentrated in the over 65 (+12%) and under 14 age segments (+14.5%) which are also more vulnerable and in need of accessible care (see figure 38). Whilst these age segments are growing in line with the rest of London, they significantly exceed national growth projections." (8.8.4)

Issue identified by the Panel and relevance to "Four Tests"	Specific points raised	References to supporting evidence (please note that numbers in brackets refer to sections in the Independent Review Report, attached as Appendix 1)
3. Significant public opposition to proposals. Relevance to the Secretary of State's Four Tests: "Strengthened patient and public engagement" "Consistency with current and prospective patient choice."	Opposition to SAHF proposals, and concerns about risks to the health and well-being of the local population if they are enacted, has been expressed in a number of public meetings, including: • Meetings of the Save Our Hospitals Campaign • Ealing's Full Council (cross Party) • Ealing Health and Adults Scrutiny Committee • Joint Health Overview and Scrutiny Committee • Ealing Shadow Health and Well-Being Board (strategic group and reference group) A number of Full Council motions (19th July 2011; 31st January 2012; 17th July 2012) have been passed which demonstrate that all political parties in the borough are united in their aim to secure health services valued by the local community, and oppose the process of "pitting one hospital against another" as a means of responding to drivers of change on health services. The Shadow Health and Well-Being Board met on the 6th September to discuss the SAHF proposals. Stakeholders on this group include the Chair of the CCG, Chief Executives of local NHS organisations and representatives from key Voluntary and Community Sector groups (including patient advocacy and support groups). Whilst the Board agreed that the context and case for change meant that "do nothing" was not a feasible option, a number of concerns were raised in relation to the specific proposals set out in SAHF. These included:	On 26th July the Health and Adults Scrutiny Committee considered the SAHF programme's proposals and heard views from concerned residents and local clinicians. On the basis of this meeting, the Committee has submitted a response to the Joint Health Overview and Scrutiny Committee setting out a number of concerns with proposals in SAHF. (This response is attached as Appendix 4.) The response is based around concerns relating to the approach and deliverability of the programme, and how the programme impacts on Ealing. Much of the latter debate refers to Ealing Hospital, however, the Panel also states that it opposes the downgrading of any hospital which serves local residents, and that services currently provided in Charing Cross, Central Middlesex and Hammersmith Hospitals are regarded as valuable assets in the local health economy. A summary of relevant Full Council motions is attached as Appendix 5. A summary of the key points raised at the meeting of the Shadow Health and Well-Being Board is attached as Appendix 6. In the light of these concerns, it cannot be said at this time that the Shadow Health and Well-Being Board supports the proposals set out in SAHF.

Issue identified by the Panel and relevance to "Four Tests"	Specific points raised	References to supporting evidence (please note that numbers in brackets refer to sections in the Independent Review Report, attached as Appendix 1)
	• The sustainability of the model; • Lack of appropriate risk assessments; • Lack of appropriate Primary Care arrangements in the community and Integrated Care arrangements outside of Hospital before reconfiguration takes place; • Concerns relating to travel time and transport issues which undermine some of the claims made in the SAHF business case; • Failure of SAHF to adequately take into account specific issues and pressures relating to the needs of the local population and population growth; • Concerns over the future of local hospitals, in terms of the quality and nature of services provided, and potential for SAHF to create confusion on the part of local people as to what facilities are offered on which sites; • Concerns relating to the consultation process, including the way it is framed, its length, the lack of information available in other languages, and concerns that the local community are not being given the opportunity to properly understand the proposals.	
4. The methodology used by SAHF to identify and choose between the potential options is fundamentally	Important information in relation to financial assumptions and costs is missing from the business case. The financial assumptions are not accepted by local NHS organisations. The "Generic Economic Model" referred to in the pre-consultation business case has not been shared with local stakeholders.	Sections 7.4 and 7.6.46 to 7.6.57 of the independent review report set this out in detail. Some key points in these sections of the report include: "The baseline financial modelling has been completed, reportedly using the respective organisations' own actual and forecast information for the financial year 2011/12. It appears that this

Issue identified by the Panel and relevance to "Four Tests"	Specific points raised	References to supporting evidence (please note that numbers in brackets refer to sections in the Independent Review Report, attached as Appendix 1)
flawed.. Relevance to the Secretary of State's Four Tests: "Clarity on the clinical evidence base" "Consistency with current and prospective patient choice"		information has not been independently verified to ensure that the information has been developed in a consistent way by each trust. Indeed, there is recognition that further work will be required to complete a "Generic Economic Model" to support any capital business cases. This is necessary analysis that should have been completed before consultation began." (7.4.4) "The vast majority of stakeholders interviewed during the course of this review felt that the assumptions were highly unrealistic and did not feel confident that the savings would be achieved as set out in the business case. In particular concerns were expressed about the under-developed nature of primary care in Ealing." (7.4.6) "The overall value for money assessment in the business case gives the highest rating to Option 5 and the second highest rating to Options 6 and 7. However this is open to challenge. The differentiation between Options 1 to 4 and Options 5 to 8 is primarily a function of the capital costs estimate. As suggested above, the capital estimates work needs to be significantly strengthened to arrive at the true capital cost of each of the estimates. The differentiation between Options 5 to 8 is entirely a function of the impact on site and Trust viability and the NPV calculation. Both the methodology and the application are open to challenge, as this does not give a sufficiently accurate differential value for money assessment between the options." (7.6.57)

Issue identified by the Panel and relevance to "Four Tests"	Specific points raised	References to supporting evidence (please note that numbers in brackets refer to sections in the Independent Review Report, attached as Appendix 1)
	There is a lack of information in relation to assessment of impact on equality groups.	Sections 6.4.1 – 6.4.12 of the independent review report set this out in detail. Some key points in this section of the report include: "The business case makes reference to the equalities impact analysis (EIA), stating that one had been commissioned from Mott MacDonald in May 2012, with three reports produced, to ensure that the proposed reconfiguration of services complies with the PSED. The analysis looked at the impacts of the proposed options on populations with protected characteristics (plus an additional category of social deprivation) within NW London and does not provide a detailed disaggregation of data at borough level." (6.4.2) "For each issued raised, the EIA provides an impact appraisal and suggested mitigations and opportunities. However this has yet to be reflected in detailed SaHF proposals. It would clearly be appropriate for the EIA's conclusions to be systematically reflected in any detailed change proposals going forward." (6.4.6) "In particular, the work done to engage with traditionally vulnerable groups is open to challenge." (6.2.12)
	There is a lack of detailed information about implementation, in particular in relation to risk management of implementation.	"The Office of Government Commerce (OGC) [...] undertook a Health Gateway review in April 2012. They gave the overall programme an amber/green assessment. Their recommendations included: "Identify clearly the benefits to patients proposed for

Issue identified by the Panel and relevance to "Four Tests"	Specific points raised	References to supporting evidence (please note that numbers in brackets refer to sections in the Independent Review Report, attached as Appendix 1)
		each Borough, together with who owns them and how they will be measured". It is not clear whether this recommendation has been met. In particular LBE has not been engaged in the relevant discussions; "Review risk management for the programme to establish a comprehensive and auditable process. The review team highlighted a number of risks reported by stakeholders but not recorded in the risk register including the lack of time allowed for review and reflection during the tight timescale and potential challenge regarding the different approach being taken to reconfiguration in South London; "Clarify the service models for Urgent Care Centres and Accident & Emergency Departments". The review team indicated that stakeholders were concerned about the absence of detail and that there was some scepticism as to whether the alternative services will be in place to deliver the planned benefits; "Engage with stakeholders, in some case at an individual level, to ensure that remain fully supportive of the proposals". As indicated elsewhere in this report the senior leadership of LBE report that they have not been adequately engaged. It should be noted that the OGC review team did not interview anyone from local government during the course of their review." (6.7.6)
	The independent review sets out a number of examples of where patients may behave differently to that assumed in the business case – not least because they may be confused as to which services they can and cannot access at their locality hospital.	It is concerning that the patient flow modelling too readily assumes that patients have access to sufficient knowledge to act in the most rational way. There is also limited assessment of how A&E department would cope with additional volume due to unanticipated behaviour as the modelling has in-built assumptions about patient behaviour. For instance, it is assumed that: Patients with major issues will go to a hospital with an A&E (if not coming via ambulance); Patients with minor issues will know of, and

Issue identified by the Panel and relevance to "Four Tests"	Specific points raised	References to supporting evidence (please note that numbers in brackets refer to sections in the Independent Review Report, attached as Appendix 1)
		therefore go to, an Urgent Care Centre; and 111 and other initiatives will reduce overall A&E admissions. (7.8.12) "...patients do not, and sometimes cannot, always act in the rational way in which the business case (particularly the patient flow modelling) assumes. Information about suitable locations for treatment is not always communicated evenly and habit or instinct often determines a patient's reaction, particularly for non-English speakers, the old or the vulnerable." (7.8.13) "Furthermore, there is not sufficient understanding amongst Ealing residents of the differences between A&E and urgent care, particularly since the services at UCCs vary from borough to borough." (7.8.14)

Issue identified by the Panel and relevance to "Four Tests"	Specific points raised	References to supporting evidence (please note that numbers in brackets refer to sections in the Independent Review Report, attached as Appendix 1)
5. Insufficient detail has been provided about how clinical services will be delivered in an integrated way across sites and a broader vision of integration across the whole health community has been weak. In addition the scale and pace of proposed changes is not credible given the unrealistic increases needed in primary and community care capacity. Relevance to the Secretary of State's Four Tests: "Support from GP commissioners" "Strengthened patient and public engagement"	The proposals do not reflect a feasible strategy for the health economy in Ealing and wider locality. Concerns have also been raised about the feasibility of Out of Hospital provision to absorb and manage the impact of the proposed changes.	"The outline plan set out in the business case shows the out of hospital improvements being in place by the end of March 2015, but crucially it shows the hospital transition work commencing in the first half of 2013. This is open to challenge. The business case itself refers to the "challenging schedule" to deliver the improvements in Out of Hospital care. These improvements should be in place demonstrably (with performance measured against robust metrics) before the hospital transition work is started." (8.3.5) "Although the business case refers to a number of risks associated with delaying the hospital transition, the risks of reducing hospital capacity before the alternatives are in place are greater." (8.3.6)
	The plans say that local community services will be expanded but there is no evidence that community and Out Of Hospital services will have sufficient capacity within the required timescales.	"A review of the programme was undertaken by the National Clinical Advisory Team (NCAT). NCAT supported the proposals in principle and in particular supported the proposal to change the current configuration of A&Es to five A&Es. However, in doing so it highlighted, amongst other points, the importance of "[ensuring] capacity and capability exists within the Out of Hospital services to operate 24/7". Similarly, in looking at the proposals for maternity and paediatrics, NCAT stated highlighted "the need to ensure that community services are in place before closing acute services". As considered elsewhere in this report, currently this capacity and capability is not in place." (6.7.2) "In addition, NCAT recommended that a clear set of Out of Hospital outcome metrics be developed. The business case indicates that this has been done, but the metrics do not appear to have been included in the business case." (6.7.3)

Issue identified by the Panel and relevance to "Four Tests"	Specific points raised	References to supporting evidence (please note that numbers in brackets refer to sections in the Independent Review Report, attached as Appendix 1)
"Clarity on the clinical evidence base" "Consistency with current and prospective patient choice."	Particular concerns have been raised about the capacity of local primary care and community services to absorb the impact of the proposed changes.	Sections 7.7.25 – 7.7.35 of the independent review report set out specific issues relating to this point in some detail. Points include: "Central to all of the potential options is a significant shift of care from hospital care to primary and community care. There is insufficient evidence that the primary and community care developments will deliver sufficient capacity and capability to support such change. The anecdotal evidence collected during the production of this report indicates a high level of uncertainty (from managers and clinicians) about primary care and community care's ability to deliver the shift in care from local hospitals. Specifically the proposed model of care, based on the establishment of new standalone Urgent Care Centres and GP networks, is very largely untested and unproven. In this context, this section of the report provides an analysis of the ability of primary care to absorb excess demand created by the downgrading of Ealing Hospital." (7.7.25) "In this context, another major concern identified in this review is the ability of primary care to absorb increased demand. As well as relocating cases from Ealing Hospital to surrounding hospitals, a major intention and consequence of SaHF will be an enhanced role for primary care providers to deliver services out of hospital, mainly through GP practices, care networks and health centres. It is understood that this currently rated as a "red" risk by NHS North West London with no mitigating action identified." (7.2.6)
6. Inadequate attention given to the responses during and	There is no evidence that concerns expressed during the consultation have been taken into account.	The response from NHS NWL to the Council's consultation submission, and to consultation submissions across NWL, demonstrates that the proposals going forward for decision are

Issue identified by the Panel and relevance to "Four Tests"	Specific points raised	References to supporting evidence (please note that numbers in brackets refer to sections in the Independent Review Report, attached as Appendix 1)
after the consultation. Relevance to the Secretary of State's Four Tests: "Strengthened patient and public engagement" "Clarity on the clinical evidence base" "Consistency with current and prospective patient choice"		unchanged as a result of the feedback the NHS has received. Furthermore, the response does not engage with the detail of the Independent Review the Council commissioned to help with its consultation response. The NHS NWL response to the Council's consultation submission is attached as Appendix 7.

5. Conclusions

5.1 On the basis of the information above, the claim set out in NHS NWL documentation that the SAHF proposals meet the Secretary of State's "four tests" for reconfiguration is open to challenge. The following from section 6.3 of the Independent Review report sets out a summary of the key reasons for this:

5.1.1 "The [NHS NWL pre-consultation business case] acknowledges the current NHS "Four Tests", required to be met by all reconfiguration proposals before they can proceed, namely: Support from **GP commissioners;** Strengthened public and patient **engagement;** clarity on the **clinical evidence** base; consistency with current and prospective **patient choice.** The assertion in the business case is that the "Four Tests" have been met, and indeed NHS London has confirmed that from they are satisfied that the tests have been met, in accordance with the most recent guidance. It is this review's contention however that this is open to challenge. Regarding the support from **GP commissioners,** this has not been demonstrated, as engagement with the newly developing CCGs is unequivocally given as proxy evidence of general GP support. CCGs are not yet statutory bodies and their leaders are not necessarily representative of the individual member practices. In the business case it is proposed that an online poll of GPs will be conducted at different stages of the consultation. This should have been done at the pre-consultation stage. The views of front-line GPs are not evidenced in the business case and there is anecdotal evidence that many local GPs do not support the proposals. Indeed Ealing CCG has confirmed that while it is supportive of the consultation process it does not necessarily support the proposals themselves."

5.1.2 "In the section regarding strengthened public and patient **engagement** it states that the JHOSC agreed the consultation plan. From discussions with the chair of the JHOSC this appears to be overstating the case. It also references a wide range of engagement activities. This is insufficiently evidenced in the business case. The substance of the discussions is not included. The response of the various groups to the proposals is not provided. The impact that those responses had on the proposals is not clear."

5.1.3 "In the section regarding the clarity about the **clinical evidence** base, the business case reiterates the evidence base. The hub of the core argument for reconfiguration is restated, namely that there are currently unacceptable variations in the quality of services across NW London and that "there are significantly improved outcomes for patients and improved patient experience when certain specialist services are centralised"12. However this theoretical hypothesis has not been tested against the actual outcomes and current patient experience in NW London."

5.1.4 It is also stated that the clinically led nature of the development of the proposals has "ensured that the clinical vision and standards lead the reconfiguration proposals". This is open to challenge. The achievement of the clinical vision and standards can be decoupled from the reconfiguration proposals. The business case states that "all London providers will be held to account against [the clinical] standards over the next three years and local GPs in their clinical commissioning groups are putting in place processes to ensure they are delivered". This is open to challenge. It suggests that plans are proceeding prior to consultation. It also potentially reinforces the point that the clinical standards can be delivered without the need for radical reconfiguration."

5.1.5 "The business case also looks at the issue of the impact on **patient choice.** It states that "the proposals' impact on patient choice is complex and difficult to quantify". The business case states that "SaHF has maintained the balance between providing integrated, localised care and safe, high quality services, centralising services where to do so would significantly improve service provision". This is open to challenge, particularly from an Ealing perspective. There is no assessment of how local people really feel about the proposed reductions in

service at Ealing Hospital. There is no evidence that the proposed hospital reconfiguration will enhance their choice of care."

5.1.6 "The business case also makes reference on a number of occasions to a Travel Advisory Group. It states that the advice of the group will be reported to the Programme Executive, but it is not clear how this advice has been reflected in the proposals."

6. Additional issues.

6.1 The Panel will have noted that NHS NWL responded to the Borough's formal response to the consultation process. While the response endeavours to respond to the various points raised by the Borough consistent limitation in NHS NWL's response are apparent:

6.1.1 The response doesn't engage with the detail of the Borough's consultation response;

6.1.2 The response inappropriately conflates support from various professional bodies (e.g. the Royal College of Midwives) with support for SAHF's preferred option;

6.1.3 A number of statements are made within the response without corroborating evidence;

6.1.4 The response argues that a NW London wide assessment of the impact of SaHF is equivalent to a detailed borough by borough analysis. This is clearly not the case given the variation in population health need across NW London;

6.1.5 The response does not address the past and current inadequate engagement with local government, both as a key stakeholder and a provider of essential social care.

6.2 The review of consultation responses by Ipsos Mori was undertaken on behalf of NHS NWL.

6.2.1 It concludes that "there is support for many of the proposals outlined in the consultation document, and a widespread acceptance of the case for change. There is majority support for the proposal that there should be five major hospitals in North West London and Option A."

6.2.2 However it also concludes that "there has been clear and vocal opposition to the proposed closure of A&E and other services in some areas, particularly Ealing and Hammersmith and Fulham." This comment reflects the divisive nature of the SAHF process and proposals.

7. Recommendations for the Panel.

7.1 Panel are asked to:

7.1.1 Review and discuss the content of this paper;

7.1.2 Agree next steps and actions in relation to future development of "Shaping a Healthier Future" proposals.

8. Other appendixes

This paper is Appendix 1 to the Cover Report. Other Appendixes are as follows:

Appendix 2: Independent Review of Shaping a Healthier Future proposals, by Tim Rideout
Appendix 3: Shaping a Healthier Future – Ealing Hospital Board consultation response
Appendix 4a: Shaping a Healthier Future Response letter from Ealing CCG to Jeff Zitron
Appendix 4b: Ealing CCG ballot on Shaping A Healthier Future
Appendix 5: Ealing Health and Adult Scrutiny Panel submission to the JHOSC in relation to Shaping a Healthier Future
Appendix 6: Summary of Full Council motions relevant to Shaping a Healthier Future

Appendix 7: Summary of key points raised by Shadow Health and Well-Being Board in relation to Shaping a Healthier Future
Appendix 8: NHS NWL feedback to Ealing Council on its consultation response to Shaping a Healthier Future
Appendix 9: NW London Joint OSC Final report October 2012
Appendix 10: Recommendations to the Joint Committees of Primary Care Trusts in North West London, Feb 19th 2013

Please note that the content of Appendix 2, the independent review report, has been colour coded according to particular themes, as follows:

1) Consultation process: turquoise;
2) Clinical case and clinical support: yellow;
3) SAHF methodology: pink
4) Feasibility of SAHF proposals: green
5) Substantial material used in the section in this paper relating to the "four tests": grey.

APPENDIX 2

"Shaping a Healthier Future"

An Independent Review

Conducted by Tim Rideout Limited on behalf of the London Borough of Ealing

September 2012

Appendix 2

"Shaping a Healthier Future" – An Independent Review

Contents:

The London Borough of Ealing

"Shaping a healthier future" – an independent review

1. Executive Summary

1.1 "Shaping a healthier future" (SaHF) is NHS North West London's proposed programme of change for both out of hospital and hospital services. A pre-consultation business case has been developed and the proposals are now subject to formal consultation, closing on 8 October 2012.

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

1.3 The proposals represent a radical reconfiguration of local health services, with an increased emphasis on out of hospital care and a reconfiguration of NW London's hospitals. For Ealing, this specifically means a significant reduction in the scope and breadth of services provided at Ealing Hospital.

1.4 The London Borough of Ealing (LBE) has commissioned an independent review of these proposals, from Ealing's perspective on behalf of everyone who lives in, works in, and visits Ealing

1.5 The independent review's conclusions are as follows:

a) **The context for this review is agreed:**

- The objectives of SaHF are appropriate (i.e. of improving service quality and reducing unwarranted variation, improving the health of local people through the provision of better care, and ensuring that organisations are financially viable for the long term);

- The current provision of local healthcare is not acceptable, as it is too often characterised by unacceptable levels of quality and service and unwarranted variation, substantial health inequalities, and an unsustainable financial position;

b) **This review welcomes the opportunity to comment on the proposals, but there are some significant concerns about SaHF's arrangements for engaging and consulting with local people:**

- The adequacy of the pre-consultation engagement of key stakeholders, notably patients, public, clinicians and LBE itself is open to challenge;

- In particular, more should have been done to engage with those local people who are most vulnerable and disadvantaged;

- The timing of the consultation is open to challenge. Consideration should be given to amending the current hurried timetable to allow for further consultation with the affected parties, detailed impact assessment work to be undertaken and revisions to be made to the decision making arrangements;

- The decision making arrangements are inappropriate. Consideration should be given to amending the arrangements to ensure that any decisions are made by the new NHS and local government arrangements that come in to effect on 1 April 2013, rather than key decisions being made by organisations on the eve of their abolition;

c) The proposed improvements to Out of Hospital Care are appropriate but there are concerns about the realism and deliverability of both the proposed scale and pace of the improvements:

- The proposed clinical standards and visions are appropriate;

- The proposed improvement of Out of Hospital care is appropriate, given the current shortcomings in primary care and the significant extent to which the proposed reconfiguration is dependent upon these improvements. Detailed plans should now be developed and urgently implemented before any reduction is hospital services is decided upon, let alone begun;

d) There are significant concerns about the methodology used to identify and choose between the various reconfiguration options. The methodology is fundamentally flawed and therefore the conclusions are open to challenge:

- The assumption that NW London has an over-provision of acute hospitals (and A&Es) is open to challenge;

- The options appraisal and the resultant preferred option (and secondary options) are open to challenge, on the grounds of the sequential approach (which potentially distorts conclusions and prioritises travel time above quality contrary to local preferences), the selective choice of indicators, the total absence of an assessment of real quality and performance assessment, the lack of sufficiently detailed assessment in critical areas (e.g. travel times) and the practical application of the indicators (including a high level of double counting);

- The options appraisal fails to take into consideration local plans which will have a major impact upon the base case (e.g. the merger

between Ealing Hospital NHS Trust and North West London Hospitals NHS Trust);

- The underlying financial model used to establish the "base financial position" has not been subject to independent verification and cannot necessarily be relied upon to support true comparisons between hospitals. In some cases it is also at odds with organisations' own views of their underlying financial position;

e) The independent review's detailed analysis raises some significant concerns with the various assessments in the options appraisal:

- The total lack of clinical quality as a differentiating assessment criterion is at odds with its place as the top priority for patients and clinicians;

- The proposed future configuration will leave many patients with no choice but to attend a hospital providing poorer service than under the current configuration;

- The proposed configuration may leave the local health systems in NW London unable to respond to expected increases in population and co-morbidities, and exceptional demands (e.g. major incidents);

- There is insufficient analysis of patient flows in the proposed options e.g. incoming A&E flows;

- The timeline for implementation is hurried and unrealistic, with insufficient implementation of new primary care and community services before hospitals are downgraded;

- The reconfiguration does not take into account the specific needs of the local population, which has a relatively high burden of specific diseased and conditions (e.g. diabetes, tuberculosis);

f) Therefore this independent review concludes that:

- The proposed changes to the essential services used by people who live and work in Ealing and in particular the proposed service reductions at Ealing Hospital in line with plans to designate it a "Local Hospital" are not based upon a sound premise given the flaws in the methodology;

- The readiness of the local health system to cope with the scale of change proposed has not been demonstrated and consequently represents a significant risk to the safe and effective delivery of healthcare across Ealing;

- The scale of change proposed, and in particular the significant and potentially adverse impact on the people of Ealing, has not been adequately explained or addressed;

- Further, significant work should be done to understand, in substantially more detail, the impact on local people and their health needs;

- There should be a more transparent articulation by the leadership of the local NHS of the motivations behind the proposals, most notably the need to reduce expenditure and the NHS imperative to ensure that all NHS Trusts achieve Foundation Trust status.

2. Introduction

2.1 In June 2012 the leadership of the NHS in north west (NW) London published proposals to substantially change and reconfigure local health services, affecting the boroughs of Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington & Chelsea, and Westminster, and those boroughs outside of NW London whose residents use services in NW London.

2.2 The proposed programme of change is entitled "Shaping a healthier future" (SaHF) and is set out in a pre-consultation business case published on 20 June 2012 and a consultation document published on 2 July 2012, at the beginning of a fourteen week consultation period that will end on 8 October 2012.

3. Purpose

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

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

3.3 Consequently LBE has commissioned an independent review of the proposals in order to assess their implications and robustness from LBE's perspective and to inform LBE's formal response to the consultation.

3.4 This report represents the output from the independent review. It provides a considered assessment of the business case from LBE's perspective. It suggests those aspects of the proposals that are appropriate, those aspects that are potentially open to challenge and those aspects where further information and/or clarification are required. The report should be read along side the pre-consultation business case and the consultation document.

3.5 The independent review was undertaken by Tim Rideout (a freelance independent expert with significant previous senior management experience in the NHS and specialising in change management, financial strategy and organisational turnaround), supported by relevant experts.

3.6 The review comprised:

- A systematic review of the pre-consultation business case;
- A testing of aspects of the business case using additional sources of information with the support of relevant experts (e.g. on travel times, relative hospital performance, patient flows);
- Discussions with key internal and external stakeholders (a list is provided at Appendix 1).
- A distillation of the review's findings with senior members and officers at LBE.

4. Context

4.1 The SaHF proposals have been developed by the leadership of the NHS in North West London, supported by the management consultancy firm McKinsey, in light of the challenges they have identified that face local health services, namely:

- A growing and ageing population;
- A limited number of clinical specialists;
- Inadequate NHS facilities; and
- Increasingly tight financial budgets.

4.2 In response to those challenges, proposals have been developed, affecting each borough in NW London, that in summary:

- Seek to commit local health services to a number of principles and service standards;
- Substantially develop primary care services (primarily those services provided by family doctors (GPs) but also pharmacists, opticians and dentists) and community services (those services provided at home or in the community e.g. district nursing); and
- Radically reconfigure hospital services across NW London (with three options, including a preferred option, proposed).

4.3 Specifically for Ealing, the option preferred by NHS North West London would result in significant changes for all of the hospitals serving the Borough's population and particularly Ealing Hospital (Ealing Hospital NHS Trust), with the following services no longer being provided by that hospital:

- Accident & Emergency (24 hours a day, 7 days a week);
- Emergency surgery;
- Non-elective (i.e. unplanned) medicine;
- Non-elective surgery;
- Complex elective (i.e. planned) medicine;
- Complex elective surgery;
- Intensive Care Unit (ICU) level 3;
- Inpatient paediatrics; and
- Obstetrics & maternity

4.4 It is proposed that the patient activity associated with these services would mainly transfer to the West Middlesex Hospital, with smaller transfers to Central Middlesex, Northwick Park and Hillingdon Hospitals. This is considered in more detail later in this report.

4.5 As a result, taking NW London as a whole, SaHF has the biggest impact on Ealing's residents. The business case estimates that for the preferred Option the percentage of Ealing's patient activity impacted by the proposed reconfiguration is as follows:

- 53.9% of inpatient admissions
- 9.6% of outpatient attendances
- 30.0% of A&E attendances.[1]

5. Review of the pre-consultation business case

5.1 The review of the business case broadly considers:

- The pre-consultation and consultation **process**;
- The **methodology** used to generate the proposals;
- The **implications** and **impact** of those proposals; and
- The underlying **motivation** behind the proposals.

6. Review: Process

6.1 This section of the report examines the engagement undertaken by NHS North West London in developing the proposals, the timing of the consultation and the decision making arrangements.

[1] Shaping a Healthier Future Pre-Consultation Business Case Volume 18 p35

6.2 Pre-Consultation Engagement

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

6.2.2 The business case states that "Shaping a healthier future" builds on significant previous work. The "Case for Change" was published in February 2012. However the business case does not articulate the extent and nature of stakeholder engagement relating to this previous work.

6.2.3 Appropriately, great emphasis is placed on the need for extensive clinical engagement and leadership. The business case states that the programme has been clinically led and supported by GP commissioners and hospital clinicians. This is supported by signed statements from the four Medical Directors who have led the work and the eight CCG clinical chairs. However the extent to which this work has been influenced by McKinsey's own views and models is not clear. The extent to which the programme is genuinely supported by front-line clinicians across NW London and in particular Ealing is not clear. The evidence gathered during the course of this review indicates that there are a significant number of local clinicians (GPs and hospital clinicians) that have serious concerns about the proposals and that consequently do not support them (see Appendix 2 as an example of local clinicians' concerns).

6.2.4 The business case equates support from the leaders of the "shadow" CCGs with support from GPs in general, thereby meeting the requirement that such changes are supported by local GPs (one of the reconfiguration "Four Tests" established by the Secretary of State for Health in 2010). It is clear that the leaders of the "shadow" CCGs have been actively engaged in developing and promoting elements of the business case, particularly the Out of Hospital proposals and that the proposals have been supported by the "shadow" CCG boards. However the underlying assumption of GP support is open to challenge. The support of the "shadow" CCG chairs and their boards does not automatically equate with the support of local GPs. Indeed, there is evidence that a large number of local GPs have significant concerns about the proposals and their implications for Ealing. The CCG Chair (and SaHF's programme lead) has confirmed that while the CCG's Governing Body gave its support for the formal consultation to proceed, it does not necessarily support the proposals.[2]. The CCG has

[2] the Minutes of the Extraordinary CCG meeting of 25th May include at 3.1: **NWL Reconfiguration – The Case for Change** Mark Spencer presented – "Improving healthcare for two million people in North West London" to the group and advised that following the meeting the Chair would be asked to sign a letter on behalf of the CCG Board giving support

confirmed that in the face of the opposition of a majority of its member practices to the proposals, it would withdraw its formal support. This position is not reflected in the business case.

6.2.5 Regarding hospital clinicians, the summary of clinical engagement meetings attended by programme representatives indicates variable engagement across NW London. Specific mention is made of the engagement of Ealing Hospital NHS Trust clinicians. However, evidence collected during the course of this review indicates that a large number of Ealing Hospital's clinicians have serious concerns about the proposals and do not support them.

6.2.6 It appears that local public health clinicians and professionals have only had a very limited engagement in the development of the proposals. Although public health directors attended a number of the stakeholder events, they have not had a formal connection with the programme, have not been directly engaged in the modelling and options appraisal, and have not been given an opportunity to assess the impact of the proposals on the health of local people.

6.2.7 The SaHF programme team did include a public health specialist. He reviewed the information available from various Public Health Observatories, including the health profile for Ealing. This identified that although the overall mortality rate for Ealing is falling and is below the England average, the Borough is worse than the England average for obesity in children, physically inactive adults, hospital stays for alcohol related harm, drug use, diabetes, tuberculosis, acute sexually transmitted infections, and early deaths from heart disease and stroke.[3]. In line with the findings of the 2010 Marmot review into health inequalities.[4] SaHF's core response to these issues is the proposed development and improvement of out of hospital services (primary and community care).

6.2.8 However, the impact of the proposed hospital reconfiguration on the health of people living and working in Ealing does not appear to have been assessed. This is a significant omission. It is clearly essential to understand the impact of the proposals on each of the borough's populations. The Directors of Public Health, given their statutory roles and responsibilities, should have played a key role in this.

6.2.9 The statements made in the business case relating to wider engagement and involvement in shaping the proposals are also open to challenge. The business case sets a number of stakeholder

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to the planned consultation for "Shaping a Healthier Future", it was confirmed that agreeing to the consultation did not mean that the CCG agreed with the outcomes of the consultation.

[3] Health Profile 2012 Ealing produced by the English Public Health Observatories

[4] Fair Society, Healthy Lives: The Marmot Review – Strategic Review of Health Inequalities in England post-2010

engagement principles[5]. The principles are sound and should be supported. However, they do not address the apparent democratic deficit in the process. It is difficult to see how such proposals can be legitimised democratically without both the active engagement and support of local government. Currently, significant aspects of the proposals do not have the support of LBE.

6.2.10 As should be expected, explicit stakeholder mapping has been undertaken[6]. The mapping makes reference to the "political" stakeholder grouping including various local government representatives (Health Overview & Scrutiny Committees, Borough Councillors, Borough cabinet members). Explicitly the business case states that "there has been significant engagement with political stakeholders throughout the pre-consultation period"[7]. This is contrary to the views of senior members and officers at LBE. There has been no attempt to engage LBE at a senior level on a sufficiently detailed basis. In particular LBE has confirmed that the Council has had only limited opportunity to influence the strategy and that a number of serious concerns and questions have been raised which have not yet been fully answered.[8] Given the profound impact on local health services, this is a significant omission.

6.2.11 Patient and public engagement are crucial elements of pre-consultation work. Pre-consultation engagement events took place on 15 February, 23 March and 15 May 2012. The business case states that these were "the main focus of [the] engagement with the wider public"[9]. This appears to indicate that approximately 360 members of the public (approximately 0.018% or 1 in 5,000 of the population of NW London) attended the events. It is not clear how many members of the public were actively engaged through other mechanisms pre-consultation. Given the significance of the proposals, greater engagement of the public should have taken place pre-consultation. In addition it is not clear how many residents of Ealing were actively engaged pre-consultation. Again, given the proposed impact of the proposals for Ealing, targeted local engagement should have taken place.

6.2.12 In particular, the work done to engage with traditionally vulnerable groups is open to challenge. The business case makes reference to the requirement to understand the potential effects of the proposals on the protected groups under section 149 of the Equality Act 2010 and briefly references work to engage and consult groups and communities that are seen as seldom heard and traditionally under represented. However detail is not explicitly provided on the nature of the engagement, the issues and concerns raised by those groups, and the

[5] Shaping a Healthier Future Pre-Consultation Business Case Volume 1 p25
[6] Volume 1 p26
[7] Volume 1 p37
[8] Cllr Julian Bell and Cllr Jasbir Anand's letter to Cllr Lucy Ivimy, Chair of the JHOSC 30th August 2012
[9] Shaping a Healthier Future Pre-Consultation Business Case Volume 1 p33

programme's response. This is an important and unfortunate omission, given the legal requirements and the diverse nature of Ealing's people and communities.

6.2.13 Going forward it is intended that more work will be done to engage the public and that "this will include work with local authority colleagues who support voluntary and community sector networks... who are able to access a large number of community members through the work they undertake".[10]. This engagement activity should have taken place before the development of the pre-consultation business case.

6.2.14 The NHS, in pursuing such service changes, is legally required to engage with Health Overview & Scrutiny Committees (HOSC). For this programme a Joint HOSC (JHOSC) has been established, with the participation of most of the individual HOSCs. The JHOSC has only recently been formally established (operating in shadow form until July 2012) and the chair of the committee feels that the joint arrangements were not given sufficient time to be established before being asked to make crucial decisions (e.g. on the timing of the consultation and the process following consultation). Therefore the adequacy of HOSC engagement is open to challenge. It is not clear that the individual HOSCs, before the JHOSC was established, formally approved the consultation timetable. In addition, the process following consultation, including the feeding back to the HOSCs the points raised through the consultation process and the subsequent decisions has yet to be established and should be clarified as a matter of urgency.

6.2.15 Finally, the extent to which the views expressed by stakeholders have been taken into account in shaping the proposals is open to challenge. The business case sets out the themes that arose from the engagement activities and the basis on which "the programme has incorporated these messages into [the] proposals".[11] In a number of cases the theme does not in fact appear to have been explicitly addressed (e.g. the impact on protected groups; further explicit consideration given to mental health and the elderly). The business case should have set out the manner in which each issue raised has been explicitly addressed, clearly indicating where some were not. Reference is made to the production of Borough information packs for consultation describing the changes for specific Boroughs although it is not clear if this has now been done.

6.3 The "Four Tests":

6.3.1 The business case acknowledges the current NHS "Four Tests", required to be met by all reconfiguration proposals before they can proceed, namely:

[10] Volume 1 p34
[11] Volume 1 p31

- Support from **GP commissioners**
- Strengthened public and patient **engagement**
- Clarity on the **clinical evidence** base
- Consistency with current and prospective **patient choice**

6.3.2 The assertion in the business case is that the "Four Tests" have been met, and indeed NHS London has confirmed that from they are satisfied that the tests have been me, in accordance with the most recent guidance. It is this review's contention however that this is open to challenge. Regarding the support from **GP commissioners**, this has not been demonstrated, as engagement with the newly developing CCGs is unequivocally given as proxy evidence of general GP support. CCGs are not yet statutory bodies and their leaders are not necessarily representative of the individual member practices. In the business case it is proposed that an online poll of GPs will be conducted at different stages of the consultation. This should have been done at the pre-consultation stage. The views of front-line GPs are not evidenced in the business case and there is anecdotal evidence that many local GPs do not support the proposals. Indeed Ealing CCG has confirmed that while it is supportive of the consultation process it does not necessarily support the proposals themselves.

6.3.3 In the section regarding strengthened public and patient **engagement** it states that the JHOSC agreed the consultation plan. From discussions with the chair of the JHOSC this appears to be overstating the case. It also references a wide range of engagement activities. This is insufficiently evidenced in the business case. The substance of the discussions is not included. The response of the various groups to the proposals is not provided. The impact that those responses had on the proposals is not clear.

6.3.4 In the section regarding the clarity about the **clinical evidence** base, the business case reiterates the evidence base. The hub of the core argument for reconfiguration is restated, namely that there are currently unacceptable variations in the quality of services across NW London and that "there are significantly improved outcomes for patients and improved patient experience when certain specialist services are centralised"[12]. However this theoretical hypothesis has not been tested against the actual outcomes and current patient experience in NW London.

6.3.5 It is also stated that the clinically led nature of the development of the proposals has "ensured that the clinical vision and standards lead the reconfiguration proposals".[13] This is open to challenge. The achievement of the clinical vision and standards can be decoupled from the reconfiguration proposals. The business case states that "all London providers will be held to account against [the clinical] standards

[12] Volume 2 p91
[13] Volume 2 p92

over the next three years and local GPs in their clinical commissioning groups are putting in place processes to ensure they are delivered".[14]. This is open to challenge. It suggests that plans are proceeding prior to consultation. It also potentially reinforces the point that the clinical standards can be delivered without the need for radical reconfiguration.

6.3.6 The business case also looks at the issue of the impact on **patient choice**. It states that "the proposals' impact on patient choice is complex and difficult to quantify".[15]. The business case states that "SaHF has maintained the balance between providing integrated, localised care and safe, high quality services, centralising services where to do so would significantly improve service provision".[16] This is open to challenge, particularly from an Ealing perspective. There is no assessment of how local people really feel about the proposed reductions in service at Ealing Hospital. There is no evidence that the proposed hospital reconfiguration will enhance their choice of care.

6.3.7 The business case also makes reference on a number of occasions to a Travel Advisory Group. It states that the advice of the group will be reported to the Programme Executive, but it is not clear how this has advice has been reflected in the proposals

6.4 Equalities Impact Analysis:

6.4.1 The Equality Act 2010 introduced the Public Sector Equality Duty (PSED) that requires public bodies in their decision making to consciously think about the Act's three aims:

- The elimination of unlawful discrimination;
- Advancement of equality of opportunity between people who share a protected characteristic and those who do not; and
- The fostering of good relations between people who share a protected characteristic and those who do not.

[redacted] The business case makes reference to the equalities impact analysis (EIA), stating that one had been commissioned from Mott MacDonald in May 2012, with three reports produced, to ensure that the proposed reconfiguration of services complies with the PSED. The analysis looked at the impacts of the proposed options on populations with protected characteristics (plus an additional category of social deprivation) within NW London and does not provide a detailed disaggregation of data at borough level.

6.4.3 The EIA sets out the particular health service need for each protected characteristic group, noting that they are disproportionately dependent on health services as their health tends on average to be poorer. It

[14] Volume 2 p94
[15] Volume 2 p94
[16] Volume 2 p96

then considers the potential NW London-wide impact of the proposed changes on those groups. As would be expected, given that one of the stated overall aims of SaHF is to improve the quality of care, the EIA concludes that in general terms the protected characteristic groups will benefit disproportionately from the expected improvements in quality.

6.4.4 The EIA also considers the potential negative impacts, but at a more granular level. It considers the risks to local good practice at meeting the needs of disadvantaged people developed over time by local hospitals. For example, it highlights the following: "In recognising that over 100 languages are spoken across their local Borough, Ealing Hospital NHS Trust has been working with members of the public and voluntary and community organisations to improve patient information and access to services. Developments include a central booking point for face-to-face interpreting and 24/7 telephone interpreting services. Within Ealing Hospital NHS Trust, a resource for all staff has been developed, which contains information about the religious and cultural needs of our local community to enable staff to provide more culturally sensitive care"[17].

6.4.5 The EIA highlights the risk that, following hospital reconfiguration, such good practice may not be replicated by the "new" receiving hospitals and this may reduce local confidence in the post-reconfiguration arrangements. The EIA's assessment is that this is likely to have the greatest impact on BAME groups. The EIA suggests a number of potential mitigating actions that could be taken to address this issue. In a similar way the EIA identifies the following potential negative impacts:

- Negative service impact during the period of transition;
- Disruption of the relationships between patients and clinicians; and
- Longer journeys to access emergency, paediatrics and maternity care.

6.4.6 For each issued raised, the EIA provides an impact appraisal and suggested mitigations and opportunities. However this has yet to be reflected in detailed SaHF proposals. It would clearly be appropriate for the EIA's conclusions to be systematically reflected in any detailed change proposals going forward.

6.4.7 The EIA then considers in more detail the impact of NHS North West London's preferred option for areas where there are high densities of "scoped in" equality groups, particularly looking at travel times. It concludes that "under Option 5, 41% of people living within critical equality areas are likely to experience an increase in journey time to a major hospital by car and by blue light ambulance and 38% by public transport."[18] The impact is judged to be greatest on visitors and carers.

[17] Equality Impacts – Strategic Review p60
[18] Equality Impacts – Strategic Review p69

6.4.8 The EIA states in terms of the reconfiguration to "Local" and "Major" hospitals that "Under Option 5, the quantitative analysis shows that scoped in equality groups located in LB Ealing and LB Brent, with some lesser impacts in LB Hounslow are likely to be most are most likely to be affected".[19], and provides an assessment of the groups most effected. For Ealing these are:

- Children;
- Younger people;
- Older people;
- People with a disability;
- South Asian people; and
- Socially/health deprived communities.

6.4.9 In addition, for Ealing, children under the age of one, pregnant and child-bearing age women, Bangladeshi and Pakistani communities, and socially/health deprived communities will be impacted most by the proposed changes to maternity services.

6.4.10 A similar analysis is provided for Options 6 and 7. Clearly, as Option 7 designates Ealing Hospital as a "Major" hospital, the impact upon the Borough's people is far less.

6.4.11 The business case states that Mott MacDonald's review was seen as the first piece of work in the analysis of the proposed configuration on protected groups and that further work will be undertaken during the consultation period. The Mott MacDonald review specifically states that "Engaging with [the] equality groups to understand their needs during the consultation process and further reconfiguration planning will be essential to ensure that inadvertent discrimination is avoided and equality of outcomes are maximised".[20].

6.4.12 However the EIA work done to date is on a NW London-wide basis and has not looked in sufficient detail at the impact on each borough. Given the risks identified in the EIA for vulnerable groups, such detailed work should have been completed before the proposals were finalised and formal consultation started.

6.5 The consultation process:

6.5.1 The formal consultation will run from July to October 2012 and for the decision making to take place from October 2012 to January 2013, with implementation from January. This is open to challenge. In addition to the points made at 6.6 below and notwithstanding the fact that the consultation period runs for fourteen weeks (two more than the custom and practice minimum) it is not good practice to consult over the

[19] Equality Impacts – Strategic Review p72
[20] Equality Impacts – Strategic Review p94

summer when stakeholders are not able to give the consultation their full attention.

6.5.2 There were also reported problems at the start of the consultation period. The printed material was not readily available until three weeks after the consultation began.[21]. Of particular importance for Ealing, material was not readily available in other languages (40% of the people who live and work in Ealing do not have English as their first language and "the population of Ealing schools has changed considerably in the last four years. The proportion of pupils who do not speak English as their first language has increased from 44% in 2001 to 57% in 2011".[22]).

6.5.3 The consultation document itself is very complicated and is structured to support the preferred option rather than provide a sufficiently open consideration of the alternatives, offering those consulted a very limited range of options.

6.5.4 Furthermore, the overall nature of the SaHF consultation is potentially divisive. Many stakeholders interviewed during the course of this review expressed the view that the process (either inadvertently or deliberately) pitches clinician against clinician, hospital against hospital, and borough against borough.

6.5.5 During the course of the consultation claims have been made by those leading the programme that are not supported by evidence. For example it has been claimed that every year of delay in implementing the reconfiguration will result in 200 lives lost. This has not been substantiated with clear evidence. In addition it has been publicly claimed that Ealing Hospital's Obstetrics and Gynaecology Department cannot recruit midwives and has relatively poor outcomes (e.g. a higher than appropriate number of caesarean sections). These claims are not supported by local evidence. Indeed there is considerable evidence that demonstrates that Ealing's maternity outcomes are relatively good. Appendix 3 provides a more general example of the dissonance between the views of the clinicians leading the programme and some of those who work within Ealing.

6.6 Decision making:

6.6.1 It should be noted from the outset that the proposals have been developed during a time of major organisational change within the NHS. The recently passed 2012 Health Act notably results in the abolition of Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) from 1 April 2013, and their replacement by local Clinical Commissioning Groups (CCGs) and the NHS Commissioning Board. In NW London there will be eight CCGs mostly coterminous

[21] Fulham Reference Library, the first Library to receive the consultation documents, has confirmed that it received them on 23rd July, 21 days after the beginning of the consultation.
[22] Children and Young Peoples Plan 2011-2014, App 1, Version 7 20/12/2011

with local authorities. The proposed Ealing CCG is coterminous with LBE.

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

6.6.3 Crucially, PCTs and SHAs will still be in place at the conclusion of the consultation and will formally make the decisions on "Shaping a healthier future", shortly before their abolition. The JCPCT (Joint Committee) of the eight PCTs has taken the decision to proceed to consultation on the proposals and will "ultimately, take the final decision on whether to proceed with proposed service changes".[23] Given the significance of the proposals, it is far more appropriate for any decision to be considered and made by the eight CCGs, once established and authorised, after 1 April 2013. It will clearly be impossible to hold PCTs (and their officers) to account for these decisions once they have been abolished. The new CCGs should clearly take responsibility for such matters, once they are statutorily able to do so. They have a stake in the future and can subsequently be held to account for those decisions.

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

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

[23] Shaping a Healthier Future Pre-Consultation Business Case - Volume 1 p20

6.7 Programme assurance:

6.7.1 The programme has been subject to a number of external scrutiny processes.

6.7.2 A review of the programme was undertaken by the National Clinical Advisory Team (NCAT). NCAT supported the proposals in principle and in particular supported the proposal to change the current configuration of A&Es to five A&Es. However, in doing so it highlighted, amongst other points, the importance of "[ensuring] capacity and capability exists within the Out of Hospital services to operate 24/7"[24]. Similarly, in looking at the proposals for maternity and paediatrics, NCAT stated highlighted "the need to ensure that community services are in place before closing acute services"[25]. As considered elsewhere in this report, currently this capacity and capability is not in place.

6.7.3 In addition, NCAT recommended that a clear set of Out of Hospital outcome metrics be developed. The business case indicates that this has been done, but the metrics do not appear to have been included in the business case.

6.7.4 NCAT also highlighted the importance of significantly more detail on the proposed Urgent Care Centre's financial, staffing and service models, including the "case mix for A&Es and Urgent Care Centres"[26]. This has yet to be set out in detail.

6.7.5 NCAT also recommended a number of further actions, including "completion of blue light activity and travel time modelling"[27]. It is not clear whether this has been done.

6.7.6 The Office of Government Commerce (OGC) also undertook a Health Gateway review in April 2012. They gave the overall programme an amber/green assessment. Their recommendations included:

- "Identify clearly the benefits to patients proposed for each Borough together with who owns them and how they will be measured"[28]. It is not clear whether this recommendation has been met. In particular LBE has not been engaged in the relevant discussions.

[24] Volume 2 p79
[25] Volume 2 p80
[26] Volume 2 p79
[27] Volume 2 p80
[28] Health Gateway Review: Review 0 : Strategic Assessment Version 1.0 Final Page 9 http://www.northwestlondon.nhs.uk/_uploads/~filestore/06186BBA-1471-46B3-861F-BA6FBE007505/06%20OGC%20Gate%200%20Report%20Ver1%200%20FINAL%202012%2005%2004.pdf

- "Review risk management for the programme to establish a comprehensive and auditable process".[29] The review team highlighted a number of risks reported by stakeholders but not recorded in the risk register including the lack of time allowed for review and reflection during the tight timescale and potential challenge regarding the different approach being taken to reconfiguration in South London.

- "Clarify the service models for Urgent Care Centres and Accident & Emergency Departments".[30] The review team indicated that stakeholders were concerned about the absence of detail and that there was some scepticism as to whether the alternative services will be in place to deliver the planned benefits.

- "Engage with stakeholders, in some case at an individual level, to ensure that remain fully supportive of the proposals".[31] As indicated elsewhere in this report the senior leadership of LBE report that they have not been adequately engaged. It should be noted that the OGC review team did not interview anyone from local government during the course of their review.

7. Review: Methodology

7.1 This section of the report reviews the methodology used to develop the proposals. While, at a high level, the argument appears to be cogent and logical, there are key aspects of the methodology that are open to challenge.

7.2 The case for change

7.2.1 The proposals are predicated on the need for substantial change that must start now. In general terms the business case sets out compelling reasons for the need to change health services across NW London, including:

- The changing and increasing needs of local people;
- The impact of new technologies;
- The relatively unsustainable and poor performance of some local services; and
- The pressure on public finances (with very low real terms growth in funding).

7.2.2 There is an assessment of the changing demands on the NHS in NW London. This assessment should be tested again LBE's own analysis of the changing demographic of the Borough. There are concerns that the SaHF proposals do not adequately take account of the extent the

[29] Page 11
[30] Page 12
[31] Page 13

NW London's population is expected to grow in the near future, further aggravated by the relatively high number of local people in Ealing not counted by the census, particularly in Southall. In addition there are current plans to build approximately 4,000 new homes in Ealing. It is not clear whether this has been taken into account when developing the SaHF proposals. The needs of local people are explored in more detail later in this report.

7.2.3 The business case also references modelling that indicates that the budget would need to rise by around 5% per year in real terms to accommodate these demands. However this modelling is not provided with the business case. The business case states that, in addition to the planned efficiency savings of 4% per year, services also need to be redesigned to be more affordable and to ensure that money is spent in the best way. However a 4% per annum efficiency savings target is relatively low compared to the savings currently required in nearly all other parts of the public sector. However, the business case does not explore any real alternatives to service reconfiguration that could be pursued in order to achieve the savings required.

7.2.4 The business case's financial model starts from the premise that service reconfiguration is the most effective means of achieving financial stability and sustainability for North West London. However other trusts are successfully meeting the current quality and financial challenges without the need for radical reconfiguration.

7.2.5 Indeed, there are other options open to the NHS organisations in NW London. Locally, the potential merger of Ealing Hospitals NHS Trust and North West London Hospitals NHS Trust merger should be addressed first before reconfiguration. In addition there are other means of achieving financial sustainability not addressed within the business case, including:

- Renegotiation of Public Finance Initiative (PFI) contracts: The two North West London Trusts that are projected to be in deficit in 2014/15 under the "do nothing" scenario.[32] are subject to PFI contracts (West Middlesex and Central Middlesex). Clearly the terms of the PFI arrangements are contributing to the financial difficulty. Recently there has been a widespread call for PFIs to be re-examined and to take advantage of (a) the reduction in Bank of England interest rates to 0.5%, (b) the Government guarantee to borrow, and (c) the limited ability of PFI holders to borrow;

- Patient pathway reconfiguration: An examination of the reconfiguration of services in South East London has shown that 'radial' (as opposed to 'concentric') reconfiguration involving specialist/tertiary hospitals, DGHs and community care providers

[32] Shaping a Healthier Future Pre-consultation Business case Volume 3 p54

could "do much more to drive up quality and drive down costs than reconfiguration across DGHs providing similar services".[33]; and

- Commissioner/provider agreement to modify Payment by Results (PbR): NHS Commissioners can agree to apply a modified version of PbR to reflect local needs and circumstances.

7.2.6 The proposals are based on a number of academic studies, including a number of King's Fund reports ("Reconfiguring Hospital Services" and "Where next for the reforms? The case for integrated care"). Such studies provide the core evidential sources for supporting the need for centralisation of specialised services and specialist teams. This is a critical point in the business case. However it is not clear what alternative models and concepts were considered. It is also not clear how these fundamental concepts were evaluated, considered and agreed.

7.2.7 Reference is made to a number of changes recently made in NW London and the moves to already centralise critical services in order to deliver high quality (e.g. in Major Trauma and Stroke services.[34]) and the improvements in integrating care. The business case states that more change is needed.

7.3 The principles and objectives:

7.3.1 The following objectives are proposed:

- To prevent ill health in the first place;
- To provide easy access to high quality GPs and their teams; and
- To support patients with long term conditions and to enable older people to live more independently.

7.3.2 The objectives are appropriate. However the key enabler identified in the business case is securing much needed improvements in primary and community care, not hospital reconfiguration. The business case sets out patient satisfaction rates for primary care in NW London for 2010/11, demonstrating that 79% of GP practices have below national average satisfaction scores. The conclusion reached merits quoting in full: "The effectiveness of the delivery of GP services is highly variable and often below national averages. This variation means we are not consistently delivering the kind of high quality primary care we should be"..[35]

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[33] Palmer, K. (King's Fund) 2011, Reconfiguring Hospital Services: Lessons from South East London. Available at: http://www.kingsfund.org.uk/publications/reconfiguring.html

[34] Although the move to HASUs (Hyper-Acute Stroke Units) coincided with the broad scale introduction of thrombolysis, making it difficult to disaggregate the benefits of centralised care compare with those of clot-busting drugs.

[35] Shaping a Healthier Future Pre-Consultation Business Case Volume 1 p46

7.3.3 This conclusion is sound. However it does pose further questions not addressed in the business case. Firstly, no evidence is provided that demonstrates that the improvements required in GP services are dependent on hospital reconfiguration. Rather this requires the increased investment already assumed within CCG current financial plans and improved performance management and delivery. Secondly, given the current low levels of patient confidence in GP services, improvements need to be made before the burden on those services is further increased as a consequence of reductions in hospital services. This is considered in more depth later in this report.

7.3.4 There is some evidence of the need for local hospitals to improve the quality of care, given some issues relating to patient satisfaction and staff confidence and some variation against clinical indicators. However there is also evidence that in many instances the care received by NW London's patients is of high quality, and this should be protected. This is covered later in this report.

7.3.5 Clearly the intention to improve the quality of care should be supported. However this does not in itself automatically lead to a need to reconfigure hospital services. In the first instance the focus should be on improving performance within the current configuration. The options for this are not sufficiently addressed in the business case.

7.3.6 One of the key arguments for hospital reconfiguration and rationalisation is that the limited availability of senior medical personnel (particularly at weekends) has a detrimental impact on clinical outcomes. A number of studies, including the National Confidential Enquiry into Patient Outcomes and Death (2007), are cited as evidence. This is sound. However the theory should be tested against the actual outcomes currently achieved at local hospitals. There is no evidence to demonstrate that the theoretical hypothesis is borne out by actual experience in NW London. There are clear indications in fact that many of the current outcomes are satisfactory, notwithstanding the limited availability of senior medical personnel and specialist teams. The business case does not explore other ways of securing sufficient cover that are not dependent on service rationalisation. The business case states that "there is insufficient staff available to provide such increased cover across all units, even if it could be afforded and skills could be maintained"[36]. However evidence is not provided to support this statement.

7.3.7 The business case also states that "with NW London's growing population it is increasingly hard to provide a broad range of services around the clock at the existing nine acute hospital sites to the standards...patients should expect"[37]. This is open to challenge. It is not clear what alternatives to service rationalisation have been

[36] Volume 1 p51
[37] Volume 1 p51

explored in order to address this issue. Making the case for the rationalisation of A&E departments, the argument is made that "we have more A&E departments per head of population than other parts of the country and this makes it harder to ensure enough senior staff are available"[38]. Again, this statement is not supported by evidence. It is not clear whether the pattern in NW London has been compared with truly comparable populations. It is also not clear that local outcomes in A&E departments support this theoretical proposition.

7.3.8 Furthermore, there is evidence that indicates the "over-provision" of A&E departments is not as marked as claimed. The whole UK population is served by 240 Type 1 emergency departments[39] for a population of 62.3m people[40]. That equates to 259,425 people per A&E. NW London currently has 8 Type 1 emergency departments, serving a population of just under 2m people. That equates to 247,150 people per A&E, 5% less than the national figure. Should the reconfiguration proposals proceed NW London will be served by 5 Type 1 emergency departments. That would equate to 395,440 per A&E, 52% more than the national average.

7.3.9 The central conclusion reached within the business case is that "in order to meet these challenges and improve the quality of care provided across NW London, we believe we need to "reconfigure" our services and change the way they are currently provided across our hospitals, GP practices and other community care sites"[41]. As previously stated, given the significance of this statement, it remains open to challenge given the absence of evidenced consideration of appropriate alternatives.

7.3.10 In light of the above, the Business Case considers the local NHS "estate" in NW London and concludes that the area has an over-provision of acute hospitals for the size of the local population when compared with the average for England. This too is open to challenge. Comparisons should not just look at the size of population but also the relative complexity and need. It is not clear if this assessment is based on a comparison with similarly complex and growing populations.

7.4 The financial base case

7.4.1 Financial analysis is a key element of the underpinning rationale for the proposed changes. Again, on the face of it, the argument appears to be cogent and logical. However, again there are aspects of the financial model that are open to challenge.

[38] Volume 1 p51
[39] College of Emergency Medicine
[40] ONS mid-year estimate, 2010
[41] Shaping a Healthier Future Pre-Consultation Business Case Volume 1 p52

7.4.2 The financial model begins with an analysis of the current financial position across NW London, to provide the baseline against which the business case's proposals will be compared.

7.4.3 It is again asserted that there are "extreme financial pressures"[42] facing the NHS in NW London and the need for unprecedented levels of efficiency savings (4% per annum). Consequently, the business case states that "a major part of any future configuration of health services in NW London is the degree to which it can help address the financial challenge and create a sustainable health economy"[43]. This drive to ensure financial sustainability is clearly appropriate. However the link between financial sustainability and reconfiguration is not unequivocally made. Other parts of the country are successfully addressing these financial challenges without the need for such radical reconfiguration. Indeed the extensive service redesign work currently under way in South London has to date taken a very different approach.

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

7.4.5 Current savings plans are already assumed within the financial baseline position. These indicate that commissioners in NW London (currently PCTs; CCGs from 1 April 2013) will need recurrent savings by 2014/15 of £381m (or 10% of the 2011/12 budget), £138m of which will be set aside for investment, particularly in Out of Hospital services. £228m (60% of the savings) are planned to come from the acute hospital sector, most of which have already reportedly been identified. This represents a reduction in acute hospital income of between 9 and 15% based on current levels of patient activity, mainly focussed on reductions in outpatients and non-elective activity.

7.4.6 This differentially affects the NHS Trusts in NW London. Imperial College Healthcare NHS Trust has the lowest savings total at 9% of turnover while West Middlesex and Hillingdon both have the highest figure of 15%. Ealing Hospital NHS Trust has a quoted savings target of 12%. The variation in savings figures between Trusts increases the difficulty in making genuine comparisons. In addition there is no assessment of the realism of these assumptions. The vast majority of stakeholders interviewed during the course of this review felt that the

[42] Volume 1 p55
[43] Volume 1 p56

assumptions were highly unrealistic and did not feel confident that the savings would be achieved as set out in the business case. In particular concerns were expressed about the under-developed nature of primary care in Ealing. This is considered later in this report.

7.4.7 High level financial forecasts for 2014/15 are set out by Trust. In total this indicates a forecast overall deficit of £8m (0.44% of total budgets), with Chelsea & Westminster the only Trust in what is deemed to be a viable position with a forecast surplus of £8m or 2.61% of turnover (Ealing Hospital has a forecast surplus of £1m or 0.9% and West Middlesex a forecast *deficit* of £3m or 2.4%). However this assessment of financial viability is not accepted by the vast majority of hospital senior managers interviewed during the course of this review. Their view is that their respective organisations are in a healthier financial position than that set out in the business case. In addition, the forecast figures are directly informed by the assumptions around savings. Were Ealing to deliver savings equivalent to West Middlesex, Ealing's forecast position would be deemed to be viable.

7.4.8 The differences between trusts are in reality marginal and subject to significant change depending on changes in the underlying assumptions and actual delivery.

7.5 The clinical model

7.5.1 The business case sets out the proposed models of healthcare to be implemented across NW London and the clinical standards that have been designed to improve overall quality.

7.5.2 In summary the proposals are underpinned by three core principles:

- "Localising routine medical services means better access closer to home and improved patient experience;
- Centralising most specialised services means better clinical outcomes and safer services for patients[44]; and
- Where possible, care should be integrated between primary and secondary care, with involvement from social care, to ensure seamless patient care".[45]

7.5.3 At a high level the principles are sound. However in applying the principles in order to determine how care should be delivered across NW London, it is also important to take into account the actual quality of care (and outcomes), other factors and constraints (e.g. the specific needs of local populations), and to allow sufficient time for each phase of development to be established before moving to the next phase.

[44] Although the programme lead for SaHF confirmed that the evidence base for this principle only applies to certain services, notable stroke, heart attack and major trauma and to a lesser extent surgery and paediatrics. There is no such current evidence to support the centralisation of A&Es

[45] Shaping a Healthier Future Pre-Consultation Business Case Volume 2 p4

7.5.4 A significant part of the business case is devoted to setting out proposals to change and improve Out of Hospital care, including the individual high level strategies developed by the shadow CCGs, with support from McKinsey. The plans are based on additional investment of £120m (presumable from the £138m referred to earlier, already assumed in the financial baseline). Again, in general terms the proposals appear to be sound.

7.5.5 However a great deal more work is required to develop the Out of Hospital strategies to the level of detail sufficient to support implementation (this is particularly the case regarding the Ealing strategy which is one of the least developed and is somewhat "numbers light").

7.5.6 In addition, a number of assertions are made that require further empirical testing. In summary, it is stated that the developments planned for Out of Hospital care will take the pressure off local hospitals. The business case states that "we will implement these changes to have them in place to support the proposed hospital reconfiguration in 2014/15".[46]. However, critically, the proposals to reconfigure hospital services are due to begin implementation before the Out of Hospital developments have been fully implemented. This is open to challenge. The two programmes of development should be decoupled. The Out of Hospital strategies should be fully implemented and evaluated before any final decision is made on hospital reconfiguration, and certainly before reconfiguration actually starts.

7.5.7 The business case provides examples of improvements in Out of Hospital services to date.[47]. However these are relatively small in scope compared with the scale of overall change proposed in the business case and limited evidence of the impact of these improvements to date is provided. The business case acknowledges that "parts of the borough strategies will need to be in place before acute services are moved to ensure that changes are made in a planned and safe way".[48]. However the business case is not clear about which parts need to be implemented first. The business case also doesn't explain why the strategies can't be implemented in full before final decisions on hospital reconfiguration are made.

7.5.8 Locally, notwithstanding the need for much more detail, there is much that is generally sound in the Out of Hospital strategy developed for Ealing.[49] and for the other NW London boroughs. However these proposed improvements are not dependent on hospital reconfiguration (e.g. the investment required of £9-11m has already been identified within baseline plans) and in many instances simply reflect good

[46] Volume 2 p6
[47] Volume 2 p17
[48] Volume 2 p76
[49] Volume 2 p11

practice in delivering high quality GP and community services. In light of the substantial investment enjoyed by the NHS over the last ten years, the longstanding evidence of relatively poor quality in primary care and the health challenges facing local people, it could be argued that these improvements should already have been secured. These improvements should now be further developed and implemented as a matter of urgency.

7.5.9 The principles and standards proposed for Out of Hospital care[50] are sound. However, the practical development of this model for Ealing should be developed with the full involvement of all parties (including LBE) and should be developed in such a way as to specifically meet the needs of local people. Currently the eight CCG level strategies are generic and lack sufficient detail to support implementation.

7.5.10 The business case also sets out the proposed clinical model for hospital care. The focus is on improving outcomes in emergency surgery, and A&E, maternity and paediatrics (although it is not clear what process was used to identify these three areas of focus). The clinical visions and standards for these specialties[51] are appropriate. There is an expectation that the new CCGs will work from the outset with local NHS providers to ensure that delivery improves in accordance with those standards.

7.5.11 However, a key aspect of the business case is the estimated impact on the workforce of implementing the clinical standards. This is a critical part of the clinical model. Under the reconfiguration proposals the business case states that "it is not currently expected that additional consultant workforce will be required to provide the services required for Emergency Surgery and A&E"[52]. This should be tested further, to determine the viability of maintaining the current configuration by changes to the current workforce. Additional workforce is assumed to be needed for maternity services and potentially for paediatrics.

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

7.5.13 Having proposed a number of clinical principles and standards, the business case sets out the proposed service models for delivering the proposed principles and standards. At the heart of the proposals is a model comprising eight settings of care[53], ranging from "home" to

[50] Volume 2 p19
[51] Volume 2 p24
[52] Volume 2 p31
[53] Volume 2 p40

"specialist hospital". In particular it proposes a distinction between "local hospitals" and "major hospitals", with fewer services provided at the former (e.g. an urgent care centre rather than a full A&E department).

7.5.14 In support of this model, it is stated that "primary care [is] at the heart of the change".[54] It states that "at the moment variable quality of primary care services and poor coordination between services mean that more people end up in hospital than need to".[55], although this isn't quantified in the business case. This should be tested further. Again, given current capability in primary care it could be argued that these services need to demonstrably improve before reducing hospital capacity. A common framework has been developed for improving primary care.[56]. Again, this is appropriate. However this does not require formal consultation and should be decoupled from the case for reconfiguration and implemented as a matter of urgency.

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

7.5.16 The business case describes the "local hospital" as "a seamless part of the landscape of care delivery...networked with local A&Es".[57]. However the implication is that a percentage of patients attending the urgent care centre of a "local hospital" in the first instance will then have to be transferred to the A&E department of a "major hospital" with the consequent increase in inconvenience and risk. In effect Urgent Care Centres will face an undifferentiated "take" (cohort of patients). Insufficient information is provided on the detailed implications of this model.[58] Other than a high level analysis it is not clear in sufficient detail which patients will require escalation to A&E from Urgent Care Centres and which current A&E patients will be treated at Urgent Care Centres.[59]. There is no current evidence that demonstrates that such "standalone" Urgent Care Centres can safely and appropriately handle the undifferentiated take that will in reality present, without co-location with a Type 1 A&E. The current A&E at Ealing Hospital serves a population with a relatively high burden of disease, exhibiting above average prevalence of tuberculosis, diabetes and cardiovascular disease. However there is only very limited evidence of how the

[54] Volume 2 p42
[55] Volume 2 p42
[56] Volume 2 p43
[57] Volume 2 p52
[58] LBE has informally received an Urgent Care Centre "exclusion list", although the status of this is unclear and it is not clear if the patient flow modelling within the business case has been based on this list.
[59] As previously noted by NCAT.

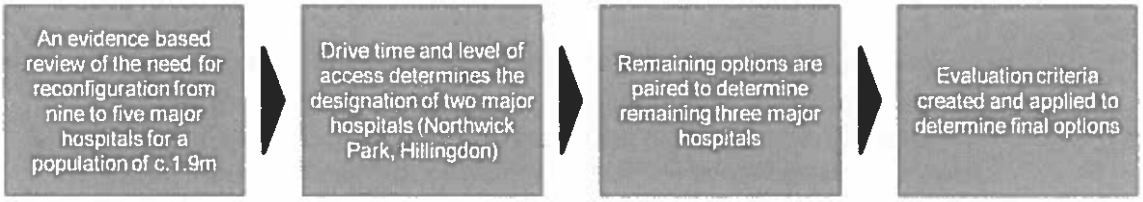
Urgent Care Centre model will be developed in such a way as to successfully meet these needs. The business case assumes that "clinicians in Urgent Care Centres will develop strong working relationships with those in acute facilities".[60]. However, the basis for this assumption is not provided.

7.5.17 The conclusion reached in the business case is that "none of the current existing nine acute hospital sites in NW London is able to deliver the desired level of service quality that will be sustainable in the future".[61]. However this is not supported by empirical evidence.

7.6 The options appraisal:

7.6.1 At the core of the business case is a sequential options appraisal model (in the business case this is described as a "funnel") that is used to identify a small number of options. The high level approach of determining the number and location of major hospitals needed in NW London is detailed in Volume 3 of the business case. The methodology is illustrated in figure 1 below.

Figure 1: Summary of options appraisal



7.6.2 Fundamentally, the sequential nature of the option identification process does not provide the opportunity for all options to be tested on a truly comparable basis, as some options will have (or may have) been discounted before a specific element of appraisal is applied, and therefore options that may well have scored well in terms of later elements of the appraisal are dismissed before an assessment can be undertaken. In particular it unnecessarily limits the extent to which options can be tested in terms of quality and access, the criteria ranked most important by patients and clinicians. The impact of this will become clearer over the course of the next section of this report.

7.6.3 The other fundamental challenge to the methodology relates to its almost exclusive focus on organisations and institutions, rather than the needs and preferences of local populations. NW London, and indeed Ealing in particular, are home to a highly diverse and complex set of communities and groups. Ultimately any proposals to substantially reshape health services in the area need to be developed,

[60] Volume 2 p54
[61] Volume 2 p57

at least in part, on a sufficiently detailed needs basis. This is a major omission in the current methodology. It is particularly important for Ealing that any proposed service change needs to take into account Ealing's relatively high burden of disease. There is no evidence that this has been done when shaping the reconfiguration proposals.

7.6.4 A number of key principles were established to inform the options development process[62], although it is not clear what alternatives were considered. The business case states that the principles were then used by clinicians to agree "that the options development process would be driven by the location of the major hospitals in NW London to ensure the appropriate delivery of urgent and complex secondary care across London"[63]. This decision to give primacy to "location" as the primary decision making driver is open to challenge. Other factors could have been used, including the current quality and performance of services, the differential needs of local people, and the current and potential interdependencies (i.e. the impact of the proposed changes to urgent and complex secondary care on other services).

7.6.5 The business case states that a number of "hurdle criteria" were used to establish the right number of major hospitals[64] (and thereby determine the proposed reduction from the current nine). The objectives of delivering acute clinical standards, deliverability and affordability are not in themselves contentious. However the criteria developed to meet the objectives are restrictive and do preclude consideration of other options for meeting the objectives.

7.6.6 Clinicians concluded that "their desired clinical standards could not be met if all nine current NW London acute sites ... were to become major hospital sites"[65]. This is attributed to manpower and skills/experience constraints, and staffing costs. The business case does not provide the evidence for this conclusion. Given its importance in underpinning the proposal to reduce services provided at four of the nine sites, this is a significant omission.

7.6.7 The clinicians did not feel that there was sufficient reason for changing the current specialist hospitals. Consequently the key focus was to determine how many major hospitals should be located in NW London.

7.6.8 Clinicians ruled out consideration of any new "brown" or "green" locations.

7.6.9 The clinicians considered evidence about factors that were judged to contribute to high quality clinical care, including links between senior staff presence and quality, patient volumes to maintain skills, technology and the interdependencies between different acute and

[62] Volume 3 p4
[63] Volume 3 p4
[64] Volume 3 p4
[65] Volume 3 p5

support services. The business case states that as a result of this consideration clinicians "identified that there should be between three to five major hospitals in NW London to support the projected population of 2 million"[66], with a view that more than five major hospitals would lead to sub-optimal care. The proposals centred on five as the proposed number, primarily in light of current capacity constraints. Although explained in summary terms, the detailed evidence base for this decision to propose five major hospitals is not provided with the business case and is therefore open to challenge.

7.6.10 The core argument rests on the number of emergency surgeons available to support the rotas at each site, and the relatively low population catchment per current rota. However this should be tested further. The extent to which this takes account of the differential needs of local people and the significant population increases anticipated over the coming years is not clear. The theory is also based on sound but general supporting evidence developed by the Royal Colleges. Again, this should have been tested further against the current reality of service need in NW London.

7.6.11 Regarding paediatrics and maternity services, the business case proposes that there be five paediatric inpatient units and five maternity units, to be part of the proposed five major hospitals. However the business case does indicate that this may need to be reviewed in the future in light of the availability of consultant staff.

7.6.12 Having concluded that there should be five major hospitals, the business case sets out the basis for determining the options for the location of those hospitals. The identification of the options for location is entirely predicated on an analysis of the impact of changes to travel times (both "blue-light" ambulance and "private" patient travel).

7.6.13 The decision to only use travel times to determine the location of the five hospitals is open to challenge. It clearly would be appropriate for other factors to be considered, including relative clinical performance, population need and the interdependencies of other services.

7.6.14 The travel analysis has been derived using Transport for London's HSTAT travel time database. HSTAT is the Health Service Travel Analysis Tool which can demonstrate changes in accessibility and journey time by public transport, car, cycling and walking resulting from proposed changes in location of health services. The analysis derives from TfL's accessibility model CAPITAL and combines these with key Socio-economic information based on the 2001 census data and health related datasets.

7.6.15 The business case concludes that because of the reported disproportionate impact on local people should Northwick Park or

[66] Volume 3 p6

Hillingdon no longer provide major hospital services, it is proposed that they should both be major hospitals in the new configuration. This is open to challenge on a number of counts.

7.6.16 However, there is insufficient robust rationale for automatically earmarking only two sites (Northwick Park and Hillingdon) as major hospital sites. The business case undertook a piece of analysis of blue light travel times analysing the impact of removing the A&E departments for all eight hospitals[67]. The removal of Northwick Park and Hillingdon showed the greatest area that would be affected if these A&E destinations were removed. Ealing appears to be the third largest (and darkest blue – indicating further drive time) area affected if Ealing's A&E is removed thus meaning that Ealing residents would have to travel further. No rationale was provided as to why *only* Northwick Park and Hillingdon were earmarked as major hospital sites, and not Ealing Hospital or West Middlesex. St. Mary's, Chelsea & Westminster and Charing Cross were discounted due to the lesser impact of removing these A&E departments which, given the greater population concentration with a smaller area, is slightly more justified.

7.6.17 Removing one hospital in a geographical pair does impact on car travel times, contrary to the statements in the business case. Once Northwick Park and Hillingdon have been earmarked as major hospital sites, the business case then couples the remaining hospitals into geographical pairs. Ealing and West Middlesex are paired together. The methodology of determining which remaining hospitals become major hospitals is based on the statement that removing services at one of each hospital in a pair has little impact on travel times[68]. Travel time analysis[69] indicated residents would see a 10-13% increase in average journey times if Ealing was not a major hospital, however, West Middlesex remained. No evidence was given on the impact of increased ambulance times on mortality ratios, and why a 10-13% increase in travel time was determined as low impact.

7.6.18 Given the proximity of Hillingdon to Wexham Park (out of area but with a Type 1 A&E, and closer to Hillingdon than Ealing is to West Middlesex), it could have made sense to designate the two major hospitals as Northwick Park and Ealing[70]. The result would have been a different series of potential options (illustrated in figure 2) going forward into the options appraisal.

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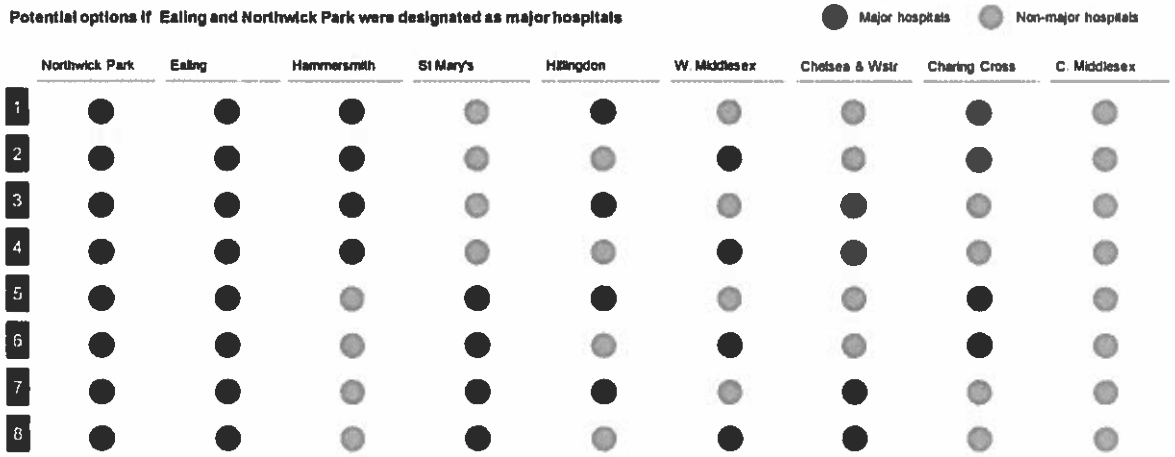
[67] Volume 3 p14
[68] Volume 3 p22
[69] Volume 3 p19
[70] This is assuming that it is necessary to have 5 major hospitals and discounting clinical standards as a differentiator (as per the methodology used in SaHF)

Figure 2:



7.6.19 Furthermore, in overall terms the travel times analysis is insufficiently detailed. Whilst the increase in public transport, blue light and private car travel time has been analysed no information has been provided regarding the increase in walking and cycling journey times. It is possible that people who live within close proximity to a current hospital may choose to walk or cycle. This is not addressed in the business case. As the predicted routes have not been included in the analysis, it is not clear whether the assumed routes have sufficient capacity for the additional patients/visitors to the major hospitals or what impact (in terms of delays) this could have on the network as whole. It is also not clear whether the delays calculated consider any future growth on the network. Also, the business case does not provide further necessary ancillary information (e.g. whether sufficient bus connections are in place and whether all the bus stops meet accessibility standards and, in the case of rail/underground, whether the stations have step-free access). In addition the analysis does not appear to consider whether there are adequate facilities at the major hospitals to accommodate the additional increase in patients/visitors i.e. parking facilities. It should be noted that a more detailed analysis of the impact on travel times is due to be completed by the NHS by the end of the consultation.

7.6.20 The travel times analysis is also insufficiently sensitive to reflect the differential needs of the different population groups in NW London. Specifically, Ealing contains areas of high social deprivation (for example in Southall). Many local people have no private transport and rely solely on public transport. However the travel times analysis has not taken sufficient account of the impact on such populations.

7.6.21 In particular, LBE's strategic transport planning team submit that there is a deficiency of direct bus links from Ealing to both West Middlesex and Hillingdon Hospitals. Additionally, access to Northwick Park Hospital will be via two to three buses depending on starting location,

and journey times are estimated to be between 50 to 80minutes. Each round trip is estimated to cost £5.40. LBE has expressed the concern that this may encourage people either to call ambulances or not seek treatment.

7.6.22 It should also be noted that the travel times analysis has not been subject to independent verification. LBE's Strategic Transport Department state that this is a usual requirement with an exercise of this nature.

7.6.23 Finally, this aspect of the business case is open to challenge as no other factors beyond an analysis of travel times have been used at this stage to determine the location of the proposed "Major Hospitals".

7.6.24 The conclusion of the analysis of travel times and consequent impact on changes to patient flows between hospitals (should patients actually behave in the way anticipated in the business case) is that in addition to Northwick Park and Hillingdon, the remaining three major hospital sites should be at:

- Either Charing Cross of Chelsea & Westminster
- Either Ealing or West Middlesex
- Either Hammersmith or St Mary's

7.6.25 This is articulated by the eight options that are subject to further evaluation in the business case.

7.6.26 In order to evaluate the options, a number of criteria were developed[71], with reported input from clinicians and patients. While the final criteria are broadly sensible, interestingly a number of criteria suggested by clinicians and patients were not accommodated, including integration of services, health equality across NW London, and support for preventative care and help for patients to manage their own conditions. Notwithstanding the reasons given for their exclusion, this is potentially contentious and open to challenge. The inclusion of such criteria would go some way to addressing the inadequate population focus of the current proposals.

7.6.27 Having determined the evaluation criteria, sub-criteria were developed for each individual criterion. Some of the assumptions made in this part of the process are open to challenge.

7.6.28 Regarding the clinical quality criterion (ranked the most important by both patients and clinicians), the position has been adopted that "current clinical quality at Trust level was not a useable proxy for future clinical quality at site level after reconfiguration was complete"[72]. This is a contentious statement and is open to challenge. It was proposed

[71] Volume 3 p28
[72] Volume 3 p28

because the assessment used current mortality rates at Trust rather than site level. Given the importance of the quality aspect of the option appraisal site level information should have been secured in order to allow for appropriate and necessary comparisons. The management teams of a number of the respective trusts have indicated that this information is available at site level. The current quality of services in considered in more detail later in this report.

7.6.29 Regarding distance and time to access the service (again a highly important criterion for patients and the public), the business case places much less emphasis on this issue at this stage of the options appraisal given that the criterion was a fundamental part of the basis for identifying the eight options. This is open to challenge. A much more detailed analysis on a more granular individual population and group basis should have been used to inform the options appraisal. This is considered later in this report.

7.6.30 In summary, the subsequent option appraisal assesses the eight options against the following evaluation criteria:

- **Quality** of care;
- **Access** to services
- **Value** for money
- **Deliverability**
- Impact on **research** and **education**

7.6.31 Key aspects of the actual application of the evaluation criteria are open to challenge.

7.6.32 Quantitative approaches to measuring **quality** of care were superseded by a qualitative approach that evaluated all eight options with an identical high scoring. The business case identified three methods of evaluating quality of care, the most highly ranked criterion according to the public and clinicians.

7.6.33 The first method used quantitative Dr. Foster clinical quality data to compare mortality rates (2010/11) by trust. Ealing performed no worse than its paired Trust (West Middlesex), where both Trusts performed better than the national average on one metric each. Ealing Hospital's Hospital Standardised Mortality rate is statistically better than expected, although the Trust does not score so well against the other mortality indicators.

7.6.34 The second approach looked at quantitative "quality dashboard" data, which only indicate with a binary Y/N whether 62 quality metrics are above national averages, rather than weighting metrics according to importance and looking at relative performance between trusts. Ealing's current performance is reported as the worst in NW London (scoring above the national average against 46 of the 62 indicators). However it would have been appropriate for the scores to have been

disaggregated and examined in more detail on a site basis to give a much clearer view of relative respective clinical quality.

7.6.35 The third approach, and the one adopted, sought qualitative agreement across clinicians that all eight options should be scored identically due to the fact that the eight options had been designed to achieve the highest levels of clinical quality. The business case states that "the reconfiguration is being pursued to achieve the clinical standards and the improved clinical quality through the reshaped clinical service models...After reviewing the data available on clinical quality, local clinicians agreed that all eight options...had been designed to achieve the highest levels of clinical quality and that the additional data reviewed at this stage of the evaluation did not provide any significant information that allowed them to differentiate between options on this basis"[73]. This is highly contentious and is open to challenge. Relative clinical quality is clearly of the utmost importance to patients, the public and clinicians. Should the current data really be inadequate for the purposes of site level comparisons, steps should have been taken to secure adequate data and for a detailed assessment to have been undertaken to inform the options appraisal. This undermines the credibility of the options appraisal.

7.6.36 A discussion on how the options appraisal would have been affected if clinical quality indicators were used to differentiate between options is detailed later in this report.

7.6.37 The patient experience element of the quality criteria includes an assessment of the quality of the respective estates across the nine sites, based on the assumption that there is a correlation between the quality of the hospital or clinic where a patient is treated and their experience. In order to use this as a comparative measure of patient experience the business case uses nationally collected site level information (from ERIC returns) in terms of the proportion of space deemed to be not functionally suitable as NHS space and the age of the estate[74]. This does not take into account in any way current patients' views of the respective sites. Therefore the information's use in this way is somewhat open to challenge. In addition Ealing's estate is assessed as "low" quality, despite the assessment indicating that all of the space is functionally suitable. The assessment appears to be based purely on the age of the estate, which in fact compares favourably with other trusts in NW London. This is considered further later in this report.

7.6.38 Much more appropriately, the patient experience criteria also incorporate recent patient experience data[75]. It should be noted that Ealing, West Middlesex, Northwick Park and Central Middlesex score statistically below the national average in respect of the rating of the

[73] Volume 3 p37
[74] Volume 3 p39
[75] Volume 3 p40

care received by patients. Ealing is the only NW London Trust that scores statistically below national average in terms of patients' assessment of the respect with which they were treated. Ealing has the third best score in relation to patients' desire level of involvement in their care. However, the business case states that "the difference between all the scores is minimal and indeed the national scores have a very small range. Local clinicians did not feel that using this data in isolation gave them sufficient basis to differentiate between the options"[76]. This is open to challenge. Given its source and focus, this is a much better indicator of respective patient experience than the "proxy" estate indicator.

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

7.6.40 In terms of distance and time to **access** services, all of the options have been rated the same despite earlier travel times analysis demonstrating clear differentiation between hospitals.

7.6.41 All eight options scored the same for "Access to Services". When evaluating "Access to Services" in the options appraisal, the business case states that all eight options have been rated the same in recognition that the time travel analysis has been used in the development of the options and that the analysis has not enabled any differentiation between the options. Access to services is differentially affected by the removal of different hospitals and this differentiation is demonstrated in the business case[77], which illustrate the varying impact on blue light and private car travel times when different hospitals are removed.

7.6.42 Consequently this aspect of the option appraisal is open to challenge. Access was rated as a highly important issue by patients and the public and it is not credible to suggest that there is no difference at all between the options.

7.6.43 It may, therefore, be argued that rather than developing options based on "Access to Services" and then subsequently discounting it from the options appraisal, it should instead be incorporated into the full options appraisal, particularly given its ranked importance from key stakeholders. On the basis of the aggregating the impacts of reconfiguration on maximum and average peak journey times, options without both Ealing and West Middlesex would have ranked lowest[78], options without two of West Middlesex, Ealing and St Mary's would

[76] Volume 3 p40
[77] Volume 3 p14 & 15
[78] On the basis of the analysis provided in figure 12.3 in volume 3, page 14

also have been ranked very low. Using the options used in the business care, the scores for the access to service criteria may have been those as illustrated in figure 3:

Figure 3:

Configuration	West Middlesex Hammersmith C&W Northwick Park Hillingdon	West Middlesex Hammersmith Charing Cross Northwick Park Hillingdon	Ealing Hammersmith C&W Northwick Park Hillingdon	Ealing Hammersmith Charing Cross Northwick Park Hillingdon	West Middlesex St Mary's C&W Northwick Park Hillingdon	West Middlesex St Mary's Charing Cross Northwick Park Hillingdon	Ealing St Mary's C&W Northwick Park Hillingdon	Ealing St Mary's Charing Cross Northwick Park Hillingdon
Evaluation score	--	--	--	--	-	-	-	-

7.6.44 'Access to Services' was the primary factor in determining the status of Northwick Park and Hillingdon as major hospitals, despite "Quality of Care" being ranked the most important criterion by stakeholders. The evaluation criterion "Access to Services" was applied before the full options appraisal and hence the primary factor in determining the location of two of the major hospitals. However, "Quality of Care" was ranked the most important criterion by both the public (24% of votes, compared with 10% for "Access to Services") and clinicians (28% of votes, compared with 6% for "Access to Services"). It may therefore be argued that either "Quality of Care" should have been the primary indicator, or better yet, "Access to Services" should have been evaluated as part of the full options appraisal, with potentially a lower weighting during the evaluation and scoring process. If the latter approach had been adopted, this would have impacted on the final options and the scoring of those options significantly.

7.6.45 In terms of patient choice (included within the access criteria), the business case gives the highest rating to the "two options [that] result in a lower reduction of sites in obstetric and elective care as well as leading to five Trusts having major hospitals".[79]. Indeed, emphasis is placed on patient choice benefitting from a greater number of Trusts (not sites) offering services. This argument is open to challenge on two counts. Firstly, no evidence is provided to support the proposition that patient choice is enhanced by the number of trusts as opposed to sites offering services to patients. Secondly, the distribution of sites between NHS organisations is not fixed and can be changed.

7.6.46 In terms of value for money, the evaluation uses a number of criteria. In terms of the estimated capital cost of the additional capacity required by the reconfiguration the only real difference highlighted is between those options that include Hammersmith Hospital as a Major Hospital (Options 1 to 4) and those that don't (Options 5 to 8).[80]

7.6.47 The capital cost estimates also incorporate an assessment of backlog maintenance costs. In light of the relative age of the respective estates, Charing Cross Hospital and Hillingdon Hospital have the

[79] Volume 3 p44
[80] Volume 3 p 47

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

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

7.6.49 Furthermore, market conditions may undermine some of the real estate assumptions outlined in the business case. Option 5 aims to be in place by 2014/15 (indeed, this fast implementation boosts the attractiveness of this option in the assessment of deliverability, considered below), however the market is unlikely to be liquid enough to allow the sale of land to be completed so quickly.

7.6.50 In addition, the following tasks would need to be undertaken in order to complete a sale and these are very unlikely to be completed by 2014/15:

- Final approval for reconfiguration (early 2013);
- Designation and valuation of land for sale by Ealing Hospital Trust (4 months);
- Application for demolition (4 to 6 months);
- Application for land use change (a more attractive strategy in order to maximise return upon sale) (9 months);
- Decanting and demolition of current buildings (6-9 months), debris removal (2 to 4 months);
- Locating a suitable buyer (variable: estimated at 6 to12 months); and
- Negotiation and contract completion (2 months minimum).

7.6.51 It is of particular concern that the business case proposes to replace the current Ealing Hospital with a local hospital which is only to be 1 hectare in total area.[81]. Not only is this a radical downsizing of the current 5.3 hectare site (with no published analysis of the size of estate needed to support the new patient flows) but it also does not appear to consider any future options for healthcare provision at this site in the future in order to sell public assets to fund service change.

7.6.52 The overall conclusion reached in the business case is that Options 1 to 4 have a much higher capital cost than Options 5 to 8 (which are ranked equally for this criteria). As demonstrated above, the capital cost element of the value for money criteria is open to challenge. It is

[81] Volume 3 p.50

based on unrealistic assumptions, very high level figures (often crude averages) and is not a properly assessed estimate of the true capital costs impact of each option.

7.6.53 The value for money criteria also include an assessment of the likely transition costs associated with each of the options. This assessment uses an average cost assumption of "12 months disruption at £250 cost per bed-day".[82]. The basis for this calculation is not provided. On this basis, there is a difference of approximately £30m (or 50%) between each of Options 1 to 4 compared with Options 5 to 8. There is no significant difference between Options 5 to 8 and they have consequently all been ranked equally. This is open to challenge, as further more detailed work should be done to secure a better estimate of likely transition costs.

7.6.54 The value for money element also looks at the financial viability of the hospital sites and NHS Trusts in NW London, and the impact on this of reconfiguration (although a number of the trust senior managers interviewed during the course of this review did not agree with this assessment of financial viability). Clearly this is a key motivation underlying the proposals. This uses the financial base case information referred to in the above, so the issues identified with the model also directly impact on this assessment. Compared with the "do nothing" assumption that forecasts an £8m deficit across the acute sector, all of the reconfiguration estimates improve the position ranging from a forecast total surplus of £12m (Option 8) to £47m (Option 5). These values equate to 0.66% and 2.58% of total revenue respectively. This is arguably a marginal difference and the actual outcome will be influenced by many other factors, most notably the effectiveness of financial management and control within the hospitals and the effectiveness of GP commissioners in managing patient demand. However this information is used to differentially rank the options. This is open to challenge.

7.6.55 Finally in terms of value for money, a Net Present Value (NPV) calculation is included, bringing "together all of the financial evaluation issues through a discounts payment profile, calculated over 20 years".[83]. The values are reported relative to the financial base case "do nothing" assessment. Whilst a valid evaluation method, it is of concern that the NPV method 'double counts' certain criteria in the options appraisal, resulting in a bias towards options involving lower capital investment or transition costs. This is evident in Options 5 and 4 where low capital requirements and transition cost inevitably score well under the NPV category (Option 5) and vice versa for those options with higher costs (Option 4).

[82] Volume 3 p52
[83] Volume 3 p 56

7.6.56 Furthermore, it is unclear whether Trust CIP targets (which would impact replacement capital expenditure and operating costs) are included in the modelling of the NPV. These cost programmes will go ahead regardless of reconfiguration and therefore should not be used to distinguish between options. The NPV will also favour those options which are expected to yield benefits sooner. This is not undesirable but it is also addressed later in the business case under "Deliverability" in the assessment of expected time to deliver. Figure 4, summarises some of the concerns with the NPV calculations.

Figure 4

Net Present Value calculation

	Component	Comments
Investment and Cost	Up front capital investment	Already addressed by Value for Money analysis under "capital cost to the system"
	Ongoing replacement capex	Impacted by CIP, e.g. varies according to capital equipment model (e.g. managed equipment services, leasing etc.)
	Operating costs for new assets	Impacted by CIP
	One off transition costs	Already addressed by Value for Money analysis under "transition costs"
Benefits	Consolidation savings	Connected to deliverability under "expected time to deliver"
	Net change in fixed costs	Partially addressed by Value for Money analysis under "surplus for acute sector"
	Capital receipts	-

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

7.6.58 The **deliverability** criteria include an assessment of the workforce using recent national work force date and staff survey results as a proxy indicator. The appropriateness of this as a proxy is open to challenge. The business case states that "Chelsea and Westminster can be seen to have scores that are statistically better than the scores achieved by other Trusts"[84]. This too is open to challenge. Ealing's scores are generally good and are all better than those of West

[84] Volume 3 p61

Middlesex with the exception of the sickness absence rate. Indeed the business case notes that West Middlesex's scores "are statistically worse"[85]. Consequently options that include West Middlesex as a "Major Hospital" are rated lower in terms of the evaluation of the workforce.

7.6.59 The deliverability criteria also include an assessment of the expected time to deliver each option. This assessment should be challenged. It includes again (double counting) information from the financial base case based on the premise that "it is very difficult for Trusts facing such financial difficulties to make the changes in services as part of the reconfiguration"[86]. No evidence is provided in support of this statement and it doesn't take account of other proposed actions, most notably including the merger between Ealing Hospital NHS Trust and North West London Hospitals NHS Trust. The assessment also uses again the assessment of new capacity required (a double count). Finally, it incorporates an assessment of the movement of adult and maternity beds. Currently, in overall terms this assessment of expected time to deliver ranks options 5 and 6 as equal highest.

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

- Changes to the designation of the Major Trauma Centre at St Mary's;
- Current location of stroke units;
- Changes to the location of the Hyper Acute Stroke Unit (HASU) at Charing Cross.

7.6.61 The whole issue of "deliverability" is also considered in more detail later in the report in the section below on "Readiness".

7.6.62 The business case's assessment gave Options 5 and 6 the highest rating. Options that contain Ealing over West Middlesex are scored slightly worse due to the Stroke Unit at West Middlesex and the fact that Ealing is the only site without a stroke unit.

7.6.63 The last element of the option appraisal was an assessment of the impact on research and education. In terms of potential disruption, no differentiation was made between the options beyond seeking to protect the position at Hammersmith and St Mary's (as they scored particularly well in the 2011 National Training Survey)[87]. The ultimate conclusion of this element is that it is critical for research to be co-located with clinical delivery and therefore Options 5 to 8 were ranked the highest.

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[85] Volume 3 p61
[86] Volume 3 p62
[87] Volume 3 p65

7.6.64 The summary evaluation ranked Options 5, 6 and 7 the highest, with Option 5 ranked the highest, stating that Option 5 "was significantly better than the other options".[88]. As stated above this is open to challenge. The options appraisal is open to challenge in terms of the sequential approach, the selective choice and method of application of indicators, the absence of an assessment of actual quality and performance (a key weakness), the lack of sufficiently detailed assessment in critical areas and the practical application of the indicators (including a high level of double counting).

7.6.65 Significantly, the only differences between the assessment of Option 5 (which has Ealing Hospital designated a "Local Hospital") and that of Option 7 (which has Ealing designated a "Major Hospital") are:

- The patient experience assessment, driven by an inappropriate use of estates indicators;
- The financial viability and surplus assessment, the accuracy and materiality of which is open to challenge;
- The Net Present Value calculation, that double counts previous measures and is open to challenge;
- The workforce assessment, that inappropriately underrates Ealing Hospital compared with West Middlesex; and
- The co-dependencies assessment, in light of the absence of a stroke unit at Ealing..[89]

7.6.66 Clearly, a central element of any response to the consultation should therefore be a fundamental challenge to the basis of the options appraisal and its conclusions.

7.6.67 For clarity at this point in the report, and in line with the business case, the highest ranking options (5, 6 and 7) are henceforth referred to as Options A, B and C. Option A is NHS North West London's preferred option.

7.7 Readiness:

7.7.1 The proposals assume that the various parts of the NHS in NW London have (or will have) the capability and capacity to implement the proposals. There are aspects of this assumption that are not supported by evidence which in turn question the extent to which this assumption is realistic.

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[88] Volume 3 p69

[89] The stroke unit was moved from Ealing Hospital in 2010, despite the local population's relatively high prevalence of strokes and contributing factors. This could be seen as evidence of a long standing plan to reduce services at Ealing Hospital. It should be noted however that stroke outcomes have improved since the centralisation of stroke services in London, although this did coincide with the introduction of the more extensive use of clot-busting drugs.

7.7.2 In terms of current adult bed capacity across NW London, assuming the full delivery of the planned hospital savings of £228m, it is estimated that 1,005 fewer adult acute beds spare will be needed. Of this total, 104 (32% of total adult beds in the hospital) relate to Ealing Hospital and 119 (37%) to West Middlesex. In percentage terms, Chelsea & Westminster and West Middlesex are estimated to have the largest number of excess beds of all nine hospitals in the analysis.[90] and it is stated that "having this number of beds without reducing the number of sites is an inefficient and expensive use of buildings".[91]

7.7.3 However, there is no evidence that alternatives have been explored that could deliver the necessary efficiencies. In particular, given that over a third of the adult bed capacity at West Middlesex is estimated to not be required in the medium term, it is notable that the business case does not explore other ways of ensuring that West Middlesex is viable, other than the transfer of activity from Ealing Hospital.

7.7.4 The readiness of other facilities to absorb excess demand should also be considered. Failure of this analysis to consider the impact of redirected patient flow from downgraded hospitals towards designated major hospitals is of great concern. As a result, activity flows under the various options have been remodelled in this review in order to provide a more detailed picture of the actual increase in volumes, rather than percentages, that receiving hospitals would be required to absorb.

7.7.5 Regarding data quality, the data on current activity levels presented in the business case conflicts with data gathered from HES. Given the opaqueness of much of the modelling in the various business cases, this could be owing to any of the following reasons:

- Use of SLAM data or Trust level data as opposed to HES data;
- Inclusion or exclusion of services that have not been stated in footnotes e.g. UCC; and
- Modifications or adjustments made in consultation with Trusts, but not detailed in the commentary.

7.7.6 For A&E data, the business case chooses to use QMAE data as opposed to HES data.[92]. The variance between the two sets is significant (see figure 5) particularly as Ealing Hospital is shown as having a negative difference, whereas the other Trusts mostly have a considerable positive difference. For inpatient data, the points of delivery (elective, non-elective, maternity) are not completely reconcilable with HES inpatient data which are not broken down any further than by 'inpatient episodes' and consequently this has not been subject to any additional analysis as part of this review. It is also

[90] Shaping a Healthier Future Pre-Consultation Business Case Volume 1 p64
[91] Volume 1 p64
[92] Whilst the level of detail that HES data provides is more granular (including time of day of admissions and age groups of patients), QMAE excludes planned follow-up attendances and includes unplanned follow-up attendances giving a better reflection of emergency cases.

unclear whether day cases are included in the activity levels in the business case. Given these uncertainties, this review's analysis of inpatient flows uses HES data and the analysis of A&E and outpatients uses data presented in the business case for consistency.

Figure 5 – Comparison of A&E attendances data sources

Point of Delivery (POD)	Data source	Chelsea and Westminster Hospital NHS Foundation Trust	Ealing Hospital NHS Trust	West Middlesex University Hospital NHS Trust	North West London Hospitals NHS Trust	The Hillingdon Hospitals NHS Foundation Trust	Imperial College Healthcare NHS Trust
A&E	HES	83,624	91,231	105,617	172,300	105,925	181,770
	QMAE	107,991	84,224	105,614	289,407	105,901	254,858
	HES vs. QMAE	24,367	-7,007	-3	117,107	-24	73,088

Source: HES

Figure 6 – Comparison of Outpatients (Attendances) data sources

Point of Delivery (POD)	Data source	Chelsea and Westminster Hospital NHS Foundation Trust	Ealing Hospital NHS Trust	West Middlesex University Hospital NHS Trust
Outpatients	HES	492,669	195,294	243,294
	Shaping a Healthier Future	485,211	178,794	202,594
	HES vs. SaHF	7,458	16,500	40,700

Source: HES, Shaping a Healthier Future

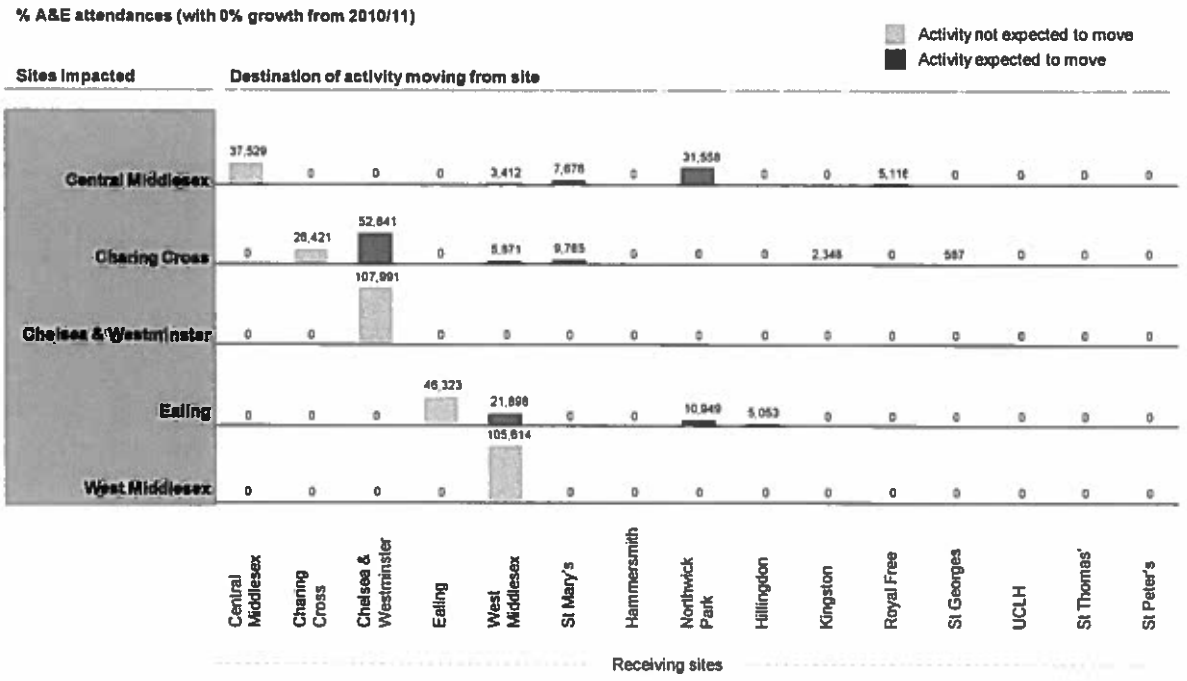
7.7.7 This section of the report provides an analysis of the increased volume of attendances at A&E.

7.7.8 The summary of A&E activity as presented in the business case.[93] details a total of 946,671 episodes in 2011/11. The modelling of patient flows however takes into consideration the projected changes in A&E volume based on the proposed plans and estimates total activity in 2014/15 to be 748,500 episodes comprising 372,000 (A&E major and standard) and 376,500 (A&E minor – presumably to be treated by UCCs and A&Es as appropriate).[94]. This represents a decrease of 21% in 4 years, or an annual reduction of 6%. This is open to challenge as it is overly optimistic given that A&E admissions in London have historically risen by about 3% per year. As assumptions around the rate of volume growth by hospital site have not been clearly detailed in the business case (i.e. how the volume of 748,000 episodes is distributed is not laid out), this report's analysis of volumes therefore uses current activity and assumes that the various initiatives to reduce admissions offset this organic long term increase. These calculations remain

[93] Volume 1 p.15
[94] See Shaping a Healthier Future, appendix L

illustrative of the impact that service reconfiguration will have on the proposed major hospitals.

Figure 7:



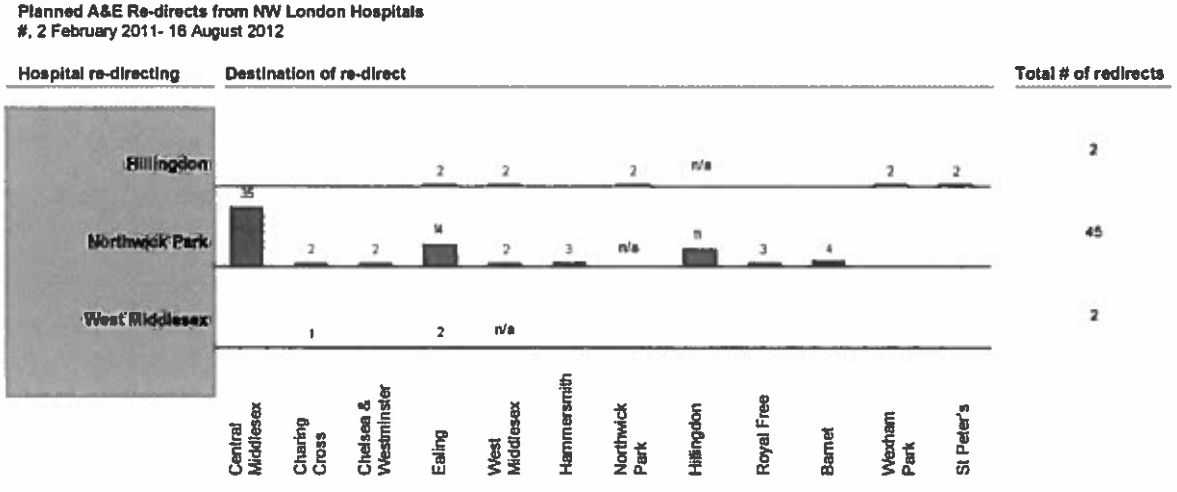
Source: Shaping a Healthier Future, remodelled

7.7.9 Under option A (the preferred option), the business case estimates that 45% of Ealing's A&E activity will move to surrounding hospitals, namely West Middlesex, Northwick Park and Hillingdon. Based on 2010/2011 data, this represents 37,901 of the current volume of 84,224 and is assumed to be the more urgent or serious cases unable to be treated by the Urgent Care Centre (UCC)[95]. Option A will also involve the downgrading of Charing Cross hospital, requiring 73% of its A&E activity to go elsewhere.

7.7.10 In addition, and of particular relevance for Ealing, there is evidence that the A&E at Northwick Park Hospital is struggling to meet current demand before any reconfiguration. For the period 2 February 2011 to 16 August 2012, for 8% of days (45 of 561 days) cases were diverted away from Northwick Park to other local hospital as a result of capacity constraints (figures 8 and 9). For 13 days cases were diverted to Ealing Hospital[96].

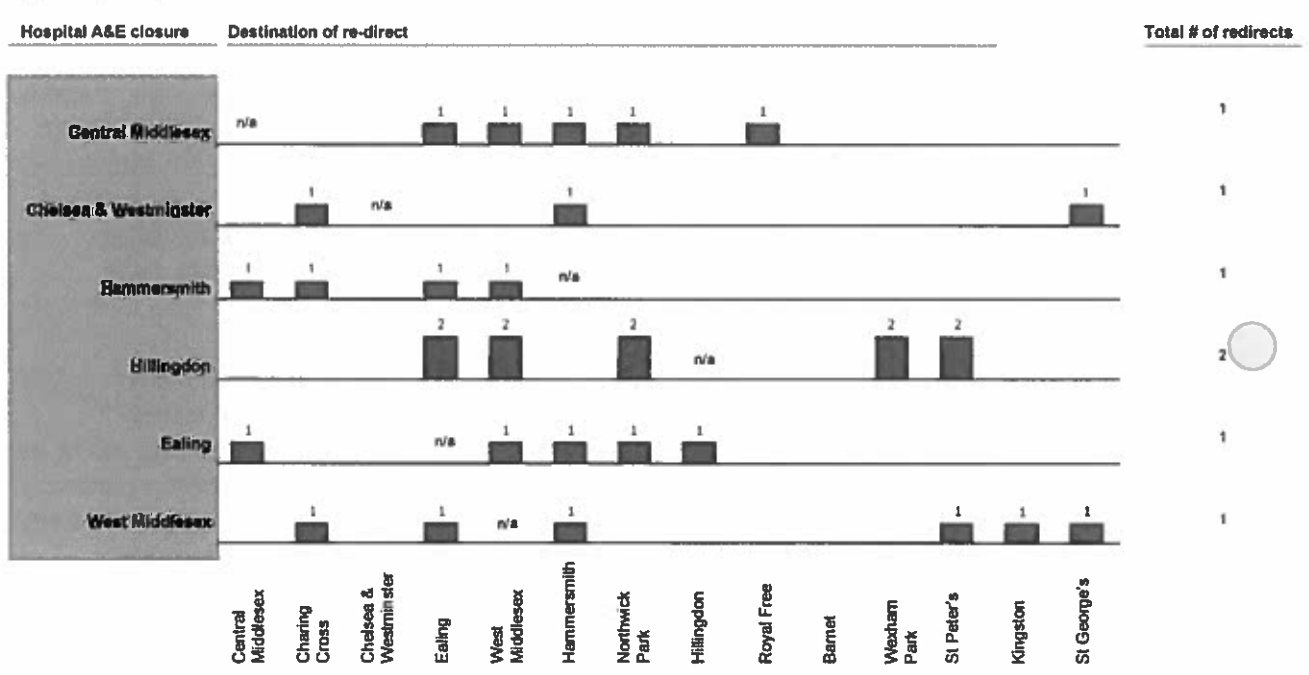
[95] It is assumed that case mix data has been used to determine which cases are best dealt with by the UCC and which requires an A&E department.
[96] Divert Freedom of Information Request (FoI)

Figure 8:



Note: (1) Total of destinations do not sum to total #of redirects as multiple sites often receive redirected flow
(2) "360 re-directs" assumed to be closest sites circling hospital

Figure 9:

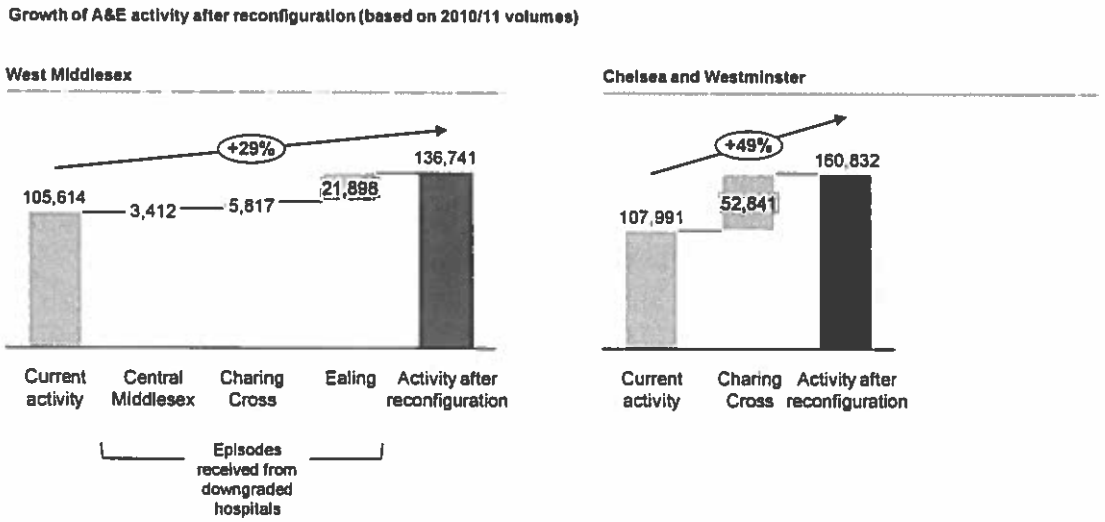


Note: (1) Total of destinations do not sum to total #of redirects as multiple sites often receive redirected flow
(2) "360 re-directs" assumed to be closest sites circling hospital

7.7.11 Furthermore, by presenting in the business case narrative volume in percentage terms and not in patient actual numbers, the impact of

increased patient flow towards designated major hospitals has been underemphasised.

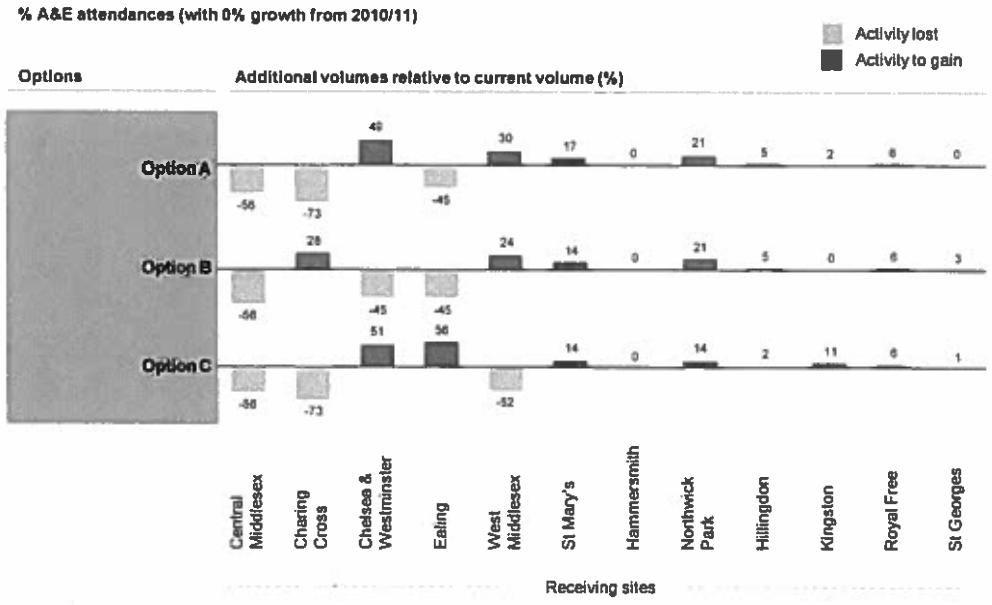
Figure 10:



Source: Shaping a Healthier Future, remodelled

7.7.12 Under option A, the A&E departments at West Middlesex and Chelsea & Westminster will be most severely impacted by the planned configuration. As demonstrated by figure 10, under current volumes, this would result in the former receiving 29% more episodes and the latter receiving 49%; a significant level of volume increase for this A&E department.

Figure 11:



Source: Shaping a Healthier Future, remodelled

7.7.13 Figure 11 shows that in each of the options A to C, there will be four hospitals that will experience an uplift of at between 49% and 10% of their current A&E volumes. There are several concerns with the implications of this analysis:

- This dramatic increase in volume is likely to comprise the more serious and resource-intensive cases which cannot be addressed by the UCCs (i.e. presumably the list of procedures and conditions listed on the UCC exclusion list);
- Additional volumes are likely to peak at busy periods, exacerbating existing stresses on the services; and
- It is not clear from the business case how the additional space and staffing requirements will be addressed within existing A&E departments.

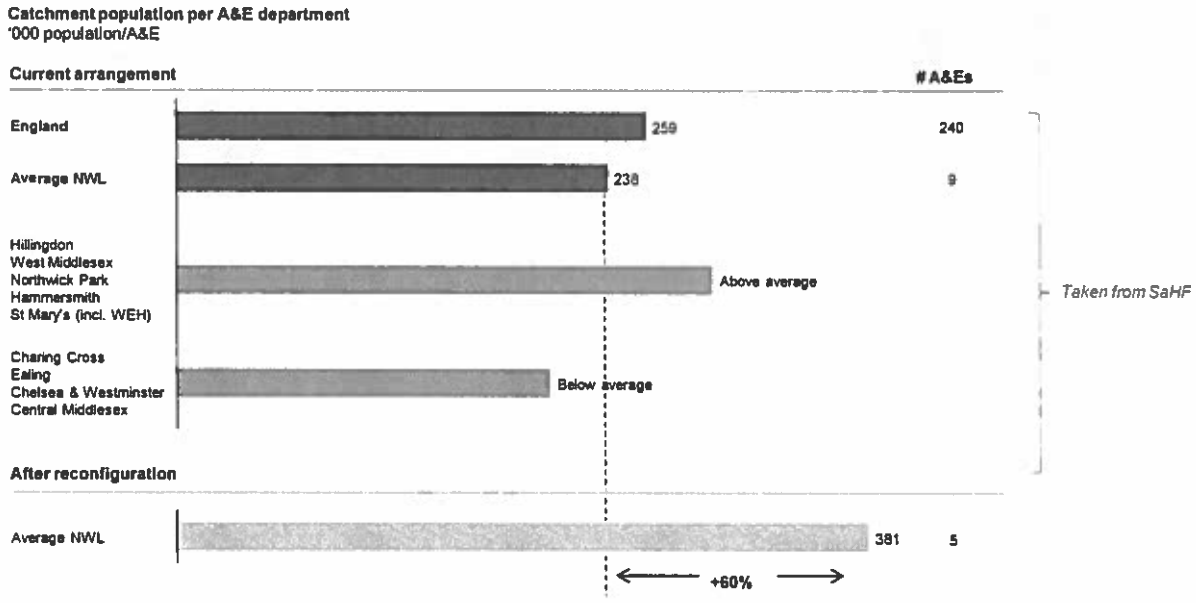
7.7.14 The ability for some A&Es to absorb extra volume is challenged by analysis presented in the report highlighting that Hillingdon, West Middlesex, Northwick Park and St Mary's (all of which will experience increased volume) have above average number of people already in their catchments. This review's assessment is that this indicates one or more of the following:

- The A&E is running at or close to capacity;
- The A&E unit experiences high volumes; and
- There is less potential for efficiency gains through scale to be achieved.

7.7.15 As stated earlier in this report, the business case asserts that there is a theoretical overprovision of A&E services in NW London. However, there is a considerable risk that the reconfiguration plans will be implemented too quickly. The reduction from 9 A&E departments, serving 2 million residents, to only 5 A&Es equates to a 60% increase in the average patient catchment population which the remaining A&E will need to quickly adapt to (see figure 12)[97].

[97] It should be noted that this analysis uses slightly different data sources than the analysis earlier in this report. However the assessments are consistent.

Figure 12:



Source: Shaping a Healthier Future

7.7.16 As stated previously, under option A, Ealing and Charing Cross hospitals are due to lose their A&E departments, and this review's analysis suggests that West Middlesex and Northwick Park will need to absorb (relative to their current volumes) the greatest volume under this configuration. From a clinical perspective, this review includes an assessment of performance criteria for A&E departments across North West London to demonstrate the current suitability of A&Es to absorb volumes from these downgraded hospitals (figure 13).

Figure 13: Summary of A&E performance indicators

Clinical quality indicator	Benchmark (YTD – May / Jun 2012).[98]	Hospitals most affected by reconfiguration A					
		Ealing	Charing Cross	West Middlesex	Northwick Park	Chelsea & Westminster	Hillingdon
4 hour wait times (QMAE)	Score (%)	97.69%	97.73%	97.76%	96.66%	98.45%	97.98%
	NWL average	⇧	⇧	⇧	⇩	⇧	⇧
	National target	⇧	⇧	⇧	⇧	⇧	⇧
Unplanned re-attendance within 7 days	Score (%)	9.30%	6.77%	9%	9.07%	5.11%	6.89%
	NWL average	⇧	⇩	⇧	⇧	⇩	⇩
	National target	⇧	⇧	⇧	⇧	⇧	⇧
Time to initial assessment (95th percentile)	Score (mins)	51	21	21	49	14	8
	NWL average	⇧	⇩	⇩	⇧	⇩	⇩
	National target	⇧	⇧	⇧	⇧	⇩	⇩
Time to treatment (median time)	Score (mins)	62	54	46	81	55	65
	NWL average	⇧	⇩	⇩	⇧	⇩	⇧
	National target	⇧	⇩	⇩	⇧	⇩	⇧
Patients that left without being seen (%)	Score (%)	3.90%	1.58%	3%	3.15%	4.50%	2.94%
	NWL average	⇧	⇩	⇩	⇧	⇧	⇧
	National target	⇧	⇩	⇩	⇧	⇩	⇧
A&E score		-	+	+	--	+	-

Source: Trust A&E performance indicator data.

Notation on reading metrics tables

- Arrows: Indicates whether score is above or below benchmark
- Colour: Green indicates positive performance, Red indicates negative performance

For example,

⇩ Indicates score is below benchmark, and that this is bad (e.g. % of patients waiting under 4 hours)

compared to:

⇩ Indicates score is also below benchmark, but this is good (e.g. % patient left without being seen)

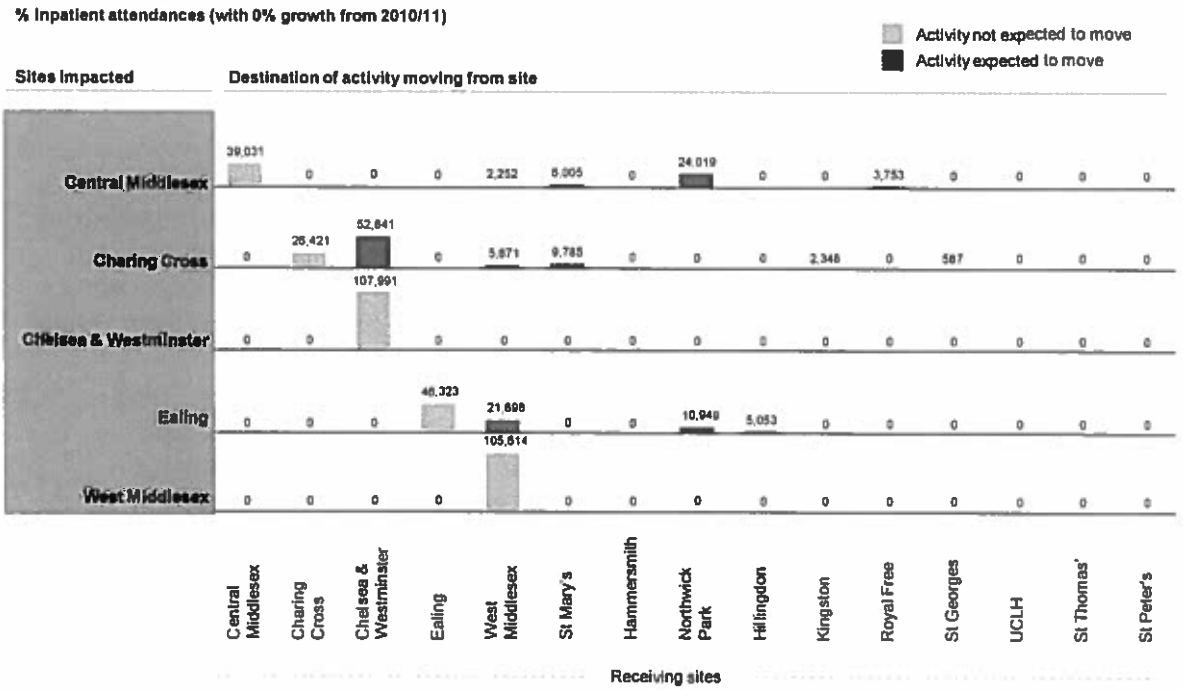
7.7.17 This analysis raises serious doubts about the current performance of Northwick Park compared to peers (although it should also be noted that Ealing Hospital's current performance is also relatively poor). This is especially the case for the time to initial assessment and time to treatment where the Trust misses the former national target by 225% (49 mins vs. 15 mins) and the latter by 35% (81 mins vs. 60 mins). This

[98] 12-month data up to either June or May 2012 (i.e. a full year cycle to allow for seasonal variation). For Ealing, the latest publicly available data set covers April 2011 to February 2012, West Middlesex uses a 10 month average weighted by patient volume.

consistently poor performance against standard metrics.[99] is of concern given Northwick Park, under reconfiguration option A, will receive 20% more A&E episodes than it currently receives. The majority of these additional cases will be Ealing residents that would have attended Ealing Hospital or Central Middlesex. The ability for Northwick Park, already with the most number of cases in North West London by a long margin, to meet performance targets and improve both clinical outcomes and patient experience whilst absorbing additional volume (particularly from Ealing Hospital) is of serious concern. This reconfiguration will lead to Ealing residents needing to travel further to receive a lower standard of care than that which they are used to receiving at their local hospital.

7.7.18 This section of the report provides an analysis of the proposed inpatient flows.

Figure 14:



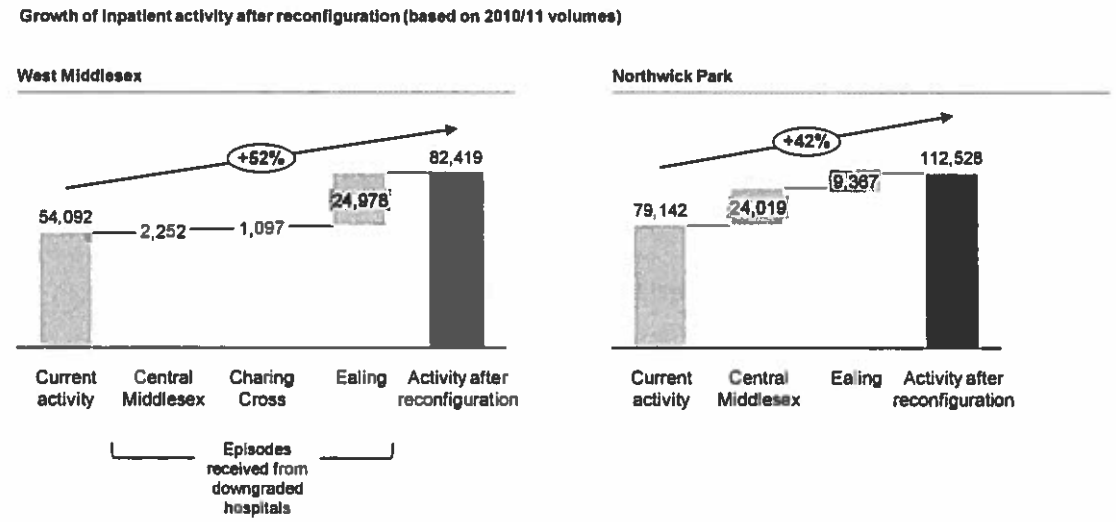
Source: Shaping a Healthier Future, remodelled

7.7.19 A similar overburdening of major hospitals will be experienced with the transfer of inpatient cases from local hospitals. Under option A the majority of the movement will be from Ealing and Charing Cross hospitals (figure 14), with West Middlesex, Northwick Park and Chelsea & Westminster Hospitals impacted by major increases in

[99] See North West London Hospitals A&E Clinical Quality Indicators scorecard, for examples see:
http://www.nwlh.nhs.uk/_assets/docs/general/AE%20Indicators_May12_with%20narrative.pdf
and
http://www.nwlh.nhs.uk/_assets/docs/general/Transparency/Copy%20of%20AE%20Indicators%20Scorecard_Sep11.pdf

patient numbers. When modelling patient flows using actual volumes of patients, this represents an incremental gain of 52% and 42% respectively (figure 15).

Figure 15:

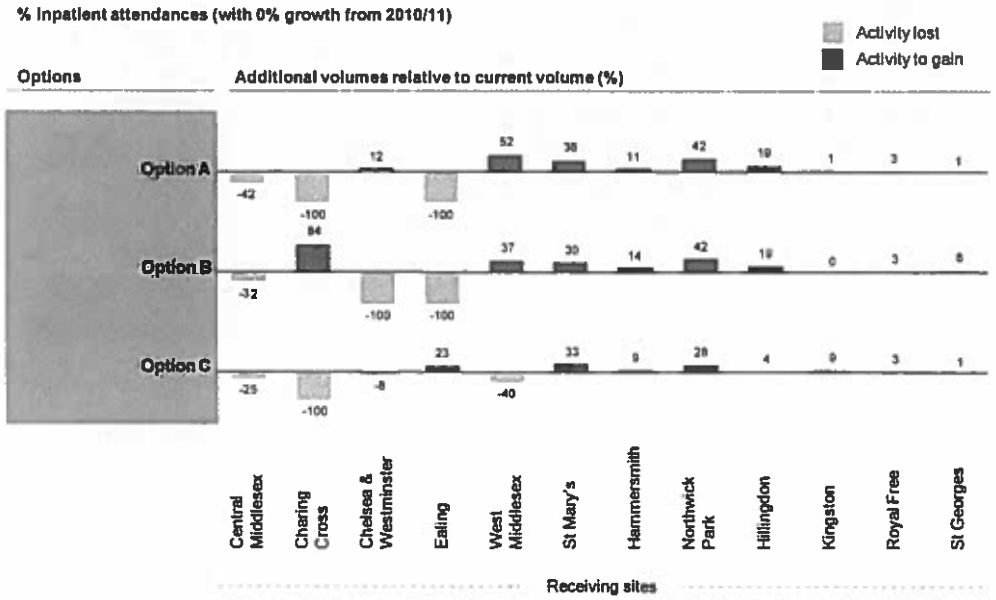


Source: Shaping a Healthier Future, remodelled

7.7.20 Whilst option A places considerable strain on West Middlesex and Northwick Park hospitals, option B will impact on a greater number of hospitals (in particular Charing Cross). Option C, on the other hand, appears to distribute the burden of additional inpatients more evenly across the sites in North West London, with the greatest burden being faced by St Mary's (an increase in volume of 33%).

7.7.21 It is not clear from the business case that West Middlesex and Northwick Park have the capacity to cope with these increased volumes. Planning to increase out of hospital care may reduce some volumes but to date the analysis has provided no reassurance that there is a clear plan in place to provide for these patients needs.

Figure 16:



Source: Shaping a Healthier Future, remodelled

7.7.22 Consequently, there are concerns in terms of the ability of secondary care to absorb increased demand. The above analysis (figure 16) demonstrates that each of the preferred options A to C, even at current volumes, will result in materially significant increases in episodes for hospitals in North West London. The business case argues that consolidation of services will drive up clinical standards, however it does not assess the readiness or ability of receiving hospitals to absorb this extra demand from downgraded hospitals from either an estates/capacity perspective or from a current clinical standards and operational efficiency perspective.

7.7.23 Additional capacity will require capital investment into new facilities or, at the very least, a reconfiguration of estate space, but this has not been taken into account in sufficient detail in the options appraisal. The business case appears to assume that these volumes can be absorbed by the new major hospitals and by additional primary care facilities. However, the business case does not include any analysis of the expected volumes and case-mix of patients requiring treatment in this new configuration and the plan for the additional primary care facilities is still under development.

7.7.24 In addition, aligned to the concerns regarding local hospitals' ability to meet the increased demand that would result from the proposed reconfiguration, it is not clear if the London Ambulance Service's capacity to absorb the increased work load resulting from the establishment of standalone UCCs has been established. This is a key issue and should be tested further.

7.7.25 Central to all of the potential options is a significant shift of care from hospital care to primary and community care. There is insufficient evidence that the primary and community care developments will deliver sufficient capacity and capability to support such change. The anecdotal evidence collected during the production of this report indicates a high level of uncertainty (from managers and clinicians) about primary care and community care's ability to deliver the shift in care from local hospitals. Specifically the proposed model of care, based on the establishment of new standalone Urgent Care Centres and GP networks, is very largely untested and unproven. In this context, this section of the report provides an analysis of the ability of primary care to absorb excess demand created by the downgrading of Ealing Hospital

7.7.26 In this context, another major concern identified in this review is the ability of primary care to absorb increased demand. As well as relocating cases from Ealing Hospital to surrounding hospitals, a major intention and consequence of SaHF will be an enhanced role for primary care providers to deliver services out of hospital, mainly through GP practices, care networks and health centres. It is understood that this currently rated as a "red" risk by NHS North West London with no mitigating action identified.

7.7.27 This review's assessment of the ability of primary care to absorb this excess demand covered three areas:

- GPs per 100,000 population;
- Age of GPs;
- Emergency admissions for acute conditions normally managed in primary care; and
- Patient satisfaction with current GP services.

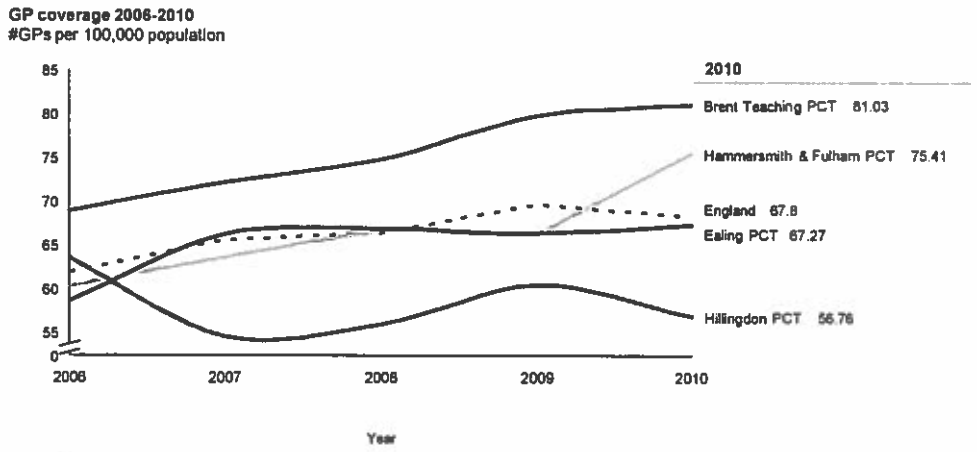
7.7.28 This review's analysis has shown that, relative to other North West London boroughs and the national rate, Ealing has an average number of GPs per 100,000 of the population (2010: 67.27) sitting mid-way between the extremes of Brent and Hillingdon. The crude number of GPs within the Borough has risen at around 1.45% year-on-year since 2004, slightly lower than the national rise of 1.72%. However, this is compared to an estimated year-on-year growth rate in GP consultations of 2.8% nationally.[100] and an increase in the average number of consultations per patient per year of 2.7% year-on-year.[101].

[100] The estimated total number of consultations in England rose from 217.3 million (95% CI 197.7to 237.0 million) in 1995 to 300.4 million (95% CI 290.9 to 309.8 million) in 2008. Trends in Consultation rates in General Practice – 1995-2008: Analysis of the QResearch database, NHS Information Centre, 2 September 2009.
http://www.ic.nhs.uk/webfiles/publications/gp/Trends_in_Consultation_rates_in_General_Practice_1995_2008.pdf

[101] Average number of consultations per patient per year have risen from 3.9 in 1995 to 4.2 in 2000 to 5.5.in 2008 reflecting that those with chronic diseases are living longer. See Deloitte (2012) Primary Care: Today and Tomorrow. And, Trends in Consultation rates in General Practice – 1995-2008: Analysis of the QResearch database, NHS Information Centre, 2

All of this indicates an increasingly challenged national primary care system with GPs and nurses required to provide an even greater range of services for a larger number of people.

Figure 17:



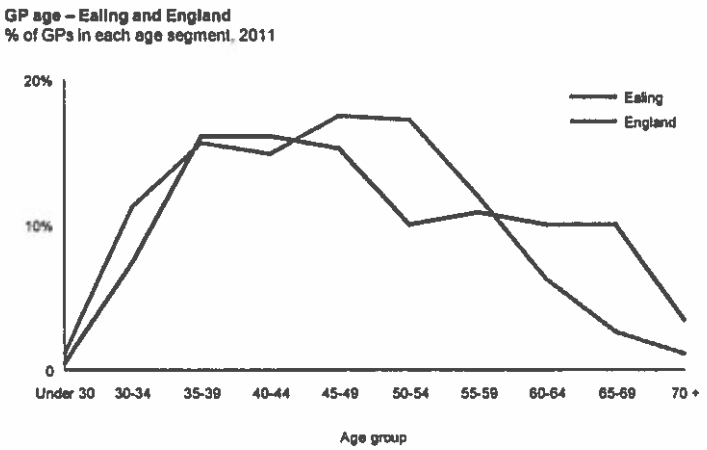
Source: NHS Information Centre

7.7.29 Locally this concern is compounded with the age profile of the GPs within Ealing. As figure 18 illustrates, compared to the rest of England, Ealing has a significantly older GP population with a far greater number in or approaching retirement age.[102]. Without reassurances of an adequate pipeline of experienced talent, the next decade will be increasingly reliant on locums (an expensive option unlikely to improve patient experience) and a need to relocate or attract GPs from elsewhere in the country. These will be critical weaknesses for both primary care to absorb excess demand from downgraded hospitals and the success of local out-of-hospital strategies.

September 2009.
http://www.ic.nhs.uk/webfiles/publications/gp/Trends_in_Consultation_rates_in_General_Practice_1995_2008.pdf

[102] According to PWC, this is a London-wide problem. See:
http://www.london.nhs.uk/webfiles/Corporate/Workforce%20Strategy/Baseline%20report%20on%20primary%20care%20workforce%20issues%20in%20London.pdf

Figure 18:

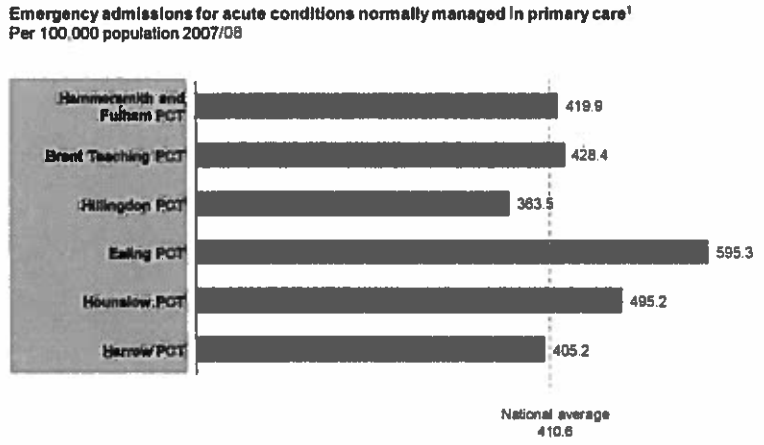


Source: NHS Information Centre

7.7.30 Data presented in the North West London Hospitals and Ealing Hospital merger business case also implies that residents in Ealing too often present at A&E for conditions that could otherwise have been dealt with in primary care (see figure 19). Whilst the data presented are used to support the need for enhanced community services, something which is to be welcomed, it also demonstrates two other likely problems:

- That residents in Ealing feel more comfortable visiting A&E as opposed to their GP or primary care provider (and consequently significant energy and time would need to spent "re-educating" the public to make different choices); and
- That the work/investment required to reduce this figure to an acceptable level (at least in line with the national average), and to consequently reduce demand for local A&E department is far more pronounced than for neighbouring boroughs.

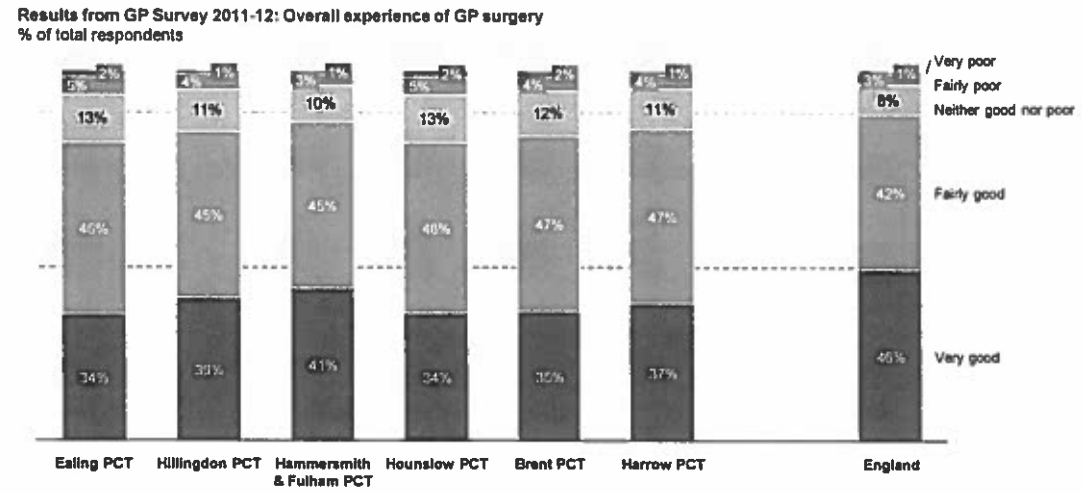
Figure 19:



Source: Stronger Together Full Business Case, reproduced

Note 1: Emergency hospital admission acute conditions usually managed in primary care (ICD-IU codes H66, O-H66.4, H66.9, I11.-, I50.0, I50.1, I50.9, J02.0, J02.8,J02.9, J03.8, J03.9, J04.0, J06.0, J06.8, J06.98, J31.0-J31.2, N15.9, N30.0, N30.0)

Figure 20:

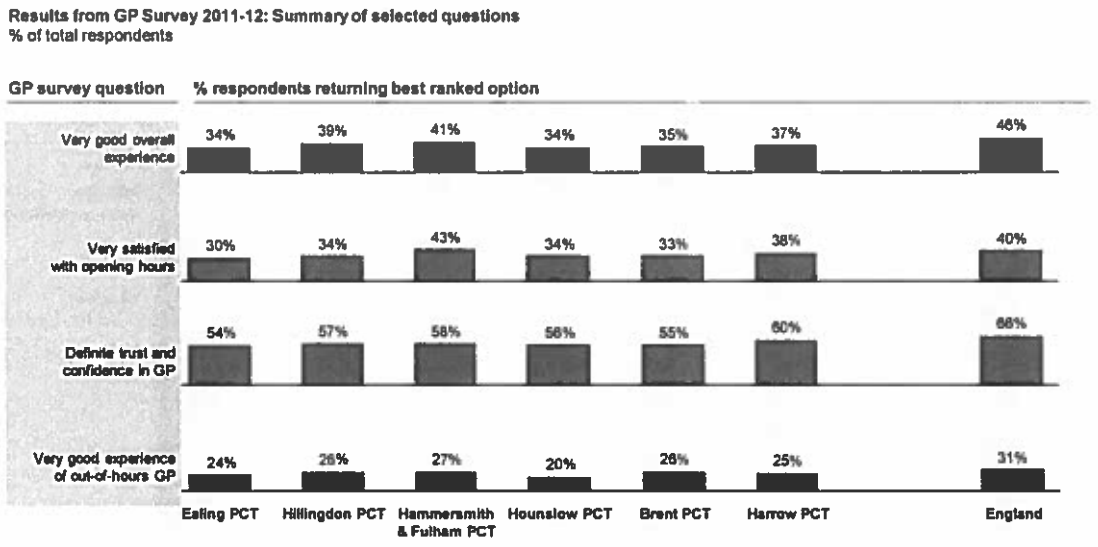


Source: GP survey 2011-12

7.7.31 The results from the 2011/12 GP survey demonstrate that residents of Ealing have a low opinion of local GP services as only 34% of respondents rated GP services as very good, compared to a national average of 46% (figure 20). Indeed, satisfaction with GP services across all neighbouring boroughs is significantly lower compared to the national average demonstrating that residents of NW London already have poor experience with their GPs.

7.7.32 The analysis also addressed other questions from the GP survey that were felt to be applicable to the reconfiguration of services across North West London. In every question, Ealing significantly underperforms against the national average and it is the bottom performer in three of four questions compared to neighbouring boroughs (see figure 21).

Figure 21:



Source: GP Survey 2011-12

7.7.33 Furthermore, there is evidence that concerns regarding the capacity and capability of primary care in Ealing have been apparent for some time. In January 2005, Ealing PCT's Board received a paper that stated "despite earlier funding via the Tomlinson Programme, Ealing continues to have a very high percentage of our 194 GPs working either alone or with one partner with registered practice populations of between under 1,000 to over 12,000 patients, in 84 practices. The profile of general practice, based mainly on small practices working out of former houses is not sustainable or desirable as a foundation for delivering the kind of primary care necessary to support the targets set out in the LDP."[103]

7.7.34 Locally, there have also been more recent concerns about performance. In terms a patient demand, Ealing PCT's performance team have previously stated[104] that:

- Attendance growth over the last two years has been 14% per year on average;
- Monthly average daily attendance is now 272[105];
- Patients attending are geographically located in close proximity to A&E;
- Two thirds of attendance are during normal GP practice opening hours;
- 26 practice codes account for 50% of volume, these practices are within Ealing PCT's control;

[103] Extract: Ealing PCT Local Delivery Plan, 2006-2008 DRAFT, dated 18 Jan 2005 p2
[104] Ealing PCT Performance Support Team and Saigei Limited – Source: Colin Standfield 11 July 2011
[105] This appears to amount to 99,280 per annum.

- 2.5% of GP codes account for 25% of attendance volume as does 2.5% of Practice Codes; and
- There is no relationship between the size of the practice and presenting volumes.

7.7.35 Collectively these sets of analysis have three major implications:

- Ealing residents are already experiencing poor levels of primary care: Major improvements in primary care are therefore needed before any reconfiguration takes place to ensure than clinical standards are improved in the light of increased demand, this will require significant investment and time;
- Ealing residents do not have the confidence in their GPs: Hospital services will continue to experience pressure because patients feel that they will be treated better at hospital than at a general surgery; and
- Ealing may face a shortage of GPs: Without replacement talent, primary care services will not be able to provide the manpower or skills required to meet local need, particularly as the range of services expected to be delivered by them expands.

7.8 Sensitivities

7.8.1 It should be noted that the business case does include a sensitivity analysis, testing the robustness of the options appraisal. It confirms the conclusions reached in the options appraisal.

7.8.2 However, the analysis is entirely predicated on the core assumptions and principles that underpin the option appraisal and consequently exhibits the same flaws.

7.8.3 In particular it is a matter of concern that the financial modelling presents no upside case or upside sensitivity analysis. Excluding an upside analysis emphasises the implicit message that reconfiguration is critical and therefore must go ahead unchallenged. Showing caution is good practice but it would be helpful to be assured that Option A is still the preferred option under scenarios with upside factors. Two potential upsides are noted in the "do nothing case" and yet the impacts of these are not modelled:

- Higher than expected demand growth; and
- Potential for Trusts to bid for investment in out of hospital services

7.8.4 Furthermore, it would have been good practice to include a number of other potential upsides to be captured by the sensitivity analysis, including but not limited to:

- Demand growth is >1% higher than expected, with Trust income allowed to grow;
- Fixed costs saving are 10% greater than expected; and
- Case mix: Demand growth is greater in higher contribution, non-elective surgery and emergency cases (equally this review would also expect the downside to be tested, i.e. that cases of lower margin/unprofitable cases grow, or remain in Trusts that are experiencing greatest financial difficulty).

7.8.5 The level of cumulative scenario analysis could also be refined. Whilst the analysis takes into consideration the event that the four sensitivities with the greatest financial impact should occur simultaneously (yielding an NPV of -£16m against the base case), this does not differentiate between which sensitivities out of the 16 are more *likely* to happen. Two options for this could have been:

- A high-level of assessment of impact vs. likelihood (e.g. by plotting options on a 2x2 grid) to highlight those options that could easily occur at the same time; and
- An assessment of inter-dependencies between options (e.g. sensitivity i [time to deliver reconfiguration] and sensitivity k [new build/refurbishment costs], would both occur at the same time in the event that new hospitals were not built on time).

7.8.6 The modelling of patient flows (as presented above) across NW London was re-run for this review to take into consideration 2 possible scenarios in 2014/15 based on current levels:

1. Growth (decline) in volumes in line with the 2008-2011 CAGR by hospital
2. Annual growth of 6% (the increase in volume at the London SHA level) across all hospitals

7.8.7 Using HES data, CAGR growth in A&E episodes over 3 years was calculated (see figure 22). Ealing's health and social care economy has had some success in reducing A&E episodes and, whilst data from the North West London Hospital Trust vary considerably, it exhibits the most marked increase in episodes between 2008 and 2011. These 3-year CAGR rates are more reflective of Trust-wide initiatives to reduce/redirect A&E flow than long-term trends in A&E episodes per se and therefore they cannot be realistically extrapolated. However, it is important to recognise the pressure that continued growth of A&E admissions puts on currently underperforming A&E departments. If A&E volumes at Northwick Park experienced 17% year-on-year growth, by 2014/15 it would need to handle 382,486 episodes, as well as redirected volumes from Ealing and other downgraded hospitals.

Figure 22: A&E volume 2008-11

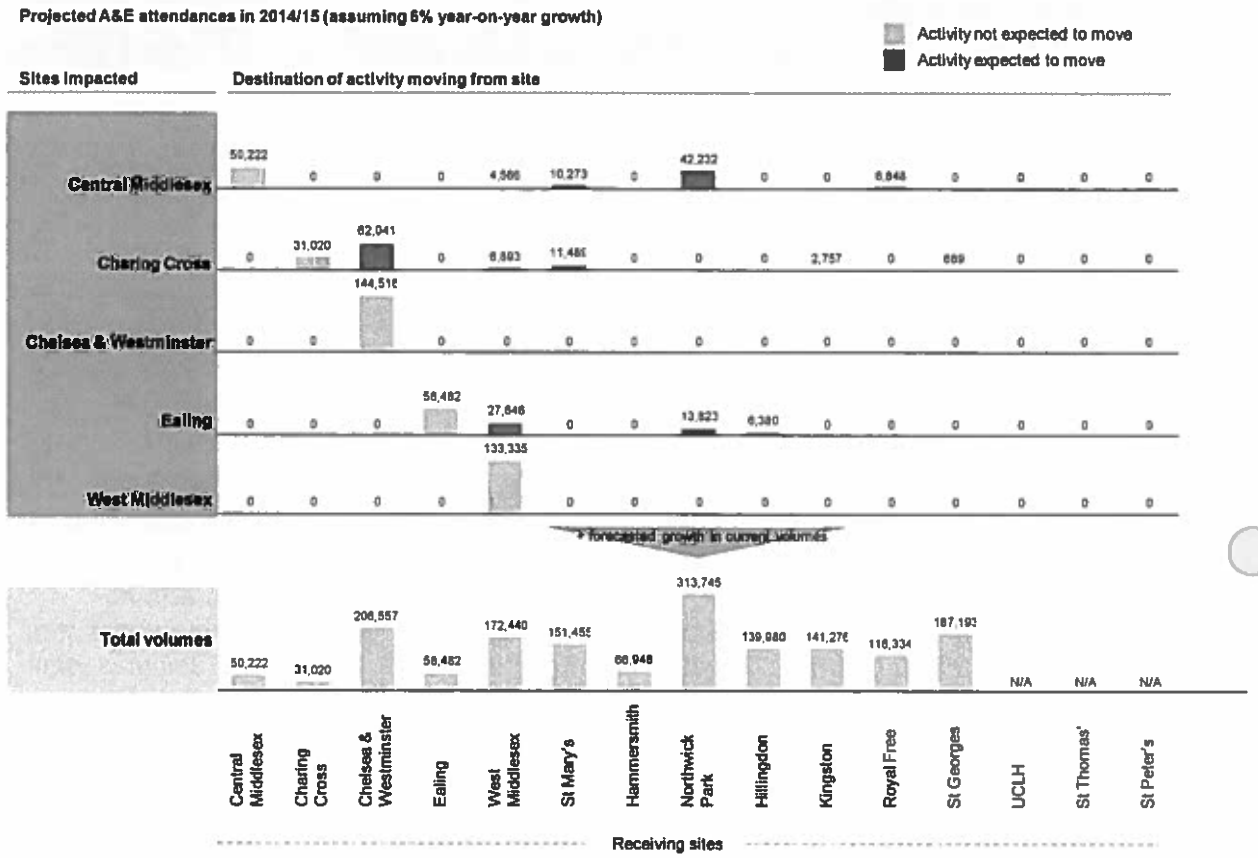
	London SHA	Chelsea and Westminster	Ealing	Imperial	North West London	Hillingdon	West Middlesex
2010-11	*4,186,825*	107,991	84,224	254,858	289,407	105,901	105,614
2009-10	4,013,356	100,746	98,812	235,341	245,779	103,980	102,725
2008-09	*3,728,326*	97,574	98,324	216,716	211,397	99,112	97,541
CAGR 2008-11	6%	5%	-7%	8%	17%	3%	4%

Source: QMAE returns from HES

7.8.8 Whilst efforts are in place in order to reduce the burden on A&E departments, and some of these are detailed in SaHF, the fact remains that A&E episodes across London have increased year-on-year since 2008. The increase is driven largely by population growth and co-morbidity amongst older people (a relatively faster growing segment of the population). The volume projections were remodelled using a year-on-year growth figure of 6% p.a. (the London SHA 3-year CAGR) to highlight the reallocated volumes in 2014/2015.

7.8.9 Under this scenario (figure 23), once again Northwick Park will experience a significant increase volume of A&E episodes (313,000+ cases) with Chelsea & Westminster being required to absorb a substantial volume from Charing Cross. This scenario highlights that not only will A&E episodes within the present day catchment of the downgraded hospitals increase year-on-year, but the those hospitals (such as Northwick Park) will also experience 'natural' volume increase. The extent that these hospitals are able to cope with this increased demand whilst maintaining high clinical standards is therefore seriously under question and it worrying that the success of this reconfiguration relies entirely on the successful implementation and expected outcomes of the out of hospital strategies in North West London. And all of this, before the out of hospital strategy for the locality has been designed, let alone implemented.

Figure 23:



Source: Shaping a Healthier Future, remodelled

7.8.10 This section addresses the potential impact of "patient irrationality" on patient volume flows:

7.8.11 As discussed above, the business case assumes that patient volumes will move to the next nearest hospital. For example, in the case of Ealing:

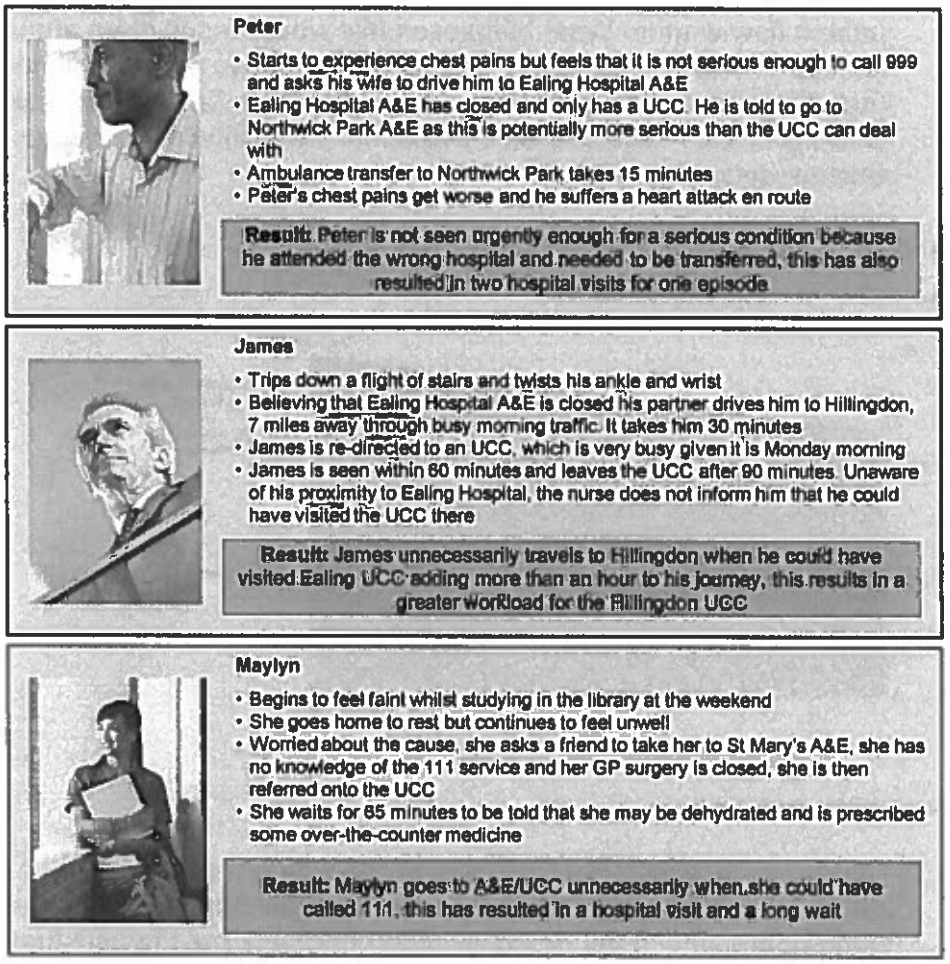
- 45% of A&E cases will move to alternative hospitals;
- This 45% will be redistributed to West Middlesex, Northwick Park and Hillingdon on the basis of proximity; and
- 55% of A&E cases will be or can be dealt with by the UCC at Ealing.

7.8.12 It is concerning that the patient flow modelling too readily assumes that patients have access to sufficient knowledge to act in the most rational way. There is also limited assessment of how A&E department would cope with additional volume due to unanticipated behaviour as the modelling has in-built assumptions about patient behaviour. For instance, it is assumed that:

- Patients with major issues will go to a hospital with an A&E (if not coming via ambulance);

- Patients with minor issues will know of, and therefore go to, an Urgent Care Centre; and
- 111 and other initiatives will reduce overall A&E admissions

Figure 24 – Examples of patients behaving differently to that assumed in the business case



7.8.13 Although figure 24 describes fictional examples, they are realistic enough to demonstrate that patients do not, and sometimes cannot, always act in the rational way in which the business case (particularly the patient flow modelling) assumes. Information about suitable locations for treatment is not always communicated evenly and habit or instinct often determines a patient's reaction, particularly for non-English speakers, the old or the vulnerable.

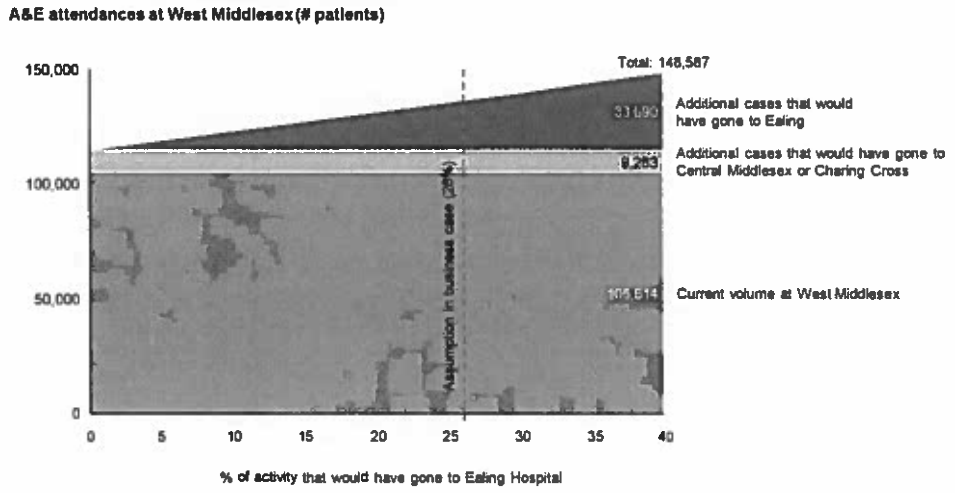
7.8.14 Furthermore, there is not sufficient understanding amongst Ealing residents of the differences between A&E and urgent care, particularly since the services at UCCs vary from borough to borough.

7.8.15 Clinically, the result of these behaviours could be worse outcomes and poor patient experience. Operationally, the result could be inefficient

use of resources, multiple hospital visits and unexpectedly high volumes (particularly at weekends).

7.8.16 To illustrate the impact of patients not attending the "correct" A&E, this review modelled the patient flow to West Middlesex in the event that patients that would ordinarily go to Ealing went to West Middlesex instead (figure 25). In the upper-most scenario that 40% of Ealing's patient flow went to West Middlesex this would result in an annual volume of 148,587 episodes, nearly a third above current volumes (including the additional volume redirected from Central Middlesex and Charing Cross – which is also subject to variability for the same reasons described above).

Figure 25: Source: HES, remodelled



Source: Shaping a Healthier Future, remodelled

7.8.17 The extent to which West Middlesex, and other hospitals in NW London, would be prepared for these changes in patient flow has not been addressed in the business case, nor have the impacts that this behaviour would have on clinical outcomes. Precisely how NHS North West London plans to ensure that all of its two million people act in this optimal way (communication plans, PR etc.) is not outlined despite the fact the modelling assumptions depend on it.

7.8.18 In conclusion, this has highlighted a number of shortcomings with the analysis of patient flows that seriously undermine the credibility of 'Shaping a Healthier Future' in delivering its goals and improving healthcare services for local Ealing residents. The most worrying observations include:

- The inadequate acknowledgement of the additional volume that major, often poorly performing, hospitals in North West London will need to absorb;

- A lack of evidence to suggest that hospitals will be able to absorb the extra volume, and the lack of analysis demonstrating how the Out-of-Hospital strategies will be able to offset some of this volume;
- The clinical implications of poorer performing A&E departments being required to absorb a large majority of this extra volume, likely to include a more serious case-mix; and
- The assumptions embedded within the modelling of patient flows that patients will act in the most rational manner; this has not been sensitivity tested and a large element of the analysis relies on these assumptions.

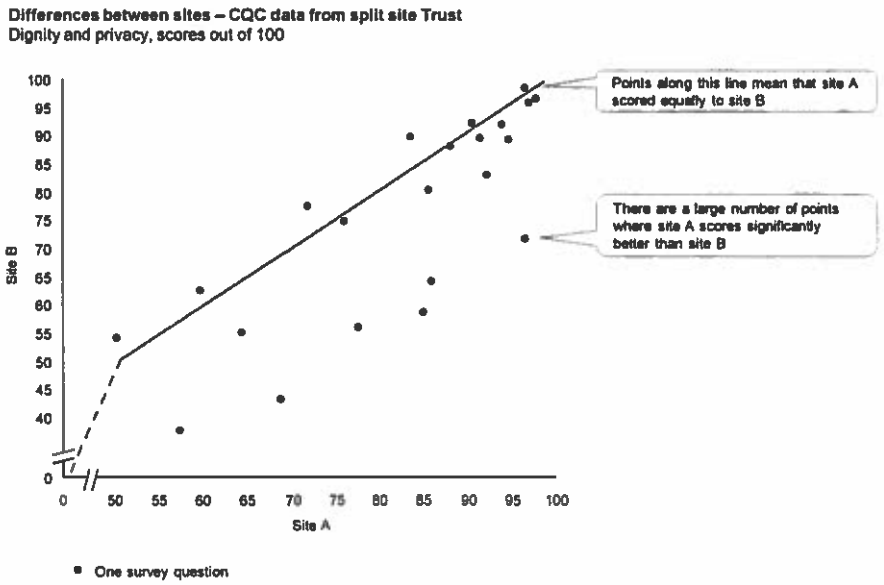
7.9 Current performance:

7.9.1 Despite stating that clinical quality is the most important driver behind the reconfiguration, the business case takes the position that the metrics used to assess current clinical quality do not "help to differentiate between pairs of options" (SaHF, 3:28). There are two primary concerns regarding this part of the business case.

7.9.2 Firstly, it is stated that local clinicians have agreed that clinical quality is to be the output of the options appraisal as opposed to an input. This assumes that the (re-)provision of services is starting from a blank page rather than adapting, adding to or removing what already exists in the present state, which is clearly not the case.

7.9.3 Secondly, data on clinical quality (and patient experience) are collected at a Trust, rather than a site, level. This could have the effect of distorting the true picture whereby higher performing hospitals within a Trust compensate for poorer performing hospitals. Given the importance of clinical quality, data should have been gathered at a site level in order to better differentiate options and to highlight those sites that are under-performance. As an illustration of this problem, figure 26 depicts CQC scores for a split site hospital, all of those data points (each data point represents one question) below the line shows that site A outperforms site B, and vice versa. It demonstrates that site A overwhelmingly performs better than site B.

Figure 26:



Source: Anonymised Trust data provided in confidence

7.9.4 As a result of the reconfiguration, Ealing residents will be most affected by the downgrading of Ealing and Central Middlesex hospitals. This downgrade will result in the local loss of the following services:

- Accident & Emergency (24 hours a day, 7 days a week);
- Emergency surgery;
- Non-elective (i.e. unplanned) medicine;
- Non-elective surgery;
- Complex elective (i.e. planned) medicine;
- Complex elective surgery;
- Intensive Care Unit (ICU) level 3;
- Inpatient paediatrics; and
  Obstetrics & maternity

7.9.5 This means that in many cases patients may have no choice but to attend a hospital which performs more poorly than current provision.

7.9.6 Rather than analysing aggregated scores of all metrics which cover all departments (as the business case has done), this review has selected data points that were most relevant to the above services in data-sets from HES, the CQC and the NHS Midlands and East Midlands Quality Observatory (providers of the Acute Trust Quality Dashboard) and applied an overall score to facilitate an appraisal based on clinical outcomes. The most reliable data sets relate to the following services (which count for half of all affected services):

- Accident and emergency
- Non-elective medicine and surgery

- Obstetrics and maternity

7.9.7 A more detailed discussion of A&E performance is included in section 7.7.[106]. A summary of A&E metrics against national targets, and an overall "performance score" based on these metrics is listed in figure 27.

Figure 27: Summary of A&E performance indicators

Metric	Benchmark (YTD – May / Jun 2012).[107]	Hospitals most affected by reconfiguration A					
		Ealing	Charing Cross	Northwick Park	West Middlesex	Chelsea & Westminster	Hillingdon
% patients waiting over 4 hours (QMAE)	National target	▲	▲	▼	▲	▲	▲
% unplanned re-attendance within 7 days	National target	▲	▲	▲	▲	▲	▲
Time to initial assessment (95th percentile)	National target	▲	▲	▲	▲	▼	▼
Time to treatment (median time)	National target	▲	▼	▲	▼	▼	▲
% patients that left without being seen	National target	▲	▼	▲	▼	▼	▲
A&E score		-	+	--	+	+	-

Source: East Midlands Quality Observatory

Note: As per the methodology in SaHF, ++refers to 'high evaluation' and - - to 'low evaluation'

Key

▼ Below benchmark ▲ Above benchmark

▒ Positive performance ■ Negative performance

7.9.8 A summary of the analysis of the clinical performance indicators for non elective medicine is shown in figure 28 below:

[106] A detailed discussion of A&E metrics is more suitable to an analysis of ability to absorb additional volumes

[107] Uses 12-month data up to either June or May 2012. For Ealing, the latest complete data set covers April 2011 to February 2012.

Figure 28: Summary of non-elective medicine performance indicators

Clinical quality indicator	Benchmark Q4 1112	Hospitals most affected by reconfiguration A[108]					
		Ealing	Imperial	North West London (incl. NP and CM)	West Middlesex	Chelsea & Westminster	Hillingdon
Emergency readmission - % within 30 days following non-elective admission	Score (%)	12.45%	13.69%	14.21%	11.40%	9.94%	12.22%
	2-year trend	Flat	Increasing	Flat	Flat	Increasing	Flat
	National mean	↓	↑	↑	↓	↓	↓
	London SHA	↓	↑	↑	↓	↓	↓
Emergency readmission - % within 2 days following non-elective admission	Score (%)	2.56%	2.45%	2.81%	2.42%	3.30%	2.91%
	2-year trend	Flat	Increasing	Declining	Flat	Increasing	Flat
	National mean	↑	↓	↑	↓	↑	↑
	London SHA	↓	↓	↑	↓	↑	↑
Non-elective average length of stay (HED)	Score (days)	3.77	4.57	4.08	3.63	3.11	3.87
	National mean	↓	↑	↓	↓	↓	↓
Non-elective evaluation		+	-	--	++	-	+

Note: Outlined arrow denotes that score is statistically significant above/below national mean; the metric "Emergency readmission - % within 2/30 days following non-elective admission (Same Specialty)" refers to small volumes and has therefore not been included
Source: HES, HED

Key

↓ Below benchmark ↑ Above benchmark

Positive performance Negative performance

7.9.9 This analysis cannot cover the entirety of "non-elective medicine" across NW London but it nonetheless illustrates that the two Trusts are performing well in these areas and thus meeting the needs of the local population in their present form. Under the proposals, Ealing residents will receive non-elective medicine/surgery at Northwick Park (North West London Hospitals) and West Middlesex instead. The former is consistently a low performer on the basis of these metrics.

7.9.10 Several data sources were used to build a picture of maternity services across North West London, with some of the key data points shown below (figure 29). The analysis has shown that no trust underperforms across these maternity services metrics thus not necessitating radical changes to maternity services across North West London.

[108] Trust level data is used as this is the only publically available data

Figure 29: Summary of maternity performance indicators

Clinical quality indicator (vs. London SHA)	Hospitals most affected by reconfiguration A					
	Ealing	Imperial	North West London	West Middlesex	Chelsea & Westminster	Hillingdon
% of deliveries via Caesarean Section – Elective	↓	↑	↑	↓	↑	↓
% of deliveries via Caesarean Section - Non Elective	↑	↓	↓	↓	↓	↑
Emergency re-admission - % babies within 30 days following delivery	↓	↓	↑	↓	↓	↑
Maternity evaluation	+	+	-	++	+	-

Source: HES, CQC

Key

↓ Below benchmark ↑ Above benchmark

Positive performance Negative performance

7.9.11 Three metrics taken from the CQC patient satisfaction are used to assess patient experience. They are chosen out of a possible 64 questions for inpatients and 39 questions for outpatients and are assumed to be most suitable for measuring patient experience on the basis of their use by the Dr Foster Trust Awards. As well as analysing the up-to-date CQC data, this review analysed the overall patient experience scores captured by the Quality Dashboards which is summarised in figure 30).

Figure 30: Summary of patient experience indicators

Patient experience indicator	Score / benchmark	Hospitals most affected by reconfiguration A						
		Ealing	Imperial	North West London	West Middlesex	Chelsea & Westminster	Hillingdon	Range
Overall inpatient experience measure (2010-11)	Score /10	6.7	7.5	6.7	7.0	7.3	7.3	0.8
	London SHA	↓	↑	↓	↓	↑	↑	
Overall inpatient experience measure (2010-11)	Score /10	7.4	7.9	7.5	7.6	7.7	7.6	0.5
	London SHA	↓	↑	↓	[illegible]	↑	[illegible]	
Overall A&E experience measure (2008-09)	Score /100	70.0	74.7	71.4	71.5	74.5	70.4	4.7
	London SHA	↓	↑	↓	↓	↑	↓	
Patient experience score		--	++	--	-	++	-	

Source: East Midlands Quality Observatory

Key

↓ Below benchmark ↑ Above benchmark

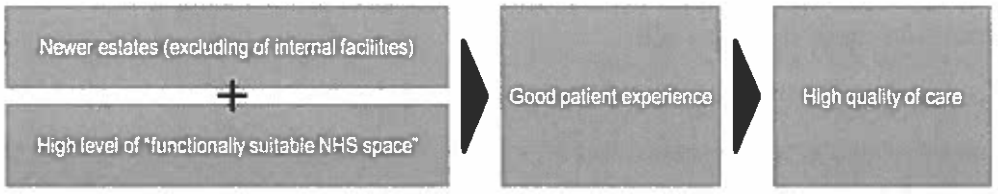
Positive performance Negative performance

7.9.12 The analysis shows that patient experience scores are quite tightly distributed, making it difficult to differentiate between Trusts on the basis of these alone. Ealing Hospital clearly has room for improvement, but the business case has not addressed how patient experience will be adversely affected by the configuration. Reconfiguration could have adverse effects for two reasons:

- Changes in workforce: Patient experience is largely a result of person-to-person contact and operational efficiencies. The reconfiguration will break up teams and redistribute them around North West London ; and
- Additional volumes: As discussed below, the additional volumes experienced by inpatients and A&E departments could result in longer waits, the need to be "efficient" (and thus reducing contact time) and a period of transition when Trusts adjust to the new configuration.

7.9.13 By arguing that clinical quality cannot be used as a differentiator, patient experience becomes the defining factor in determining 'quality of care'. As previously stated, It is concerning to see the use of estate quality as a metric for assessing patient experience. Figure 31 depicts the logic used in the business case:

Figure 31: Quality of care scoring logic

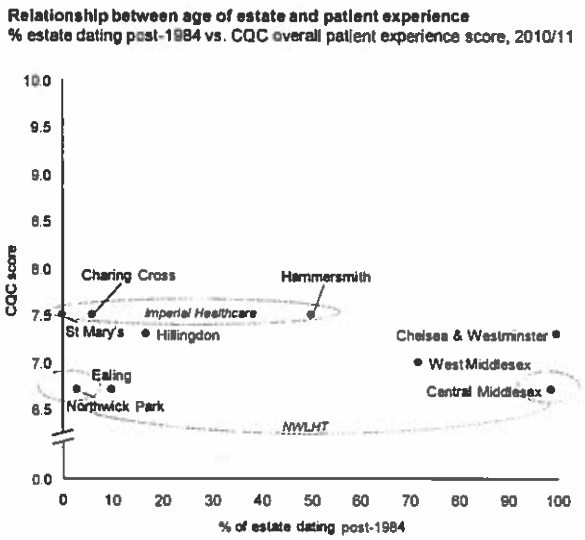


7.9.14 As a consequence, high quality of care becomes predicated on two factors:

- Level of functionally suitable NHS space: This is defined as the "Percentage of occupied floor area that is below Estatecode Condition B for functional suitability".[109] which is quite a broad and subjective metric to use
- Age of estate: This is defined as the age of the buildings as opposed to the standard/age of the internal facilities; this results in the analysis overlooking refurbishment or adaptations that may have taken place since the building was built, any aesthetic quality (e.g. Victorian architecture) heightening patient experience, or the appropriateness of the estate for patient need. Figure 32 illustrates at a high-level that the age of estates is not directly to patient experience.

[109] Estates and Facilities Information Returns (ERIC) Data Fields and Definitions. Available at: http://www.hefs.ic.nhs.uk/Downloads/DataDefinitions2010-11.PDF

Figure 32:



Source: Midlands and East Quality Observatory, ERIC data 2010/11

7.9.15 Firstly, there appears to be inconsistency in how the criteria are used. For example, whilst 90% of Ealing Hospital's estate dates from 1964 to 1984 (with 10% being newer) and 0% of its space not being functionally suitable, it receives a 'low' estate quality rating compared to Charing Cross, rated 'medium', which has proportionally older buildings and 4% of space not being functionally suitable. It is difficult to see why Ealing Hospital should be rated lower than Charing Cross, or even Hillingdon.

7.9.16 Secondly, it is not clear why post-1964 and post-1984 have been chosen as key thresholds when estate age data provided is far more granular by decade (i.e. pre-1948, 1948 to 1954, 1955 to 1964 etc.).

7.9.17 Lastly, if estates data were vital in the assessment of patient experience (after all there are many influential studies demonstrating that good quality estates can lead to better clinical outcomes.[110]), there are a range of more appropriate ERIC (Estates Return Information Collection) metrics that could be used instead, for example:

- PEAT (Patient Action Environment Team): Although a self-assessment, this provides a comprehensive overview of the suitability of an estate and provides a clearer link between quality of care and estate quality
- Patient-occupied floor area relative to total area: This would provide a measurement of how much estate was dedicated to clinical care compared to administration or non-medical purposes
- Total capital investment: This would determine the level of upgrades, refurbishment and renewal in an estate, excluding day-to-day maintenance

[110] S. Waller and H. Finn (King's Fund) 2004, "Enhancing Healing Environments: A guide for NHS Trusts" Available at: http://www.kingsfund.org.uk/publications/enhancing_the.html

- Single bedrooms for patients: This could link estate characteristics to comfort, privacy, dignity and thus patient experience

7.9.18 Whilst it is logical to want to promote the use of newer buildings and better estate utilisation, these factors do not sufficiently correspond to good patient experience, let alone high quality of care. In fact these metrics would be more suitable in a discussion on financial efficiency than on quality of care. This example demonstrates how the exclusive use of quantitative data (particularly to quantify difficult-to-quantify factors such as 'patient experience') has induced assumptions that have adversely distorted the options appraisal.

7.9.19 Particularly concerning is the impact that downgrading of Ealing Hospital will have on general staff morale and the performance of teams. This is particularly significant given that, compared to other Trusts in NW London, Ealing Hospital performs well on the annual Department of Health staff satisfaction survey. This review's analysis took the three key metrics that the DH uses to compare Trusts (KF31, 34 and 35) as well as an indicator of overall satisfaction. In overall satisfaction, KF31 and KF35, Ealing Hospital Trust actually ranks in the top 20% of all acute Trusts nationally (figure 33).

Figure 33: Staff satisfaction metrics

Indicator (vs. London SHA)	Hospitals most affected by reconfiguration A					
	Ealing	Imperial	North West London	West Middlesex	Chelsea & Westminster	Hillingdon
KF31: % staff able to contribute towards improvements at work		↑	↓	↓	↑	↓
KF34: Staff recommendation of the trust as a place to work or receive treatment	↓	↑	↓	↓	↑	↓
KF35: Staff motivation at work	↑	↑	↑	↓	↓	↑
KF32: Staff job satisfaction	↑	↓	↓	↓	↑	↓
Workforce Overall	+	++	--	--	+	--

Source: Department of Health

Key

↓ Below benchmark ↑ Above benchmark

Positive performance Negative performance

7.9.20 The assessment in this section has highlighted how alternative sets of data or a different options appraisal method can easily lead to different outcomes. To illustrate this, all of the scores from the previous section have been tallied together and has led to a different set of conclusions from those made in the business case (see figure 34).

Figure 34: Overall scoring

Score	Trusts most affected by reconfiguration A					
	Ealing	Imperial / Charing Cross	North West London	West Middlesex	Chelsea & Westminster	Hillingdon
Non-elective score	+	-	--	++	-	+
Maternity score	+	+	-	++	+	-
Patient experience score	--	++	--	-	++	-
Staff satisfaction	+	++	--	--	+	--
A&E score	-	+	--	+	+	-
Overall	+	++	--	+	+	-

7.9.21 If clinical quality was the key determinant for designating hospital status (i.e. major vs. local) then this analysis highlights that a different set of conclusions could be reached compared to the business case. Under the analysis here West Middlesex and the sites with Imperial Healthcare Trust would likely remain as major hospital whereas Hillingdon and Northwick Park would not. It further illustrates how the approach and data sets used have more significantly impacted the outcome of the options appraisal as opposed to clinical realities.

7.9.22 Furthermore, the audit work within Ealing Hospital NHS Trust does appear to indicate that the Trust has shaped its services to meet local demand (as evidenced in the Mott MacDonald equality impact review in terms of BAME populations) and that in many instances clinical outcomes are relatively good in those areas that would be downgraded under the preferred option (see Appendix 4 for illustrative examples).

7.9.23 In conclusion, this analysis of clinical outcomes and patient experience continues to support our contention that 'Shaping a Healthier Future' is methodologically flawed and arrives at a pre-determined conclusion that is not in the interests of the residents of Ealing. In particular:

- Scoring all Trusts equally on clinical performance (i.e. figure 14.4) undermines the credibility of the business case as a clinically led strategy, and not a financially-driven re-engineering;
- Arguing that all Trusts have the same clinical performance is inappropriate; there is variation, particularly in the departments that will be lost by the hospitals recommended to be downgraded;

- Patient experience is inadequately assessed given the elevated importance of this criterion in determining a score for quality of care; and
- The selected use of certain criteria and data skews the assessment against Ealing Hospital and overlooks the shortcomings of other Trusts which are set to remain as major hospitals

8. Implications & Impact

8.1 This section of the report reviews the implications and impact of the proposals for Ealing.

8.2 Scale of change:

8.2.1 Ealing Hospital is currently the 7th (out of 9) largest hospital in terms of all activity, and has the lowest amount of non-NW London activity as a proportion of all activity. Consequently Ealing is relatively the local Hospital most focussed on serving its local population. As a result reductions in service at Ealing will have a proportionately greater impact on local people. Conversely approximately one quarter of West Middlesex's activity relates to non-NW London patients.

8.2.2 The analysis supporting Option A, the preferred option, states that "the vast majority of activity [for NW London as a whole], around 91%, will be unaffected by the reconfiguration proposals. Inpatient activity will be affected the most, with 22% of activity estimated to be impacted".[111] This estimate assumes that the patient flows will change as predicted. This is of course largely dependent on patient and clinician behaviour as considered in detail earlier in this report.

8.2.3 As considered in more detail earlier in this report, under Option A "the significant impact of reconfiguration on inpatient activity will be the movement of activity from Charing Cross and Ealing... Almost half of the inpatient activity at Ealing is likely to move to West Middlesex, with the remainder going to Northwick Park and Hillingdon".[112] The analysis supporting this statement indicates that 48% of inpatient activity will move to West Middlesex, 23% to Hillingdon, 18% to Northwick Park and 9% to Central Middlesex, with none remaining at Ealing.

8.2.4 Also as considered in more detail earlier in this report, the estimated movement of out patient activity for Ealing Hospital is as follows: 9% will move to West Middlesex, 4% to Northwick Park and 2% to Hillingdon with 85% staying at Ealing. For A&E attendances the estimated movement is as follows: 26% to West Middlesex, 13% to Northwick Park and 6% to Hillingdon, with 55% staying with Ealing.

[111] Volume 4 p31
[112] Volume 4 p32

8.2.5 This represents a major change service and is open to challenge. Beyond the overall aspiration to improve quality as a result of the reconfiguration, the business case does not quantify the impact of this change on the quality of care of patients that results from these moves and there has been no attempt to test this changed pattern of care against the needs to local patients and the public. This work should be done as a matter of urgency.

8.2.6 Furthermore, this has a potential detrimental impact on the new Ealing CCG's ability to influence the care commissioned for local people. Effectively the proposals fragment Ealing's health care across a number of different providers. It is unlikely that Ealing will be a major commissioner of any of the receiving trusts.

8.2.7 Clearly as Option C (previously Option 7) designates Ealing Hospital as a Major Hospital, it results in much less change for Ealing, with a 33% movement in inpatient admissions. The impact of Option B (previously Option 6) on Ealing Hospital is similar to that of Option A.

8.2.8 Under Option A, the above estimate of 91% of activity remaining unaffected is for NW London as a whole and for all NW London providers. The specific impact on the population of Ealing is much more significant. The business case estimates that for the preferred Option the percentage of the activity impacted by the reconfiguration is as follows:

- 53.9% of inpatient admissions
- 9.6% of outpatient attendances
- 30.0% of A&E attendances.[113]

8.2.9 Ealing's residents face the most disruption and change as a result of the proposals. Indeed the impact on Ealing is significantly greater than for any of the other boroughs, with the exception of Hammersmith & Fulham.

8.2.10 For both boroughs, it is essential that before any decisions are made, the impact of these changes is tested on a needs based population basis, rather than being primarily driven by the need to ensure NHS Trust organisational sustainability. For Ealing, this should be undertaken by the new CCG in partnership with LBE (and its new public health directorate) and the new Health and Wellbeing Board. This could be a key aspect of LBE's response to the consultation.

8.3 Transition and implementation:

8.3.1 As previously discussed, the timetable going forward includes the end of the consultation period in October with subsequent decisions to be made by the JCPCT.

[113] Volume 18 p35

8.3.2 In the meantime the business case sets out a high level implementation plan to show how transition would work, with the aim of having fully implemented all changes by 2015/16.

8.3.3 Concerns regarding the timing and nature of the consultation and decision making processes are set out elsewhere in this report.

8.3.4 A key issue in terms of implementation is the relationship between the implementation of the Out of Hospital strategies and the acute hospital reconfiguration. The business case states that the "Out of Hospital transformation should begin immediately and that this critical improvement work needs to be complete by the end of March 2015. Subject to decision making and having the necessary capacity and efficiency improvements in place, implementation of changes to acute provision could then be complete in full by March 2016".[114].

8.3.5 The outline plan set out in the business case shows the out of hospital improvements being in place by the end of March 2015, but crucially it shows the hospital transition work commencing in the first half of 2013. This is open to challenge. The business case itself refers to the "challenging schedule"[115] to deliver the improvements in Out of Hospital care. These improvements should be in place demonstrably (with performance measured against robust metrics) before the hospital transition work is started.

8.3.6 Although the business case refers to a number of risks associated with delaying the hospital transition, the risks of reducing hospital capacity before the alternatives are in place are greater.

8.4 Impact on staff

8.4.1 As indicated by the stakeholder interviews conducted during the course of this review, there is a real risk that the downgrading of Ealing Hospital will directly effect the Hospital's ability to retain and recruit staff, with a loss of clinical expertise as a result. Clearly this would have a direct impact on the stability and sustainability of Ealing Hospital. Previous evidence elsewhere would indicate that this effect will be felt once the decision has been made to downgrade Ealing, even before actual reconfiguration begins.

8.5 Implications of proposed merger

8.5.1 The business case does not explicitly highlight the impact that the proposed Ealing and NWLH merger will have on the financial modelling. The key elements of the merger business case are[116]:

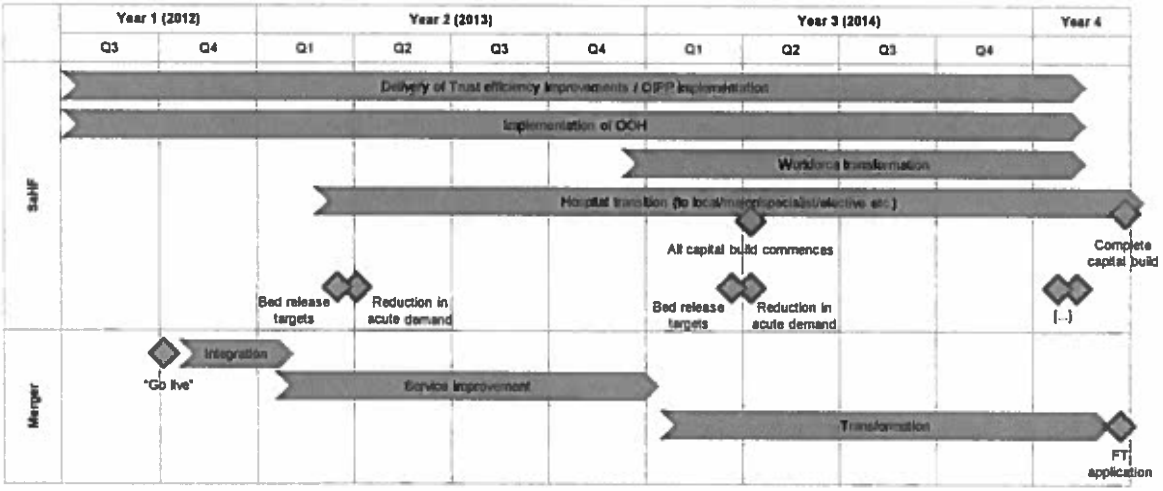
[114] Volume 5 p4
[115] Volume 5 p5
[116] See "Stronger Together: The Proposed merger of Ealing Hospital NHS Trust and The North West London Hospitals NHS Trust, Outline business case" October 2011.

- That a combined Trust (EHT and NWLHT) without service reconfiguration would exist in deficit every year (with a total deficit of £44.4m between 2012/13 and 2015/16). However, after accounting for £7m in annual savings, the annual deficit will reduce to £2.3m by 2015/16 and the total deficit between 2012/13 and 2015/16 reduces to £17.4m; and
- Despite the £2.3m deficit in 2015/16, the 1% surplus requirement for FT status is to be achieved through a "range of actions detailed in the Final Business Case [...] in response to the latest commissioning intentions"; and
- With service reconfiguration, the merged Trust could generate a net surplus between £5.2m and £24.5m.

8.5.2 The merger business case states that "The [merger and SaHF] are not actually related and in fact, either programme could take place independently of the other".[117] but it is unclear whether (a) the implementation costs and synergy savings have been taken into consideration into the SaHF modelling and (b) CIP savings in the SaHF business case are on a pre-merger basis. It is also difficult to see how the two programmes can remain unrelated when the modelling of the merger, without service configuration, still produces a deficit (and thus requires a £12-15m subsidy into order to achieve a 1% surplus in 2014/15).

Figure 35:

Timeline of implementation of SaHF and EHT - NWLHT merger



Source: SaHF, Stronger Together Full Business Case

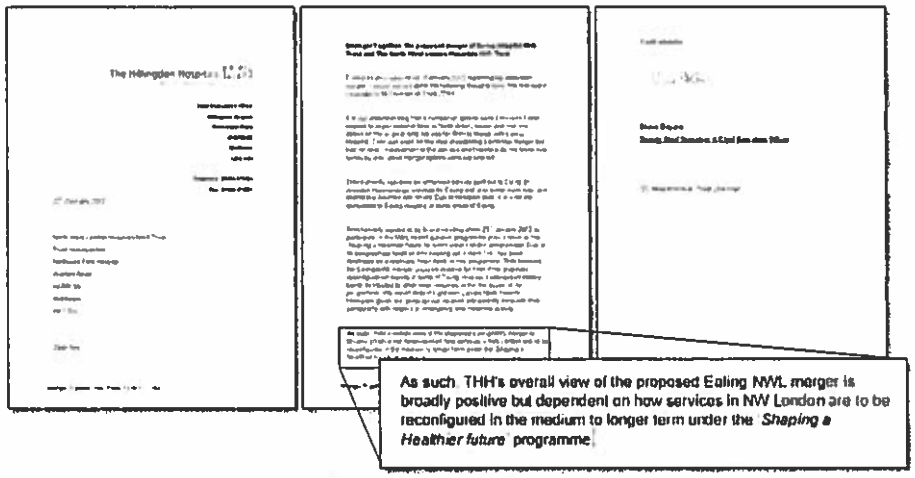
8.5.3 It appears that the proposed merger, and the clinical and financial implications, has not been fully considered as part of this review and this is a major concern. SaHF does not take into account the efficiencies and service improvement plans through the merger, and

[117] Merger Full Business Case p69

that proper consideration of the proposals would significantly impact the outcomes of SaHF. Currently the two processes are planned to occur over the same period (see figure 35): it is this review's view that the merger of EHT and NWLHT should have gone ahead before a wider, more disruptive and less locally focused NW London-wide strategy was implemented.

8.5.4 The merger adds risk to the SaHF process if the new Trust leadership reviews their service portfolio and changes the service mix to address funding shortfalls or the clinical needs of their enlarged catchment area. Even other local Trusts recognise the interdependency between the merger and SaHF, as figure 36 demonstrates. Therefore, the relationship between the proposed merger and the SaHF programme has not been sufficiently well considered nor articulated in a consistent way that is clear to all stakeholders.

Figure 36:



Source: Stronger Together, Full Business Case p.284

8.5.5 Lastly, if a merger between Ealing Hospital Trust and NWLHT is the best means of both securing the future of the two Trusts and helping them achieve FT status, then the results of the merger before any radical reconfiguration or downgrading of services through SaHF should be addressed first.

8.6 Impact on Emergency Planning and Resilience

8.6.1 The leadership of LBE have expressed serious concerns regarding the potential impact of the proposals on the ability of local NHS organisations to respond adequately to a major incident or emergency.

8.6.2 Recent history has shown that London is a priority target for terrorist activity. In addition the current local A&Es provide a core resource in responding to any major accidents involving, for example, Heathrow Airport and Paddington Station.

8.6.3 The issue of emergency planning and resilience does not appear to have been addressed at all by the SaHF team. Clearly the proposals need to be stress tested against such potential incidents. This omission to date is a cause for concern.

8.7 Impact on Social Care

8.7.1 A key omission in SaHF is the absence of any detailed modelling of the potential impact on social care services (for children, adults and older people).

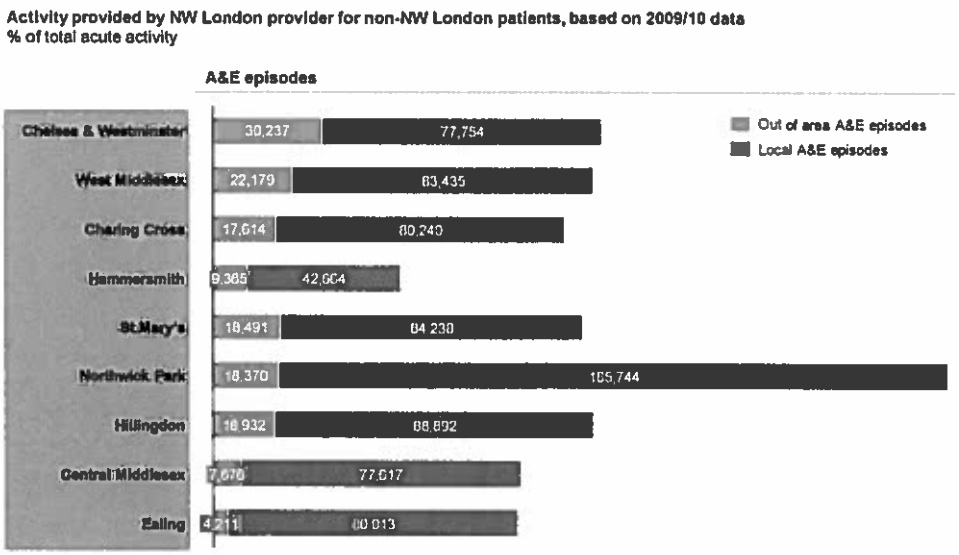
8.7.2 This is a matter for concern and a key omission given the close relationship between social care and the health services subject to the proposed reconfiguration.

8.8 Local population and implications of local needs

8.8.1 A major concern is that, despite creating a system based around 'local' and 'major' hospitals, SaHF fails to build a case for reconfiguration which is actually based on local needs. Instead the methodology is driven by the financial and practical needs of institutions whilst the local population is treated in a homogenous way with very little assessment how reconfiguration will impact them.

8.8.2 As stated earlier, Ealing Hospital is currently the 7th (out of 9) largest hospital in terms of all activity in NW London, but has the lowest amount of non-NW London activity (see figure 37). This demonstrates that Ealing is more focussed on serving its local population and consequently reductions in service at Ealing will have a proportionately greater impact on local people. In comparison, approximately one quarter of activity at West Middlesex (the hospital that Ealing is "competing" with) relates to non-NW London patients.

Figure 37:

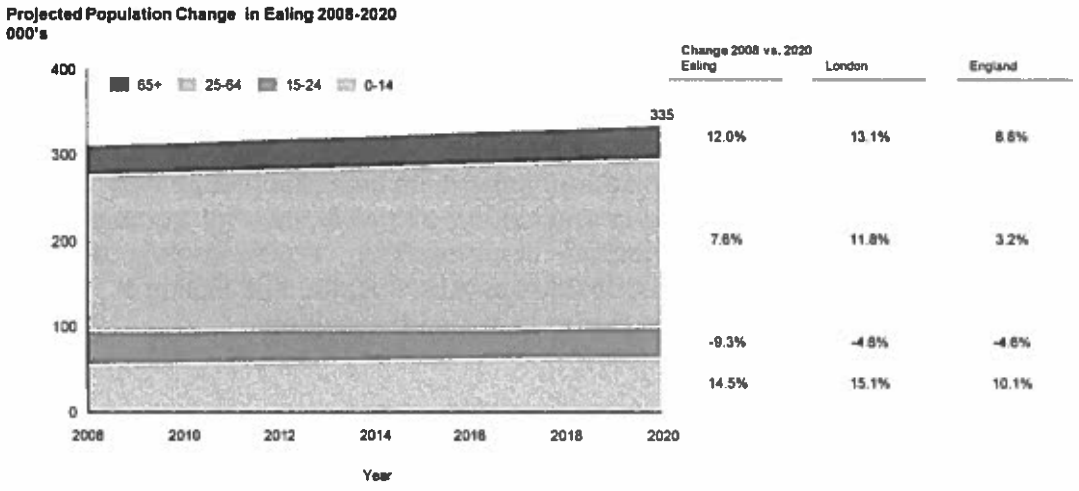


Source: Shaping a Healthier Future

8.8.3 When these proportions are translated into volumes it is evident that, by current activity.[118] the closure of A&E at Ealing Hospital would impact around 80,000 local residents (see figure 37). Therefore despite having some of the lowest A&E volumes in NW London, when non-NW London activity is stripped out Ealing has a similar level of local A&E activity to West Middlesex and Charing Cross Hospitals.

8.8.4 Up until recently analysis indicated that the London Borough of Ealing had a population of around 317,000 people which was expected to reach 334,700 by 2020, continuing to place greater demand on local health care services. The most recent ONS data however indicate that the Borough's current population is already around 339,300, suggesting a much larger population by 2020 than previously anticipated. Significantly, most of this population growth will be concentrated in the over 65 (+12%) and under 14 age segments (+14.5%) which are also more vulnerable and in need of accessible care (see figure 38). Whilst these age segments are growing in line with the rest of London, they significantly exceed national growth projections.

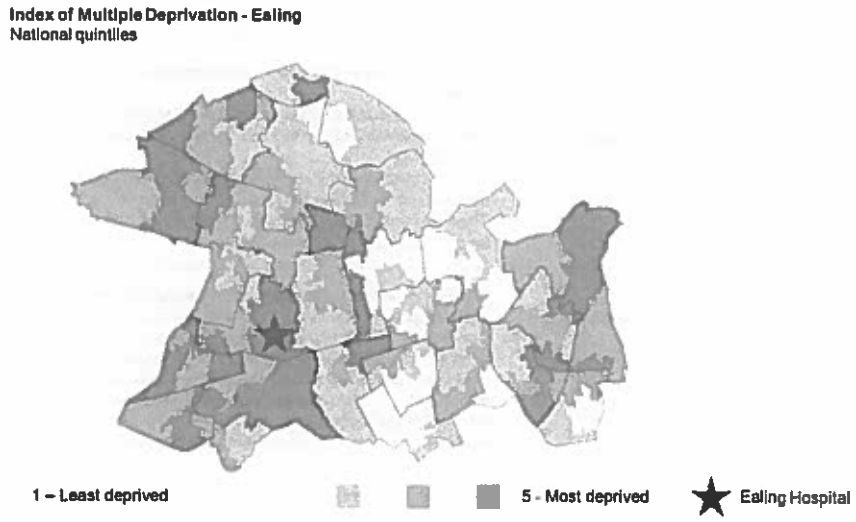
Figure 38:



Source: ONS, based on 2008 projections

[118] Using the most recent data set from 2009/10

Figure 39:



Source: Ealing JSNA

8.8.5 Evidence.119 demonstrates that there is a strong relationship between the health and life expectancy of a population and levels of deprivation or inequality. The borough of Ealing experiences significant inequalities with large areas being in the bottom two quintiles for multiple deprivations in the country (see figure 39). It is concerning that this level of deprivation will be exacerbated by the proposals in SaHF. Figure 40 summarises key inequality indicators for Ealing and analyses the impact that downgrading Ealing Hospital will have on local residents.

[119] For example, see D. J. Hunter and A. Killoran (NHS Health Development Agency) (2004), 'Tackling Health Inequalities: Turning policy into practice?' Available at: http://www.who.int/rpc/meetings/Hunter_Killoran_Report.pdf

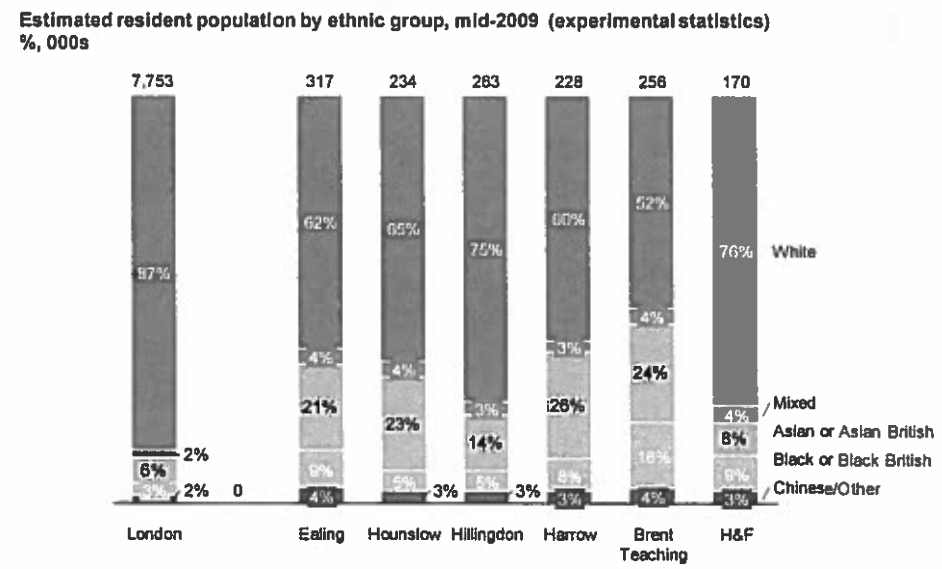
Figure 40: Summary of inequality measures and impacts

Inequality measure	Ealing performance	Implication of Ealing Hospital downgrading
High index of multiple deprivation	• Scores show significant areas of deprivation particularly in Southall and Northolt	• Both Southall and Northolt are situated within close proximity to Ealing Hospital. • Figure 39 shows the position of Ealing Hospital situated within an area that is predominantly in the two most deprived quintiles of multiple deprivation • The downgrading of Ealing Hospital is therefore likely to impact these deprived communities most • These inequalities are likely to be widened given poor health indicators and lack of access to private transport
High median income inequality	• Ealing has a median income range of £20,501 • The lowest median income is in Southall Broadway £19,150, the highest median income is in Southfield (£39,651)	• Southall Broadway, with the lowest median income, is situated within 2 miles of Ealing Hospital, and thus most impacted by the downgrading • Conversely, Southfield is situated in the most south-eastern corner of the Borough. They will be less affected by the downgrading of Ealing. However, they will also face difficulties in accessing a major hospital after reconfiguration. Charing Cross (to be downgraded to a local hospital), Hammersmith (to become a specialist hospital) or Central Middlesex (to become a local/elective hospital)
Mean income is low	• The mean income of Ealing is low compared to the London mean of £35,643	• With lower disposable income, Ealing residents are more reliant on publicly funded healthcare • Other health need indicators are likely to be lower compared to the rest of London resulting in greater level of healthcare need.[7]
Number of free school meals is high	• A quarter of secondary school students are eligible for free school meals • This rate is above the London average and nearly double the national average	• This metric illustrates that children in the borough are generally less well-off compared to other London boroughs • Social deprivation of Ealing children leads to increased health problems (indeed, obesity amongst boys in Ealing is higher than the national rate, for girls it is higher than the London rate).[120] • The closure of inpatient paediatrics(and an added risk of de-skilling of paediatrics expertise at Ealing) means that children with health difficulties must be treated elsewhere, this is more significant given that Ealing's 0-14 year old population is growing rather faster than any other segment
Life expectancy is varied	• For males, there is a range of 9 years in life expectancy between the best and worst performing wards. For females, there is a difference of 7 years	• Health outcomes vary significantly between wards in Ealing • This difference is closely related to the indices of multiple deprivation (see above)

8.8.6 Ealing also has a notably diverse community compared to the national average, with BME communities making up around 40% of the population. Asian or Asian British populations make up the majority of this (see figure 41) and Ealing Hospital has services that are able to cater towards these groups with a greater focus than surrounding hospitals in terms of translation services, the ethnic make-up of the medical and non-medical workforce and the training of staff in cultural sensitivities. Mott MacDonald's equalities review highlights the risk of this good practice and expertise being lost, with an adverse impact on patients' experience. These ethnic groups also experience a far higher rate of diseases such as diabetes, which is discussed below.

[120] S. McKay and A. Atkinson (2007) Disability and Caring Among Families with Children: Family employment and poverty characteristics. *Research Report no 460, Department of Work and Pensions*. Available at: http://www.ggy.bris.ac.uk/pfrc/completed_research/Reports/DWPDisabilityCaring_FullReport.pdf

Figure 41:



Source: ONS

8.8.7 This section assesses the prevalence of chronic disease in Ealing:

8.8.8 As assessment of the prevalence rates of major disease groups highlights the particular health issues of Ealing residences (see figure 42).[121]. For most conditions, Ealing rates either above the English rate or above the London rate. In 4 of the 7 groups, Ealing has one of the worst 3 rates within NW London. Notably high is the prevalence of cardiovascular conditions, for which prompt urgent care in emergencies is critical.

[121] Prevalence rates are comparable to mortality rates, which can be found in the Ealing JSNA

Figure 42: Prevalence of chronic conditions in Ealing

	Worst rate in NW London	Above England rate	Above London rate	Worst 3 in NW London (out of 8)
COPD	×	✓	×	×
Cardiovascular disease	✓	×	✓	✓
Coronary heart disease	×	×	✓	✓
All cancers	×	×	×	×
Chronic kidney disease	×	×	×	×
Diabetes	×	✓	✓	✓
Stroke	×	✓	✓	✓
Tuberculosis	×	✓	✓	✓

Source: NHS Information Centre Population Health Indicators 2010/11, JSNA/Eastern Region Public Health Observatory 2010, Diabetes Health Intelligence 2010, Health Protection Agency 2010/11
Note: Cardiovascular disease includes angina, stroke and coronary heart disease, as well as other circulatory diseases

8.8.9 These particular health issues are frequently attributable to the social deprivation and demographic factors discussed above. For example, tuberculosis rates are exceptionally high in Ealing (66.6 cases per 100,000 of population vs. a national rate of 15.3) and this is largely attributable to overcrowding, poor living conditions, poor access to healthcare and other indices of social deprivation[122]. Conditions such as diabetes are also especially prevalent in the South Asian population due to dietary factors, genetics and sedentary lifestyles[123], hence the high prevalence of diabetes in Ealing is unsurprising. This analysis highlights that the particular needs of Ealing's residents are closely related to demographic and socio-economic factors and are not necessarily the same as the rest of NW London. As a result Ealing Hospital, particularly working in partnership with GPs and Ealing Council, occupies a unique position in being able to meet these local needs and is effective at serving those needs. This was also evidenced during the stakeholder interviews.

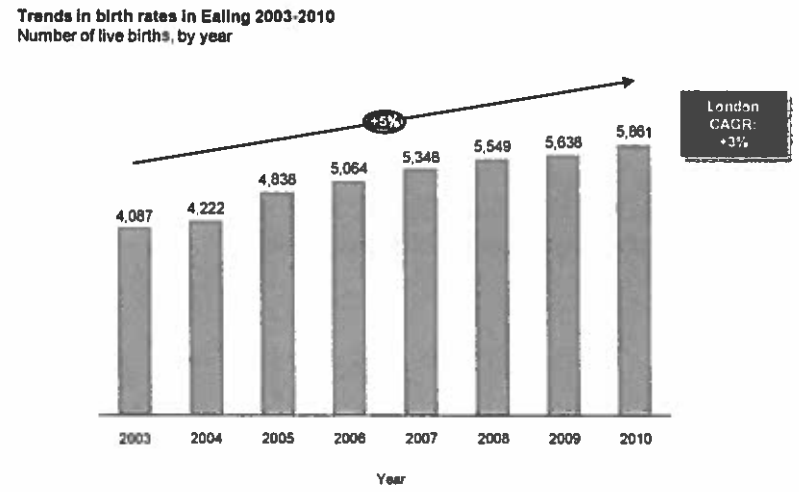
8.8.10 This section assesses the maternity needs of the local area:

8.8.11 A n analysis of birth rates shows that between 2003 and 2010 the number of births in Ealing was increasing year-on-year at a rate of 5%,

[122] Health Protection Agency (2006). Health Protection: Enhanced Tuberculosis (TB) Surveillance, NWPHO Monthly report – November 2006. Available at: http://www.cph.org.uk/showPublication.aspx?pubid=273
123 Diabetes UK and South Asian Health Foundation (2009) Recommendations on diabetes research priorities for British South Asians. Available at: http://www.diabetes.org.uk/Professionals/Publications-reports-and-resources/Reports-statistics-and-case-studies/Reports/Diabetes-UK-and-South-Asian-Health-Foundation-recommendations-on-diabetes-research-priorities-for-British-South-Asians/

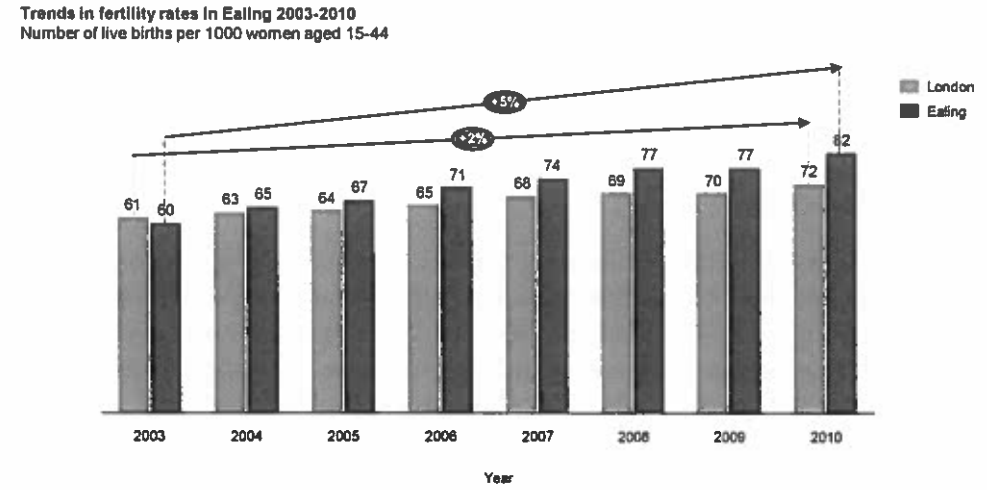
compared to a London-wide rate of only 3% (see figure 43). Furthermore, as figure 44 shows, year-on-year growth in fertility rates for Ealing is 5%, compared to a London rate of 2%. Therefore, not only are there more births occurring in Ealing compared to the remainder of London, but more women in Ealing are having children compared to their London cohort. Despite this, the reconfiguration proposals intend to remove maternity services from Ealing's local hospital where there is clearly a future need for them.

Figure 43:



Source: ONS, NHS Information Centre

Figure 44:



Source: ONS, NHS Information Centre

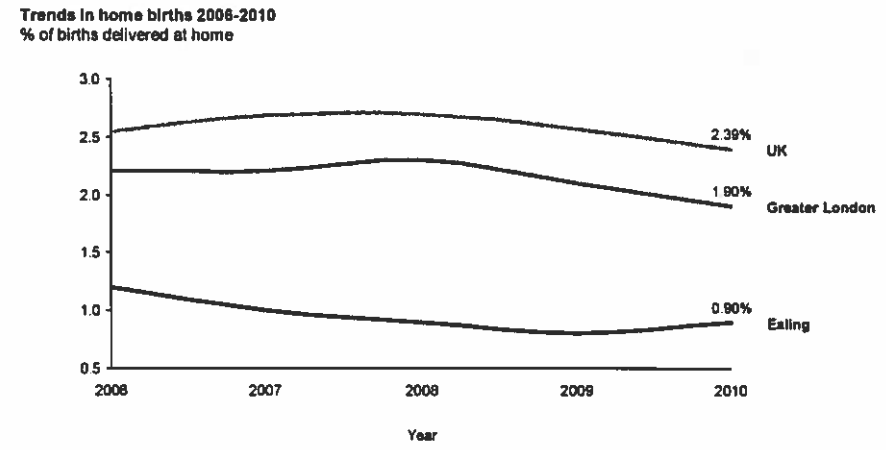
8.8.12 There is clear evidence that levels of greater deprivation are linked to increased mortality and complexity of births.[124]. The planned loss of consultant obstetric services will therefore impact the more deprived

[124] For example, see L. Smith et al., 2010. Nature of Socioeconomic inequalities in neonatal mortality: population based study, BMJ;341:c6654

with the potential for serious clinical consequences. The removal of these services also appears to contradict the vision for maternity services laid out in the Maternity Matters and the National Service Framework for Children, Young People and Maternity Services (NSF) and Healthcare for London, which all promote local choice.

8.8.13 Choice will be further restricted since the number of home births in Ealing[125] is significantly below both the national and London rates (see figure 45) and has fallen since 2006. The number of women delivering at home is dropping across both the UK and London. This means that women in Ealing, compared to the rest of London, either prefer to have their babies in hospital or that the support to enable them to choose to give birth at home is not widely offered. This is despite evidence from the BMJ[126] suggesting that home births are more cost-effective than hospital admissions (~28%). It is concerning that the absence of a maternity nearby at Ealing Hospital may result in more women being concerned about the available levels of support in the event of complications, further limiting the uptake of home births.

Figure 45:



Source: BirthChoiceUK, provided by ONS

8.8.14 The current nationwide challenges to midwifery recruitment and retention have also not been adequately addressed fully by SaHF. These challenges will not only reduce the quality of clinical care for expectant mothers in Ealing, but undermines the assurance that NHS North West London can deliver on plans to offer more maternity care in the community.

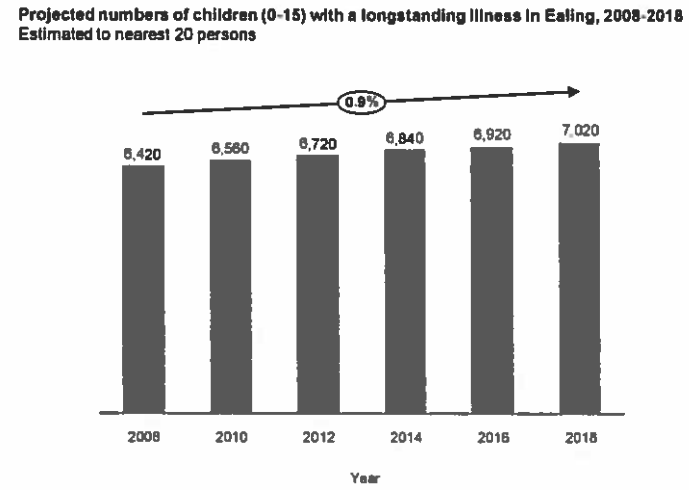
8.8.15 This section assesses the need for acute childrens' services in the local area:

[125] This is representative of the whole of NW London – only Hillingdon comes close to the 1.9% rate of London at 1.6%

[126] Schroeder et al., (2012) Cost effectiveness of alternative planned places of birth in woman at low risk of complications: evidence from the Birthplace in England national prospective cohort study, *BMJ 2012;344:e2292*

8.8.16 The transferral of inpatient paediatric services from Ealing Hospital will have a great impact on younger residents of Ealing which, as noted above, is an especially fast growing segment of the local population. The number of children living with a long standing illness in Ealing is projected to grow to over 7,000 by 2018.[127] (figure 46) There is also an established link between levels of deprivation and the numbers of children living with long term illness.[128] These young people will depend on local services able to cater to their needs with minimal disruption to their lives.

Figure 46:



Source: Ealing Council

8.8.17 The loss of inpatient and specialist paediatric services will increase the financial and emotional burden on families having to visit one of the major hospitals.[129], this will be particularly difficult for families in Ealing with low incomes. It is also important that inpatients are closer to friends and family so they can visit regularly and make a positive impact on a child's well-being.

8.8.18 There is local concern that the level of paediatric expertise at the Urgent Care Centre will be reduced as inpatient paediatric services are moved from Ealing Hospital. As a result there are no reassurances that children attending the UCC will receive adequate and appropriate

[127] As acknowledged in the Hillingdon JSNA there is a lack of data at a national and local level on the numbers and characteristics of disability or limiting illnesses amongst children in order to make meaningful comparisons

[128] S. McKay and A. Atkinson (2007) Disability and Caring Among Families with Children: Family employment and poverty characteristics. *Research Report no 460, Department of Work and Pensions*. Available at: http://www.ggy.bris.ac.uk/pfrc/completed_research/Reports/DWPDisabilityCaring_FullReport.pdf

[129] Department of Health (2003) Getting the Right Start: Standard for Hospital Services. Available at: http://www.nhs.uk/NHSEngland/AboutNHSservices/Documents/NSF%20children%20in%20hospitalDH_4067251[1].pdf

expertise at the time that it is needed. If parents cannot receive this assurance then in emergencies they are more likely to attend A&E instead.

8.8.19 In response to some of the concerns expressed above SaHF's programme lead, Dr Mark Spencer, stated that the impact on Ealing residents is not as large as implied. Of the total population of approximately 340,000 people, Ealing Hospital looks after about 180,000 with the rest being currently treated at other trusts. As outpatient and urgent care is largely unaffected, the impact is principally on:

a) Slightly further to travel in an emergency to A&E (Dr Spencer has stated that he couldn't find any evidence that the small increase in time has a clinical impact);
b) On relatives visiting Ealing residents admitted to Major sites out of the borough if Ealing is chosen after consultation as a local hospital; and
c) A deprived population having a local hospital designed to improve care of Long Term Conditions, rather than patch up flares caused by poor chronic care.

8.8.20 Dr Spencer has also said that he could find no evidence that a deprived population disproportionately needs an extremely local acute service (given that there would be a major hospital only 3.5 miles from Ealing Hospital, or Hillingdon Hospital only 4 miles from Southall Broadway).

8.8.21 However Dr Spencer's comments appear to be at odds with published evidence. A 2007 study concluded that "decisions regarding reconfiguration of acute services are complex, and require consideration of many conflicting factors. Our data suggest that any changes that increase journey distances to hospital for all emergency patients may lead to an increase in mortality for a small number of patients with life threatening medical emergencies, unless care is improved as a result of the reorganisation. However, even then it is not certain that it would be acceptable to trade an increased risk for some groups of patients, such as those with severe respiratory compromise, for a reduced risk in other groups such as those with myocardial infarction".[130]

8.8.22 Therefore, notwithstanding Dr Spencer's comments, it is the contention of this independent review that SaHF fails to consider in sufficient detail the particular health needs of the local population of Ealing. The downgrading of Ealing Hospital will also result in the widening of inequality within a borough that already experiences high levels of

[130] The relationship between distance to hospital and patient mortality in emergencies: an observational study Jon Nicholl, James West, Steve Goodacre, Janette Turner emj.bmj.com 10th September 2007

health and socio-economic inequality. In particular our areas of greatest concern are:

- Locally focused services: Removal of a local hospital with services tailored to the specific medical needs of its deprived population will reduce choice and is likely to worsen outcomes for this population;
- Maternity services: Longer journeys to the nearest maternity unit for women in labour means greater inconvenience, a poorer patient experience and, in times of complicated births, greater clinical risk; and
- Inpatient paediatric services: Greater distance away from home means inconvenience for worried families and significant disruption to sick children's lives.

8.9 Benefits.

8.9.1 Clearly the business case is proposed on the basis that implementation of the changes will result in benefits for local people, patient, staff and the NHS organisations themselves.

8.9.2 The benefits (improved outcomes, patient experience etc) would clearly be welcomed, and most are largely the result of meeting the proposed clinical standards. However the business case does not consider alternative options for delivering the clinical standards other than reconfiguration.

8.9.3 However, the benefits would only be realised with careful management and close measurement. The business case recognises that "there can sometimes be a 'dip' in performance during implementation"[131]. The business case does not explain what this would mean in practice. This again highlights the need to decouple the improvement in services from the proposed, and the inevitably disruptive, reconfiguration of hospitals.

8.9.4 The business case itself does not set out the potential dis-benefits of the proposals. This should clearly be tested further to establish from the perspective of NHS North West London, what the potential dis-benefits are. In particular analysis should be done to determine how these differentially fall, particularly by borough and by people in disadvantaged groups.

8.10 Dis-Benefits

8.10.1 As stated above, the business case doesn't provide an assessment of the likely dis-benefits that could result from the proposals, beyond the risks associated with the transition period.

[131] Volume 2 p76

8.10.2 This issue should be stress tested further via an assessment of the impact on Ealing's population. In particular the following issues should be explicitly tested.

- Clinical outcomes: the potential for these to be adversely effected by increased travel time and delayed access to emergency services, and the impact on the population of the other proposed changes (e.g. to maternity services, the reliance upon the untested urgent care centre model);
- Primary care development: the impact of services not being improved as proposed, whilst hospitals proceed to reduce their capacity;
- Equality and human rights: the impact on the most vulnerable groups of people (particularly children and older people) in Ealing's diverse population;
- Increased complexity: the establishment of a new "tiered" system of local healthcare (including "local" and "major" hospitals) has the potential to significantly confuse patients and the public; and
- Loss of expertise: the potential significant loss of clinical and culturally competent expertise at Ealing.

9. Motivation

9.1 The business case sets out a number of clear reasons for the proposals, including a "case for change".

9.2 The case for change is predicated on the need to improve the quality and sustainability of local health services. Objectively, these arguments are sound in terms of justifying the need for some form of change. The status quo is not viable, in either service or financial terms. However, there are arguably other drivers influencing NHS North West London that have not been fully articulated in the business case.

9.3 Such a key driver will be the national imperative to ensure that all NHS provider trusts become Foundation Trusts in the next few years. It should be noted that of the thirteen NHS organisations in NW London, five (38.5%) are Foundation Trusts and eight (61.5%) are NHS Trusts. There are relatively fewer Foundation Trusts in NW London than on average nationally. It is Government policy to eventually move all NHS trusts to Foundation Trust status once they have been confirmed as viable in service and financial terms. Ealing Hospital NHS Trust and West Middlesex University Hospital NHS Trust are not yet Foundation Trusts. A significant motive underlying the business case will be the desire to ensure that all local organisations are "fit" to become Foundation Trusts. However, this is not explicitly stated in the business case. This motivation, and its implications, should be clearly articulated. In addition, the need to ensure the viability of current NHS organisations and structures should be balanced against the need to meet the needs of local people. The latter should be given primacy, and the organisational arrangements should be tested and shaped to meet those needs.

9.4 In particular, one unstated motive appears to be the need to support the financing of West Middlesex Hospital's PFI debt, by transferring activity from Ealing to West Middlesex.

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

10. Conclusions

10.1 This report provides LBE with a thorough review of the "Shaping a healthier future" pre-consultation business case from an Ealing perspective. This section provides a summary of key issues and concerns.

10.2 The independent review has identified a number of fundamental flaws in the approach taken by NHS North West London to determine the changes that should be made to local health services. Broadly the key flaws can be categorised as:

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

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

10.3 Methodology

10.3.1 There are fundamental problems with the methodology used by NHS North West London.

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

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

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

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

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

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

10.3.5 In light of the cumulative impact of the above, the methodology is fundamentally flawed and the conclusions reached are consequently open to challenge.

10.3.6 Specifically this brings into question NHS North West London's preferred option, which includes downgrading Ealing Hospital, and transferring key services, including A&E, to West Middlesex Hospital. The differences between the hospitals reached using the methodology are confined to:

- The patient experience assessment, driven by an inappropriate use of certain indicators;
- The financial viability and surplus assessment, the accuracy and materiality of which is subject to challenge;
- The Net Present Value calculation, that double counts previous measures and is subject to challenge;
- The workforce assessment, that inappropriately underrates Ealing Hospital compared with West Middlesex; and
- The co-dependencies assessment, in light of the absence of a stroke unit at Ealing.

10.4 Clinical outcomes

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

- Current clinical quality is insufficiently analysed and reflected within NHS North West London's proposals; and
- Although there are clearly areas where Ealing Hospital and other NHS organisations serving Ealing need to significantly improve the care provided, there is considerable evidence of high quality care under the current configuration that has not been taken into account when identifying or differentiating between the options.

10.4.2 In light of the above, it is highly inappropriate to seek to transfer services away from Ealing Hospital. This would put at risk that current quality and potentially expose local people to:

- The adverse effects of increased travel time and delayed access to emergency services, and the impact on the population of the other proposed changes (e.g. to maternity services);
- The impact of primary and community services not being improved as proposed, whilst hospitals proceed to reduce their capacity;
- The heightened impact on the most vulnerable groups of people in Ealing's diverse population.
- The Increased complexity of the proposed "tiered" system of local healthcare (including "local" and "major" hospitals) which has the potential to significantly confuse patients and the public; and
- The potential significant loss of clinical expertise at Ealing Hospital.

10.4.3 Furthermore, there is insufficient evidence to demonstrate that the NHS bodies that will experience an increase in patient volumes as a result of

the proposals will be ready in time to meet this demand. This is a major risk.

10.5 Impact

10.5.1 Insufficient account has been taken of the adverse impact on people who live and work in Ealing.

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

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

- 53.9% of inpatient admissions
- 9.6% of outpatient attendances
- 30.0% of A&E attendances

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

10.6 Additional concerns

10.6.1 In addition to the three key issues above, there are a number of additional concerns with the proposals and the way in which they have been developed.

10.6.2 Firstly, inadequate public consultation took place during the development of the proposals. Public participation was largely confined to three pre-consultation engagement events that were attended by in total approximately 360 members of the public (about one in five thousand of the population of NW London). Crucially given the large scale impact on the people of Ealing, there were no specific attempts to engage with local people (and particularly the most vulnerable groups) during the pre-consultation period.

10.6.3 Secondly, the formal decisions following consultation are scheduled to be made by the local Primary Care Trusts on the eve of their abolition. This is highly inappropriate, as it will clearly be impossible to hold PCTs (and their officers) to account for these decisions following abolition. Decisions should not be made until the new CCGs are formally established and authorised and are working in partnership with the new Health & Wellbeing Boards.

10.6.4 Thirdly, specifically there is currently insufficient capacity and capability in primary and community services to support the proposed changes (which include the removal of 1,000 adult beds from the acute sector). While the proposals include plans to strengthen "Out of Hospital" care, these developments are currently not planned to be fully implemented until some time after the hospital reconfigurations have commenced. No decisions should be finally made about hospital reconfiguration until the Out of Hospital strategies have been implemented and performance assessed as successful against a number of appropriate metrics.

11. Recommendations

11.1 This section of the report considers the options available to LBE in taking this matter forward.

11.2 It is not credible to seek to support a "no change" option, as the evidence of unwarranted variation in clinical quality and patient experience, and the unsustainability of the current financial position is readily apparent.

11.3 Consequently LBE should acknowledge the need for change, but that the strategic response needs to be developed:

- by all local partners, explicitly including the new NHS and health bodies (the CCG and the Health & Wellbeing Board), the local providers and LBE itself;
- in a way that is less about the imposition of a top down model and more about developing an integrated service proposition that builds upon the current strengths of local services; and
- in a way that is informed by a close understanding of differential local need and the impact of potential change.

11.4 Linked to this, there is clearly an urgent priority to engage (or continue to engage) in the detailed development of the Out of Hospital Strategy. In particular LBE should seek to understand the metrics that should be developed to ensure that implementation can be subject to independent verification. This could be used to support the development of conditions to be met before hospital reconfiguration could proceed.

11.5 LBE should continue to engage public opinion. In addition it should seek to ensure that local clinicians have an opportunity to make it clear

how they feel about the changes. During the course of this review a number of local clinicians have expressed significant concerns about the proposals.

11.6 It would also be appropriate to initiate further discussions with the key parties, notably the new London office of the NHS Commissioning Board, the NHS Trust Development Authority, Ealing Hospital's and West Middlesex Hospital's senior management and the local CCG.

11.7 In the meantime this report should now be used:

- To inform the development of LBE's further engagement on this issue;
- To support the LBE Health Overview & Scrutiny Committee in continuing to hold the NHS to account during and after the consultation period; and
- To inform LBE's formal response to the consultation, due to end on 8 October 2012.

Tim Rideout Limited
September 2012

Appendix 1

Stakeholders interviewed during the course of the independent review and in the preparation of LBE's response to the consultation:

Dr Onkar Sahota	Local GP, member of the London Assembly and Chair of the Save Our Hospital Campaign
Mr Colin Standfield	Secretary of the Save Our Hospital Campaign
Dr Jackie Chin	Director of Public Health, NHS Ealing
Cllr Abdullah Gulaid	Chair of the Ealing Health Overview & Scrutiny Committee
Dr Jenny Vaughan	Consultant Neurologist, Ealing Hospital NHS Trust
Cllr Julian Bell	Leader, LBE
Gareth Shaw	Campaign Manager, Save Our Hospital Campaign
Bridget Olsen	Save Our Hospital Campaign
David Archibald	Executive Director, Children and Adults, LBE
Cllr Gregory Stafford	Health Spokesman, Conservative Group, LBE
Dr Mohini Parmar	Chair, Ealing Shadow CCG
Nick O'Donnell	Assistant Director, Strategic Transport, LBE
Dr Charles Cayley	Ealing Hospital NHS Trust
Dr Amarjit Sethi	Ealing Hospital NHS Trust
Cllr Jasbir Anand	Health and Adult Services Cabinet Member, LBE
Dr Mark Spencer	Medical Director, Shaping a Healthier Future, NHS North West London
Cllr Nigel Bakhai	Health Spokesman, Liberal Democrat Group, LBE
Julie Lowe	Chief Executive, Ealing Hospital NHS Trust
David McVittie	Chief Executive, North West London Hospitals NHS Trust
Angie Bray MP	MP for Ealing Central and Acton

Steve Pound MP	MP for Ealing North
Virendra Sharma MP	MP for Ealing, Southall
Steve Shrubb	Chief Executive, North West London Mental Health NHS Trust

Appendix 2

SOH Ealing Hospital Consultants Statement

Statement by the consultants of Ealing Hospital NHS Trust

July 2012

NHS NW London has made proposals under their plans "Shaping a Healthier Future" (SHF) for the development of health services in North West London over the next four years. The plan, which is being considered by the Joint Committee of Primary Care Trusts, puts forward several different potential scenarios for the reconfiguration of hospital services within North West London. Two out of 3 of these scenarios involve closing Ealing Hospital accident and emergency department completely. NHS NW London have a publicly-stated preferred option before consultation which will result in the closure of the A and Es at Central Middlesex Hospital, Charing Cross Hospital, Hammersmith Hospital and Ealing Hospital. It is very unlikely that West Middlesex Hospital (the hospital Ealing has been pitted against in the consultation) with its PFI will be able to function as anything other than a major acute hospital so the preferred option above is the most likely outcome of their plans.

Closure of the accident and emergency department at Ealing would by necessity lead to the loss of Women's and children's services followed by inpatient acute beds across the trust so it becomes what they have called a local hospital with GP and rehabilitation beds with a stand-alone urgent care centre. Outpatients and a limited range of diagnostic services will be provided. We, the consultants of Ealing Hospital, are completely committed to retaining a high quality full, 24/7 accident and emergency department at Ealing. As a consultant body we submit that the urgent care centre only functions safely with co-localised specialist services on-site and that the investment in community care planned as part of SHF will not be able to fill the gap created by the major loss of services which will happen on the Ealing site if these plans go through.

We have no doubt that retaining a full accident and emergency at Ealing is in the best interests of the people of the borough of Ealing who use the hospital in their thousands every year. Indeed, over 100 thousand adults and children a year attend the urgent care centre and our accident and emergency department at all hours for their

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

We recently met with a large number of GPs from across the whole of the borough of Ealing, and on a free vote, not a single GP agreed that Ealing Hospital should lose its A and E department. This shows that local clinicians from the hospital and across the community strongly support the fact that Ealing Hospital A and E should stay open and continue to serve the local population. A GP survey done as part of this meeting showed that local GPs, whose patients actually use Ealing Hospital regularly, share all the same concerns we do about the urgent care centre being made to function as a stand alone facility and the fact that community care provision will not fill the gap. They were also very concerned the number of patients who will have to move further to find the care they really need and that this will disproportionately affect the elderly and those on low incomes and those who don't have English as their first language.

We recognise that the SHF program is making statements about improving healthcare for local people in tough economic times. We also fully recognise the need for the NHS to optimise the efficiency and productivity of its services in the current economic climate. We wish to continue to work with other partners in North West London to strengthen clinical pathways and in particular to complete our planned organisational merger with North West London Hospitals NHS Trust. The case for merger is built on a clinical vision of being 'Stronger Together' in a clinically led and patient centred organisation. We welcome the opportunity to work in the future with our managers and The Trust Board, our neighbouring hospitals and the GPs to continue to develop and improve the excellent services that we already offer to our local people.

Dr Frank Geogehen, Dr Jenny Vaughan ,Co-Chairmen of The

Ealing Hospital Support Committee

On behalf of the consultant body at Ealing Hospital NHS Trust

Appendix 3

Dr Jenny Vaughan's assessment of an interview conducted with Dr Mark Spencer, the SaHF programme lead

Reporter Michael Russell (EG) put readers' concerns to Dr Spencer (MS) and his responses are below. Ealing Msc has put the rebuttal in bold after each answer "what will happen/is happening".

1.Ealing Gazette (EG): If this is such a good idea why do so many GPs seem to be against it?

Mark Spencer (MS): Ealing Hospital consultants emailed the 340 GPs in the borough and managed to get 35 to come to a meeting where 33 voted against the plans. It's largely GPs from Southall who use Ealing Hospital a large amount. It's not surprising their not supportive of the changes and are concerned about potential increasing workload that they would create.

What actually happened: This is not correct at all. We addressed the meeting and explained how the invites were done and that the GPs who were invited and expected to come were those who use Ealing Hospital the most. Acton GPs were more concerned about the future of Charing Cross where they send the bulk of their patients but were nevertheless still concerned about these plans. Many GPs came representing their whole practice (of between 4-8 Gps) so it was a representative sample and we received emails from many of those who could not come in support. These facts are not mentioned despite this and to suggest that Southall GPs don't want the hospital to close because it increased their work load ignores those who on the night raised such important concerns from across the patch and the genuine concerns of Southall GPs for their patients.

2.EG: Ealing's A&E treats 45,000 patients a year who cannot be treated by the urgent care centre (for minor illnesses and injuries) how are the remaining A&Es going to cope with the extra patients?

MS: Ealing A&E sees about 100,000 patients a year, of these 65,000 are treated at the urgent care centre. Of the 45,000 patients treated at Ealing A&E a year about half are admitted to hospital, the others are managed in the A&E and discharged.

What actually happens: Ealing A&E and the urgent care centre (UCC) see about 110,000 patients a year, of these 65,000 are managed at the urgent care centre (run by Care UK) but 17,000 of these they cannot manage solo and send through to Ealing A and E (46/patients per day) as they need the back up. 1/3 of this number has to be admitted to the hospital direct and the total number of type 1 A attendances at A and E at Ealing hospital has not changed in the last year and stands at 45, 000 per year

MS: Going forward I expect urgent care centres to be of a higher calibre than they are now. We're doing work, such as training and introducing a larger variety of different doctors so we'd expect them to take about 70 to 75 per cent of patients.

This shows that Dr Spencer is acknowledging that the current UCC will not work effectively for the residents of Ealing in scenario A from SAHF. Dr Spencer is suggesting that more work will be done to develop a UCC model that does work but at present this model simply does not exist. This is a fundamental issue as the SAHF comments about the type of service that local residents will receive and how many will have to travel to access safe emergency services is predicated on the UCC seeing a high proportion of current AE attendees. Without a robust, tested model for a stand alone UCC being available we cannot see how these plans could be allowed to progress.

So there are no clear plans to say how the urgent care centres will safely ensure the right calibre of doctor in the UCCs and for our case mix. Co-localisation of specialist services and on-site back up will deliver the best model here. Organisations like the primary care foundation back this and say that case mix consideration is so important. This means that the right model for Ealing, given its population, must be co-localised services with an A and E to ensure the safest care in this situation

MS :The problem in A&E in hospitals like Ealing at the moment is the number of consultants available during an emergency is limited. It's not just financial but there aren't enough out there to recruit.

What actually happens: Ealing hospital has an excellent complement of consultant A and E staff and has fully staffed rotas and its performance is improving and currently sits well with that achieved by many of the neighbouring hospitals. The clinically negotiated merger will allow us to strengthen those areas which are very difficult for a smaller Trust to have a sufficient critical mass. The suggestion that there are not enough senior staff to deal with an emergency situation is not what we recognise to be the case at Ealing at all but we would contend that the merger will allow us to deliver all the standards needed. All hospitals are challenged by this at the moment and GPs and patients should be part of how this is done and not a top down centralised process which ignores their concerns.

3. MS: We know that if you get admitted to hospital on a Friday night, compared to a Monday morning, you're eight per cent more likely to die. You're much less likely to see a senior doctor who can assess you and put the right treatment in place more quickly. Consultants are on call but they're not working there at night. We want to improve the quality of care by enabling people to see senior doctors more quickly.

Talk to senior consultants in any of our threatened sites and they agree there should be fewer hospitals. The little bit of extra travelling time has little clinical impact.
Already at the moment if you have a heart attack you'll be taken to Harefield or Hammersmith because getting there saves lives. The evidence is getting to the right place matters more than getting to the closest place.

What actually happens: We agree that heart attack and stroke patients should have centralised facilities for thrombolysis. These patients constitute 3-4 % of the emergency workload. The studies around an excess mortality at the weekend are interesting and here is the one I think is being referred to http://jrsm.rsmjournals.com/content/105/2/74.full. What it actually states is that although there does appear to be an excess mortality at 30 days if you are admitted at the weekend, you are less likely to die in hospital on a Sunday than on a Wednesday! The authors also argue that the effects and cost of centralising may not be a justifiable expense with scarce resources (see the conclusion).

Anyway the most important issue is the study that looks at the health outcomes of patients managed in stand-alone urgent care centres in the UK and comparing this with those managed in UCCs linked to an on-site ED, especially in the casemix seen in hospitals like Ealing. This has not been done and SAHF should ensure that this model is safe and shown to be safe before subjecting thousands of our patients to it.

Under the model proposed for Ealing by SAHF the risk is that patients could be delayed in accessing the care they need when they cannot be managed by the urgent care centre. At present there are 46 patients a day coming to Ealing who cannot be managed solo and require on-site review (either from the ED or on-site specialist) before either discharge (2/3 of this figure) or admission (1/3 of these referrals form part of the 45, 000 type 1 A attendances to Ealing per year). No inpatient beds will mean that 46 patients will need to be transferred to major acute hospitals **PER DAY** on the Ealing site. There is no cost modelling or any safety assessment in SAHF plans of what impact this will have. The other sites with a stand-alone ED will have the same problem and there is no overall picture of how the ambulance service will deal with this extra strain on resources.

Patients not wanting to enter this system, as they have concerns that the UCCs may not be able to deal with their problems, will choose to over-ride it and try and get to the nearest A and E. The problem here will then be over-loading of the system as at present with Central Middlesex Hospital A and E only open during the day the number of people per A and E works out as virtually the same as the national average. After losing 3 more A and Es in NWL there will be 395,440 people per A and E, a disadvantage of 52% which is a massive over-compensation which will occur as a result of these plans. **Populations in the other boroughs affected in NWL**

need to know this figure as it translates as much greater pressure on their services too.

4. EG: What other services would be lost if Ealing loses its A&E and would be provided at the scaled-down hospital?
MS: One current plan would be to build a new hospital costing £20 million. It would have out patients, diagnostics, retain the Moorfields Eye Hospital services, endoscopy, renal dialysis and there would probably be about 100 beds for rehabilitation and GP admissions. It would be built next to Meadow House Hospice whose work would continue.
Also we'd have a centre for multi- disciplinary working, teams of doctors and nurses, dieticians, chiropodists etc to manage diabetes and other conditions. There wouldn't be paediatric inpatient but there would be outpatients and the urgent care centre would include GPs trained in paediatrics.
And the recommendation at the moment is there would be no maternity unit. Ealing hospitals maternity unit is small and has trouble recruiting midwives to manage rotas and has very high emergency caesarean rates.

What actually happens: The recruitment crisis in midwifery has been the case for many years and many hospitals both nationally and locally have problems recruiting. **Ealing hospital is in the middle of a merger process with Northwick Park Hospital already to improve midwife availability but this is being negotiated safely with all the relevant clinicians involved and not just being pushed through by a top down re-organisation which is not listening to clinicians who actually work at Ealing and local GPs.** We do not recognise a statement like this which refers to very high emergency caesarean rate and does not also make allowances for the complexity of presentation and rates of other illnesses such as diabetes (17% in some wards in Southall, one of the highest in the country) which we know increases the likelihood of c-section. We are also note that the c-section rate at some other hospitals in North West London, not under threat of closure, are higher, yet this was not mentioned so the whole picture has not been given here. It's the case that up to 25 % of our inpatients at a given snapshot have diabetes or diabetic-related problems compared with 10% nationally. Dr Spencer does not mention this very well known fact.

Ealing consultants took the trouble to ask what most local GPs really want on the Ealing site and they did not ask for a 20 million pound building as outlined above. Infact neither have the thousands of members of the public who have heard about these plans either. **This building, if it goes ahead, will be a monument to a failed process and will never replace what has been lost and is not what the population really needs. We know that local GPs and patients support Ealing Hospital retaining its A and E and co-localised services on-site.** We hope that such a sum of money being

mentioned before the consultation even ends will not influence the outcome.

5.EG: How will people know exactly which hospital a sick person should go to. Will they turn up to an urgent care centre only to be told to travel to another hospital?

We've got a lot of time to educate people so people can understand how the system will work.

The 111 non-emergency number is being rolled out which will be able to give advice about the best place to go, whether it's an A&E an urgent care centre, a walk-in centre and if you need to go an A&E they'll tell you the best one to go to. Patients will learn quickly.

The danger at the moment is people go to Hammersmith or Central Middlesex with acute belly pain and there aren't the surgeons there to deal with it. The general population don't know that. Or that Charing Cross Hospital doesn't have paediatrics.

The system at the moment is already very complicated we're making it simpler.

And if someone went to an urgent care centre and it was assessed they needed to get to an A&E there would be rapid transfer available to a major hospital.

What will actually happen

One of the main risks identified by the National Clinical Advisory Team (NCAT) was that SAHF needed to make it very clear what was available on each site and that there were real concerns that this would otherwise really affect patients ability to access healthcare and understand what they should do when ill. There was no comment that they thought the service would become simpler for patients as suggested above.

Based on pilot data, 111 is unlikely to be the first port of call for many of the local people in Ealing borough. Lots of research has been done on the effectiveness of telephone access for NHS services. There is very clear evidence that telephone access "seems to disproportionately serve populations with the lowest expected need". Furthermore, our study only included individuals in households and it is likely that groups living outside private household, including those without homes and migrants, will be more reliant on direct access rather than telephone or booked services. http://jpubhealth.oxfordjournals.org/content/30/1/75.full.pdf.

Also the main problem is the triage. It is by protocol as it is not administered by medically trained personnel. The result is that anything presenting will generate the final common denominator more likely ie more strain on GPs and urgent and emergency care services. Recent evidence has shown that since the NHS 111 pilots began, there has been a 17% increase in people presenting at urgent care and walk in centres across England. If this is to be the main access point in NHS NW London then actually it will lead to an

increase in visits to an already over-stretched system and cost more.

6.EG: The changes will create a black hole in the Ealing and Acton area for hospital patients. Have you worked out how much longer it will take for people to travel to their next nearest hospital?
MS: From my surgery in Acton I'm at the centre of the black hole. I can get to St Mary's, Paddington in 15 minutes and West Middlesex in 20 minutes. This black hole your describing seems more like a light shade of grey. Even in rush hour it's not that bad. Hammersmith would be my closest hospital and the extra distance from there to Paddington is very small. And from Acton Main line you can get to Paddington in 12 minutes.
We've looked at travel times in peak, off peak and blue light and we're working with the London Ambulance Service using their data to assess travel times.
Clearly those most seriously ill will be taken by blue light so the impact on them would be least.

What actually happens: We don't recognise these figures at all and wonder if they are actually motor bike times being quoted. The travel aspect (esp. for relatives as our patients seem to have very large, very impoverished and very closely knit families) does not appear to have been addressed at all. For the elderly trying to access healthcare this will be very, very significant and they are supposed to be the ones to have the greatest say in our health services are reconfigures when it comes to consulting the population as a whole. There are no direct bus links to West Middlesex Hospital from many points in Ealing. Most patients in Ealing needing to get to Hillingdon will need to own a car. We know that there are many patients in Ealing who do not own one. There are no direct bus links to either West Mid or Hillingdon hospital from Ealing, catching two buses is required.

When it comes to accessing Northwick Park Hospital you require 2-3 buses depending on where you live and journey times vary between 50 and 80 minutes. The cost is of the order of £5.40 round trip (X the number of family members)...not cheap. We know that lack of access by relatives also increases length of stay so this will have an on-cost as the length of stay will increase in the secondary care sector. Many people will simply ring an ambulance or not go at all. Not going at all is likely to result in much worse clinical outcomes or a delayed presentation with an individual more likely to require an expensive ITU bed and an increased length of stay, costing far more overall.

7.You are expecting patients to be treated within the community, such as by GPs, nurses or enabled to manage their condition at home. I struggle to book a doctor's appointment now, how are you going to improve services so less people need to go to hospital?

MS: Each borough's clinical commissioning group (in North West London) is creating strategies to improve primary and community care in the borough. They're all remarkably similar and are looking at improving access, managing long term conditions better, enabling people to manage their own diseases, looking what more pharmacists can do to help people more and how GPs can work together as networks to share resources.
We're investing £138 million across north west London within the next three years which include some building and refurbishing of health centres but mainly on staff. We can't make any changes to hospitals until this is in place.

What will actually happen: Once a decision is made to close a hospital's A and E that hospital will find it very difficult to staff rotas safely and this will have a knock on effect across all the specialist services at Ealing as well. All the hospitals where a downgrade decision has been made will have the same challenges. The risk of this approach is that interim closures will take place much earlier than the time plans allow and the community care will not be able to take up the strain of what has been lost.

We have been told that there will be £138 million divided across all the boroughs. **This will mean that in Ealing, for example, the local population will lose many of the services they rely on at Ealing hospital and will only benefit from a share of this money.** This investment needs to be set against A 20 million rebuild has been suggested to take place on the Ealing site but there is no evidence at all that local people want this and if they were given real choice they would not want to lose the A and E on the Ealing site. On 27/6/12 not a single GP at Trailfinders supported the closure of Ealing A and E from across the patch thousands of local people do not want this to happen either. The concern would be that this sum of money is being trailed whilst a consultation on the plans is taking place and whether this might influence the process.

8.EG: How much money do you need to save and how much will these changes save?
MS: We need to save four per cent every year because we need to invest four per cent to provide better services, new cancer drugs, dealing with an aging population etc.
At the moment across north west London we have real problems. Chelsea and Westminster is in financial balance but Northwick Park and

Imperial hospitals are in quite a lot of financial difficulty. Ealing Hospital has been managing its budgets but is predicting it won't be able in the future.
We have a very unstable situation and risk going the way of South London where administrators are drawing up plans to cut services. If these changes happen we will be in financial balance. We came up with these changes as a clinical group thinking of ways of improving services before passing them on to the financial team to see if they would work. Our plans are about redistributing services rather than cutting them.
This isn't easy but I think it's better than what's happening in South London which we are going to see repeated in other parts of London. If we don't make these changes we're third on the list

What will actually happen: Telling people hospitals must lose services because of debt has to be properly balanced against patients not being able to access the care they need locally as downgrading all these hospitals will also put the others under direct stress. **St Georges Hospital in Tooting has recently had to stop taking GP referrals for a number of conditions as reported this week by the Evening Standard. The article stated that this was due to concerns over missed waiting time targets so GPs there are apparently having to refer elsewhere. This is even before they have gone ahead with the planned closure of the A and E at St Heliers which was proposed by NHS SW London earlier this year and St Georges is supposed to take a lot of the St Helier patients! The system is not working in many areas even before these changes are being pushed through. The risk is massive that all this change will over load and already over-stretched system which will then break down.**

SAHF has not costed many of the "hidden" impacts of its proposals. It is unlikely that these changes will ensure financial balance once these impacts are costed. For example, there is no assessment on how much extra it will cost to staff the new look UCCs (they say they will not be supporting the current model) as they have not fully developed the model which is needed or described how it will be delivered.

There is also no costing on the extra impact on the ambulance service (LAS).NCAT (National Clinical Advisory Team) specifically drew attention to the fact that the business model did not mention any economic analysis of the secondary transfer of patients within the region. It is not clear either what will happen to primary ambulance borne patients when the bed base proves inadequate to meet demand. No secondary care bed increase is being planned and at present there is very good evidence that major hospitals in the sector already cannot meet demand. They have allocated a sum of money to community services but they have not demonstrated that this spend will be able to meet the extra demand created by the loss of services at so many

sites. **This is an absolutely key fact.** The pace of change will mean that there will be no slack in the system and primary and secondary providers will just be expected to make this happen against a backdrop of large cuts in social care (150 million across the sector).

South London is not a direct comparison. The problems of South London NHS trust are as follows: a merger took place of 3 widely separated independent hospitals, one of which had a crippling PFI contract. However well the hospital performed financial balance was not possible with this backdrop.

Financial shroud-waving should not be used as a device to justify pushing through a high risk multi-site reconfiguration as it does not put the safety of patients first which should be the top priority. Telling the public this is simply about "redistribution of services" is not telling them the whole story. That is the only way we can account for the outpouring of anger, disbelief and amazement seen in the population who will be most affected by this. It also fails to take account of the very real concerns expressed by so many local GPs who have years of experience in looking after them.

Appendix 4

Locally produced clinical audit information: Ealing Hospital NHS Trust

Ealing Hospital Data Summary
1). ITU deaths / Severe community acquired pneumonia
May 2009 – July 2012
Total number of patients: 929
Average risk of death on admission 34%
Ealing outcomes: 19% died
ICNARC (Intensive Care National Audit and Research Centre) methodology for the calculation of the risk of death scores used which are APACHE II risk of death predictions calibrated to the UK case mix.
Severe Community Acquired Pneumonia UK ICNARC case mix vs Ealing ITU
Aug 2009 – July 2011
Total number of patients: 97

	%ITU admissions	% predicted risk death	% ITU deaths
National	6	49	37
Ealing	15	47	24

2). Respiratory
Adult Asthma: BTS Ealing Hospital vs National data

	% on regular tx discharged on increased preventer Tx (n)	% with new diagnosis discharged on inhaled steroids (n)	% poor compliance who had reasons for poor compliance addressed (n)
National	25.69% (1452)	82.12% (168)	73.37% (184)
Ealing	46.15% (13)	100% (4)	100% (5)

BTS Adult Community Acquired pneumonia
Patient admission sources

	Emergency Dept	GP referral	Other
National n=1706	69.87%	22.57%	2.99%
Ealing n=91	82.42%	10.99%	*5.49%

*other = Urgent care centre + mental health trust

	Time between admission and CXR <2hrs (n)	Time between admission and 1st dose antibiotics <4hr (n)	Readmission within 30d discharge
National	43.34% (1659)	57.42% (1611)	9.4 % (1706)
Ealing	50.55% (91)	64.37% (87)	14.3 % (91)

3). Orthopaedics Trauma Audit and research network performance review 2012

Pre-operative hip scores for patients in Ealing are lower than surrounding boroughs ie more functional limitations.
Outcomes from joint replacement surgery comparable with other NWL trusts with short waiting times
Highly commended on recent trauma inspection visit December 2011
Ealing ranked third after St Mary's and Chelsea regarding TARN data compliance
4). Tuberculosis
Table 1.4: Rate per 100,000 population* of new TB notifications in London residents by PCT of residence and year of notification - reported to the London TB Register

North West						
Brent	88.4	101.5	113.5	116.6	116.1	123.1
Ealing	76.7	77.3	64.4	69.8	66.2	78.8
Hammersmith & Fulham	46.7	39.4	39.5	43.6	32.4	40.7
Harrow	57.8	56.8	59.2	59.6	59.5	66.9
Hillingdon	50.4	50.7	60.0	46.9	46.6	50.0
Hounslow	63.1	61.7	60.2	73.4	81.1	77.7
Kensington & Chelsea	29.8	17.9	29.4	29.4	21.2	28.9
Westminster	36.7	36.7	29.2	33.3	24.9	25.7
North West Total	**58.7**	**58.5**	**59.7**	**61.4**	**58.7**	**64.2**

Table 1.6a: Proportion of new TB notifications in London residents completing treatment
within 1 year of notification by PCT of residence – reported to the London TB Register

PCT of residence	% of all TB cases completing treatment				
	2006	2007	2008	2009	2010
North West					
Brent	86.7%	86.5%	88.9%	88.9%	85.9%
Ealing	80.0%	79.7%	85.9%	88.2%	77.7%
Hammersmith & Fulham	91.3%	85.3%	82.4%	82.4%	89.1%
Harrow	91.1%	86.9%	89.8%	89.0%	81.0%
Hillingdon	77.8%	83.5%	84.2%	84.6%	82.3%
Hounslow	63.0%	79.4%	69.4%	82.0%	76.6%
Kensington & Chelsea	81.1%	87.5%	86.8%	88.0%	83.3%
Westminster	84.7%	79.1%	89.9%	92.8%	84.1%
North West Total	**81.6%**	**83.2%**	**85.0%**	**87.1%**	**81.7%**

Appendix 3: Ealing Hospital NHS Trust incorporating the community services of Brent, Ealing and Harrow

NHS North West London Shaping a Healthier Future: Consultation Outcome

1) Summary

Ipsos Mori reported on the consultation responses to the Shaping a Healthier Future (SaHF) proposals at a public engagement meeting on Wednesday 28 November and public Joint Committee of Primary Care Trusts (JCPCT) on 6 December. This paper summarises their report and the response of the Board of this Trust as discussed at a Board meeting on 13 December 2012.

2) The Consultation

Consultation on SaHF was led by NHS North West London on behalf of the 8 North West London and 3 neighbouring Primary Care Trusts and ran through the summer of 2012 concluding in early October. Consultation feedback was received from a number of organisations including the Joint Health Overview and Scrutiny Committee (JHOSC) and some individual OSCs, Royal Colleges, NHS and other organisations and the general public. Public responses were analysed and presented by Ipsos MORI. The full response can be found at www.healthiernorthwestlondon.nhs.uk/

Some challenges to the consultation process have been received. These group into a number of categories:

- Two Trusts in Option A (Chelsea and Westminster and West Middlesex) financed separate campaigns and these skewed the results. No other hospital which could have been affected in NW London did this.
- Not enough effort was made to target 'hard to reach' groups
- The consultation documentation and questionnaire was biased

Concerns received by the Trust directly have been directed to NHS NWL. NHS NWL will now move to develop a post consultation decision making business case (DMBC) which will make a recommendation to the final decision-making JCPCT currently planned for 19 February 2013.

3) Impact on EHT merger with NWLHT

Board members are aware that the merger has not yet been approved and that we have been asked to undertake further analysis on the impact that SaHF would have on the merged organisation's Long Term Financial Model (LTFM). This work is ongoing. At the time of writing it is not clear whether Option A will become the base case assumption for the LTFM or whether it will be modelled as a scenario.

If option A is backed in full the ICO and particularly the hospital's position, other than as part of a larger organisation is extremely precarious. Should the merger, or at least considerable joint working, stall or stop, the Trust is likely to face considerable difficulties in attracting staff and patients. This could make financial and clinical viability questionable even if SaHF has not reached decision or implementation phases.

4) Impact of Option A on EHT

Option A would mean that Ealing Hospital became a local hospital with no Accident and Emergency Department or maternity unit. Community services in Brent, Ealing and Harrow would also develop new services as more care is moved away from hospitals and into the community. The Board notes that Option A was backed by just over 4% of GP practices in Ealing and the majority were in favour of Option C, in which Ealing hospital is developed as a major acute hospital.

Discussions with local clinicians including hospital staff, community staff and GPs suggest that the proposals in Option A are more radical for Ealing Hospital than is clinically necessary. The Board is therefore asked to consider a response to NHS NWL which argues for the retention of a different mix of services on the Ealing site even if option A is implemented.

This would potentially include:

- Retention of day surgery at Ealing
- Retention of endoscopy at Ealing
- Retention of large elements of a maternity service, other than deliveries to include ante natal care, post natal care, obstetric ultrasound, Day Assessment Unit and Early Pregnancy Unit either based on the Ealing site or using innovative community solutions, such as a 'Mums and Midwives' shop on Southall or Ealing Broadway.
- Retention of a range of Radiology services

A detailed potential services list is attached at appendix 1.

It is important that any changes to the original Option A remain aligned with the SaHF case for change, especially around meeting all appropriate quality standards; are supported by local commissioners and are operationally and financially viable.

Option A is heavily reliant on an effective out of hospital strategy and with this in mind the ICO's community services need to be supported to deliver high quality care closer to home. It is vital that these services are supported by commissioners through this time of change.

The Board meeting was attended by a number of senior consultants from Ealing who expressed real concerns about the impact of Option A on their patients. A draft letter from the Medical Staff Committee to Jeremy Hunt, Secretary of State for Health, was also tabled at the meeting. In particular Board members were asked to note the strong level of local support for Ealing Hospital, the support for the hospital from local General Practitioners and the risks of further disadvantaging an already vulnerable population.

5) Next Steps

NHS NWL will now produce a post- consultation business case based around a preferred option. This post consultation business case will revisit the financial analysis, and start to look at the practicalities of implementation.

The Board wishes to reaffirm its earlier view that Ealing Hospital should remain an acute hospital (Option C within the SaHF proposals). Notwithstanding that view and without prejudice to it the Board believes that there is a strong case for amending the range of services offered on the Ealing

site in Option A if this goes through as a the preferred option. The Board wishes to play a strong role in influencing the post consultation decision making business case.

6) Recommendation

The recommendations from the EHT Board are therefore:

a) The EHT Board has reaffirmed its previous statement that a major acute hospital on the Ealing site would best suit the needs of the local population (similar to Option C of the consultation).
b) However, the Board is also mindful that it previously supported the case for change and stated that it would respect the outcome of consultation. The Board notes that concerns have been raised about the quality of the consultation and that it may be subject to challenge.
c) If despite the above Option A goes through as the preferred option, the Board would ask NHS NWL to consider amending Option A to include a wider range of services on the Ealing site. A potential list of services has been produced which would meet the objectives contained within the consultation document which stated that the majority of patients would be cared for locally.
d) The Board considers that it is vital that a fully funded out of hospital strategy should be in place in Brent, Ealing and Harrow before any changes to acute care at Ealing Hospital are implemented. The Board requires this to be in place and delivering the required reduction in the emergency workload across the north west London sector before it can sanction any changes to the configuration of acute care. There should be clear objective evidence of this happening so that no patients are put at risk.

Julie Lowe
Chief Executive
3 January 2013

Appendix 1

Potential Services excluding mental health services based on site

Core

Urgent Care Centre
Outpatients (adults and children)

Local Hospital Services

Core plus:

GP practice
Pharmacy
Therapy services
Ambulatory paediatrics
Diagnostics including X ray, CT, Ultrasound and endoscopy
Community Beds
Palliative care (Hospice)
Community Day care
Satellite renal dialysis unit

Additions for Post Consultation Business Case

Core plus local hospital services plus:

MRI
Non- delivery maternity services including early pregnancy unit, mums and midwives unit, day assessment unit, obstetric scanning, ante and post natal clinics
Diabetes centre
Day surgery
Programmed investigations unit (medical day cases)
Ophthalmology outpatients and day surgery

Appendix 4(a) Shaping a Healthier Future Response letter from Ealing CCG to Jeff Zitron

10.09.2012

Dear Mr Zitron

Ealing Commissioning Group has undertaken a ballot of all our member practices to seek their views on the SAHF consultation. We understand the case for change and understand that to deliver health care to high quality clinical standards, some hospital services will need to be provided differently in the future.

We are appending the results of the ballot.

Ealing Clinical Commissioning Group has concerns about the scale and proposed timing of the configuration. We also have concerns about travel times for car and public transport users.
We need to ensure that Out Of Hospital Care is fully embedded and operational before any changes are made in the acute sector. Public transport routes will need configuring to respond to these proposed changes.

Kind Regards

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Appendix 4b: Ealing CCG ballot on Shaping A Healthier Future

Ealing Clinical Commissioning Group

ECCG GOVERNING BODY MEETING – ITEM 19

RESULT OF BALLOT OF MEMBER PRACTICES ON 'SHAPING A HEALTHIER FUTURE'

REPORT BY PHIL PORTWOOD AND PHILIP YOUNG, RETURNING OFFICERS

Following the decision of the CCG to hold a ballot of all member practices on the key consultation questions asked in the 'Shaping a Healthier Future' consultation, we were asked to act as the Returning Officers. The administration of the ballot was undertaken by Sylvia Parry in our Governance Team, who we would like to thank for her hard and efficient work.

Ballot papers were issued to all 79 practices that are members of the Ealing CCG. In accordance with the ECCG constitution, practices were allocated 1 vote for every 1,000 patients on their lists as at 1st April – meaning that there were 399,000 votes available. At our request, the ballot papers were issued using unique anonymous numbers, so that we were not able to identify how any individual practice had voted and hence ensure the confidentiality of the ballot was maintained.

Practices were asked to return ballot papers by 4pm on the 4th October – in practice that point, and a further 9 received 17 ballot papers before we began the count at 1pm on 5th October. We decided to count the late votes separately, although the results below include them in the totals. There were only marginal differences in the voting percentages between those votes received on time and late.

Two practices chose to split their votes on question 1 and three on question 2, and it is therefore only possible to show the results for the questions by votes cast rather than also by practices voting.

Results	Votes Number	Votes %	Practices Number	Practices %
Turnout				
Voting	166	41.6%	26	32.9%
Not Voting	233	58.4%	53	67.1%
Question 1 - "The Case for Change"				
Agree	113	68.1%		
Disagree	53	31.9%		
Question 2 - "Which of the consultation options do you support ?"				
Option A	19	11.4%		
Option B	30	18.1%		
Option C	90	54.2%		
Abstained	27	16.3%		

Philip Portwood and Philip Young
Returning Officers for the Ballot and Lay Members of the Ealing CCG

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Ealing
www.ealing.gov.uk

APPENDIX 5: Health and Adult Social Services Standing Scrutiny Panel, Ealing Council: Submission to the JHOSC

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

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

Deliverability of the Programme

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

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

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

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

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

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

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

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

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

Sensitivity Analysis and Risk Management

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

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

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

GP and Community Support, and Early Implementation of the Consultation

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

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

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

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

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

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

Presentation and Use of Data

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

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

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

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

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

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

Community Need and Access to Services

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

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

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

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

In relation to accessibility of services to these communities, Mott Macdonald's travel analysis states that 'significant' travel impacts on critical equality areas will be 'very low' if the preferred option is implemented, and that none of the population will, under blue light conditions, experience an increase in journey times of 10 minutes for either major or maternity services. Similarly 'low' impacts are modelled for private car travel. However, the analysis is clear that the impact percentages for users of public transport are 'far higher', with 20% of the populace in critical equality areas experiencing an increase in journey times of over 10 minutes to access major hospital services, and 61% of the populace having a journey of over 30 minutes (an increase of 17%). Figures for maternity services are 8% and 50% respectively. These increases would result in a total of 108,588 people across NW London, the majority of which are in Ealing, potentially experiencing significant travel impacts when trying to access major hospital services from within critical equality areas. In addition, 74,297 people would experience significant impacts when trying to access maternity services, again from within relevant critical equality areas and with the majority being in Ealing.

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

that, with journey numbers, the equalities impact assessment is not able to tell us exactly how many people from critical equality groups will be affected by significant travel impacts.

Moreover, the public transport modelling in the PCBC, in Appendix H (separated from the main analysis in chapter 12), seems to support the local reality that there are currently poor public transport links between Ealing and West Middlesex Hospitals. That appendix predicts a shift of only 14% of patients from Ealing to West Middlesex if the preferred option was implemented, which arguably reflects the fact that there are no direct bus links and the subsequent difficulty of getting there. A submission from the Chief Executive of Ealing Hospital to the JHOSC also emphasises the Trust's belief that more people will travel to Hillingdon hospital because of the better quality transport links, although only 15% of patients using public transport are expected to make this journey. There is also no consideration in the PCBC about the cost impact of these longer journeys on those who must undertake them, and this extends to those using taxis, otherwise covered by private car modelling and therefore assumed to be impacted relatively minimally.

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

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

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

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

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

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

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

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

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

In Support of Ealing Hospital

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

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

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

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

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

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

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

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

Councillor Abdullah Gulaid and Councillor Anita Kapoor

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

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APPENDIX 6: Summary of recent Full Council motions relating to Shaping a Healthier Future and proposed changes to health services in North-West London

Agreed at Council 17th July 2012

After a unanimous vote the motion, as amended, was **agreed.**

The motion read:

"This council reaffirms the position on Ealing Hospital agreed in a meeting of the Council in July 2011 as well as the position agreed regarding Central Middlesex Hospital in January 2012.

The council believes that the Healthier Futures consultation document is not currently compatible with these positions.

This council resolves to do everything it can to campaign against the proposals outlined in the consultation and in favour of the positions set out by the council in July 2011 and January 2012 and welcomes the all party support for the Save Our Hospitals campaign.

This council is also concerned about the potential loss of the A&E departments at Charing Cross and Hammersmith hospitals."

Agreed on 31st January 2012 (demonstrating cross party support for Central Middlesex):

"Council notes its position on Ealing Hospital as agreed at the meeting of the Council held on 19th July 2011.

Council agrees to adopt the same principles for Central Middlesex Hospital. Therefore:

This Council opposes the closure of Central Middlesex Hospital, whether this is done directly or through running down acute services until the hospital becomes unviable or simply a large polyclinic.

This Council is committed to keeping Central Middlesex Hospital as a district general hospital, which serves the needs of its local community

Council notes that there have been significant proposals for changes at both Ealing Hospital and Central Middlesex Hospital.

Council notes that the preferred future service configurations proposed in the NHS document Stronger Together would mean that both hospitals were closed as district general hospitals.

Council notes that the primary stated driver for the merger is the need to improve clinical outcomes.

Council believes that clinical outcomes will not be improved through cuts and closures and that the only way to ensure clinical improvement is to invest in services at Ealing and Central Middlesex Hospitals.

Council resolves to ask the Leader of the Council and the portfolio holder for health to write to the Chief Executives of the hospital boards and the Secretary of State for Health to clearly state the Council's position on this issue and to demand that there is sufficient investment in both hospitals to allow them to remain district general hospitals."

It was moved as an amendment by Councillor Stafford and duly seconded, that the motion be amended so that it reads,

"Council notes its position on Ealing Hospital as agreed at the meeting of the Council held on 19th July 2011.

Council agrees to adopt the same principles for Central Middlesex Hospital. Therefore:

This Council opposes the closure of Central Middlesex Hospital, whether this is done directly or by running down acute services until the hospital becomes unviable or simply a large polyclinic.

This Council further opposes a merger if it is means worse clinical outcomes for patients or less choice.

This Council is committed to keeping Central Middlesex Hospital as a district general hospital, which serves the needs of its local community.

Therefore this Council resolves to participate fully in all consultations on the merger on a cross-party basis to achieve the best outcome for the residents of Ealing."

Agreed 19th July 2011 (relating to the proposed merger and safeguarding of services at Ealing Hospital):

"Council notes that Ealing Hospital Trust and the North West London Hospital Trust have discussed a possible merger and have released a Strategic Outline Case for such a merger.

Council notes that in answer to a question from Virendra Sharma MP the Prime Minister stated, "There are no plans to close [Ealing] Hospital."

However, this Council opposes any future proposal to close Ealing Hospital, whether this is done directly or by running down acute services until the hospital becomes unviable or simply a large polyclinic.

This Council further opposes a merger if it is means worse clinical outcomes for patients or less choice.

This Council is committed to keeping Ealing Hospital as a district general hospital, which serves the needs of its local community.

Therefore this Council resolves to participate fully in all consultations on the merger on a cross-party basis to achieve the best outcome for the residents of Ealing."

APPENDIX 7

Ealing Local Strategic Partnership

Health and Well-Being Board

6th September 2012, 6:00 - 8:00 pm,
Room M5.12, Ealing Council, Perceval House, W5 2HL

Extracts from Draft Minutes

"Ealing LINk [have worked to] co-ordinate support sessions in the community around completing the consultation online or via hard copies, in the form of road shows; outreach workers reaching hard to reach groups; meetings for older people and sporting communities. They worked with Support for Living groups to design an easy to read version to be taken to events organised specifically for people with learning disabilities and the travelling community. [During these activities] **the public reported that the consultation and response documents were difficult to tackle and understand.** An overview will be put together by LINk. LINk have also responded to the consultation directly to NHS North West London."

"**...concerns with respect to the whole process and its complex issues were expressed around:**

- the sustainability of the model,
- lack of solid risk assessments in place,
- some risk factors not looked at/ mentioned at all in the case for change,
- lack of solid Primary Care arrangements in the community and Integrated Care arrangements outside of Hospital before reconfiguration takes place,
- travel and transport,
- the local population make-up and growth,
- the future of the local hospital, with smaller provisions of services onsite,
- need to look at whole healthcare system and the impact of any such changes on it,
- hospitals having difficulties achieving targets, and maintaining high quality care,
- workforce and training,
- reservations around the consultation itself, including the way it is framed, its length, the lack of information available in other languages,
- proposals not being clearly understood by the local community, etc.

The Board were given an overview of the Independent Review [of "Shaping a Healthier Future proposals and business case commissioned by the Council].

The Board welcomed the report as a very good technical analysis and looked forward to the alternative options that would be proposed as part of the review as this would further discussion and contribute to the shaping of any future decisions and outcomes made to deliver the new models/ systems."

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North West London

NHS North West London
Southside
105 Victoria Street
London, SW1E 6QT

Tel: 020 3350 8000

Martin Smith
Chief Executive
Ealing Council
Perceval House
14-16 Uxbridge Road
London W5 2HL

22 January 2013

Dear Martin,

Shaping a Healthier Future: Response to Ealing Council

Thank you for your response to the *Shaping a healthier future* consultation. Ipsos MORI has now published its assessment of the responses and reported that 17,022 submissions were received through the different consultation channels available – official paper and online response forms, emails/letters and a number of petitions. The full Ipsos MORI report and a press release are available at www.healthiernorthwestlondon.nhs.uk.

The responses received during consultation from key stakeholder groups are also available to download at www.healthiernorthwestlondon.nhs.uk. These include responses from Local Involvement Networks (LINks), Royal Colleges, Councils, Health Overview and Scrutiny Committees, MPs, Clinical Commissioning Groups (CCGs) and hospital, mental health and community trusts.

I appreciate that the nature of the services and the proposals themselves are contentious and I understand the strength of feeling in local communities. Therefore I welcome your recognition that there is a need for the NHS to change and that difficult decisions must be made.

Below I comment on your response, starting with the "suggested immediate next steps" and then with your "key conclusions and response" and relevant summary of outcomes from the review you commissioned.

Your proposed immediate next steps

Through this letter we are providing specific responses to the points you make in your letter. I should say that our overall response will be encapsulated in the Decision-Making Business Case (DMBC) to be presented to the Joint Committee of PCTs on 19 February for final decision-making.

Regarding how Ealing's response will be used to inform decision-making, members of the programme have considered your response and provided the Joint Committee of PCT members and Clinical Commissioning Group Chairs with briefings on your (and other stakeholder) responses and the issues you have raised.

Clinical Working Groups have also considered stakeholder responses and discussed the implications for their proposals. All the members of these groups have access to all stakeholder consultation responses in full including Ealing Council's and the views of the public through the analysis conducted by Ipsos MORI. These responses were also presented to the JCPCT at its meeting in public on 6 December. This response encapsulates the outcomes of the considerable internal discussions.

NHS North West London does not accept that the SaHF proposals fail to reflect the needs of Ealing residents. The SaHF proposals that were consulted upon were based on clinical advice provided by the SaHF Clinical Board which comprises, amongst others, all NWL's CCG Chairs and Trust Medical Directors. The CCG Chairs and Medical Directors, as representatives of the Board, described their proposals in their foreword to the Pre-Consultation Business Case and explained that their recommendations were based on:

- a clear imperative to change the way the NHS delivers healthcare in North West London.
- developing "Out of Hospital" care, so that patients can more easily access a broad range of good quality, localised care services with their GP practice co-ordinating services.
- centralising emergency care and other specialist services on fewer sites, to ensure that those who do need to attend hospital can always access the best quality care.

The Clinical Board was very clear that their proposals would improve clinical outcome; patient and staff experiences would improve for the population of the whole of North West London (including communities in Ealing); and NHS services would become more financially sustainable.

As you will be aware the formal consultee under Section 244 of the NHS Act 2006 is the North West London, Joint Health Overview and Scrutiny Committee. Its response to the consultation states "We recognise that the development of the proposals have been "clinically-led" and approved by a Board comprising the Medical Directors of the Acute Providers and Chairs of Clinical Commissioning Groups (CCGs) in NW London...We accept that a clear, logical process of evaluation was used to arrive at the three options presented for consultation.... Importantly it has reached a broad agreement on the strength of the clinical case for reconfiguration of the accident and emergency provision."

Ealing Hospital's response to consultation stated that "The Board agreed with SaHF premise that to leave healthcare in North West London as it is would be untenable."

In contrast I note that Ealing's Health and Adult Social Services Scrutiny Committee has submitted a response to the Joint Health Overview and Scrutiny that states the Committee "opposes the downgrading of any hospital which serves residents..." and the Council's first request to the NHS is "that the proposals set out under SAHF are replaced with proposals for change which better reflect the needs and views of local people..."

Yet the report commissioned by the Council states that "the objectives of ShaHF are appropriate"; "the core principles to localise, centralise and integrate services are „sound""; and "the current provision of local health care is not acceptable:- unacceptable levels of quality and service; substantial health inequalities; unsustainable financial position." We recognise these areas of concern and agree the ShaHF programme is designed to meet these concerns. We have not received alternative proposals that meet these three objectives.

I would also draw to your attention the Dilnot report (Commission on Funding of Care and Support, 2011) which stated that: "We still pretend that the core business of the NHS is acute hospital treatment, when it is now community- based care systems"

It is unclear from your response what clinical evidence the Council has that the Clinical Board's recommendations would not result in improved outcomes for local communities – including those in Ealing. Ealing Council's rejection of this fundamental clinical recommendation, but apparently without evidence, somewhat constrains any dialogue we are having with the Council if the current SaHF proposals are to be replaced as described in your response. Nevertheless we remain committed to dialogue with the Council.

Your key conclusions and response

1. It is disappointing that you believe there are "profound flaws with the SaHF business case". I should say that the business case was signed off by all the NHS organisations in North West London and subject to quality assurance by NHS London prior to consultation. In our view the pre-consultation business case was (and still is) a perfectly acceptable assessment on which to decide to consult on a number of proposals. The decision-making business case will contain more detail and will provide decision-makers with the information needed to make decisions.

   You state:

   - that many patients will have no choice but to attend a hospital providing poorer services than the current system; that there is a risk of losing valued and high quality maternity services; that alternatives other than hospital reconfiguration were not considered; and the proposals are not driven by the health needs of the local population (including insufficient assessment of equality issues).

I draw your attention to The London Health Programmes (2011) adult emergency services case for change which showed that change was necessary across London. The King's Fund* has brought together a range of evidence in its reports e.g. Transforming our Healthcare System, Reconfiguring hospital services and Improving Health and Healthcare in London: Who will take the lead? which all state that there is considerable risk in the current system. The National Confidential Enquiry into Patient Outcome and Death details unacceptable risks in the way the NHS currently deals with urgent and emergency care.

Clinicians are united in their belief that current quality and consistency of hospital care is not good enough. Recent studies have shown that in London, weekend hospital mortality rates are 10% higher than for those admitted on weekdays; and less than half of all emergency surgical admissions in North West London were seen by a consultant within 12 hours (a standard the Royal College of Surgeons believes is necessary). If all North West London providers achieved the same Hospital Standardised Mortality Ratio as the best trusts, this would equate to approximately 800 lives a year that could be saved.

Our proposals for a new way of working are clearly aligned with: the King's Fund's recommendations on how to overcome the current problems inherent in the existing system; with the Royal College of Physicians' recommendations regarding increased consultant cover at night time and weekends The

Royal college of Physicians: an evaluation of consultant input into acute medical management in England, Wales and NI; with the Clinical Board from London Health Programmes (LHP) which agreed a set of standards for A&Es that brought together the wisdom from the previous documents and the standards recommended by Royal Colleges and published them; with The Academy or Royal Colleges (Benefits of Consultant Delivered Care) and the College of Emergency Medicine (Shape of the Medical Workforce) and the Royal College of Surgeons report Delivering High Quality Surgical Services for the Future which states that "*The preferred catchment population size, as recommended in previous reports, for an acute general hospital providing the full range of facilities, specialist staff and expertise for both elective and emergency medical and surgical care would be 450,000–500,000.*" The Royal College believes this size of catchment is needed (as opposed to smaller ones) to support a high quality acute hospital.

In response to the consultation:

- the College of Emergency Medicine stated "We are persuaded by the evidence suggesting that the healthcare system in North West London needs consolidating in order to provide the best possible care within the emergency pathway."

- the Royal College of Surgeons said "The College of Surgeons and its representatives have been closely involved with both the development and the quality assurance of these standards, which indicate an urgent need to collocate important emergency surgical services on fewer sites throughout the Capital."

- the Royal College of Paediatrics and Child Health has stated "We strongly support the case for change set out in the consultation document. We agree that in North West London, as in a number of other areas of the country, services are spread too thinly to ensure safe, sustainable, high quality care. Our own modelling, in common with that of the project team, demonstrates that only by reducing the number of inpatient units will we be able to improve outcomes for the sickest patients."

I am therefore unclear as to the evidence for your assertion.

In understanding the needs of the local population we have conducted extensive pre-consultation and consultation and commissioned various reports – including a more detailed equalities impact assessment than was previously available. This report will be made available on the programme website in order to inform decision making.

Our proposals included developing major hospitals that would significantly improve the outcomes of the most seriously sick patients; and urgent care centres with services specifically designed around local needs.

- you have concerns that the travel time analysis doesn't reflect reality.

The travel analysis compared travel times of well over 1,000 different areas in North West London by Super Output Area. The analysis has been conducted in partnership with London Ambulance Service and Transport for London – both of whom are content with the way in which the assessment has been made; and we have established a Travel Advisory Group comprising representatives of those two

organisations and a range of other stakeholders (including representation from Ealing Council) and public representatives to consider and scrutinise our analysis.

- concerns regarding the capacity of primary care to cope and that plans to improve the primary care infrastructure are not scheduled to be implemented until after reconfiguration.

We completely accept that improvements to existing primary and community services are critical to our proposals and can understand why some stakeholders regard this as a risk. Indeed, to manage this risk we intend to put significant additional resources into primary and community services and the implementation of new services – the pre-consultation business case described an investment in out of hospital services of over £120 million.

The programme has consistently stated that hospital reconfiguration would not occur until improvements in primary care were achieved and therefore I do not accept your assertion that primary care infrastructure is not scheduled for implementation until after reconfiguration. We are not planning reconfigurations of major hospitals that will impact on primary care until the system is ready to allow for this and we are working to develop a toolkit that will measure and report on the progress of implementation and use of services across NWL. This would assist commissioners, providers and any programme board in assessing the most appropriate time to make changes to services. We would, of course, ensure changes only took place at an appropriate time and be guided by the principle that no services would be changed or closed unless, and until, a safer alternative was in readiness. For clarity, the specific decision on when an existing hospital service could safely transfer would be made by local CCGs during the implementation phase.

- concerns over pressure on acute services, the capacity of stand-alone UCCs and the ability of the broader health system to cope.

I am happy to acknowledge your concerns but cannot see any evidence you have provided that indicates flaws in the assessments we have put before yourselves and the public.

Firstly, intrinsic to our proposals are capital schemes to increase the capacity of the five major acute hospitals.

Secondly, I would like to make it clear that UCCs will not be the sole deliverers of urgent care locally, rather they will work as part of a network of primary and community services to meet local urgent care demand. Currently, from time to time, patients wait too long before they can be admitted through the existing A&Es. We acknowledge that people find it difficult to understand why reducing the number of A&Es would improve this. However, our view is that long waits for admission are far more clinically effectively addressed by improving local urgent care services so that only those patients who most need an A&E service attend A&E. We believe UCCs and their associated primary and community care systems will deal with urgent care more effectively by being more integrated than is possible with an A&E primarily designed for the most severe cases.

- support from primary practitioners is highly dubious – this point is discussed in section 5 of this response.

- the proposed configuration will leave the NHS unable to respond to future demand.

It is important to bear in mind that the council itself (and almost every single other stakeholder) acknowledges that the current system is unable to respond to current and future demand. We believe that the business case indicates that our proposals a) put the NHS in a significantly better position to respond to future (as yet unknown) changes in predicted and unknown healthcare needs and developments in healthcare knowledge and b) takes sufficient account of population changes.

- there has been a lack of appropriate risk management and modelling in relation to civil protection and emergency planning and failure to engage with the local authority regarding these issues.

I am disappointed that the Council has not taken the opportunity to make specific comments in its response to consultation regarding where it perceives the proposals to be lacking with regard to civil protection and emergency protection. I believe the proposals would provide the NHS with a significant advantage (compared with the current arrangements) in coping with any civil protection or emergency issues, however the programme is very willing to engage with the authority in these matters.

- you have concerns over the potential negative impact on clients of children"s and adults" social care.

I should say that Ealing out of hospital strategies have been discussed and presented to (and supported by) Ealing Council representatives at the Health and Well Being Board. Nevertheless, if there are other concerns I would have expected to see these issues raised in your response to consultation.

With regard to the other points you make, I do not accept that there has been a failure to take into account the quality of services currently provided – indeed clinicians have debated this point on a considerable number of occasions.

The Clinical Board would be happy to receive your assessment of the potential „significant" loss of clinical expertise – currently a number of emergency and urgent services are struggling to fill posts and recruit staff and the general consensus amongst Clinical Board members is that these proposals would be very beneficial in attracting high quality staff and retaining existing staff.

Nor do I accept your assertion that the public will be confused by the proposals. The recommendations we made in the consultation document (which elicited thoughtful comment from the public) were to standardise many services – which are currently fragmented and of varying quality and consistency. For instance, current urgent care centres offer very different services at different times of the day – our proposals recommend standard core services 24/7. I think the public will recognise this and engage with us – although I accept there will be a need to publicise services and I would welcome working with the council to ensure the public are well informed. We would expect to mount public awareness campaigns locally when specific service changes are implemented.

I also think the programme has been very clear in its messaging that the NHS needs to find savings if it is to develop a sustainable healthcare service. The baseline for the Pre-Consultation Business Case (PCBC) model uses NHS provider trusts" and PCTs" figures which are independently audited each year. The programme"s models and plans have been also been independently reviewed by the Office for Government Commerce and the National Clinical Advisory Team. The figures used were agreed

by all trusts and PCT finance directors. The Decision-Making Business Case (DMBC) will completely refresh of all financial and activity data to bring the plans up to date. It uses 2012/13 Trust data on activity and costs and models the changes from this point forward. In addition the model takes into account allocation growth including assumptions around demographic growth. The DMBC will involve a much more detailed look at the shortlisted options selected for consultation and will provide a more detailed estate solutions and therefore the associated costs. Alongside this, more detailed work has taken place on the transitional costs of the changes, the opportunities for enhanced local hospitals, the requirements for Out Of Hospital hubs and the need for investment in primacy care facilities. From this work the programme is seeking to establish the ranking of the three options and to assess whether this is the same as at the time of the PCBC or whether it has altered.

2. Regarding the consultation approach and process, the programme has followed best practice and relevant NHS guidance in line with previous NHS consultations in London and elsewhere. Our selection criteria and priorities were tested with the public, users stakeholders, clinicians and the programme's board members. The consultation was also subject to quality assurance by NHS London and approved at their public Board Meeting on 28 June 2012 prior to the launch of consultation. I should add that during and since consultation we have been working with the Consultation Institute to seek their guidance and assurance that we have conformed to best industry standards. We expect their final report on the consultation shortly.

3. As stated earlier in this response, we commissioned an Equality Impact Assessment prior to consultation and have commissioned a more detailed assessment in association with a specific analysis on the proposals and economic deprivation. We have obtained legal advice on this matter at several stages of the programme and have been assured that we have met our legal duties.

4. Regarding your claim that there is profound lack of public support. Whilst I accept that the NHS has much work to do in explaining both the detail contained in the proposals and the benefits (which are complex); I would draw your attention to the fact that 56% of the respondents to the consultation who gave their postcode as being in Ealing supported having five major hospitals in North West London. This figure was much higher in other parts of the area. It is not surprising that, if asked if they would prefer their local hospital to have an A&E or another, more distant hospital, many residents state that they would choose their local one.

5. I acknowledge that there some local clinicians do not support the proposals. However, it would be surprising if proposals of this nature were met with unanimous support. Indeed, it would be difficult to imagine any change of this nature that could achieve that level of support. I would however draw your attention to some key points regarding clinical support which we believe are compelling.

   - The key recommendation that moving to five „major acute" and four „local" hospitals would improve quality of care for all North West London (NWL) residents, including Ealing, came from a Clinical Board comprising all eight Clinical Commissioning Group (CCG) Chairs and the Medical Directors of every Trust in NWL.

   - More locally, when Ealing CCG balloted its practices on two questions, two thirds of those who voted agreed with the case for change, including centralisation of hospital services. It should be noted only 42% of practices voted and on the second question the majority voted for Option C.

- We are confident that these proposals do enjoy considerable clinical support across North West London and this support is underlined by the support of key clinical representative bodies. Regarding the proposed changes in acute care, not one national clinical body responded to suggest that the proposals were clinically flawed. For example:

    - the Royal College of Surgeons said "Because of the importance of these standards for emergency surgical care, the College of Surgeons has been represented on the North West London reconfiguration Board to ensure that the principals of best practice in emergency surgical care will be strengthened and improved by the chosen or preferred options for change. The College and its representatives have been involved in the consultation process, and would only endorse patterns of reconfiguration which would lead to improved outcomes for the treatment of emergency surgical patients."

    - the Royal College of Physicians has responded by saying "The RCP has become increasingly concerned with the standards of care, particularly as they relate to services for elderly acutely ill patients with co-morbidities in hospital, and has published the evidence for these concerns in a report *Hospitals on the Edge? The Time for Action*. Many of the drivers for change identified in your consultation are echoed in this RCP report.

      The RCP believes that there will need to be radical services re-design to ensure that patients receive safe and high-quality care that they deserve at all times. For many communities this will require reorganisation and consolidation of hospital services to facilitate the optimum application of hospital services for patients. This must be accompanied by supportive improvements in primary, community and social are, recognising the needs of public and patients across the spectrum of potential health intervention.

      The RCP cannot comment on specific service location or distribution, but the principles and the approach adopted in *Shaping a healthier future* resonate with the analysis the RCP has published in its review. The pre-investment in community services is essential to the proposed model and is welcomed by the RCP. Consequently the RCP strongly supports the direction for service re-design as proposed as in the best interests of public and patient services."

    - and the Royal College of Midwives has said "The RCM does accept, in general, that hospital care in North West London should be based on the principles of localising routine services, centralising specialist care and integrating primary and secondary care5. Accordingly, we recognise that there needs to be some concentration of obstetric-led care for women and infants that require emergency or specialist care.

6. I do not accept that the SaHF programme represents an unnecessarily divisive approach. The Council has accepted that difficult decisions need to be made and the programme is clear that the proposals as set out in the consultation document would benefit all residents in North West London.

7. The consultation timeframe met all the government guidelines and the consultation response rate was favourable when compared to other consultations. In determining the length of consultation the programme was conscious of the balance to be made in enabling the public and stakeholders the opportunity to become engaged in the process and the clear message from many clinicians and stakeholders that any delay would be unacceptable.

Conclusion

As I mentioned at the start of this letter, I appreciate these proposals are contentious. However local (and nationally respected) clinicians have told me unequivocally that we should, and must, reconfigure the services the NHS provides in North West London. I am disappointed we have not been able to work as co-operatively as I would have hoped, to adapt our proposals to take into account genuine issues.

However we are working towards developing services that truly reflect the needs of local residents and I welcomed the recent meeting we had to discuss how we might do this. I would appreciate more joint working both at an executive and officer level as we go forward. There is much work to do – all of which could be better developed in unison.

If you have any further questions or concerns please contact us at consultation@nw.london.nhs.uk.

Yours sincerely

Dr Mark Spencer
Medical Director, Shaping a healthier future

Cc: Councillor Julian Bell
Councillor David Millican
Councillor Gary Malcolm
Anne Rainsberry, Chief Executive NHS NWL
Daniel Elkeles, Accountable Officer for the Central London, West London, Hammersmith and Fulham and Hounslow Clinical Commissioning Groups
David Mallett, SRO *SaHF* Programme Delivery
Dr Mohini Parmar, Ealing CCG Chair
Rob Larkman, Accountable Officer for Brent, Ealing, Harrow and Hillingdon Clinical Commissioning Groups

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

Preface by Chairman

The proposals put forward in "Shaping a Healthier Future" are for a substantial reconfiguration of the accident and emergency provision in North West London. They include changes to emergency maternity and paediatric care and, if any of the options put forward in the consultation are implemented, there will also be major changes in non emergency hospital services in certain boroughs. Such changes can evoke a strong emotive response and demand close scrutiny.

The Joint Overview and Scrutiny Committee is made up of members from each of the boroughs of North West London and those neighbouring boroughs likely to be affected by the proposals. Individual members have a wide range of views and represent boroughs for which the impact of these proposals will be very different. The committee has sought to probe all important aspects of the case put forward in "Shaping a Healthier Future" without acting as a standard bearer either for strong advocates of the proposals or for those opposed to them.

Despite its inherent differences, the committee has been able to reach a broad consensus on many of the important issues before it. Importantly it has reached a broad agreement on the strength of the clinical case for reconfiguration of the accident and emergency provision. It has, though, not found it appropriate to endorse any one of the particular options put forward.

It has also identified a number of key areas where it has concerns and where the evidence placed before it was inadequate to allay those concerns, despite the best endeavours of the committee. These include: the success of the 'out of hospital' strategy which underpins the projections of fewer bed space requirements; the impact of the proposals on non emergency and routine patient visits and family visits; the functioning of urgent care centres; and the likely future of those hospitals facing a major downgrade. All those concerns are detailed in this report.

With these concerns presently unanswered, the Committee has recommended that it continues to provide scrutiny of these proposals as they are developed further, with the objective of ensuring that whatever proposals are ultimately implemented have first been thoroughly thought through.

Councillor Lucy Ivimy

Chairman, North West London Joint Health Overview & Scrutiny Committee

Contents

1. INTRODUCTION AND BACKGROUND

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

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

We formally adopted the following terms of reference:

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

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

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

2. EXECUTIVE SUMMARY

This Executive Summary sets out the conclusions of the scrutiny of "Shaping a Healthier Future" undertaken by the North West London Joint Health Overview and Scrutiny Committee.

Overall Case

We support the drive to improve the quality, safety and sustainability of emergency care in NW London. The need to address current variations in services and poor outcomes for patients is urgent. The case has been clearly made.

We recognise that the development of the proposals have been "clinically-led" and approved by a Board comprising the Medical Directors of the Acute Providers and Chairs of Clinical Commissioning Groups (CCGs) in NW London.

We accept that a clear, logical process of evaluation was used to arrive at the three options presented for consultation.

We believe that a compelling case has been made for future provision to be based on:

- a comprehensive network of specialist skills and expertise covering hospital and out of hospital care
- transparent patient pathways and protocols which ensure patients gain timely access to the right services for their needs
- an appropriate combination of Accident and Emergency (A&Es) and Urgent Care Centres (UCCs) located across the sub region
- comprehensive, efficient and accessible out of hospital arrangements
- cost-effective provision and delivery of better outcomes at lower cost.

We note that most patients under each option would continue to be seen at the hospitals in which they are currently seen. But we also believe the proposed changes may have a significant impact on certain patients and communities, especially in relation to non-urgent access to services. In respect of urgent "Blue Light" ambulance transport we accept that the change in travel times is likely to be marginal.

In fulfilling our responsibilities as a JHOSC we have examined issues objectively in respect of North West London as a whole, respecting the role of individual OSCs to address more local implications. We have considered a number of risks and concerns which have emerged from witness evidence and analysis.

We have agreed a number of specific recommendations which we believe will strengthen the proposals and increase the likelihood of positive implementation.

Main Areas of Concern

However, through the scrutiny process our work has identified a number of issues that we would like to see addressed as these proposals are developed :

- **Out of Hospital Strategy**. There are concerns over the readiness and capacity of out of hospital services, the realism of timescales for change and the likelihood of cost transfer from the NHS to others. GPs may not buy-in to improve access to, responsiveness of and effectiveness of primary and community care, which could result in higher demand and cost for urgent and unscheduled care.
- **Urgent Care Centres.** The way the proposed network of A&Es and UCCs will work together, the flows of patients across the system and the staffing needs are not clear to all our members.
- **Finance.** The precarious financial status of some NHS Trusts calls into question the sustainability of services and their ability to provide care at the levels envisaged. Lack of finance for major hospitals to address deficient estate and to co-locate core services, means none of the acute reconfiguration options are financially viable.
- **Workforce.** Insufficient skilled staff might be retained in the health economy, especially during transition, meaning service quality may deteriorate, with some services failing altogether
- **Local Hospitals.** The impact of the emergency care change on the future of hospitals not designated as major hospitals may be greater than set out in the consultation. There is a danger that mental health, learning disabilities and other specialities will not be given the necessary degree of priority.
- **Measurable Outcomes.** It is difficult to see what measures have been agreed to track progress on improving quality and safety across the region.
- **Demand and Population Growth**. GP referrals to and emergency use of acute care might continue to grow beyond the assumptions in the proposals.
- **Equalities Impact and Non-urgent Transport**. There is insufficient analysis of the impact of the proposals on travel at a borough level, especially for the poorest and most vulnerable communities. Plans to reduce any negative impact on access to re-located services by some local populations are not yet identified.
- **Risks.** Our work also identified a number of key risk areas, relating to the further development and implementation of the proposals, which would need mitigation.
- **Public Understanding**. Citizens in the most affected areas do not appear to understand the proposals fully or have confidence that they will work. This is a significant concern given the proposals depend on the public changing their behaviour and patterns of attendance. For example, the concept of UCCs is not fully understood by local people and will need further explanation and communication.

In relation to the consultation process we believe that there has been a clear process based on communication and explanation. This has included a series of public meetings, road-shows, stakeholder events, information and dedicated phone lines. We feel that ultimately the success of the consultation has to be judged by the degree of understanding, trust and confidence which is generated in citizens and

staff. At this point we believe more needs to be done if this test is to be met in future.

Recommendations

Our recommendations therefore are:

1. Proposals for out of hospital care are developed further, with the direct involvement of non-NHS partners, to arrive at agreed resource models for each borough. Action : Health and Well-being Boards.

2. More information is produced on how patients flows will change in the new system and what will happen to patients borough by borough. Action : NHS NW London.

3. Milestones for how the Out of Hospital proposals will be implemented, to what standard and what measures will be used to track reductions in acute admissions and the trigger points for the implementation of the "Shaping a Healthier Future" Proposals. Actions : Clinical Commissioning Groups and Health and Well-being Boards (HWBs).

4. Plans are produced which set out how all parts of the population will be educated in how to use the new models of provision – in particular Urgent Care Centres. Action : Directors of Public Health.

5. Joint commissioning between local authorities and CCGs and between the CCGs themselves should be strengthened to deliver better coordinated care. Action : Health and Well-being Boards and Clinical Commissioning Groups.

6. Measurable standards and outcome measures are developed. Action : NHS NW London.

7. Involvement of staff in the development of the proposals will help to create greater ownership and ensure smooth implementation together with a Workforce Strategy . Action : NHS NW London, provider organisations and Trades Unions.

8. Detailed equalities impact assessment is developed and also plans for mitigation are developed. Action : NHS NW London, Transport for London and London Ambulance Service.

9. That the JHOSC is constituted to provide continuing scrutiny of the development of proposals and the responsiveness to this report and other responses received to the consultation. Action : Local Authorities.

Our focus on risks and concerns does not mean we support delay in addressing the current problems with emergency care. Our intention is to be constructive. We welcome the reassurances from NHS NW London that they recognise many of these concerns and that they have already started to address them with their partners.

The full report explores the case for change, the risks, and the key issues that reflect the engagement with evidence and the deliberations of the Committee.

3 MAIN THEMES

3.1 Case for Change

Overall

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

We also understand there are a number of important drivers which make change a matter of urgency. In particular JHOSC notes

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

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

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

The case is made for urgent change to hospital-based emergency care with the implication being that failure to adopt one of the options (such as Option A) might require emergency action to protect quality and safety. Equally every reassurance is given throughout the proposals that no change to physical capacity and location will actually be made until out of hospital provision is in place, which may take three to five years.

Integrated Vision

We feel the case for change would be stronger, be better understood and have a greater chance of success if it could be located in a clear and agreed strategy on

integrated health and social care for North West London. We feel the model of consultation could focus on a more up-to-date approach which values the active engagement of partners, staff and the public in co-designing solutions to complex problems facing health and social care.

Impact on Patient Experience

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

It is a strength that the proposals are presented as clinically-led. This should not however overshadow well-established customer intelligence about local services. We believe a simple, balanced and owned means of tracking forward progress which takes a rounded view of patient experience is important. The JHOSC is willing to provide this if desired.

Option Appraisal

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

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

Financial Case

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

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

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

Delivery

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

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

- flow of dependency patients in A&Es and then into hospital beds
- the case mix for A&Es and UCCs
- modelling admission rates and lengths of stay.

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

We ourselves feel that we have received a high level of process responses to questions where factual answers would have been preferable. For example, we have requested detail on equalities impact. NHS NW London has responded that further work has been commissioned from the same firm that undertook the initial high-level assessment. This work is timed to support the decision-making process and so will report in early 2013, rather than provide information we believe is essential to proper consultation. Equally, in respect of travel and transport, work has focused on transfer of patients by blue-light transport. We have concerns that a similar level of analysis has not been spent on the nitty-gritty issues which matter to local populations – the actual implications for friends and family who are visitors or patients or those who need to make regular hospital visits as part of their on-going care.

Non-Emergency and Urgent Care Services

A&Es and UCCs offer an easily accessible entry point for those presenting with the full range of emergency, urgent and less urgent mental health issues. The way complex interconnections between emergency care and mental health will be handled in future have not emerged from the consultation clearly or in sufficient detail.

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

Social Care

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

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

Managing the Transition

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

3.2 Impact on Care

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

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

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

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

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

We have been disappointed in the lack of clarity in response to our questions on basic detail. We would have liked reassurance that sites which are affected by a "down-sizing" of services will remain sustainable or will not suffer reputational loss and are able to function as local hospitals. We would have liked to have seen clear, local agreements that the plans as described will work and implementation plans detailing resources agreed. In addition we have seen no evidence that :-

- the patient flows are clear
- staffing requirements have been fully modelled and that these have been tested against different scenarios
- contingencies have been considered should patient flows and population predictions change
- existing hard-pressed physical spaces, such as the emergency provision in Northwick Park Hospital, can absorb higher throughput

We have not received the clarity we would have liked about the proposed division of A&Es into 'major and standard' and 'minor' facilities, about what constitute 'major' and 'standard' cases and what are the differential outcomes attributed to the UCCs as a result of whether they are attached to an acute facility or stand alone. We have

reluctantly to conclude that the models of care, the patient volumes and case-mix and the movement of patients between proposed UCC and A&E facilities still remain unclear.

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

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

NHS Trusts' Wider Plans

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

What the proposals mean for each site affected has we believe been underplayed during the process. The focus on emergency care hides deeper changes. It has not proved possible for the JHOSC to get a simple, consistent or convincing picture of what local people and staff could expect to see at Charing Cross, Ealing or Central Middlesex Hospitals as a result of the removal of emergency services and other facilities and services related to them. We have been frustrated by the absence of information from key providers, such as Imperial College Healthcare NHS Trust, on their future development plans for sites and services. We are concerned that by treating this as a stand-alone consultation the implications for larger-scale financial and clinical plans, at a time of significant change in the NHS, have not been fully factored into the proposals.

3.3 Out of Hospital Care

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

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

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

In the context of out of hospital care it is clear that a number of councils have concerns that there might be significant cost-shifting from NHS budgets to adult social care and housing. In the absence of locally agreed plans between key agencies and given the lack of staff buy-in at this point, we believe the projected timescale of three years has to be treated with caution and might be considered optimistic.

We fully support the view that building capacity amongst primary care clinicians and improving quality – especially out of hours - is critical to the success of the programme and to the maintenance of safe acute services. At present satisfaction levels with access to GP services in North West London are below national averages. This makes building capacity to the right standard, as rapidly as required to make "Shaping a Healthier Future" work, a significant challenge. We believe that acute service reform should only proceed when there has been a thorough independent verification of measurable improvements in the quality of community services, taking into account the views of patients and Healthwatch.

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

- the extent to which small-scale integrated care pilots can be confidently extrapolated as providing the expectations of capacity placed on them by "Shaping a Healthier Future";
- the ability for community services to meet the needs of highly transient populations in some areas;
- the extent to which out of hospital care can actually reduce the relentless increase in unscheduled demand – especially out of hours.

3.4 Travel, Accessibility and Equalities Impact

Travel and Transport

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

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

Emergency Ambulance Provision – "Blue Lights"

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

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

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

Non-urgent Transport

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

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

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

Equalities Impact

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

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

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

3.5 Risk Analysis

We accept that the there is a high level of risk attached to doing nothing. There are a number of risks which arise from any proposal for complex change – in the development and consultation and decision-making phases, as well as in respect of implementation. It is established as a routine part of sound governance for the Board responsible for development and delivery of proposals to identify key risks, to agree appropriate mitigations and to monitor their impact on a continuing basis.

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

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

Theme	Risk
Case for Change	The money available in the system reduces and hence there is neither the capital nor the revenue available to implement the plan or that the finances no longer flow in the way envisaged.
	Issues raised by NCAT, Expert Clinical Panels and the OGC Health Gateway Review have not been effectively responded to.
	Case for change places too much confidence in the evidence of

	small scale pilots and their replicability and scalability as part of a major change programme.
	Local authority or CCG Commissioners are not bought into the plan or behave independently of it.
	CCGs do not commission in a way that is consistent with the proposals.
	The business cases for the individual components of the plan do not align with the proposed changes and assumptions set out in the plan.
Impact on Acute Care	Risk to patient quality of moving care to providers who lack the capacity or capability to respond to increased demand.
	Clinical education and the speed of implementation of research are compromised as established patterns of provision are disrupted.
	As services are transferred it will be difficult to maintain quality in those providers undergoing significant change as capacity or morale may reduce.
	Staff who have traditionally worked in hospital settings may choose not to work in the community.
Out of Hospital Care	Demand for acute services is not reduced and so resources designated for investment in community services are no longer available.
	Proposed integration through Health and Well-being Boards of a coherent model of prevention and promotion of mental and physical health and well-being is running parallel to an NHS focused change programme leading to missed opportunities for improved patient experience.
	Lack of sufficient capacity and capability across the system while new health and social care architecture is being built compromises the governance, capacity and coherence of greater integration with local government.
Travel and accessibility	Pattern of informal care is broken as carers or those self-managing long term conditions have to travel further afield to receive care.
	Staff do not wish to travel further afield.

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

We have received a response to these risks that have gone a long way to addressing our issues. However, we believe that further monitoring and mitigation of the risks to implementation will be necessary as the project moves forward.

3.6 Underlying Assumptions

Workforce Issues

Change on this scale needs to focus on the skills, motivation, recruitment and retention of staff. We fully accept that the network depends on having the right staff in the right place, with new working arrangements between consultants, middle grade staff, nurse specialists and GPs. It can be seen as an opportunity to create a genuine network of expertise embracing a wide range of different skills and professional backgrounds.

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

We are concerned that this underestimates the likely impact on individual staff. There does not seem to be an overall workforce plan or model from which the figures derive, nor a group responsible and accountable for gaining agreement with professional bodies that the model is sound. We would echo the assessment of the NCAT Emergency and Urgent Care Report and maternity and paediatrics report about priority areas on workforce following visits to NHS NW London earlier in 2012. In particular we would support fully its assessment that more work needs to be done on :

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

Pace of change.

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

Public education.

We found the evidence provided by the College of Emergency Medicine compelling around the complexity of emergency care. "There is an overlap between the case mix that may be seen in an Emergency Department and those that can be seen in

the UCC. Which facility is better for the patient may not be easily defined at the initial assessment for a significant number of patients".

It is apparent that the general public is not clear what an Urgent Care Centre is and that this will need further explanation and communication. This suggests there is real potential for confusion amongst the public and a danger, as a result, of even reduced speed of access to the right care and treatment arising from the separation of A&E and UCC facilities. If it is difficult for the professional staff to be clear on where a patient should go how much more difficult will it be for a member of the public at a time of stress?

Serious doubts have to be raised about the reliance of the plans for change on a programme of wholesale re-education of the public about emergency care. In deprived communities there is the potential for language and other barriers to mean that care pathways might not be effectively communicated. The 111 service which is designed to enable people to make informed choices about their care will help in this regard. However, it will be a challenge to enable people to make informed choices within the timeframe available.

Population

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

Emergency Planning

We received reassurances from the NHS London Emergency Preparedness team that "the North West London health system described in the proposal will have sufficient resilience built-in to handle surges in demand such as those posed by concurrent major incidents." We also heard that "the numerical modelling that has been done to date shows that the plans will generate an excess of bed capacity in the order of 10% over what is required for the area."

3.7 Consultation Process

Any changes to A&E provision are notoriously difficult for the public to accept and for staff to embrace. This means that the process of consultation needs to be grounded in a genuine commitment to engage with the public, with staff and with partners from

the outset - in identifying the key issues and co-designing the solutions together. This builds necessary trust and confidence and reduces public anxiety.

Public Engagement

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

Consultation Period

We acknowledge that there was an extension of the consultation period at the request of the shadow JHOSC. However, we have throughout questioned the wisdom of conducting a consultation over the summer months at the same time as the Olympics, the Paralympics and the holiday season. We would suggest the consultation has as a result failed to allow local populations sufficient time to digest and engage with the plans and their likely consequences. The added problem this summer has been distractions of proposed mergers, reconfigurations, financial challenges and changes to responsibilities across the public sector in north west London.

Patient Involvement

We note that there have been stakeholder events and some CCGs have set up advisory groups. Considerable reliance has been placed, in its documentation, on the Patient and Public Advisory Group (PPAG), a network of LINks Chairs, as the main path for patient involvement on the inside of the process. We question whether this is sufficient. We would have preferred to have seen more engagement of staff and their representatives about the proposed changes. This has undoubtedly lost some key potential allies and a source of valuable intelligence and support.

Remit for Consultation

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

old-fashioned division between hospital and non-hospital care and between NHS and non-NHS provision.

Appendix 1 Members of the JHOSC

Councillors :

Ivimy (Chairman)	LB Hammersmith and Fulham
Kabir (Vice-chairman)	LB Brent
Bryant	LB Camden
Collins	LB Hounslow
D'Souza	City of Westminster
Fisher	LB Hounslow
Gulaid	LB Ealing
Harrison	LB Brent
James	LB Harrow
Jones	LB Richmond upon Thames
Kapoor	LB Ealing
McDermott	LB Wandsworth
Mithani	LB Harrow
Richardson	City of Westminster
Vaughan	LB Hammersmith and Fulham
Usher	LB Wandsworth
Weale	RB Kensington and Chelsea
Williams	RB Kensington and Chelsea

Ms Maureen Chatterley Committee Member)	LB Richmond upon Thames (Co-opted Scrutiny

Appendix 2 List of Attendees

Councillor	12 July RBKC	2 Aug Harrow	4 Sept H&F	6 Sept Ealing	26 Sept Brent	1 Oct H&F	Total
Ivimy, H&F	√	√	√	√	√	√	6
Kabir, Brent	√	√	√	√	√	X	5
Harrison, Brent	√	√	√	√	√	X	5
Bryant, Camden	X	X	X	X	X	X	0
Gulaid, Ealing	√	√	√	√	√	√	6
Kapoor, Ealing	√	X	√	√	√	√	5
Vaughan, H&F	√	√	X	√	√	X	4
James, Harrow	√	√	X	√	√	√	5
Mithani, Harrow	√	X	√	X	X	X	2
Collins, Hounslow	√	√	X	X	√	√	4
Fisher, Hounslow	√	√	√	X	√	√	5
Weale, RBKC	√	X	√	√	√	√	5
Williams, RBKC	X	√	X	X	X	X	1
Jones, Richmond	√	X	X	X	√	X	2
Chatterley, Richmond Richmond co-optee	√	X	√	√	√	√	5
McDermott, Wandsworth	√	√	√	X	√	X	4
Usher, Wandsworth	X	X	X	X	√	X	1
Richardson, Westminster	X	X	X	X	X	X	0
D'Souza, Westminster	√	√	√	√	√	√	6

Appendix 3	List of Witness Statements received
Lisa Anderton NW	Assistant Director of Service Reconfiguration, NHS
Councillor Jasbir Anand	Portfolio Holder, Health and Adult Services, LB Ealing
Trevor Begg	Chairman, Patient and Public Advisory Group
Councillor Julian Bell	Leader of the Council, LB Ealing
Luke Blair	Communications Lead, SAHF
Dr Ruth Brown	Vice President (Academic and International) of the College of Emergency Medicine and Imperial College Healthcare NHS Trust
Simon Cooper	Transport for London
Dame Jacqueline Doherty	West Middlesex University Hospital NHS Trust
Daniel Elkeles	Director of Strategy, NHS NW London
Alison Elliott	Director of Adult Social Services, Brent Council
Barry Emerson London	Emergency Preparedness Network Manager, NHS
Axel Heitmueller	Director of Strategy and Business Development, Chelsea and Westminster NHS Foundation Trust
Dr Alastair Honeyman	King's Fund
Dr Adam Jenkins LMC	Chairman of Ealing, Hammersmith and Hounslow
Catherine Jones	Transport for London
Dr Susan LaBrooy	Medical Director, Hillingdon Hospital
Jeffrey Lake London	Acting Consultant in Public Health, NHS NW
Julie Lowe	Chief Executive, Ealing Hospital NHS Trust
Peter McKenna Ambulance Service	Assistant Director of Operations West, London
Abbas Mirza NW London	Communications and Engagement Officer, NHS

Dr Marilyn Plant	GP and PEC Chair of NHS Richmond
Dr Ann Rainsberry	NHS NW London
James Reilly NHS Trust	Chief Executive, Central London Community Healthcare
Russell Roberts	Principal Transport Planner, London Borough of Ealing
David Slegg	NHS NW London
Dr Mark Spencer	Medical Director, NHS NW London
Dr Tim Spicer	Chairman, Hammersmith & Fulham Clinical Commissioning Group
R.L. Wagner South West	Programme Manager, Better Services, Better Value, NHS London
Professor David Welbourn	Cass Business School

Appendix 10: Recommendations to the Joint Committees of Primary Care Trusts in North West London

Taking into account all of the evidence that has been made available to JCPCT members, the JCPCT is recommended to agree the following resolutions on the basis that, taken together, they represent the most effective way of providing high quality healthcare for patients in and residents of North West London:

1. To agree and adopt the North West London acute and out of hospital standards, the North West London service models and clinical specialty interdependencies for major, local, elective and specialist hospitals as described in Chapter 7 of the Decision Making Business Case (DMBC).

2. To agree and adopt the model of acute care based on 5 major hospitals delivering the London hospital standards and the range of services described in Chapters 7 and 9 of the DMBC should be implemented in North West London.

3. To agree that the five major hospitals should be as set out in Chapter 10 of the DMBC: Northwick Park Hospital, Hillingdon Hospital, West Middlesex Hospital, Chelsea and Westminster Hospital and St Mary's Hospital.

4. To agree that Central Middlesex Hospital should be developed in line with the local and elective hospital models of care including an Urgent Care Centre operating 24 hours a day, 7 days a week as detailed in Chapters 7,9 and 10 of the DMBC.

5. To agree that Hammersmith Hospital should be developed in line with the local and specialist hospital models of care including an Urgent Care Centre operating 24 hours a day, 7 days a week as detailed in Chapters 7,9 and 10 of the DMBC.

6. To agree that Ealing Hospital be developed in line with the local hospital model of care including an Urgent Care Centre operating 24 hours a day, 7 days a week as detailed in Chapters 7,9 and 10 of the DMBC.

7. To agree that Charing Cross Hospital be developed in line with the local hospital model of care including an Urgent Care Centre operating 24 hours a day, 7 days a week as detailed in Chapters 7,9 and 10 of the DMBC.

8. To agree that the Hyper Acute Stroke Unit (HASU) currently provided at Charing Cross Hospital be moved to St Mary's Hospital as part of the implementation of resolutions 1, 2 and 3 above and as described in Chapter 6 of the DMBC.

9. To agree that the Western Eye Hospital be moved from its current site at 153 – 173 Marylebone Road to St Mary's Hospital as set out in Chapter 10 of the DMBC.
10. To recommend that implementation of resolutions 1 to 7 should be coordinated with the implementation of the CCG out of hospital strategies as set out in Chapters 8 and 17 of the DMBC.

11. To recommend to the NHS Commissioning Board and North West London CCGs that they adopt the implementation plan and governance model in Chapter 17 of the DMBC.

12. The JCPCT commends the further proposals that Ealing CCG has developed for the Ealing Hospital in response to feedback from consultation. The JCPCT recommends that Ealing CCG and all other relevant commissioners should work with local stakeholders, including Ealing Council and Healthwatch, to develop an Outline Business Case (OBC) for an enhanced range of services on the Ealing Hospital site consistent with decisions made by this JCPCT. This OBC is to be approved by the SaHF Implementation Board before final submission.

13. The JCPCT commends the further proposals that Hammersmith and Fulham CCG has developed for the Charing Cross Hospital in response to feedback from consultation. The JCPCT recommends that Hammersmith and Fulham CCG and all other relevant commissioners should work with local stakeholders, including Hammersmith and Fulham Council and Healthwatch, to develop an Outline Business Case (OBC) for an enhanced range of services on the Charing Cross Hospital site consistent with decisions made by this JCPCT. This OBC is to be approved by the SaHF Implementation Board before final submission.

Shaping a Healthier Future's use of Data – Submission by Co-opted Member of the Panel

While the Council has referred the NW London reconfiguration on the grounds that it fails the 4 principle points this misses the far more important issues of how residents of Ealing will actually be affected. **This looks at the quality of data used and the effect this might have on the overall plan.**

One of the major problems encountered in both reports presented to Joint NW London PCTs is that any future usage of an A&E can only be accessed on current or past activity, as no one is in possession of a crystal ball.

PCBC [Pre Consultation Business Case]
It has been proved in chapter 2 fig.2:3 that published Critical Care data did not make any sense when it recorded that Hammersmith Hospital dealt with 8 cases during 2010/11 [personal knowledge said that was incorrect].

Further data showed that Imperial Trust dealt with only 71 cases [including 8 mentioned above]. When this error was pointed out, in the draft report, to NW London it remained unaltered in the final version but a reference was added noting this as incomplete data.

Subsequent evaluation of figure 2:3 showed that it had been constructed using two different sources of reference material.

NW London mixed HES online [Hospital Episodes Statistics] & QMAE [Quarterly Monitoring of Accident & Emergency] even though they can differ significantly in the value given for each Trust [Northwick Park/Central Middlesex QMAE = 289,402 while HES = 172,300 for the same activity]. Data was also given elsewhere in the PCBC on how much the various PCTs had purchased from NWLHT, at 170,754 units of activity, bringing it much closer to the HES online value.

As fig.2:3 is the first table of actual data presented in the PCBC this is the primary source for all calculations and projections of Trust activity.

DMBS [Decision Making Business Case] published prior to 19/2/2013.
This document relies in places on data drawn from the PCBC to backup some of its decision making processes.

Yet again the DMBC presents what it terms current data [Vol.1 chapter 2 page 9 fig.2:6] representing 2012/13 figures which is claimed to have been supplied by the various Trusts.

What is interesting about fig.2:6 is the reference states it covers 2012/13 but normal Department Health reporting is from 1st April to 31st March the following year, so the data presented is incomplete.

It is possible to obtain weekly Trust data published on the DH website of A&E activity [week ending on Sunday are available 2pm the following Thursday].

Firstly, data presented in fig.2:6 shows a split of A&E between Majors type 1, Minors and Urgent Care – however, all Trusts report to the Department of Health (DH), A&E major cases as 'T1' and Minors and UCC cases together as 'T3'.

Overall Trusts' T1 total figures so far reported to DH exceeds the figure the NW London group report in fig.2:6.

Initial observation clearly indicates that no one checked the figures supplied for accuracy before publication. Once again Hammersmith Hospital supplied Critical Care data stating that they had undertaken 32,383 units of activity [3,924 units higher than the 8 other hospitals totalled together at 28,459].

However 32,383 units means that each day they would need to handle 89 patients using 13 beds and result in 7 patients sharing the same bed or a rapid "hot bedding" turn round. Further data supplied by HH showed that 15,600 patients were seen in A&E but 165,300 patients were admitted as emergency or non-electives. The non-elective figure should match or be lower than the number of patients seen in A&E.

The following table looks at how DMBC data and published backdated DH data do not match.
In the lower set the backdated data should occur on the same day for both data type and the different trusts involved.

Values from fig 2:6 DMBC

	Majors T1	T1+T3 total	Non Elective
EHT	26246	117618	15305
WM	39399	140585	16819
NWL	69166	237555	54665

Reported total value published by DH 24/2/13

	Majors T1	T1+T3 total	Non Elective
EHT	37539	94366	18301
WM	52056	122395	19113
NWL	94855	102566	33722

Date values in fig 2:6 should occur

	Majors T1	T1+T3 total	Non Elective
EHT	25/11/12	-23252	13/01/13
WM	09/12/12	-18190	20/01/13
NWL	02/12/12	-40134	-20893

The results presented show a marked difference and therefore is suspicious.

The data presented in fig.2:6 is used a second time in volume 2 page 576 which is then used to produce a forecast of activity in 2015/16 as a "Do nothing" scenario [page 577].

However the data for HH still produces the same discrepancy as originally discovered. Page 577 shows the following activity changes as compared to page 576 for all Trusts:

Electives show increase
Non electives : decrease
Births : increase
General Maternity : increase
Neonates : increase
Paeds. : mixed bag some Trusts increased while others decrease
Critical Care : increase
Outpatients : decrease
Major A&E : decrease
Minor A&E : decrease
Urgent Care : decrease

Based on the fact that page 576 shows incomplete data the difference recorded shows that major A&E

will reduce by 11.8%, outpatients by 19.3%, electives by 4%, and non-electives by 12.8%. However past data clearly shows that across all specialities there has been a trend of year on year increases going back to 2005/06.

What is interesting is that a direct comparison of activity data in the PCBC (fig 2:3) and the incomplete data of the DMBC (fig 2:6) shows there has been an overall increase, even though policies have been introduced under QIPP criteria to reduce such activity.

This increase in NW London activity, as presented in the two reports [PCBC & DMBC], does not bode well for their ideas of using OOH care to reduce hospital activity most of which revolves around QIPP measures.

There are two different sets of both Travel and Activity data given in Vol 2 & Vol 5. While both sets of Travel data agree, the amount of Activity that would be affected differs between the two volumes as Vol 5 is based on PCBC activity while Vol. 2 uses a different data source.

Using DMBC data (fig 2:6) total major A&E attendances for all 9 hospitals is 298,595 which equates to 818 cases per day. So every day, in an ideal world, 91 patients would be dealt with by each A&E - but using 5 providers their workload would increase to 164 cases, an 82% increase.

From LAS data, 181,588 movements (NW London 2011/12 HES online) occurs which gives 498 A&E movements per day and would result in the 9 units receiving 55 cases, while 5 would see 100 arrivals (82% increase).

From the LAS & DMBC data 320 patients a day, attending A&E, use other forms of transport equating to 36 patients arriving at 9 units and 64 at the reduced 5.

It should be noted that a closure of Ealing's A&E unit would also result in them losing their ability to carry out elective work (this also applies to CX).

Using both sets [Vol 2 & Vol 5] of activity data indicates that between 160 and 283 patients per day would need to be seen if CM+EHT+CX lose their A&E departments. However what is not certain is the numbers of HH patients affected, as the DMBC omits to publish this.

<u>Effectively what does the reconfiguration plan mean for the residents of Ealing?</u>
Using weekly data submitted to DH by EHT between the weeks ending 17/7/11 and 8/7/12m it shows that they saw 40,530 major type 1 and admitted 20,299 as emergencies ,giving a 50.1% admission rate.

Two important facts need to be noted:

a) The dates used correspond to complete weeks that Ealing's UCC was fully functionally [opened 6th July 2011].

b) DH Trust data and DMBC Trust data may record Minors in different places as T1 or T3.

780 patients/wk or 111/day are seen in A&E [DH data].

343	49 arrive by Ambulance [HES online 2011/12 A&E data]
434	62 use other means of arrival at A&E [HES data source above]
392	56 are admitted from A&E [DH data]
1393	199 are seen by UCC [PCT data submitted to Scrutiny 20/9/12]
161	23 are transferred from UCC to A&E [PCT source above]
280	40 are admitted as Elective admissions

These numbers are a breakdown of annual DH figures and shows a potential rough daily guide to Ealing's workload.

Returning to the DMBC Activity, data found in volumes 2 & 5, it clearly shows the movement of Ealing's workload if their A&E closes. The mean values state that 52% of EHT activity will be dealt with by WM, 23% by NWLHT, 19% HILL and 5% outside of NW London area.

Therefore, based on current (week ending 24/2/13) rolling total of Ealing's A&E activity for 2012/13 [DH weekly data] of 37,539 majors type 1, then West Middlesex (WM) would see 19,520 cases and NWLHT would see 8,259. This would now give NWLHT a total of 103,114 up from 94,855 a 8.7% increase while WM would see 71,576 from 52,056 a 37.5% increase.

So far the calculations have only looked at EHT, but it will not be the only A&E closing that will have an impact on NWLHT's workload.

Although there are no figures for HH and very little movement from CX to NWLHT given in the DMBC, there will be an internal Trust movement when CM closes their A&E.

Again using the mean percentage movements [presented in Vol.2 & 5] 68.5% of CM A&E workload would be carried out in future at Northwick Park.

In order to make any meaningful calculations, with regard to the workload that NP will deal with, we need to use data provided in Fig 2:6 of DMBC as individual hospital activity figures are given.

It is not possible to use DH data since weekly NP & CM data is recorded at trust level, as NWLHT.

A&E major T1 activity for	NP	= 57,209	
: : : : :	EHT	= 26,246	23% = 6,037
: : : : :	CM	= 11,957	68.5% = 8,191

Therefore future A&E activity at NWLHT will be 71,437, a 24.9% increase in activity based on the assumption that the data provided in DMBC is accurate.

During the first five weeks of 2013 NWLHT were the worst performing Trust in England placing them in 145th place with regard to breaches of the 4 hour rule.

There were a total of 2,529 breaches recorded for the first 5 weeks with a weekly mean of 506 [range 433-624]. A total of 9,875 patients were seen by A&E with a mean weekly total of 1975 [range 1,833-2,079]. Of these patients, 74.4% were seen within the 4 hour rule [range 70-77.8] but 25.6% [range 22.2-30%] breached this marker.

What is surprising is that NWLHT ,over the same period in 2012, saw 10,798 patients but only recorded 1,218 breaches of the 4 hour rule. So this year while there has been a reduction in the number of patients seen of 8.5% there has been an increase in the number of breaches of 107%.

Latest figures (week ending 3/3/13) shows that over the last 9 weeks NWLHT has only achieved a mean value of 76% of its patients being dealt with within the 4 hour rule.

Recent information has come to light that The Board of NWLHT have been presented with data that states that during January this year, 88.11% of patients were seen in the Accident & Emergency departments within the Trust [Board paper "The Safety, Quality & Performance Report" Jan 2013]. The Board have been given data that expresses the 4 hour breaches in slightly a different way and calculates the value T1 breaches + T3 breaches against the total number of people attending the Emergency Units [major T1+ minors +UCC =T3]. This figure gives the impression that the Trust performed better than the lower percentage figure that is calculated against T1 only.

Further study of the data shows :

NWLHT	T1	Total (T1+T3)	>4hrs T1	>4hrs T3	>4hrs (T1+T3)	%>4/T1	%>4/(T1+T3)	%<4hrs	%<4hrs All
6th	2006	4280	469	25	494	23.4	11.5	76.6	88.5
13th	1950	4073	453	4	457	23.2	11.2	77.8	89.3
20th	2169	3698	508	3	511	23.4	13.8	72.3	86.2
27th	2007	4056	495	13	508	24.7	12.5	75.3	87.5
Sum	8132	16107	1925	45	1970	94.7	49	302	351.5
Mean	2033	4027	481	11.3	492.5	23.7	12.3	75.5	87.9
	*	*	*	*	***	***	***	*	*

* DH weekly data from website *** Calculation from DH data

The CQC have recently considered limiting Queens Hospital Romford [part of the Barking,Havering and Redbridge University Hospital Trust] A&E numbers because of their consistent breaches of the 4 hour rule. During the last 9 weeks (6/1-3/3/2013) BHR University Trust has outperformed NWLHT on 6 out of the 9 times by having less patients that broke the 4 hour rule.

Out of Hospital (OOH) Care

On numerous occasions NW London have stated that the OOH system must be fully working before any closures of A&E will take place. However they have never mentioned what would happen if any CCGs were not operational at the time of "going live".

Running in parallel to NW London's reconfiguration will be a similar process for SW London which requires the services of WM, as Richmond purchase 25% of WM workload.

It has been clearly stated that the OOH process will now take five years and not the original three years.

All rebuilding work, although not starting until 2016, requires planning work to commence at the end of 2014 [except St. Mary's which will start planning at the end of 2013].

A separate document submitted to Scrutiny giving alternative proposals for CX and EHT [dated 14/2/2013] sets out two alternative plans for increasing the working size of both hospitals that potential could cost as a basic model £39millon and a maximum of £176 million.

If NW London fails to deliver the OOH strategy , for any reason , financial pressures could force short cuts to be taken in the implementation of OOH. These new builds are specifically designed not to function as a District Hospital of inpatient capacity.

NW London are very keen to quote the successes of the new stroke strategy as their flagship to the reorganisation proposals.

However according to both LAS & DH data there were approximately 9100 stroke cases in the London area during 2011/12 which would result in roughly 25 cases per day. Ealing Hospital receives 49 patients a day, by ambulance, while NW London as a whole sees a total of 498 movements. There is therefore no comparison with stroke policy.

Other than the quoted Danish hospital reconfiguration [population 5.6 million and a better Health Service] the only London OOH system is the Oxleas NHS Foundation Trust [SE London PCT] which has reduced ambulance movements by about 10% [LAS data personally obtained at a meeting].

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Appendix 12a: Cover letter to Council's response to Consultation on Shaping a Healthier Future

RE: SHAPING A HEALTHIER FUTURE

Dear Anne,

Ealing Council welcomes the opportunity to respond to the consultation on proposals set out in "Shaping a Healthier Future". Further to agreement with the Shaping a Healthier Future consultation office, the Council requests that the paper enclosed and its appendices are treated as its formal response to the consultation.

As I am sure you can appreciate, emergency care, maternity and paediatric services are all highly important and sensitive issues for Ealing residents and have a strong local resonance. Nevertheless, as a Council we have looked at the proposals for redesign and relocation of services objectively, from the perspective of the impact for North West London as a whole.

To support the development of its response, the Council has commissioned an extensive review of the proposals and undertaken broad-ranging consultation with local stakeholders. Specifically, the Council's response has been shaped and informed by three key strands of activity:

- An independent review of Shaping a Healthier Future and the business case which underpins it, carried out by Tim Rideout Limited with support from a range of technical experts with extensive experience in the field of health and social care;
- Outcomes of engagement with key strategic partners including fellow members of the Joint Health Overview and Scrutiny Committee, Members of the Health and Adults Scrutiny Committee, and Shadow Health and Well-Being Board;
- Broad-ranging engagement with local stakeholders including clinicians and members of the public.

In the light of the outcomes of these activities, the Council recognises that NHS North-West London have attempted to make a strong case for the need for change, and that difficult decisions have to be made. It accepts that "do nothing" is not an option and it is in everyone's interests to ensure that there is a sustainable and effective health economy in North West London.

However, the Council is not convinced that the specific proposals presented by NHS North West London are supportable in their current form. The reasons for this position are set out in detail in its response, but suffice it to say the concerns raised relate to both the nature of the proposals and the process for their development.

Our engagement with strategic partners, for example through the Shadow Health and Well-Being Board, has demonstrated that they share a number of our concerns. In particular, the Board shares concerns that some aspects of

the proposals present significant risks to the health and well-being of local people, and threaten partnership working developed over a number of years which has shown to be highly effective at addressing the complex needs of a large and diverse population.

Notwithstanding comments on the specific proposals, the Council believes the ultimate critical test is whether NHS North West London has managed to create confidence and trust in both the process and the content of its proposals, on the part of clinicians, other professionals, community leaders, and local people. For the reasons set out in its response, Ealing Council does not believe that this test has been passed at this point in time.

The Council remains committed to working constructively with you and other parts of the NHS to help identify alternative solutions to the challenges we face. In order to secure successful change on the scale necessary, these solutions need to command substantial professional, public, and political support.

At the conclusion of our response a number of immediate next steps have been suggested. I hope you will consider these and agree to them. In any event, the Leader of the Council and I would welcome the opportunity to discuss this further at your earliest convenience.

Yours sincerely,

Martin Smith
Chief Executive, Ealing Council

CC: Lisa Anderton; Luke Blair; Shaping a Healthier Future Consultation Office; Councillor Julian Bell; Councillor David Millican; Councillor Gary Malcolm

Appendix 12b: Ealing Council's Response to Consultation on "Shaping a Healthier Future"

1 Introduction

1.1 Ealing Council welcomes the opportunity to respond to consultation on proposals set out under the heading, "Shaping a Healthier Future" (SAHF). Further to agreement with the SAHF consultation office, the Council requests that this paper is treated as its formal response to the consultation.

1.2 To support the development of its response, the Council has commissioned an extensive review of the proposals and undertaken broad-ranging consultation with local stakeholders. Specifically, the Council's response has been shaped and informed by **three key strands** of activity:

1.2.1 An independent review of SAHF and the business case which underpins it, carried out by Tim Rideout Ltd with support from a range of technical experts with extensive experience in the field of health and social care;

1.2.2 Outcomes of engagement with key strategic partners including fellow members of the Joint Health Overview and Scrutiny Committee, Members of the Health and Adults Scrutiny Committee, and Shadow Health and Well-Being Board;

1.2.3 Broad-ranging engagement with local stakeholders including clinicians and members of the public.

1.3 This paper sets out:

1.3.1 Summary of outcomes of the three strands of work listed above;

1.3.2 The Council's key conclusions in response to the consultation;

1.3.3 Suggestions for immediate next steps.

2 Summary of outcomes from the independent review of SAHF proposals and business case

2.1 Former NHS Chief Executive Tim Rideout was commissioned by Ealing Council to carry out an independent review of SAHF. The review was carried out with the support of a range of technical experts and engagement from a broad range of local stakeholders.

2.2 Members of all political parties in the borough have been engaged in the review process. A draft report was discussed during a meeting of the Cabinet on the 18th September; the full report was discussed during a meeting of the Cabinet on 5th October. The Cabinet broadly welcomed the key conclusions and recommendations set out in the review report.

2.3 The full report is attached as Appendix 1. By way of summary, the independent review concludes that whilst some aspects of SAHF are appropriate – in particular the need to strengthen primary

care and health services provided outside hospital settings – there are serious concerns about the nature of the proposals and the way in which the options put forward for consultation have been developed, and there are too great a number of flaws with the business case to make it possible to support the proposals in SAHF in their current form. Specifically:

2.3.1 The proposed configuration will leave many patients with no choice but to attend a hospital providing poorer service than under the current system;

2.3.2 Concerns that travel times analysis does not accurately reflect the reality of travelling across the borough; neither does it account for the impact of planned regeneration developments in coming years. As a consequence there are significant concerns that this will result in delayed access to health services including emergency services;

2.3.3 Concerns over the capacity of primary care to cope with the scale of the proposed changes and that plans to significantly improve the primary care infrastructure in the borough are not scheduled to be implemented until after hospital reconfiguration;

2.3.4 Concerns over pressure on acute services across North-West London resulting from the proposal to remove 4 out of 9 A&E services;

2.3.5 Acknowledgement by local clinicians that A&E services and Urgent Care Centres can work effectively together, but a number of concerns about the capacity and efficacy of stand-alone Urgent Care Centres as a substitute for current A&E provision;

2.3.6 Support for the proposals from primary care practitioners is highly dubious;

2.3.7 Proposals are not driven by the health needs of the local population, and the scale of change proposed and its impact on local people's health needs is not adequately understood and has not been tested sufficiently;

2.3.8 The clear risk of loss of valued and high quality maternity services should SAHF proposals be taken forward;

2.3.9 The proposed configuration is likely to leave NHS North West London unable to respond to increases in demand resulting from expected increases in population, not least because SAHF proposals are based on out-of-date population data which fails to recognise both the latest population estimate (over 339,000) and latest estimates of Ealing's projected population growth by 2021 (to 376,000). Recently released figures from the 2011 Census identify that Ealing's population increased by 12% between 2001 and 2011; the ONS official estimate of Ealing's current population is 4.4% higher than it was a year ago; ONS now predict further growth in Ealing's population of 11% over the next 10 years; the biggest changes will be in the older-age groups, the number of Ealing residents aged over 85 is projected to increase by 55% between 2011 and 2021.

2.3.10 The ability of the broader local health system to cope with the scale of change proposed is not demonstrated by the NHS and so represents a significant risk to the safe delivery of healthcare in the borough;

2.3.11 Lack of appropriate risk management and modelling in relation to civil protection and emergency planning; failure to engage with the local authority appropriately in relation to these issues;

2.3.12 There is a major risk that NHS services in North West London that are expected to cope with increases in demand would not be ready before hospitals are downgraded, and concerns that "major" hospitals across North West London will not be able to cope with the additional pressures on demand and capacity that will result from the changes;

2.3.13 The timeline for implementation is hurried, unrealistic and generates unnecessary risk;

2.3.14 Major flaws with the way the proposals have been developed that do not take into account alternatives to hospital reconfiguration;

2.3.15 Severe concerns about the potential negative impact on clients of children's and adults' social care and their carers;

2.3.16 The approach to assessment of impact on equality and human rights issues is flawed and insufficient;

2.3.17 A failure to take account of the quality of services currently provided and the potential significant loss of clinical expertise;

2.3.18 Concerns that patients and the public will be immensely confused by a tiered system of local healthcare which will make it difficult for people to know where to go to access services appropriate to their needs;

2.3.19 The lack of independent verification of financial models used and lack of transparency about the financial context for the proposals – for example the need to reduce expenditure and the NHS' imperative to ensure all Trusts achieve Foundation Trust status;

2.3.20 Profound flaws in the approach to public consultation during the development of the proposals and a flawed method of enabling members of the public to submit their views, despite the crucial role of the community in enabling any changes to be successfully delivered.

2.4 The Council broadly welcomes the insight and key conclusions of the independent review. The Council accepts the assertion in the report that "no change" is not a feasible way forward. However, it recognises that the variety and volume of issues identified through the review process with the SAHF proposals make support for the total package of proposals in their current form completely untenable.

3 Outcomes from meetings with key stakeholders – Full Council, Ealing Health and Adults Scrutiny Committee, Joint Health Overview and Scrutiny Committee and Shadow Health and Well-Being Board

3.1 On 26th July the Health and Adults Scrutiny Committee considered the SAHF programme's proposals and heard views from concerned residents and local clinicians. On the basis of this meeting, the Committee has submitted a response to the Joint Health Overview and Scrutiny

Committee setting out a number of concerns with proposals in SAHF. (This response is attached as Appendix 2.) The response is based around concerns relating to the approach and deliverability of the programme, and how the programme impacts on Ealing. Much of the latter debate refers to Ealing Hospital, however, the Panel also states that it opposes the downgrading of any hospital which serves local residents, and that services currently provided in Charing Cross, Central Middlesex and Hammersmith Hospitals are regarded as valuable assets in the local health economy.

3.2 A number of Full Council motions (19th July 2011; 31st January 2012; 17th July 2012) have been passed which demonstrate that all political parties in the borough are united in their aim to secure health services valued by the local community, and oppose the process of "pitting one hospital against another" as a means of responding to drivers of change on health services. A summary of these Full Council motions is attached as Appendix 3.

3.3 The Shadow Health and Well-Being Board met on the 6th September to discuss the SAHF proposals. Stakeholders on this group include the Chair of the CCG, Chief Executives of local NHS organisations and representatives from key Voluntary and Community Sector groups (including patient advocacy and support groups). Whilst the Board agreed that the context and case for change meant that "do nothing" was not a feasible option, a number of concerns were raised in relation to the specific proposals set out in SAHF. These included:

3.3.1 The sustainability of the model;

3.3.2 Lack of appropriate risk assessments;

3.3.3 Lack of appropriate Primary Care arrangements in the community and Integrated Care arrangements outside of Hospital before reconfiguration takes place;

3.3.4 Concerns relating to travel time and transport issues which undermine some of the claims made in the SAHF business case;

3.3.5 Failure of SAHF to adequately take into account specific issues and pressures relating to the needs of the local population and population growth;

3.3.6 Concerns over the future of local hospitals, in terms of the quality and nature of services provided, and potential for SAHF to create confusion on the part of local people as to what facilities are offered on which sites;

3.3.7 Concerns relating to the consultation process, including the way it is framed, its length, the lack of information available in other languages, and concerns that the local community are not being given the opportunity to properly understand the proposals.

3.4 A summary of the key points raised at the meeting of the Shadow Health and Well-Being Board is attached as Appendix 4. In the light of these concerns, it cannot be said at this time that the Shadow Health and Well-Being Board supports the proposals set out in SAHF.

4 Outcomes from engagement with local stakeholders and members of the public

4.1 The Council has played an active role in engaging members of the public in the process of discussing the SAHF proposals and potential impact on the local community, and has made every effort to help manage the immense public desire to better understand proposed changes. The Council has facilitated engagement through public meetings and events, and by making it possible for people to make their views known online through its own website. A summary of the broad range of public engagement activities facilitated and undertaken by the Council is included in Appendixes 5 and 6.

4.2 Part of these key activities has been to facilitate a public petition on the proposals. The Council feels it is important to highlight that, to date, the council has received **26,774 responses from members of the public who oppose proposed changes under SAHF.** This number is expected to increase in the coming weeks, as a significant number of additional responses are still in the process of being scanned and counted.

5 Key Conclusions and Response

5.1 The Council recognises the context for the proposed programme of change; the stated intentions of SAHF to improve health of local people; and the need for current provision of local healthcare to change and improve in order to deliver better health outcomes overall and reduce health inequalities in the borough.

5.2 In order to prepare a credible and robust response to the consultation on SAHF, the Council has commissioned a comprehensive independent review of the proposals, and undertaken extensive engagement with service users and members of the public. These activities have brought to light:

5.2.1 profound flaws with the SAHF business case;

5.2.2 significant flaws with the consultation approach and process;

5.2.3 a lack of due and appropriate regard on the part of NHS North-West London to its duties under the Equality Act 2010;

5.2.4 a profound lack of public support for the proposals;

5.2.5 a profound lack of support for the proposals from a number of local health experts and clinicians;

5.2.6 that SAHF represents an unnecessarily divisive approach to responding to the need to change, which risks elimination of valued and effective community services.

5.3 Repeated requests have been made by the Council to NHS North-West London to extend the consultation period, in order to enable local stakeholders including the public to have more time to understand, discuss and comment upon the proposals. These requests have been denied.

5.4 The Council takes its community leadership role and responsibilities to help promote health and well-being in the borough very seriously. In the light of these responsibilities and the many issues set out in this report and Appendixes, the Council cannot support the proposals set out in SAHF as they appear in their current form.

6 Suggested immediate next steps

6.1 The Council requests that the proposals set out under SAHF are replaced with proposals for change which better reflect the needs and views of local people, and extends an offer to work with NHS North West London to assist in the process of identifying alternative ways forward.

6.2 The Council requests from NHS North-West London a detailed response to the issues and concerns raised in this paper and in the independent review (attached as Appendix 1).

6.3 The Council requests a formal statement from NHS North-West London about how this response will be used to inform decision making. The Council welcomes the commitment made by Dr. Mark Spencer during a meeting of the Shadow Health and Well-Being Board Reference Group (27th September, 2012) to enter into dialogue over use and interpretation of this response to the SAHF consultation. The Council would welcome a meeting at the earliest possible time to better understand how this response can best shape and inform further thinking on the part of key decision-makers.

6.4 The Council is committed to sustaining its engagement with strategic partners, local stakeholders and the public past the close of consultation on the SAHF proposals. To that end it is keen to learn of the outcomes of the response to the consultation made by the Joint Health Overview and Scrutiny Committee, and to hold further discussions about the proposals in meetings of its own Committees and the Shadow Health and Well-Being Board. The Council would welcome a commitment from NHS North-West London to join in these discussions.

Chief Executive

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APPENDIX 13: letter to Anne Rainsberry from LBE, re: lack of response to consultation submission

By email to Anne.Rainsberry@london.nhs.uk

Anne Rainsberry
Chief Executive
NHS North West London Cluster
Southside, 105 Victoria St
London SW1E 6QT

Ealing Council
Perceval House
14-16 Uxbridge Road
London W5 2HL

t 020 8825 5000

7 January 2013

Dear Anne

Shaping a Healthier Future

As you will be aware, on the 8th October 2012 we submitted our response to the consultation on the proposals to reconfigure local health services set out in "Shaping a Healthier Future".

In a meeting of our Shadow Health and Well-Being Board Reference Group on September 27th, Mark Spencer stated that we would receive a formal written response to our submission. This was re-iterated by Lisa Anderton during a meeting on 26th November with our Director of Policy and Performance, Matthew Booth. We were informed that the response would not be ready in time for the meeting of our Health and Adults Scrutiny Panel on December 4th, but would follow shortly thereafter.

We have, however, not yet received a formal written response to our consultation submission. This is extremely disappointing given the considerable time and effort that we put into its preparation, and the significance of the issues to Ealing's residents. Furthermore, we were informed via an email sent from Lisa Anderton to our Scrutiny Officer Kevin Unwin on 18th December that the Decision-Making Business Case will not now be published until the 12th February, ahead of the "decision-making meeting" of the Joint Committee of PCTs scheduled for the 19th of February.

The absence of a response, combined with the short timescale between publication of the Business Case and the decision-making meeting, mean that the Council is completely unsighted on any measures designed to address the concerns raised in our consultation submission.

In our view, this is unhelpful and unacceptable. We stated in our consultation submission that the Council is committed to working constructively with the NHS to help identify alternative solutions to the challenges we all face. This remains the case, but is made significantly more difficult to achieve in the complete absence of information about how concerns and suggestions we have raised in our consultation response have been addressed.

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The meeting of our Health and Adult Scrutiny Committee scheduled for 7th March will be an opportunity for Councillors to consider whether there are grounds to refer the proposals in "Shaping a Healthier Future" to the Secretary of State. The Chair of the Committee, Councillor Gulaid, would like to invite NHS officials leading the Shaping a Healthier Future programme to attend that meeting.

We would be grateful if you or one of your team could confirm attendance at the Scrutiny meeting, and would welcome knowing when we can expect to receive written feedback on our consultation response.

Yours sincerely

Julian Bell
Leader of the Council

Martin Smith
Chief Executive

cc David Archibald – Executive Director - Children & Adults
Helen Harris – Director of Legal & Democratic Services
Keith Fraser – Head of Scrutiny & Committees
Matthew Booth – Director of Policy & Performance

APPENDIX 14: HEALTH AND ADULT SOCIAL SERVICES STANDING SCRUTINY PANEL

DECISION SHEET

Monday, 4th March, 2013

PRESENT: Councillors: Gulaid (Chair); Anderson, Bakhai, Byrne, D. Crawford, Gordon, Isobel Grant, Iskanderian, Kang, Anita Kapoor (Vice-Chair), Kaur, Noori and Stafford.

ALSO PRESENT : Councillors: Anand, Bell, Manro and Millican.

Co-opted Members: Dilmohan Singh Bhasin and Mr Alan Cook.

LBE Officers Present:
Matthew Booth – Head of Policy and Performance
Keith Fraser – Head of Scrutiny and Committees
Helen Harris – Director of Legal and Democratic Services
Laurie Lyle - Committee Administrator, LBE.
Kevin Unwin - Scrutiny Review Officer, LBE.

Also Present – Outside Bodies
Daniel Elekeles – Shaping a Healthier Future (SAHF Medical Director)
Susan La Brooy – SAHF (Medical Director)
Rob Larkman – CEO NHS Brent and Harrow PCT
David Mallett – Assistant Director of Strategy NHS NW London
David Mason – Legal Advisor – 'Capsticks'
Jo Murfitt - Borough Director, NHS Ealing.
Dr Mohini Parmar - Chair of Ealing Commissioning Consortium
Dr Onkar Sahota – GP, London Assembly Member (Save Our Hospitals Ealing)
Dr Amarjit Sethi – Consultant, Ealing Hospital (Save Our Hospitals Ealing)
Mr Colin Standfield – (Chair, Ealing Hospital SoS)
Duncan Stroud – NHS N.W London
Dr Jenny Vaughan – Consultant, Ealing Hospital

1. **Apologies for Absence**
(Agenda Item 1)

There were none.

2. **Urgent Matters**
(Agenda Item 2)

There were none.

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

There were none.

4. Declarations of Interest
(Agenda Item 4):

There were none.

5. Minutes (23.01.13)
(Agenda Item 5):

Resolved: It was agreed that the minutes of the previous meeting of the Panel, held on 23rd January, 2013 be agreed as a true and correct record.

6 Matters Arising
(Agenda Item 6)

There were none.

7 'Shaping a Healthier Future' – Progress Review
(Agenda Item 7)

The Panel gave consideration to the 'Shaping a Healthier Future,' proposals which seek to implement a programme of reconfigured health and hospital services in North West London.

The Panel met to discuss these proposals, and agree what steps the Council should take in light of the light of the outcomes and recent decisions taken by the Joint Committee of Primary Care Trusts (JCPCT), on 19th February 2013.

During the course of the meeting, the Panel heard evidence and contributions from Ealing Council Members, SAHF representatives, health professionals, stakeholders and interested parties.

The Panel having given consideration to the views expressed by the SAHF representatives, Members of the Council, health professionals, stakeholders and interested parties, as well as the written evidence put before it, were unanimous in their agreement that the shaping a healthier future programme, has not met the four tests for service reconfiguration set by the Secretary of State.

The Panel also unanimously agreed to authorise the Director of Policy and Performance in consultation with the Chair and Vice Chair of the Panel, to refer the proposals to the Secretary of State, on the grounds that they did not believe the proposals were in the interests of the health service in the local area.

Resolved: (i) That the Panel note the report, supporting documents and presentations to the Panel which reviewed the 'Shaping a Healthier Future' proposals and provided details of the outcomes of the meeting of the Joint Committee of Primary Care Trusts on 19th February 2013;

(ii) That the Panel feels that the shaping a healthier future programme has not met the four tests for service reconfiguration set by the Secretary of State;

(iii) That in light of (ii) above, the Panel unanimiously agrees to authorise the Director of Policy and Performance, following consultation with the Chair and Vice Chair, to refer the programme to the Secretary of State on the grounds that the proposals are

not in the interests of the health service in the local area, for the following headline reasons – further and more detailed grounds would be given in the referral documentation on the basis of the evidence the Panel had received:

Test 1: Support from GP Commissioners;

The Panel noted that there was widespread opposition to the proposals throughout the borough. This was evidenced by the continued opposition to the proposals expressed at the Council's Scrutiny meetings, public meetings and community campaigns.

The Panel also noted the signed petitions, and representations made in opposition to the proposals by local health professionals and clinicians, GPs and consultants.

Test 2: Strengthened public and patient engagement;

The Panel were concerned that the consultation process on a number of levels had failed to meet the highest standards of engagement and consultation.

The Panel heard from several people who believed the consultation documentation and questionnaire to be biased, and there was further concerns expressed at what many considered to be the use of 'leading' questions in the consultation documents;

Of particular concern to the Panel was the timing of the consultation, and the delays in the translation of consultation documents concerning the proposals, which the Panel believes impacted negatively on engagement with the local community in view of the ethnically diverse nature of the borough's population.

In addition the Panel was concerned that there was no evidence of equalities assessments being undertaken for Ealing specifically, and that the proposals would impact negatively on vulnerable groups in the borough. The Panel were also concerned that not enough had been done to target 'hard to reach' groups in Ealing.

There was failure to ensure adequate engagement with the borough's Health and Well-Being Board.

Test 3: Clarity on the clinical evidence base;

The Panel noted that under the proposals Urgent Care Centres in 'local hospitals' will be made to function as 'stand-alone' facilities, with potential risk to patients and standards of care.

The Panel expressed concerns about the deliverability of the Out of Hospital Strategy and its ability to move activity out of acute settings and absorb the impact of the changes, whilst at the same time maintaining safe and effective acute services during the transition phase.

Concerns were also expressed about the level of investment needed in primary and community care in order to deliver the capacity and capability required, and the adequacy of proposed bed provision across North West London.

The Panel queried the accuracy of the travel times for car and public transport users, set out in the documentation. Many considered the travel aspect of the proposals to be vague and ambiguous, in particular with regard to bus routes, and the costs of travel do not appear to have been adequately addressed – this would make services harder to access. Concern was expressed at how the proposals would impact on the elderly and other vulnerable groups in the borough, attempting to access healthcare or visit relatives.

The Panel noted the absence of any confirmation or guarantees from transport organisations such as 'Transport for London (TfL), that the required improvements in local transport which underpin the SAHF proposals, could be made.

Test 4: Consistency with current and prospective patient choice.

The Panel felt that the proposed reconfiguration of acute services would impact negatively on patient choice in the borough, with key services such as a full maternity unit not being available in Ealing.

The Panel also felt that the way the consultation had been constructed had arguably limited patient choice by constraining the range of options available.

8 Diabetes Review
(Agenda Item 7)

Resolved: That the Panel agree that this item may be concluded outside of the meeting in conjunction with the Chair, Vice-Chair and relevant officers.

9 The Panel's Work Programme – 2012/2013
(Agenda Item 12)

Resolved: (i) That the Panel agree the work programme as set out in Appendix 1 to the report;

(ii) That the Panel agree the following items for consideration at the next meeting of the Panel in April, 2013:

- 'Community Pharmacies – Role in Out of Hospital Care'
- 'Ealing CCG – Update
- 'Diabetes Review'
- 'End of year review and Report to Council'
- 'Panel Work Programme'

10 Date of Next Meeting
(Agenda Item 13)

Resolved: That the next scheduled meeting of the Panel takes place on: Thursday, 25th April, 2013.

Councillor Abdullah Gulaid,
Chair.

The meeting ended at 10.20pm.

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Appendix 3: summary of public engagement activity relating to changes in healthcare provision in North West London

Public engagement outcomes:

- More than 3,000 responses generated to the NHS' Shaping a Healthier Future consultation from Ealing residents
- More than 30,000 signatures were gathered for the council's petition. Local campaigners gathered a further 30,000 signatures
- Thousands of local people attended two local marches, three public rallies in local parks, a candle lit vigil and other protests outside hospitals and in Whitehall
- During the IRP review more than 4,300 local people contributed their views using council produced post-cards

Public awareness raising activity:

- Petition
- Media campaign – releases, interviews, media briefings, photo-opportunities, media enquiries
- Outdoor advertising including bus sides, bus shelters banners, posters, banners
- Direct advertising – print and radio
- Community engagement – community campaign committee, community events including a public debate, marches, rallies, information stalls, protests and vigils
- Online and Social media – web content, facebook and twitter
- Direct Mail English and translated leaflets, postcards, Christmas cards, letters and direct email
- Use of council's residents' magazine Around Ealing
- Internal communications within Ealing Council

Media coverage:

As part of the council's activity to protect local health services we have secured widespread media coverage in a range of media. There have been in excess of 300 media mentions to date. Highlights include:

1. BBC London TV: 21 June 2012: News report on reconfiguration plans
2. LBC Radio: 2 July: Interview with leader on hospital downgrades
3. BBC London TV: 13 September: Hospital plans
4. BBC London TV: 15 September: Hospital march
5. Daily Mail online 15 September: A&E shutdown farce: The backlash from doctors, experts and patients begins as closures will lead to 'more dead babies'
6. Mail on Sunday 16 September A&E shutdown farce: the backlash begins
7. Mail On Sunday 30 September 2012 : A&E
8. Evening Standard 15 October: A&E
9. BBC London Inside Out: 22 October 2012: Hospital 8-minute mini-documentary
10. Evening Standard 30 November: A&E Sham consultation
11. Evening Standard, 17 December: Don't send patients to stretched A&Es
12. BBC London News: 8 February 2013: Hospital
13. BBC London News: 15 February 2013: Hospital
14. ITV London News: 19 February 2013 Hospital
15. BBC London News: 4 March 2013: Hospital
16. ITV London: 27 April 2013: Hospital March
17. ITV News 13 August 2013: Julian interviewed in the studio re IRP review
18. BBC London 13 August 2013: IRP review
19. BBC London: 10 October 2013: JR bid rejected
20. BBC London: 19 October 2013Hospital Rally – BBC London News - 19 October
21. BBC London News 30 October 2013: Hospital announcement by SoS
22. Evening Standard 30 October 2013: Hospital announcement by SoS
23. BBC London TV 20 August 2013: Northwick Park A&E is inadequate interview with leader of the council
24. Evening Standard 20 August 2013 Northwick Park A&E is inadequate story
25. BBC London TV 12 September 2013 A&E closures at Central Middx and Hammersmith

Council news releases and statements:

Release: More time to submit views to Independent Health Commission

Published 3 February 2015

The deadline for local people to make written submissions to the Independent Health Commission examining the impact of the NHS decision to reduce hospital services has been extended to 24 February.

The **inquiry** has been set up by Brent, Ealing, Hammersmith & Fulham and Hounslow councils to examine the impact of the NHS's decision to reduce hospital services in the area, including A&E and maternity.

The councils have raised serious concerns about the scale, speed and safety of the changes and the ability of the remaining services to cope with the extra demand.

People who wish to provide written evidence to the panel are asked to email peter.smith@lbhf.gov.uk as soon as possible. People can also send submissions by post to Peter Smith, Clerk to the Commission, Room 39, Hammersmith Town Hall, London W6 9JU. The deadline was extended by a couple of weeks to 24 February to give more people the chance to provide information.

Public hearings

The Commission is also holding a series of public hearings to enable local people to hear evidence from invited speakers about changes already made, as well as those planned, to local health services in north west London.

The first session will be held on Saturday, 14 March at Hammersmith Town Hall after which the Commission will move to Ealing Town Hall on Saturday, 21 March. There will be further meetings at Hounslow Civic Centre on Saturday, 28 March and at Brent Civic Centre on Saturday, 9 May.

Barrister, Michael Mansfield QC, is heading the commission. Mr Mansfield has taken part in some of the most important legal cases, appeals and inquiries in recent times including representing Stephen Lawrence's family and members of the Hillsborough Family Support group. Dr Stephen Hirst, a retired GP from Chiswick who has extensive local knowledge, and John Lister, researcher on the People's Inquiry into London's NHS in 2012, will complete the commission.

Release: Independent Health Commission comes to Ealing

Published 27 January 2015

The Independent Health Commission set up to examine the impact of the NHS's decision to reduce hospital services in the area, including A&E and maternity, is to hold a series of public hearings across west London.

The sessions will enable local people to hear evidence from invited speakers about changes already made, as well as those planned, to local health services in north west London. It is the largest reorganisation ever undertaken in NHS history.

The first session will be held on Saturday, 14 March at Hammersmith Town Hall after which the Commission will move to Ealing Town Hall on Saturday, 21 March. There will be further meetings at Hounslow Civic Centre on Saturday, 28 March and finally, at Brent Civic Centre on Saturday, 9 May.

The inquiry has been set up by Brent, Ealing, Hammersmith & Fulham and Hounslow councils, which have raised serious concerns about the scale, speed and safety of the changes and the ability of the remaining services to cope with the extra demand.

People who wish to present their own evidence at the public hearing should write to the commission in the next couple of weeks setting out their experiences of using local health services.

Barrister, Michael Mansfield QC, is to head the commission. Mr Mansfield has taken part in some of the most important legal cases, appeals and inquiries in recent times including representing Stephen Lawrence's family and members of the Hillsborough Family Support group. Dr Stephen Hirst, a retired GP from Chiswick who has extensive local knowledge, and John Lister, researcher on the People's Inquiry into London's NHS in 2012, will complete the commission.

The changes that will be reviewed include the closures of A&Es at Hammersmith and Central Middlesex hospitals in September 2014. It will also scrutinise plans to demolish Ealing and Charing Cross hospitals, replacing them with much smaller hospitals resulting in a significant reduction in acute hospital beds as well as the removal of 'blue light' A&E services at both hospitals. In addition, it will look at the changes to maternity services in

Ealing which will mean that women will no longer be able to give birth in Ealing Hospital. The commission will also assess the quality and type of out-of-hospital provision including GP services which the NHS promised to overhaul prior to hospital services closing.

Councillor Julian Bell, leader of Ealing Council, said: "We have being saying for more than two years that the NHS's plans for this area were untested. Having good local health services is essential to all our residents. We are delighted that we have such a high-calibre commission reviewing the evidence before providing its opinion. I would urge as many people as possible to attend the hearings or provide written evidence so that their views can be taken into account."

People who wish to provide written evidence to the panel are asked to email**peter.smith@lbhf.gov.uk** as soon as possible. People can also send submissions by post to Peter Smith, Clerk to the Commission, Room 39, Hammersmith Town Hall, London W6 9JU.

Release: Independent commission to review A&E closures

Published 1 December 2014

An independent commission, chaired by leading barrister, Michael Mansfield QC, is being set up by four local councils in west London, who have been deeply concerned by deteriorating local hospital services.

The closures of hospital A&E services in west London have been followed by lengthening waiting times for residents struggling to get seen at over-burdened neighbouring hospitals. With the expected imminent spike in demand from winter pressures, fears are rising that lives are being put at risk.

Growing disquiet at the knock-on effect on other hospitals, of the closure of emergency services at Central Middlesex and Hammersmith, has also resulted in the surprise announcement by NHS England of its own inquiry into how hospital reconfiguration in west London is being handled. The councils remain concerned about the impact of closing further services at Ealing and Charing Cross hospitals on the remaining emergency services in the region.

Official NHS figures show the trusts that run St Mary's, Charing Cross, West Middlesex, Ealing and Northwick Park hospitals have all failed to meet A&E waiting time targets over recent weeks.

In the three weeks after 19 October, all three hospital trusts dipped below the national target, which says 95% of patients should be seen within 4 hours. Performance at North West London Hospitals Trust, which runs Ealing and Northwick Park hospitals, fell to just 67.8% of patients being seen within 4 hours, the second worst result in the country.

Now, four councils in Hammersmith & Fulham, Ealing, Brent and Hounslow have got together to set up an impartial inquiry to look in depth at the impact local closures are having, and at the implications of further hospital reorganisation proposals, including the planned closure of services at Ealing hospital and Charing Cross hospital in Hammersmith.

As well as reviewing the evidence provided by the NHS to support their reorganisation, the commission will be asking others to contribute evidence. It will also commission further research to fill the gaps in existing evidence.

Councillor Julian Bell, leader of Ealing Council said: "Since plans to change emergency services in our area were first suggested we have felt that our very real concerns have been

largely ignored. We have heard lots of spin about what will replace A&E services at Ealing, Charing Cross, Central Middlesex and Hammersmith hospitals but before these changes go any further we need proper answers. Emergency services in this area are already struggling so it makes no sense to cut Ealing's A&E. By engaging someone of the calibre of Michael Mansfield QC to carry out this independent review we know that the public will get a true picture of what is happening and if the NHS is keeping its word about providing new services before others are closed."

Councillor Muhammed Butt, leader of Brent Council, said: "Our worst fears, about the effects of closing local A&Es before the expansion of Northwick Park was complete, have come true. Brent residents now face the longest A&E waiting times in the country and immediate action needs to be taken to resolve this situation as we are talking about life and death emergency treatment. Further delays to the A&E improvements at Northwick Park will only make the problem worse. We will support the Independent Commission, and will be demanding answers from NHS bosses at our next scrutiny committee. West Londoners deserve the best healthcare and this joint review will be vital in shining a light on what has gone on with these botched A&E closures."

"A&E closures are already putting dangerous additional pressures on other hospitals and will only get worse if services at Charing Cross are also closed," says H&F Council Leader, Councillor Stephen Cowan. "The official figures speak for themselves, but we plan to bring some extra, independent scrutiny to examine what local trusts are doing to our hospital services. An impartial review is needed, free of vested interests, of the real and likely impact of these major hospital re-configurations and the financial reality behind them.

The leader of Hounslow Council, Councillor Steve Curran said: "Ensuring a safe and sustainable future for West Middlesex Hospital remains one of Hounslow Council's top priorities. We continue to work closely with Hounslow Clinical Commissioning Group and the NHS Trust to make sure local residents receive the best possible care."

Michael Mansfield QC last year chaired the Lewisham People's Commission, an inquiry into the proposals to close services at Lewisham Hospital. He has represented defendants in criminal trials, appeals and inquiries in some of the most controversial legal cases in the country. He represented the family of Jean Charles de Menezes and the families of victims at the Bloody Sunday Inquiry. He chaired an inquiry into the shoot to kill policy in the North of Ireland and has represented many families at inquests, including the Marchioness disaster and the Lockerbie bombing. He also represents the family of Stephen Lawrence.

He will be joined on the commission by Dr Stephen Hirst, a retired GP from Chiswick with extensive local knowledge and John Lister, researcher on the People's Inquiry into London's NHS in 2012 and Senior Lecturer in Journalism at Coventry University.

Weekly A&E figures supplied by **NHS England**

% of patients seen within 4 hours	**Week of 2 November 2014**	**Week of 26 October 2014**	**Week of 19October 2014**	**Week of 12 October 2014**
London North West Healthcare NHS Trust (Ealing, Northwick Park)	89.9 (All A&Es) 74.6 (Major A&Es)	94.1 (All) 73.3 (Major)	86.6 (All) 67.8 (Major)	91.0 (All) 78.1 (Major)

West Middlesex University Hospital NHS Trust	91.8 (All) 88.0 (Major)	89.5 87.4 (Major)	92.5 (All) 83.7 (Major)	95.6 (All) 91.6 (Major)
Imperial College Healthcare NHS Trust (St Mary's, Hammersmith, Charing Cross)	93.2 (All) 85.4 (Major)	94.1 86.5 (Major)	92.1 (All) 82.5 (Major)	94.7 (All) 87.9 (Major)

Statement

Ealing
www.ealing.gov.uk

ID 1434

28 October 2014

For Immediate Release

Response to the Care Quality Commission's inspection of Chelsea and Westminster Hospital NHS Foundation Trust

Ealing Council will write to the Health Secretary Jeremy Hunt MP to raise concerns about overstretched accident and emergency services in the north-west London region following the release of a report today (28 October) by the chief inspector of hospitals.

An inspection carried out by the Care Quality Commission (CQC) of services at Chelsea and Westminster Hospital NHS Foundation Trust found an increased demand for services at the trust, including in its accident and emergency (A&E) service. It also found that the A&E did not have the recommended levels of medical staff working there and that this service was 'experiencing difficulties' in meeting the extra demand.

Hospital staff told inspectors they believed the reconfiguration of services across London had contributed to the increase in demand. The inspectors said they had no evidence to support this view.

On 10 September, two A&E services in the region, at Central Middlesex and Hammersmith

hospitals, were closed as part of the NHS's plans to rationalise services across north-west London. This meant that people who previously used A&E services at these hospitals now have to use services at the remaining hospitals in the region, including Chelsea and Westminster Hospital NHS Foundation Trust.

Inspectors rated accident and emergency, medical care, surgery, children's care, end-of-life care and outpatient services at the Chelsea and Westminster as 'requires improvement'. Critical care and maternity and family planning were rated as 'good'. CQC rated the hospital as 'requires improvement' overall.

In August, the CQC released a report about services provided by North West London Hospitals NHS Trust. It identified a number of areas where Northwick Park Hospital needed to improve including ensuring there were enough staff to deal with A&E patients. It also wanted the trust to put in place better systems to assess and monitor the quality of A&E services to make sure they were safe and could be benchmarked against national standards.

In addition to the closure of A&E services at Central Middlesex and Hammersmith Hospitals the NHS intends to downgrade A&E services at Ealing Hospital and Charing Cross Hospital – leaving the area with five major hospitals with fully-functioning A&Es.

Councillor Julian Bell, leader of the council said: "This is the second report in as many months where the chief inspector of hospitals has highlighted concerns about the remaining A&E services in our area. Since the plans to shut A&Es were announced, I have expressed concerns about the ability of the remaining A&E services to cope with extra demand in patient numbers and this second report confirms my fears.

"We are committed to ensuring that our residents have access to the best possible health services available. I will now be writing to the secretary of state for health to reiterate the very real concerns that this council has about the NHS's plans for accident and emergency services in this area and ask that he assures us that patient safety is not put in jeopardy by further reconfiguration."

Councillor Hitesh Tailor, cabinet member for adults, health and wellbeing, said: "This report tells us that people who need to be seen quickly are waiting longer to be assessed and treated and that there aren't enough medical staff working in A&E.

"This is unacceptable and raises serious concerns about the NHS's plan to reduce services further. On reading this latest report, I am deeply concerned about the ability of A&E services to cope as we enter the winter period, when demand normally increases."

Specialist HIV and sexual health services provided by Chelsea and Westminster Hospital NHS Foundation Trust were rated as 'outstanding'. Inspectors found that staff were caring and compassionate and treated patients with dignity and respect, and the majority of patients said their experiences of care were good.

The full reports on the trust and on the hospital are available from: http://www.cqc.org.uk/location/RQM01.

Statement

Ealing
www.ealing.gov.uk

ID 1370

20 August 2014

For Immediate Release

Response to the Care Quality Commission's inspection of North West London Hospitals NHS Trust

Council calls for the NHS to rethink closing hospital services

Ealing Council is calling on the NHS to immediately halt its plans to close the A&E department at Central Middlesex Hospital after the chief inspector of hospitals found the alternative A&E service at Northwick Park Hospital to be inferior.

The inspection carried out by the Care Quality Commission (CQC) rated the A&E service at Central Middlesex as 'good' but found that same service at Northwick Park Hospital 'required improvement'.

The NHS intends to close the A&E services at both Central Middlesex Hospital and Hammersmith Hospital on 10 September as part of its plans to rationalise services across North-West London. This will mean that people who previously used A&E services at these hospitals will transfer to other local hospitals, including Northwick Park.

The CQC report which reviewed services provided by North West London Hospitals NHS Trust was released today (Wednesday, 20 August). It identifies a number of areas where Northwick Park Hospital needs to improve including ensuring that there are enough staff to deal with A&E patients. It also wants to see better systems in place to assess and monitor the quality of A&E services to make sure that they are safe and can be benchmarked against national standards.

Councillor Julian Bell, leader of the council said: "This report raises serious questions about the sense of closing a good A&E service at Central Middlesex and pushing patients to a poorer service at Northwick Park Hospital. Since these plans were announced, I have expressed concerns about the ability of the remaining A&E services to cope with extra demand in patient numbers and this report increases these fears.

"We were promised that services would only close when proper alternatives were in place, this is clearly not the case and so we expect the NHS to stop the closures."

In addition to the planned closure of the two A&Es next month there are longer term plans to provide fewer maternity units in the region, including at Ealing Hospital.

The CQC inspection report, found that maternity services at Northwick Park Hospital required improvement to ensure women received a safe and effective service. Worryingly, the inspection team found that women in labour couldn't always get the help they needed and that individual needs of some mothers were not being met. It also found the environment and equipment in paediatric services needed to be improved.

Councillor Hitesh Tailor, cabinet member for adults, health and wellbeing said: "We are committed to ensuring that our residents have access to the best possible health services available. On reading this report, I am deeply concerned about the loss of A&Es services for Acton residents.

"We know that when services shut they are gone for good. It makes little sense to close a maternity service in our borough and force mothers to travel to Northwick Park Hospital which the CQC inspector has found to be inadequate.

"The bottom line is that no changes should take place to existing hospital services until we are assured that satisfactory alternatives are in place and can cope with increased demand."

Inspectors found areas of outstanding practice at Northwick Park Hospital, including its stroke unit which it said was providing a 'gold standard service'.

The CQC's full reports on the trust and on each hospital site covered by this inspection are available from: http://www.cqc.org.uk/provider/RV8.

Statement

Ealing
www.ealing.gov.uk

ID 1131

30 October 2013

For immediate release

Cllr Julian Bell, leader of Ealing Council on the downgrade of hospitals in north west London:

Statement by Cllr Julian Bell, leader of Ealing Council on the downgrade of hospitals in north west London:

"Jeremy Hunt's statement raises as many questions as it answers and the devil will be in the detail. It is devastating that A&Es at Hammersmith and Central Middlesex will be lost. We hope Mr Hunt's promises are genuine and this isn't just a stay of execution for the A&Es at Ealing and Charing Cross hospitals.

"When you look at the IRP report it says that there will only be five major hospitals. He knows that you can only have a full A&E at a major hospital and we are left wondering if all we are being offered is an enhanced urgent care centre by another name. He has decided to close the maternity unit today which means anybody with an Ealing postcode will not be able to have their baby at their local hospital.

"If blue light ambulances can't stop there and you can't have a baby there then it isn't a proper hospital.

"What we do know is that without Ealing Council forcing an independent review and the campaigning of local people we would not have seen any concessions.

"I would like to thank everyone who signed a petition, or marched in protest to oppose these monstrous plans and let them know we will continue to fight for the best possible health services for this borough.

"We will now seek urgent discussions with the NHS and the secretary of state to find out more about these latest plans."

Release: Ealing Council's bid for judicial review on hospital plans is rejected

Published 10 October 2013

Ealing Council's request for a judicial review (JR) of controversial plans to downgrade four local hospitals has been rejected today (Thursday, 10 October).

At the oral hearing at the High Court, Mr Justice Mitting told the court that he would not allow the case to proceed to a full judicial review.

Alongside the council's bid for a judicial review, it also referred the NHS's decision to the secretary of state for health who then asked an independent panel to review the plans. The panel submitted its report to Mr Hunt in September and he is expected to make the final decision on whether the plans will go ahead shortly.

Disappointed campaigners are now pinning their hopes on secretary of state for health, Jeremy Hunt MP to reject the plans and save local hospital services.

Councillor Julian Bell, leader of the council, said: "Everyone involved in the campaign will be devastated by this decision. The future of these vital health services now rests with Jeremy Hunt who can still reject these monstrous plans. I would urge him to scrap these plans now in response to our very real concerns about the safety of these plans and the ability of remaining services to cope.

"We are holding a public rally on the afternoon of Saturday, 19 October, opposite Ealing Hospital, and I would encourage as many people as possible to attend and show their support of the campaign to protect local hospital services."

The council applied for a JR in May after the NHS approved plans to shut four A&Es and downgrade other services at Ealing, Central Middlesex, Hammersmith and Charing Cross hospitals.

The controversial plans are the largest ever attempted by the NHS despite the increasing demand for emergency services.

If the plans go ahead the NHS has admitted that 'blue light' journeys will be longer for one in three patients.

Ealing Council's cabinet will discuss the council's next steps on 22 October.

Release: Hospital campaigners to hold public rally

Published 8 October 2013

Ealing residents are being encouraged to attend a rally to show their opposition to NHS plans to cut hospital services in north west London on Saturday, 19 October.

The rally will be held in Brent Meadow, Uxbridge Road from 1pm. The entrance to the meadow is opposite Ealing Hospital, close to Hanwell Bridge.

The rally will be the third of its kind to be held since the NHS announced plans to shut A&E services at Ealing, Central Middlesex, Charing Cross and Hammersmith hospitals, and downgrade other services including maternity and paediatrics. Campaigners are concerned about the safety and scale of the NHS's plan, which would leave three London boroughs, with a total population the size of Leeds, without a major hospital.

Ealing Council referred the NHS's decision to the secretary of state for health, Jeremy Hunt MP last March. After this, Mr Hunt ordered an independent panel to carry out a review of the plans and it presented this report to him on 13 September. After the secretary of state has considered the report he will make the final decision on whether to approve the plans. This decision is expected to be made soon.

Council leader Julian Bell said: "We want as many people as possible to attend the rally to show their support for our local hospitals. It is important that the NHS and the secretary of state understand that our voice is still as loud as ever and we will not go away.

"If these plans go ahead people in Ealing will be further away for emergency treatment even under 'blue light' conditions when every second counts. Why should we accept this second rate service? We are told that these plans are in our best interests but know that they are driven by finances, not patient care or choice.

"It is not too late for the secretary of state to reject these plans. I would welcome the opportunity to speak to him about the grave concerns the council and campaigners have about what is proposed."

All political parties on Ealing Council oppose the proposals.

Release: Council goes to court in a bid to save our hospitals

Published 2 October 2013

Ealing Council will go to court on Wednesday, 9 October in a bid to secure a full judicial review (JR) of plans to downgrade four local hospitals.

Previously, a judge rejected the council's application for the judicial review of NHS plans to shut A&E departments and downgrade other services at Ealing, Central Middlesex, Hammersmith and Charing Cross hospitals. The council will now present its case for judicial review at an oral hearing at the Royal Courts of Justice in The Strand.

The controversial plans are the largest ever attempted by the NHS despite increasing demand for emergency services.

Local campaigners and the council have raised concerns about the safety of the plans and the ability of remaining services to cope. If the plans go ahead the NHS has admitted that 'blue light' journeys will be longer for one in three patients.

Councillor Julian Bell, leader of the council, said: "We welcome the opportunity to present our case in court. We will be setting out our very serious concerns about plans to decimate hospital services across north-west London and arguing forcefully for a full judicial review.

"This winter, millions of pounds in crisis payments will be spent to sustain accident and emergency services including at Ealing Hospital. This money is being spent because these services are essential. So, how can we trust people who tell us that cutting half of the emergency units in our area is safe and will actually enhance our residents' health?

"These plans are driven by cost-cutting but dressed up under the guise of health improvement and they don't stand up to scrutiny. Will the young mothers who will have to travel outside of our borough to give birth think their services have been improved? I know that if a member of my family had been seriously hurt, I would want them to get emergency care as quickly as possible, not travel miles further through London traffic before they were treated. We are fighting to protect these services for all our residents and won't stop until there are no other options open to us."

The council has also referred the issue to the secretary of state for health, Jeremy Hunt MP, who responded by ordering an independent panel to review the NHS plans. The panel's report was presented to Mr Hunt on 13 September and his decision is expected to be announced in the next few weeks.

Campaigners are expected to meet outside the Royal Courts of Justice, The Strand, WC2A 2LL on Wednesday, 9 October at 9.00am. People travelling by tube should use Temple on the Circle and District lines or Chancery Lane on the Central Line.

Release: Ealing Council pushes for judicial review

Published 13 August 2013

Ealing Council is challenging a decision to reject its request for a judicial review (JR) of plans to downgrade four local hospitals.

The council is now seeking an oral hearing at the High Court in a bid to secure a full judicial review.

The council applied for a JR in March after the NHS approved plans to shut four A&Es and downgrade other services at Ealing, Central Middlesex, Hammersmith and Charing Cross hospitals.

The controversial plans are the largest ever attempted by the NHS despite increasing demand for emergency services.

Local campaigners and the council have raised concerns about the safety of the plans and the ability of remaining services to cope.

If the plans go ahead the NHS has admitted that 'blue light' journeys will be longer for one in three patients.

Councillor Julian Bell, leader of the council, said: "This news hit us like a body blow, but we are determined to fight on. The NHS want to treat the people of Ealing as guinea pigs in the largest experiment in its history and we believe it is only right that our very serious concerns get proper consideration.

"If you plot emergency hospital services on a map of north west London, it is very apparent that there is a gaping hole of provision over Ealing. Unsurprisingly, we do not believe these monstrous plans are in our best interest and we want our day in court."

Alongside the council's bid for a judicial review, it also referred the NHS's decision to the secretary of state for health who then ordered an independent panel to review the plans. The panel is currently carrying out the review and it will submit a report to health secretary, Jeremy Hunt in September, when he will make the final decision on whether the plans will go ahead.

Release: Last chance to have your say on hospital plans

Published 9 July 2013

Residents concerned about plans to downgrade local hospital services are being urged to express their views to the panel ordered by the government to carry out an independent review.

The independent panel is in the borough to visit hospitals, meet with doctors, councillors and campaigners as it gathers evidence before making its recommendations to the secretary of state for health in the autumn.

To help residents have their say the council has produced freepost cards which are being delivered to homes and businesses across the borough this week. Councillors are encouraging residents to fill in and return the cards so that the panel can take account of the views of local people as part of the review process.

The review was prompted after the council's scrutiny panel unanimously voted to refer controversial NHS plans to downgrade hospitals in the area to the government in March. The review is expected to be finished by mid-September after which the health secretary will consider its findings before making his decision.

Proposals to shut A&E services at Ealing, Central Middlesex, Charing Cross and Hammersmith hospitals were announced last summer and resulted in widespread opposition by people from across north west London.

Under the current plans the four hospitals affected would no longer accept 'blue light' emergency cases - meaning parts of the borough would be significantly further away from life-saving treatment than they are now.

Campaigners have pledged to be out in force over the summer at community events and in the borough's high streets to make the public aware of what is proposed and gather support for the campaign.

Council leader Julian Bell said: "I and fellow councillors, from each political group on the council, gave evidence to the panel on Monday 8 July. During this session we set out the council's grave concerns about how these cuts to local hospital services would be detrimental to the health of local people. We explained that not only would vital emergency services be further away making it harder for borough residents to seek treatment they would take away choice from patients.

"Given the growing pressure that A&E and maternity departments are facing it is hard to imagine how the remaining services would cope under the strain if these vital services are taken away.

"I am hopeful that the views of local people will be given the consideration they rightly deserve and that these barmy plans will be rejected."

The Save Our Hospitals campaign will hold its next public meeting on Thursday 11 July, Queen's Hall, Ealing Town Hall between 7-9pm.

All political parties on the council are against the NHS proposals.

People are encouraged to support the **Save our Hospitals campaign** and follow the campaign on **Twitter** #HelpSOH

Release: Review into A&E closures announced

Published 24 May 2013

Jeremy Hunt MP, secretary of state for health, has written to Ealing Council to confirm that he has referred controversial plans to close four A&E departments to an independent panel to review.

The letter from Mr Hunt arrived yesterday (Thursday, 23 May) and confirmed that given the scale of the changes and the council's referral to him that he would ask the panel to carry out a full review of the plans. It is expected that the panel will complete its report by September, after which the health secretary will consider its findings before making his decision.

In March, Ealing's health and adult social services scrutiny panel unanimously voted to refer controversial plans to the government.

Councillors were angry that NHS bosses decided to push through plans to downgrade four local hospitals, claiming that they would be made at a scale and speed never tested before in NHS history. Councillors were also concerned that the plans were reliant on improvements in primary care that have not yet been achieved and without robust evidence they are safe.

Proposals to shut A&E services at Ealing, Central Middlesex, Charing Cross and Hammersmith hospitals were announced last summer resulting in widespread opposition by people from across north west London.

Under the current plans the four hospitals affected would no longer accept 'blue light' emergency cases - meaning parts of the borough would be significantly further away from life-saving treatment than they are now.

Council leader Julian Bell said: "This is good news for everyone who is campaigning to 'Save our Hospitals' and protect our vital emergency services. Accident and emergency services are under increasing strain with more people using them than ever before. After reading a report in the Mail on Sunday about the increase in deaths in the Newark area following the closure of A&E services, our level of concern has increased and we want these plans scrapped.

"NHS bureaucrats seem hell-bent on ignoring the views of the people of this borough and so I'm pleased that this panel will now review what is proposed. As these plans do not meet the four basic tests set before hospital services can be reconfigured we believe Jeremy Hunt will have no choice but to overturn the NHS decision.

"I am in no doubt that there is still a lot of hard work to do if we are to defeat these barmy plans but, rest assured, we are going to do everything within our power to fight these proposals which we fear are driven by the need to save £1billion rather than by what will deliver the best health care for our residents."

All political parties on the council are against the NHS proposals.

People are encouraged to support the **Save our Hospitals** campaign and follow the campaign on Twitter #HelpSOH

Release: Campaigners take to the streets to Save Our Hospitals

Published 29 April 2013

Thousands of people marched through the borough on Saturday to oppose NHS plans to close accident and emergency units and other services at four local hospitals.

Traffic was brought to a standstill along the Uxbridge Road as the two marches snaked from Acton in the east and Southall in the west to converge at a rally on Ealing Common.

Save Our Hospitals campaigners are claiming the march is the largest street protest ever to take place in Ealing

Politicians from across the political spectrum led protestors to the sounds of drums and vuvuzelas. The lively and good-natured marches attracted the attention of shoppers and onlookers along the routes with many drivers taking the opportunity to toot their horns in support.

The marches and rally was organised by the Save Our Hospitals campaign which is fighting the NHS decision to downgrade local hospital services. In February NHS managers agreed to close accident and emergency units at Ealing, Central Middlesex, Charing Cross and Hammersmith hospitals. This decision has been referred to the secretary of state for health by Ealing Council.

Last week Ealing Council also announced that it would apply for a judicial review to challenge the NHS's decision because it feels the plans are not in the best interests of local people.

The concerns raised by the council include failure to take into account clinical evidence, insufficient public and patient engagement, inadequate public consultation and a failure to consider the impact that stopping services would have on Ealing residents.

Leader of the council Councillor, Julian Bell said: "I'd like to thank everyone who marched on Saturday. The turn-out was excellent, with people of all ages, backgrounds and political beliefs united in a single message to the NHS – hands off our hospitals.

"People are genuinely afraid by what is proposed and want these plans to be scrapped. A woman I met on Saturday is only alive today because she reached her local A&E within five minutes. How can plans to shut emergency services be in her and other residents' best interests?

"I have promised that the council will do everything in its power to stop these plans and we will continue to fight for local people to protect our hospitals."

All political parties on the council are against the proposals.

Release: Council to seek judicial review on plans for hospitals

Published 24 April 2013

Ealing Council's cabinet last night (Tuesday 23 April) agreed to apply for a judicial review to challenge the NHS's decision to close four casualty departments and downgrade other local hospital services.

The application for legal action is being taken by the council because it feels the plans are not in the best interests of local people. The concerns raised by the council include failure to take into account clinical evidence, insufficient public and patient engagement, inadequate public consultation and a failure to consider the impact that stopping services would have on Ealing residents.

The council's legal team is expected to lodge papers with the court in the next two weeks.

In addition to the legal action, the council has already referred the plans to the government and the secretary of state for health is expected to order an independent review.

There has been widespread opposition to the plans since they were announced last summer. They would mean A&E services closing and other services being downgraded at Ealing, Central Middlesex, Charing Cross and Hammersmith hospitals. This would leave three London boroughs, which have a total population the size of Leeds, without a major hospital.

Councillors are angry that the NHS bosses have approved the plans to downgrade hospital services, and claim that the changes would be made at a scale and speed never tested before and that any success would be reliant on improvements in primary care that have not yet been achieved. There is also no robust evidence that the plans are safe or will deliver equal treatment to all Londoners in the region.

Under the current plans, the four hospitals affected would no longer accept 'blue light' emergency cases. This means parts of the borough would be significantly further away from life-saving treatment than they are now.

Leader of the council, Councillor Julian Bell said: "We are facing a David versus Goliath struggle to protect our local hospitals but will use every option open to us, including going to court, to fight to keep these vital services for our residents.

"Although times are tough and the council is facing increasing pressure on its finances, it is right we stand up and fight to protect local hospital services. If this means taking this battle to the courts, so be it.

"The changes being pushed through are not only the largest ever attempted in the history of the NHS, they are also completely untested – with our residents playing the part of unwilling guinea pigs. People are rightly frightened, angry and frustrated that their views are being so recklessly ignored."

Councillor Jasbir Anand, the council's cabinet member for health and adult services, said; "We will continue to fight these cuts in every way we can. I would urge local people to join one of the protest marches this Saturday which will travel through the borough, ending up with a rally at Ealing Common.

"We do not feel local people have been consulted properly and the views of local GPs and consultants have been sidelined. We have numerous concerns about the safety of these plans and the impact on our community which the NHS has failed to address properly which is why we have referred the matter to the secretary of state and will continue to press for these plans to be scrapped."

The march from Southall will meet at Southall Park at 11.30am, while the march from Acton will meet at Acton Park at 12.30pm. The rally will then begin at Ealing Common at 2pm.

All political parties on the council are against the proposals.

Release: Show support to Save Our Hospitals

Published 10 April 2013

Residents are urged to take to the streets on Saturday, 27 April to show their support for local hospitals, despite plans to close four out of nine A&E departments in North West London.

People can participate in the marches which will meet at both Southall Park and Acton Park and converge at a rally at Ealing Common.

Ignoring fierce opposition to the plans, NHS NW London has decided to shut A&E services at Ealing, Central Middlesex, Charing Cross and Hammersmith hospitals, and stop other services currently provided including the maternity unit at Ealing Hospital. This would leave three London boroughs, with a total population the size of Leeds, without a major hospital.

Ealing Council has since referred the NHS decision to the Secretary of State for Health, Jeremy Hunt MP so he can order an investigation into the matter by an independent panel.

Council leader Julian Bell said: "Our fight is not over. We want to send a message to NHS bosses and the secretary of state that we will not stand for this disastrous decision. Our voice is still as loud as ever and we will not go away.

"Their plans are driven by finances and not by the best interests of the people. It is not too late to change their decision and work towards a sensible alternative that provides our residents with essential health care and saves our hospitals."

The march from Southall will meet at Southall Park at 11.30am, while the march from Acton will meet at Acton Park at 12.30pm. The rally will then begin at Ealing Common at 2pm.

All political parties on the council are against the proposals.

Find out more about the **campaign**.

In addition to the marches, people can support Save Our Hospitals by following the campaign on Twitter #HelpSOH.

Release: Ealing Council refers plans to close A&Es to government

Published 5 March 2013

Ealing's health and adult social services scrutiny panel unanimously voted to refer controversial plans to close four casualty departments to the government.

Despite massive local opposition, NHS bosses want to shut A&E services at Ealing, Central Middlesex, Charing Cross and Hammersmith hospitals as well as stopping other services. This would leave three London boroughs, with a total population the size of Leeds, without a major hospital.

NHS representatives were given the opportunity to address the meeting, setting out their views on why they thought the plans would meet local health needs and to ask councillors not to refer this decision to Health Secretary Jeremy Hunt.

But, councillors are angry that the NHS bosses are pushing through the plans to downgrade hospital services, claiming that they would be made at a scale and speed never tested before, reliant on improvements in primary care that have not yet been achieved and without robust evidence they are safe or will deliver equal treatment to all Londoners in the region.

Under the current plans the four hospitals affected would no longer accept 'blue light' emergency cases - meaning parts of the borough would be significantly further away from life-saving treatment than they are now.

Council leader Councillor Julian Bell, who addressed the scrutiny meeting to encourage fellow councillors to refer the decision, gave his reaction.

He said: "The council's referral will mean that these plans will now be examined by an independent panel appointed by the government. As the plans do not meet the four basic tests set before hospital services can be reconfigured we believe Jeremy Hunt will have no choice but to overturn the NHS decision.

"It is important that we continue to show our opposition and so we are planning a protest march and rally in Ealing on Saturday 27 April. I want to encourage people across the region to come and join us. Even if their hospital isn't affected they need to consider what it will be like when more people are waiting for vital emergency treatment in fewer hospitals."

As part of its response to the NHS consultation, Ealing Council commissioned independent analysis of the plans that highlighted inadequacies in the NHS business case, consultation process and understanding on how plans would affect local people.

Councillor Jasbir Anand, the council's cabinet member for health and adult services, said; "Doctors, local people and the council have raised serious concerns during the consultation which we believe the NHS has ignored. We keep being told that these plans are clinically led but this is not borne out by the evidence, consultants at Ealing Hospital are universally opposed to what is proposed and 72% of local GPs did not vote for it either. Our fear is that these plans are driven by the need to save £1billion rather than by what will deliver the best health care for our residents. "

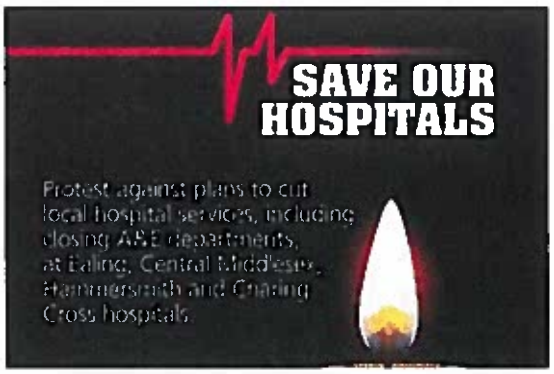
All political parties on the council are against the proposals.

People are encourage to support the Save our Hospital campaign and follow the campaign on Twitter #HelpSOH

Release: Hundreds join hospital vigils

Published 11 February 2013

Campaigners say 400 people attended candlelit vigils outside Ealing and Central Middlesex hospitals on Saturday, 9 February as part of the on-going campaign to save local hospital services.



Despite the freezing temperatures campaigners stood outside the hospitals for an hour and a half as part of a week of protests across London to oppose reductions in hospital services.

Under NHS North West London's plans, four hospitals in the region would be downgraded – including closing the accident and emergency departments at Ealing, Central Middlesex, Hammersmith and Charing Cross hospitals.

Other services, including intensive care, emergency surgery, paediatrics and maternity units at some of those hospitals, would also close.

The vigils are the latest in a series of protests held in the borough to oppose the plans. Local people marched in their thousands across the borough last September to a mass rally on Ealing Common and campaigners estimate more than 80,000 residents across the region have signed petitions asking for plans to be dropped.

On 19 February a meeting of NHS officials will decide if the plans will proceed.

Councillor Julian Bell, leader of the council, said: "The NHS bureaucrats behind these deeply flawed proposals seem to think that they can railroad them through, regardless of the views of local people or the council.

"We have said loudly and clearly we will not give up these essential health services without a fight and I can assure the NHS that the council is fighting-fit and ready to defend these hospitals."

All political parties on the council are against the proposals.

Release: Leader puts saving hospitals top of his Christmas list

Published 14 December 2012

Council leader Julian Bell is sending out a Christmas card with a difference this year - a plea to Santa to help save the area's hospitals.

The card has a note to Santa on its cover that says, 'Dear Santa, This year there's just one thing I'd like for Christmas please…' when the card is opened it reveals the **Save our Hospitals** campaign plea to stop cuts at Ealing, Central Middlesex, Charing Cross and Hammersmith hospitals.

Campaigners are determined to maintain pressure on the NHS to scrap its controversial proposals and have announced that a further major demonstration will be held on 9 February to highlight the borough's widespread opposition to the plans.

Councillor Bell said: "We will use every means possible to fight to protect our health services and stop these deeply flawed and unsafe plans from going ahead.

"Because it is Christmas I thought 'why not enlist the big man in red to help us get our message out and possibly put a few names on his naughty list?' The card does have a

serious message, though. There is nothing more important to me, and many thousands of people in the area, than ensuring that these essential services are protected."

There were three options that the NHS included in its consultation. Under its preferred Option A:

* St Mary's, Chelsea & Westminster, West Middlesex, Northwick Park and Hillingdon would continue to be major hospitals and keep services such as A&E

* Hospitals to be downgraded to local hospitals include Ealing, Central Middlesex and Charing Cross hospitals, while Hammersmith would become a specialist hospital

* Services at Ealing Hospital that will no longer be provided if the preferred option A is agreed include: A&E, emergency surgery, non-elective medicine, non-elective surgery, complex elective surgery, intensive care, inpatient paediatrics, obstetrics and maternity.

All political parties on the council are against the proposals.

People are encouraged to support the Save our Hospital campaign and follow the campaign on Twitter #HelpSOH

Release: NHS told to scrap its plans

Published 8 October 2012

Ealing Council's cabinet is calling on NHS North West London to scrap its 'fundamentally flawed' plan to decimate hospital services in the area.

Councillors attending an extraordinary cabinet meeting on Friday 5 October heard damning criticisms of the NHS's business case and consultation on plans that would see four out of nine A&Es in the area close and nine of 11 major types of services stripped from Ealing Hospital.

An independent review carried out by former NHS chief executive Tim Rideout has raised serious concerns about the way proposals have been drawn up, the speed in which they would be introduced and ability of health services to cope with the scale of change. The health expert has also queried the safety of the proposals given that they rely on primary care community services that do not yet exist. Mr Rideout also raised uncertainty over the ability of other hospitals to deal with extra demand on already stretched services.

Ealing has been singled out as the borough most affected by the plans, not least because of the adverse impact of increased travel times on local people's access to emergency services. Despite this, the report found the NHS had an inadequate understanding of the impact of the plans on local people's health as well as a failure to take into account the quality of services currently provided and the potential significant loss of clinical expertise.

Councillor Jasbir Anand, cabinet member for health and adult services, said: "This independent report confirms our worst fears. The people of this borough are being asked to

take a huge leap of faith based on an inadequate plan, driven by the need to save money rather than improving the health of local people.

We won't gamble with our health or be bystanders as our hospital services are dismantled. NHS North West London should scrap these plans now.

A report by the council's health and adult social services scrutiny panel also raised serious concerns with the NHS's approach. It questioned if the proposals could be effectively delivered by 2015 considering the scale of improvement required in out-of-hospital care and the need to ensure clinical staff were in place to make these services work. The panel said it was 'unacceptable' that the NHS had failed to provide a risk register showing how the programme would be delivered.

The panel stated its concern about increased travel times to major hospitals in the region for more than 174,000 people from key equality groups like older people and pregnant women, the majority of them Ealing residents. Using the data supplied by the NHS, in areas identified as having the highest health care needs, more than 60% of people travelling to a major hospital on public transport would have a journey of more than 30 minutes. And, 50% of expectant mothers living in these areas would have to travel for more than 30 minutes to access maternity services. This would particularly hit people in deprived parts of the borough currently served by Ealing Hospital.

Councillor Julian Bell, leader of the council said: "Local people in their thousands have signed petitions and even marched through our borough to oppose these half-baked plans to slash our hospitals. Last week, I asked the doctors behind the proposals if they were listening to the people of Ealing. Although they didn't answer my question, I hope they see sense and drop these proposals now before any more of London's precious health funding is squandered on a scheme doomed to failure.

"The reports we have considered today will be submitted as part of the council's response to this consultation. They shine a light on the inadequacies of the NHS business case, its consultation process and its plans for hospitals in the region. In short, our message to NHS North West London will be: 'Keep your hands off our hospitals', this council and the people of Ealing will fight these cuts."

The **reports to cabinet** including Mr Rideout's independent report are available on the council's website.

All political parties on Ealing Council oppose the proposals.

Release: Town Hall debate on hospital plans

Published 25 September 2012

A public debate on the future of hospital services in the area will be held at Ealing Town Hall on Wednesday 26 September at 7pm.

NHS North West London is consulting people on plans that could change the way hospital services are provided. The NHS' preferred option proposes more community-based services as well as the centralisation of some services at fewer hospitals including the closure of four out of the nine Accident & Emergency units in the area.

Representatives from the NHS and the Save our Hospital Campaign will present their arguments for and against the proposals and answer questions from the audience.

The debate will be hosted by Victoria Macdonald, health and social care correspondent, Channel 4 News.

All political parties on Ealing Council oppose the proposals and councillors are urging anyone who lives or works in the borough to get behind the campaign to**Save Our Hospitals** by signing a petition and responding to the **NHS consultation**.

Release: Expert to health check NHS report

Published 19 September 2012

Ealing Council has engaged a former NHS chief executive to carry out an independent review of controversial proposals for hospital services in the area.

Timothy Rideout, has also produced a report for Hammersmith & Fulham Council on the controversial plans that, if agreed, will see four out of nine A&Es in the area close and Ealing Hospital downgraded to a 'local hospital', stripping it of nine of the 11 major types of service.

Mr Rideout has been employed in a variety of senior health roles, both as chief executive of a primary care trust and more recently at the Department of Health. He is working alongside other experts who will forensically examine the NHS's business case used to support these proposals.

They will look in detail at the impact of the plans on local people's health as well as assumptions made by the NHS around transport times and finances. A team of council officers led by the council's chief executive is also supporting the review team's work.

The independent report will be delivered at the beginning of October and will form part of the council's official response to the NHS consultation which is set to close on 8 October.

Councillor Jasbir Anand, cabinet member for health and adult services, said: "If these plans go ahead our local hospital services will be annihilated. Mr Rideout is a highly-respected health professional and the work he and his team are doing will enable the council to properly scrutinise the NHS's proposals and respond to the consultation on behalf of our residents.

"From speaking to people I know, many have been put off filling in the NHS consultation document because it is long, jargon-ridden and forces people to answer leading questions designed to support the proposal. If this was a true consultation people should have been given the opportunity to answer 'none of the above'."

People interested in finding out more about the proposals and what they mean for local health services are invited to attend a debate between NHS North West London and the Save Our Hospitals campaign. The event will be held at Ealing Town Hall on Wednesday 26 September at 7pm.

All political parties on Ealing Council oppose the proposals and councillors are urging anyone who lives or works in the borough to get behind the campaign to**Save Our Hospitals** by signing a petition and responding to the NHS consultation.

Release: Thousands march to Save Our Hospitals

Published 17 September 2012

Traffic was brought to a standstill in parts of the borough on Saturday as residents marched in opposition to plans to cut hospital services in the area.

The march and rally was organised by the Save Our Hospitals campaign which is fighting NHS proposals to downgrade Ealing Hospital to a 'local hospital', stripping it of nine of the 11 major types of service currently provided on-site, including the A&E.

These proposals are part of a major restructure of NHS services in North West London which, if agreed, would see almost half of the hospitals in the region suffering a similar fate. Under the preferred option Charing Cross Hospital would also be downgraded to a local hospital, losing the same services as Ealing. Central Middlesex Hospital, which has already had its A&E unit reduced to a daytime-only service, would see the unit close permanently and it would also lose its intensive care unit. Hammersmith Hospital would no longer have major hospital status and would instead become a specialist hospital.

The protest march against the proposals travelled from both Southall Park and Acton Park and joined at Ealing Common where crowds took part in a rally.

Council leader Julian Bell said: "I'd like to thank everyone for turning up on Saturday and showing the NHS the strength of feeling against these plans. People in our borough will not accept these cuts and I'd urge the NHS to drop these ill-thought-out plans now.

"It beggars belief that the NHS think it's acceptable to take away essential services including A&Es, intensive care, maternity and paediatric units and force sick people to travel further for regular treatment."

All political parties on Ealing Council oppose the proposals and councillors are urging anyone who lives or works in the borough to get behind the campaign to**Save Our Hospitals** by signing a petition and responding to the NHS consultation.

Release: Ealing's maternity unit under threat in NHS plans

Published 11 September 2012

Ealing Hospital's maternity and paediatric units are under threat as NHS North West London proposes to cut hospital services.

Under the proposals Ealing Hospital would be downgraded to a 'local hospital', stripping it of nine of the 11 major types of service currently provided on-site including its maternity, obstetric and paediatric units, forcing residents to travel out of borough.

The proposals are part of a major restructure of NHS services in North West London which, if agreed, would mean almost half of the A&E departments in the region would close.

Approximately 5,800 babies are born to Ealing residents each year, with just under half being delivered at Ealing Hospital. Ealing is experiencing one of the highest increases in birth rates and in 2010 had the seventh highest birth rate in London.

In the last 10 years there has been a 30% increase in births across the borough. The total number of people aged 0 to 14 is predicted to grow by 17.2% and the number aged 10 to 14 is anticipated to increase by 43.1% between 2012 and 2035.

Council leader Julian Bell said: "With Ealing seeing increasing numbers of births, it is incomprehensible to ask expecting parents to travel to Isleworth, Hammersmith or Paddington for their care.

"Hospitals in these neighbouring areas are equally busy and also facing increasing populations. It just doesn't add up that they will be able to cope with their own increased demand, let alone the extra pressure of accommodating expecting parents from Ealing. It is clear from these plans that the NHS has no regard for the impact on our residents and their care at such a sensitive time."

All political parties on Ealing Council oppose the proposals and councillors are urging anyone who lives or works in the borough to get behind the campaign to Save Our Hospitals by signing a petition and responding to the NHS consultation.

A **march** is also being organised for Saturday 15 September, which residents are invited to attend.

Release: Join the march to save our hospitals

Published 4 September 2012

Ealing residents are being encouraged to show their opposition to plans to cut hospital services in North West London by taking part in a protest march on Saturday 15 September.

Ealing residents are being encouraged to show their opposition to plans to cut hospital services in North West London by taking part in a protest march on Saturday 15 September.

The march is part of the Save Our Hospitals campaign to fight NHS proposals which include downgrading Ealing Hospital to a 'local hospital', stripping it of nine of the 11 major types of service currently provided on-site, including the A&E.

The proposals are part of a major restructure of NHS services in North West London which, if agreed, would see almost half of the hospitals in the region suffering a similar fate. Under the preferred option Charing Cross Hospital would also be downgraded to a local hospital, losing the same services as Ealing. Central Middlesex Hospital, which has already had its A&E unit reduced to a daytime only service, would see the unit close permanently and it would also lose its intensive care unit. Hammersmith Hospital would no longer have major hospital status and would instead become a specialist hospital.

The protest march against the proposals will start at both Southall Park and Acton Park and meet for a rally at Ealing Common.

Council leader Julian Bell said: "If these plans go ahead they will leave thousands of people without local access to essential services including A&Es, intensive care, maternity and paediatric units, while those with chronic conditions will have to travel further for regular treatment.

"We want to show NHS bosses that it is not acceptable to put financial considerations before people and this march and rally is a great opportunity for residents to come together to demonstrate their outrage at these plans."

The march from Southall will meet at Southall Park at 10am and leave at 11am to travel past Ealing Hospital, through Hanwell and along New Broadway to Ealing Common.

The march from Acton will meet at Acton Park at 11am and will leave at 12pm and travel along The Vale and Acton High Street to Ealing Common. The rally will then begin at Ealing Common at 1pm with speeches and live music.

All political parties on Ealing Council oppose the proposals and councillors are urging anyone who lives or works in the borough to get behind the campaign to**Save Our**

Hospitals by signing a petition and responding to the NHS consultation. A NHS 'Shaping a healthier future' consultation roadshow is also taking place on Tuesday, 11 September at Ealing Town Hall where residents can ask questions and have their say on proposals.

Release: NHS Consultation roadshow visits Southall

Published 11 July 2012

The NHS is inviting residents to attend a roadshow about its controversial plans to downgrade hospitals in the area.

The **'Shaping a healthier future'** event will take place at the Dominion Centre, 112 The Green, Southall on Saturday 21 July between 10-4pm.

People attending the event will be able to learn more about the consultation, ask questions, and have their say on the proposals which went out to public consultation on 2 July.

The consultation's favoured option would see Ealing, Central Middlesex, Hammersmith and Charing Cross hospitals all lose their A&E departments as well as a range of other clinical services.

All political parties on Ealing Council oppose the proposals and councillors are urging residents to get behind the campaign to Save Our Hospitals by signing a petition and responding to the NHS **consultation**.

Council leader Julian Bell said: "As a council we unanimously oppose these plans which, if agreed, would dramatically reduce hospital services in the area and leave three London boroughs without A&E departments and other major hospital services.

"We need people power to defeat these plans so I would urge as many people as possible to attend this event and make their views known.

"We are asking people who live, work or visit the area to sign our petition to oppose these proposals and Save Our Hospitals."

Under the plans Ealing Hospital would be downgraded to a 'local hospital', stripping it of nine of the 11 major types of service currently provided on-site including A&E and intensive care units, as well as hospital maternity and paediatric services. The proposals are part of a major restructure of NHS services in North West London which, if agreed, would see almost half of the hospitals in the region suffering a similar fate.

Under its preferred option Charing Cross Hospital would also be downgraded to a local hospital, losing the same services as Ealing. Central Middlesex Hospital, which has already had its A&E unit reduced to a daytime only service, would see the unit close permanently and it would also lose its intensive care unit. Hammersmith Hospital would no longer have

major hospital status and would instead become a specialist hospital. If the plans get approved the council is concerned that residents would have to travel miles to reach the nearest major hospital for vital services.

Notes to Editors:

Public consultation on the NHS report 'Shaping a Healthier Future' started on Monday 2 July and is expected to run until 8 October 2012.

* There are three options that the NHS will consider as part of its consultation.

Under its preferred Option A:
- St Mary's, Chelsea & Westminster, West Middlesex, Northwick Park and Hillingdon would continue to be major hospitals and keep services such as A&E
- Hospitals to be downgraded to local hospitals include Ealing, Central Middlesex and Charing Cross hospitals, while Hammersmith would become a specialist hospital
- Services at Ealing Hospital that will no longer be provided if the preferred option A is agreed include: A&E, emergency surgery, non-elective medicine, non-elective surgery, complex elective surgery, intensive care, inpatient paediatrics, obstetrics and maternity.

Release: Politicians unite to fight hospital cuts

Published 3 July 2012

Councillors from across the political spectrum have joined together to oppose plans that could see the closure of four A&E departments in the area.

Under the plans which went out to public consultation this week, Ealing, Central Middlesex, Hammersmith and Charing Cross hospitals would all lose their A&E departments as well as a a range of other clinical services.

Residents are being urged to make their views known by taking part in the consultation and getting behind the council's campaign to Save Our Hospitals by signing its petition.

Commenting on the proposals, Councillor Bell said: "When these half-baked plans were announced last week all our worst fears and more were realised. It beggars belief that essential health services like A&E could be cut nearly in half without damaging health care for the two million Londoners using them.

"The council is committed to fighting these proposals but we need people power to defeat these plans. I want local people to join our campaign and to tell their friends, neighbours, relatives and colleagues to do the same - with a powerful single voice we can make our views known and save our hospitals."

Councillor David Millican, leader of the Conservative group on the council, said: "The NHS claims that under blue light conditions people will still be able to get to A&E quickly, but you have to wonder what the effect will be on all those with long term chronic conditions who have to make their own way to hospital, week in and week out for treatment. We hope people will get behind the council's campaign and make sure they sign the petition and respond to the NHS consultation."

Councillor Gary Malcolm, leader of the Liberal Democrat group on the council, said: "These plans will not only affect Ealing residents, but also those who work in the borough or spend their spare time here. Everyone wants the reassurance that they are never too far from help if the worst happens but, if these plans get the go ahead, for much of North West London that will no longer be true."

Release: Council hits out at plans to decimate hospital services

Published 26 June 2012

The council has hit out at plans that could see the closure of the borough's A&E and intensive care units, as well as hospital maternity and paediatric services.

Councillors in Ealing from across the political spectrum oppose the plans and council leader Julian Bell took part in a protest outside a NHS meeting in Westminster yesterday (25 June).

Under the plans Ealing Hospital would be downgraded to a 'local hospital', stripping it of nine of the 11 major types of service currently provided on-site*. The proposals are part of a major restructure of NHS services in North West London which, if agreed, would see almost half of the hospitals in the region suffering a similar fate. If the plans get approved the council is concerned that residents would have to travel miles to reach the nearest major hospital for vital services.

The NHS has published an 890-page report on the proposed restructure. Under its preferred option Charing Cross Hospital would also be downgraded to a local hospital, losing the same services as Ealing. Central Middlesex Hospital, which has already had its A&E unit reduced to a daytime only service, would see the unit close permanently and it would also lose its intensive care unit.

The council is calling on anyone who lives or works in the borough to sign its petition against the plans and to respond to the NHS consultation, which is expected to begin next week (2 July). The council's campaign e-petition can be found at **www.ealing.gov.uk/petitions**

Councillor Bell said: "Across the political spectrum we are opposed to these plans. The health services for nearly two million Londoners would be affected by these proposals and, in Ealing alone, we have a population that is significantly larger than many UK cities. Nobody in their right mind can think that it's right that a population of more than 320,000 doesn't have

a major hospital to provide essential services like A&E, intensive care, maternity and paediatrics.

"Ealing is a very busy hospital and all those thousands of patients will have to be treated somewhere. I'm sure all those who live close to other hospitals will be wondering what impact that will have on the facilities and waiting times where they are."

Councillor David Millican, leader of the Conservative group on the council, said: "The NHS claims that under blue light conditions people will still be able to get to A&E quickly, but you have to wonder what the effect will be on all those with long term chronic conditions who have to make their own way to hospital, week in and week out for treatment. We hope people will get behind the council's campaign and make sure they sign the petition and respond to the NHS consultation."

Councillor Gary Malcolm, leader of the Liberal Democrat group on the council, said: "These plans will not only affect Ealing residents, but also those who work in the borough or spend their spare time here. Everyone wants the reassurance that they are never too far from help if the worst happens but, if these plans get the go ahead, for much for North West London that will no longer be true."

Consultation on the NHS report **'Shaping a Healthier Future'** is expected to begin on Monday 2 July and run until the beginning of October.

* There are three options that the NHS will consider as part of its consultation. Under its preferred Option A:

- St Mary's, Chelsea & Westminster, West Middlesex, Northwick Park and Hillingdon would continue to be major hospitals and keep services such as A&E.

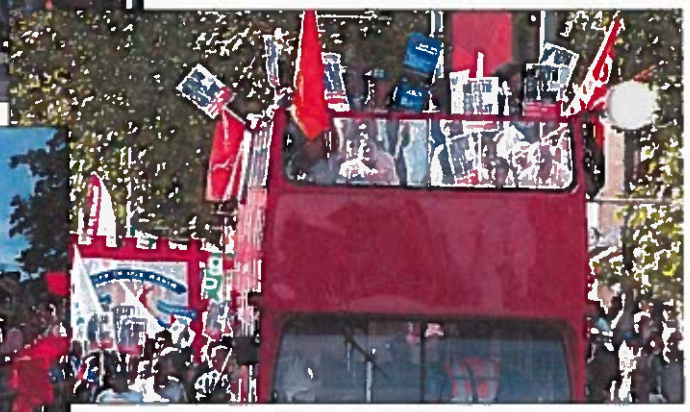
- Hospitals to be downgraded to local hospitals include Ealing, Central Middlesex and Charing Cross hospitals, while Hammersmith, including Queen Charlotte and Chelsea, would become a specialist hospital.

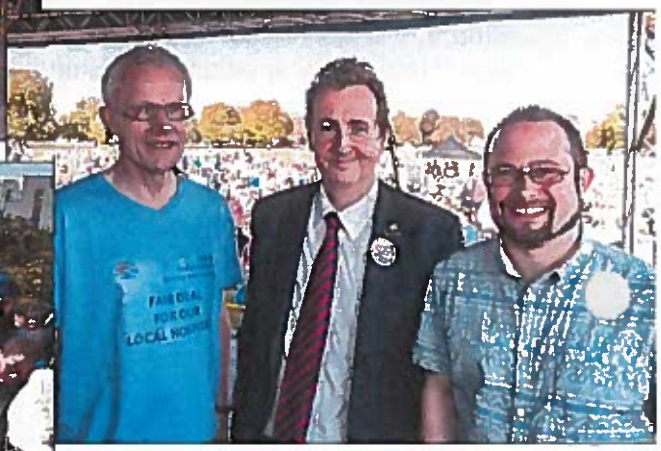
- Services at Ealing Hospital that will no longer be provided if the preferred option A is agreed include: A&E, emergency surgery, non elective medicine, non elective surgery, complex elective surgery, intensive care, inpatient paediatrics, obstetrics and maternity unit.

Two motions have been passed at meetings of the full council on **31 January 2012** and on **19 July 2011** setting out the council's opposition to plans to downgrade services at Ealing and Central Middlesex Hospitals.

Appendix:

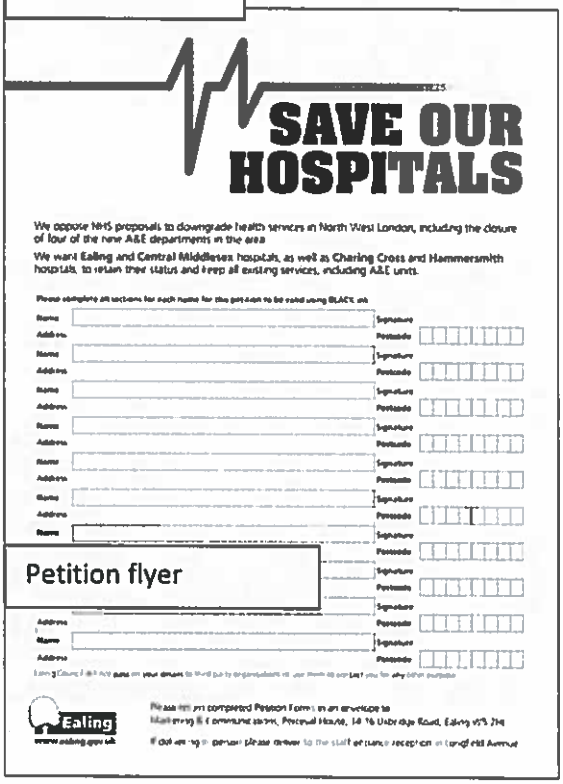
PROTEST MARCHES AND RALLIES





TERIALS

Petition sheets



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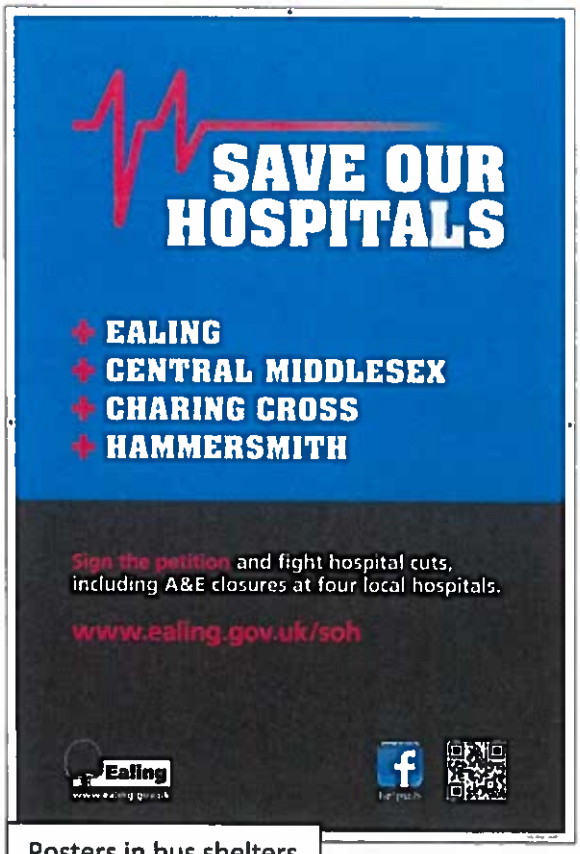

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Every life matters...

■ DEATH KNELL FOR HOSPITAL: Cllr Dame Sally Powell

■ ENCOURAGING: Ben Monks

■ CLOSURE MUST NOT HAPPEN: Nancy Purser

■ MORE PLEASE: Hermione Sacks

■ AFRAID FOR THE NHS: Tony and Anne Marie Foster

The Gazette sounded out protesters on Ealing Common about what they thought of the campaign against the cuts.

■ Councillor Dame Sally Powell, 57, Labour, Hammersmith and Fulham:

"The proximity of a hospital is essential when it's a matter of life and death and hospitals either than Ealing are miles away.

"The trust says it has tested travel time and the things are pretty much the same. But I bet they were tested at night, not in the middle of the day with heavy traffic. With a heart attack or a stroke every second counts.

"Removing an A&E is a death knell for a hospital. They close. The sites will become luxury flats, especially Charing Cross, as that's a prime location."

■ Ben Monks, 28, Ealing Common:

"It's encouraging that this issue is cross-party and that there has been so much support from members of the public.

"I strongly believe that the proposed closure to accident and emergency at Ealing Hospital would be detrimental to the healthcare of borough residents.

"Losing the four A&E departments would reduce the access to emergency care and I don't see how having fewer A&Es would lead to a better standard of care."

■ Nancy Purser, 68, South Ealing:

"My family has young and old members, so we know the importance of having accident and emergency facilities close by. These plans are ill thought-out. The nearest hospital will be miles away.

"We can't let this happen. Ealing needs an A&E."

■ Hermione Sacks, 73, Acton:

"This demonstration has been good and I hope there will be more to come. I'm hugely against cuts to A&E units in the local area.

"Where do we go if that happens? It's the distance people are going to have to go and how do we know that the service at these other hospitals will be more suitable, let alone how they will cope with the added number of people."

■ Tony and Annemarie Foster, 69 and 61 respectively, of Acton:

"We came to the demo because we fear for the whole of the NHS. It's just changed shape, there's no real rationale.

"The A&E at Ealing is convenient. It'll be alright for us because we can drive, but what about others who can't. It's taking choice away.

"The time it takes to get to these hospitals during the day, getting from here to St Mary's, that's going to be a dangerous problem.

"There's a crucial time for any trauma, so taking longer to get to hospital poses a serious risk. Every life should matter."

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Scandal of the A&E closures: Ambulance crews on brink of collapse as more and more patients need ferrying miles further

By DAVID ROSE, JO MACFARLANE and ABUL TAHER

PUBLISHED: 01:39, 30 September 2012 | UPDATED: 04:28, 30 September 2012

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The controversial wave of A&E closures is bringing Britain's ambulance services close to collapse, a Mail on Sunday investigation has found.

At just one of the threatened units – in Ealing, West London – up to 50 patients every day will need an ambulance to take them to an alternative casualty unit if the department shuts down.

Ealing is one of 26 such units being closed or downgraded across England and Wales as part of a policy to centralise services – despite fury among patients and scepticism from medical experts.

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Save our hospitals campaign
The NHS is proposing to downgrade four hospitals in North West London.
Under the proposals the Accident and Emergency departments at Ealing, Central Middlesex, Hammersmith and Charing Cross Hospitals would all close - that's four out of the nine currently in the area. It would leave three boroughs, with a population of at least 700,000, without an A&E. Other departments including intensive care, emergency surgery, paediatrics and maternity units at some of those hospitals would also close
All political parties on the council are against the proposals.
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ROYAL BOROUGH OF KENSINGTON AND CHELSEA

EVIDENCE TO INDEPENDENT HEALTHCARE COMMISSION FOR NORTH WEST LONDON

1. BACKGROUND

1.1 We welcome this opportunity to comment on the implementation of 'Shaping a healthier future' to the North West London Healthcare Commission.

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

2. ACUTE CARE

Any increased specialisation of hospital care

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

Imperial College Healthcare Trust

2.2 Imperial College Healthcare Trust has substantial infra-structure constraints and significant financial problems: it is not a foundation trust and the majority of the St Mary's and Western Eye Hospital estate is old and in many cases unsuited for contemporary patient care needs. The Emergency Department is at or near full capacity. For Imperial to cope with the influx of these specialised departments and increased

pressure on the Emergency Department there will need to be substantial funding made available to increase and improve the physical infrastructure.

2.3 The Scrutiny Committee has been told about the benefits of co-location of service on the St Mary's site, which would improve services/outcomes for patients. The Committee has also been told about a large amount of space at Imperial that could be redeveloped, the financial situation at Imperial was improving and it was hoped in time to move to Foundation Trust status.

2.4 We believe patient care must not be downgraded if/when Charing Cross departments are moved. We would like to see the detail of the future plans for all the specialist services currently based at Charing Cross. We would also like to see more detail on the plan for the Charing Cross site. We note 'recommendation 3' of the Health Gateway Review[1] was 'Develop and agree the future vision for the Charing Cross site, with the engagement of local clinicians, prior to consultation.'

Chelsea and Westminster

2.5 In the course of our committee's deliberations we have looked at capacity at the Chelsea and Westminster and discussed the potential at the site for expanding A&E and for the provision of extra beds. We have heard how they wish to positively respond to 'Shaping a Healthier Future'.

2.6 Chelsea and Westminster NHS Foundation Trust most recent CQC report (28 October) said the hospital 'requires improvement'. It would be a concern if this disappointing result was in any way related to the changes across NWL.

Emergency care

2.7 The report, 'Acute medicine and emergency general surgery – case for change'[2] pointed out that there were many avoidable deaths in emergency care due to understaffing. The report pointed to 'stark' differences in consultant hours across hospitals at evenings and weekends, and named those with the patchiest cover. We support NHS NWL's actions to tackle

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

the problems caused by understaffing in emergency care and less satisfactory staffing at weekends and evenings.

2.8 'Recommendation 6' of the Health Gateway Review[3] was 'Clarify the service models for Urgent Care Centres and Accident & Emergency Departments.'

Imperial College Healthcare NHS Trust

2.9 St Mary's Hospital most recent CQC report (7 January) said the trust 'requires improvement'. It would be a concern if this disappointing result was in any way related to the changes across NWL.

2.10 In 2009 it was obvious the hyper-acute stroke unit should be co-located with the major trauma unit, like all the major trauma units in London. During the 'Shaping a Healthier Future' consultation RBKC's OSC wrote, 'The OSC supports the proposal for a hyper acute stroke centre to be based at St Mary's hospital alongside a major trauma centre. Healthcare for London should again clearly articulate the need and benefits of co-location on the St Mary's site to the relevant commissioners and Imperial Healthcare NHS Trust.'[4] We question the decision-making that placed the hyper-acute stroke unit at Charing Cross Hospital for such a short time.

Maternity services

2.11 NHS NWL's Case for Change highlighted the poor maternity service in NWL. More than 100 mothers have died in childbirth in London in the last five years, twice the rate in the rest of the country.[5] Two inquiries have been held into the high maternal death rate in London in the last four years and both have found maternity services wanting compared with the rest of the UK.

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

[4] Overview and scrutiny committee on health - 18 March 2009 http://www.rbkc.gov.uk/COMMITTEES/Document.ashx?czJKcaeAi5tUFL1DTL2UE4zNRBcoShgo=d786M36KuepWa9SZOICDyY6qo3MQJCRiI64uEHiL6UeEu7MFehVWqA%3d%3d&mCTIbCubSFfXsDGW9IXnlg%3d%3d=hFflUdN3100%3d&kCx1AnS9%2fpWZQ40DXFvdEw%3d%3d=hFflUdN3100%3d&uJovDxwdjMPoYv%2bAJvYtyA%3d%3d=ctNJFf55vVA%3d&FgPIIEJYlotS%2bYGoBi5olA%3d%3d=NHdURQburHA%3d&d9Qji0ag1Pd993jsyOJqFvmyB7X0CSQK=ctNJFf55vVA%3d&WGewmoAfeNR9xqBux0r1Q8Za60lavYmz=ctNJFf55vVA%3d&WGewmoAfeNQ16B2MHuCpMRKZMwaG1PaO=ctNJFf55vVA%3d

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

2.12 The Care Quality Commission report 'Our Market Report'[6] (June 2012) pointed out midwife numbers are not increasing in line with demand at a number of maternity services in London. NHS NWL should re-examine the allocation of funding for midwifery and commit appropriate expenditure.

2.13 We note 'recommendation 8' of the Health Gateway Review[7] was 'Clarify the service model for Maternity services.'

2.14 The NHS NWL's pre-consultation business case only considers home or hospital births. However, the recent Birthplace Study found freestanding midwifery units are both safe and clinically and cost-effective. NICE guidance also supports this view.[8]

2.15 NHS NWL should have ensured that there is a range of birthing options available to meet varying local need, one option is a freestanding midwifery unit for low risk women.

3. LONDON AMBULANCE SERVICE

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

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

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

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

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

[8] NICE (3 Dec 14): Midwife-led units safest for straightforward births
http://www.nice.org.uk/news/article/midwife-led-units-safest-for-straightforward-births

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

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

4. OUT OF HOSPITAL CARE

4.1 The importance of getting out of hospital care right, of improving the hospital discharge experience for patients and improving the seamless transfer of care between hospital and social care was stressed on several occasions by my Committee to NHS NWL. An improvement in out of hospital services will lead to a significant improvement in people's health. We fully supported the focus on out of hospital and all the analysis showing the work needed to improve out of hospital services.

4.2 Given the scale of the shift to the community, NHS NWL should have given far more thought to social care. A whole-systems approach needs to be taken. We are particularly concerned about the lack of understanding of the financial impact of the proposals on social care. The plans will have a major impact on social care. NHS NWL should have quantified the impact on social care.

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

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

Helping people stay out of hospital

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

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

4.7 We have previously agreed with NHS NWL that North West Londoners could benefit from the provision of a broader range of services in the community. We were fully supportive of the move to provide more services out of hospital. NHS NWL need to ensure change improves the accessibility of health and social care services and the physical access to facilities where these are provided.

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

- When the Shadow JHOSC fed-back on NHS NWL's Draft Consultation Document they said, 'It is vital to include detail on the out of hospital strategy in the document as the proposed reconfiguration will rely on it if it is to be successful.'

- Recommendation 7 of the Health Gateway Review[9] was 'Provide more detail on proposed Out of Hospital services with a focus on implementation.'

5. CONCLUSION

5.1 The 'Shaping a Healthier Future' proposals are far-reaching in reshaping services in North West London, and there is clearly a need for their implementation to be carefully scrutinised.

5.2 The changes should be being monitored closely in order to identify the impact on service provision, health outcomes, patient experience, and to ensure that other services provided have not experienced an adverse impact.

5.3 It is a huge task for the Healthcare Commission for North West London to 'review the impact of the changes to the North West London health economy, arising from the implementation of 'Shaping a Healthier Future', and to assess the likely impact of planned future changes'.

5.4 The central goal must be to improve health outcomes and to achieve better value for money.

Councillor Robert Freeman,
Chairman, Adult Social Care and Health Scrutiny Committee, Royal Borough of Kensington and Chelsea

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