Independent Healthcare Commission for North West London

Submissions of Written Evidence

Volume 5

Contents:

Smith Peter

From: Tomas Rosenbaum [redacted]
Sent: 20 February 2015 16:09
To: Smith Peter; stephen.hirst [redacted]
Subject: Statement to the Independent Health Commission - Mr T Rosenbaum, Consultant Urologist

Thank you for offering me the opportunity to submit my views.

I have been a Consultant Urological Surgeon at Ealing Hospital since 1996 and since my appointment I worked to develop and provide the best possible Urology service for the local community.

This consisted of Out Patient clinics, Day Case and In-patient Operating Lists, Endoscopy Service, Urodynamics, Adult and Paediatric Urology, support of A&E and of other specialities, open phone/fax/email support of the local GPs and continence service, yearly Continence Promotion Study Day for the local health workers District/Community/Nursing Home staff all at Ealing Hospital

Over the years my clinical service grew in line with the number and needs of the local population and I received an average of 30 new referrals every week. I provided the service with the help of up to 4 Junior Staff, 1 part time Honorary Registrar and 2 clinical nurse specialists.

This large number of referrals was unexplained and inconsistent with the alleged number of the local population which is said to be 180.000. This figure must be a gross underestimate. A simple visit of the area of Southall clearly shows a very densely populated town which continues to constantly grow. The actual number is likely to be more 400.000 to 500.000.

Southall is packed in a fairly small area with very poor transverse road access to other local hospitals: West Middlesex and Northwick Park. However, radial communications are better. The population therefore come to Ealing Hospital. In line with this we developed the knowledge and expertise to serve them with their own particular health needs: higher that usual cardiovascular disease, diabetes, malnutrition, metabolic syndrome and specific infections like TB, bilharzia, filariasis.

However the population figures are still not enough to explain the large referral numbers received by Ealing Hospital. Southall has a large immigrant population of multiple origins, of which the largest group is Punjabi. Southall is in fact the largest Punjabi community outside Punjab. It is also located only 2-3 miles from Heathrow Airport.

I undertook a study and established that the population of Indian and Pakistani Punjab is about 140 million. Every week there are more that 100 jumbo jet flights between Heathrow and Punjab (Delhi, Amritsar and Lahore). Many thousands UK citizens of Punjabi origin spend multiple periods of time every year in Punjab and therefore go locally unaccounted. The flux to and from Punjab via Heathrow is vast. Their health needs are largely provided here but their contribution to the economy, culture, science and growth are also here. And so are their future lives. Their present and future potential are immense.

Ealing Hospital is located in a strategically perfect place. It is radially easily accessible from Southall and Ealing, it has excellent public transport access, mainly radially along the Hillingon Road and crucially is only 150 meters (5 min walk) away from the about to be redeveloped Hanwell Cross Rail station. Property developers are clearly on the case as building of flats and houses

is taking place furiously in the area. This will increase the need of local healthcare facilities even further.

It is madness even to suggest to downgrade, let alone to close, such a key healthcare facility. I believe that healthcare planners and the local Commissioners are driven only by dogma and are not focused on need of the local population. The resources needed to re-equip and modernise Ealing Hospital are really small compared to what would be needed to re-design roads and access to other hospitals. In any case this would go totally against more up to date thoughts that technology should be at the service of the community and not the other way round. Technology and IT communication are becoming better and cheaper all the time but our focus and most important factor must be our communities, the support of which should be at the centre of our thinking and planning.

I would be pleased to make a personal statement to the Commission.

Yours sincerely,

T Rosenbaum FRCS Urol
Consultant Urologist

Smith Peter

From: dede wilson [redacted]
Sent: 24 February 2015 15:09
To: Smith Peter
Subject: Michael Mansfield Inquiry
Attachments: [redacted] IRP-Mansfield Timescale & Impact of SaHF .docx; LBHF- Letter of concern of Impact of SaHF changes .doc

Dear Mr. Smith,

I am a resident of Hammersmith and Fulham and a patient at Charing Cross Hospital. I have been extremely concerned about what is happening to our healthcare in NW London since the consultation for the reorganization of our healthcare was announced in July 2012 just before the school holidays. Charing Cross is an exceptional Teaching Hospital, one of the top 10 in the world and what is happening makes no sense whatsoever. I have a lot of hard copy evidence I will be coming up to the Town Hall with shortly.

I am attaching and sending the evidence of irregularities of The Shaping a Healthier Future Consultation and the impact of changes first sent to the IRP in 2013. It starts with the timescale of the Consultation events and written a breakdown of the flaws in the Shaping a Healthier Future Consultation

As well as my own submission, I have written a submission on behalf of a friend who was treated at Charing Cross for 3 months in the summer and who has subsequently died since being sent home.

I have a collected lot of hard copy evidence I will be coming up to the Town Hall with shortly.

Yours sincerely,
Deirdre (Dede) Wilson

24th February 2015
Dear Mr. Smith,

I am sending in a report of a patient I have worked with as a complimentary medicine Subtle Energy Practitioner for the last three years. [redacted] went into Charing Cross A&E in June 2014 having collapsed. He had heart failure.

Intensive care saved his life with meticulous care for 3 months at Charing Cross from June to September. They were amazing. He was unconscious for much of the time and full of tubes. In September he was sent down to one of the wards to all intents and purposes to have 6 to 7 weeks of crucial rehabilitation and physio to aid his recovery and get him properly back on his feet. (All of his records are there)

This kind of care on the wards however, did not happen. He was bed ridden, miserable and anxious to get home. He was not in a fit state to cope at home on his own. Sporadic attention was not enough to help genuine recovery. He couldn't walk because of diabetes and muscle weakness. He'd been on a drip throughout most of the time in intensive care. He had lost a lot of weight whilst in intensive care but still weighed 18 stone.

They had nothing to get his feet up off the floor and keep them elevated for his circulation if he was sitting in a chair or give him proper support. He was given outsourced junk food with sugar, cups of tea with lots of sugar and biscuits. None of the treatment real treatment he needed was forthcoming. Neither proper physio and rehab or dietary guidance before sending him home. He was bewildered by it all as there was no set programme and did not know why he was there. As a result, he was even more anxious to get home. He could not walk without a walker and standing was difficult. For me, his going home was a real concern as I knew he could not cope on his own.

His long term partner had Alzheimer's and she had gone into a home when he went into hospital. Going home meant he was going home on his own. It was the first time he'd been on his own in more than 50 years. He was not in a fit physical or mental state to be able to cope without good strong support structures. He weighed 18 stone so it would require a strong, fit physiotherapist to get him up and about, be insistent and work with him.

The kind of rehabilitation and regular strong physio support he should have had in hospital for genuine recovery was not possible at home making it effectively non- existent. Those who came tried their best, but they were women dealing with an 18 stone man whose pain and

difficulty moving made him disinclined to try. His legs were down when they should have been elevated and he should have been moving around but couldn't face it. Whilst the bandages on his legs were changed, they were ulcerated and wet and a cause for concern.

He could not cope at home and booked a cruise ship holiday where he would have care and attention. He died on board. On the 20th January. This should not have happened. The contrast in care from the magnificent intensive care to barely minimal ward and non- existent rehabilitation home recovery programme was shocking. What he genuinely needed was not in place and he could not cope and inevitably died. He was an impassioned supporter of the NHS and the amazing medical teams who have been fighting against the odds to maintain high standards of care without the support or funding needed.

Those ringing these changes to privatization, leaving the hospitals underfunded and understaffed are responsible for his death. It is a direct result of this. They could not provide the care needed to keep the promises made. His records are at the hospital and other records are available from his sister in law.

Deirdre Wilson, [redacted]

Peter Smith, Clerk to the Commission, at Hammersmith & Fulham Council, Room 39, Hammersmith Town Hall, London W6 9JU

The Mansfield Inquiry
24th February 2015

Dear Mr. Smith,

I am a resident of Hammersmith and Fulham and a patient at Charing Cross Hospital. I have been extremely concerned about what is happening to our healthcare in NW London since the consultation for the reorganization of our healthcare was announced in July 2012 just before the school holidays.

I am resending the evidence of irregularities of The Shaping a Healthier Future Consultation and the impact of changes first sent to the IRP in 2013. It starts with the timescale of the Consultation events and written a breakdown of the flaws in the Shaping a Healthier Future Consultation below.

Both highlight concerns regarding engagement with the public, transparency and the Council's role reversal in its approach to dealing with the consultation in Hammersmith and Fulham. I have incorporated the emails sent with the evidence I attached or forwarded.

I have copied the Health and Scrutiny Committee's Draft report on the Consultation in September 2012 and pasted it into the document. I have not had time to go through every aspect but have highlighted key points in bold. I attended that Committee's first public meeting in September 2012.

In addition, this is followed by the scripted notes from further public meetings in September which are linked to it.

I have also included the notes from the public JPCT meeting in December where legal cogency was described. This led to letters being written to provide evidence and alternatives to the consultation options which brought about the proposed Outpatients Specialist Health and Social Care Centre. I believe all of this is completely relevant to what is happening now. I have hard evidence in files, which I will be bringing in this afternoon.

Consultation Times scale and events

June 2012
NW London NHS *Shaping a Healthier Future* Consultation announced in Chelsea Westminster Hospital news broadsheet *Trust News*, for June / July. Prior to official announcement in the media. Electioneering before voting in consultation announced.

July 2012

- Hammersmith flyover closed for major repairs as in serious danger of collapse
- M4 from Heathrow to A 4 flyover exit section closed - in danger of collapse
- London Olympics about to start. Athletes travelling along A4.
- Schools break for the Summer Holidays
- NW London NHS *Shaping a Healthier Future* Consultation announced in News
- Timing open to question.
- Local paper, the Fulham Chronicle announcement.
- SaHF and LBHF methods of informing the public of major changes to health care with huge impact are open to question. Little serious effort to communicate.

- No leafleting of residents by Hammersmith and Fulham Council to inform of:
  a.) the SaHF Consultation
  b.) the proposed threat of loss of A&Es in the Borough, at Hammersmith Hospital and Charing Cross
  c.) the loss of 500 acute beds at Charing Cross. Major hospital to be demolished to be replaced by a 24 hr GP led Urgent Care Walk in Centre (Misleadingly described as a Local hospital.)
- Save our Hospitals campaign begun.
- Save our Hospitals regular stalls in Hammersmith and Fulham and hospitals to inform patients and residents about the consultation.
- Approached GP practice. Asked to display information about Save our Hospitals and the Consultation for patients to be able to make informed choices. (Lillie Road Surgery) Told could not, as could not be seen to be taking sides.
- Fulham patients referred to Chelsea Westminster Hospital by GPs rather than Charing Cross (first hand experience)
- Patients to be affected uninformed by GPs in surgeries.
- Dr. Sam, at Lillie Road was a representative on the *SaHF* JPCT
- Visited GP surgeries throughout Fulham – no information about consultation and no hard copy documents. Generally not available in GP practices
- No information in Option B and Option C hospitals, only in Option A.

September 2012

- 17th Sept 2012 - London Borough of Hammersmith and Fulham Health and Scrutiny Committee Meeting. Critical of Imperial College Trust and SaHF (See attached scripted notes p. 8-13)

- 18th Sept - LBHF Town Hall public meeting with representatives of the SaHF Board, Save our Hospitals Chair, Carlo Nero and local Council Representatives, Nicolas Botterill and Marcus Ginn (see Fulham Chronicle article) LBHF Council petition set up online. Impression supporting residents and campaigners to Save our Hospitals

- 3rd world Option A hospitals electioneering for Consultation votes since June stepped up. Not monitored by SaHF or LBHF although knowing other Option hospitals under threat in NW London NHS were under information blackout. Voting results open to challenge. (See scripted meeting notes -19th Sept)

- Chelsea Westminster Hospital - open electioneering discovered throughout the hospital. Copies of the hospital's broad sheet, 2 page spread in *Trust News* demonstrated how to simply vote for Option A to save CWH.

- Blue voting cards available on reception desks in every out patients' department at Chelsea Westminster. Tick box cards to send in to SaHF.

- Voting instructions had no explanation of the impact of voting Option A meant closing Charing Cross (CXH) and other hospitals A&Es.

- Hardcopy Consultation booklets delivered throughout Chelsea.

- 19th Sept SaHF meeting with *Age UK,* Kensington Town Hall. Save our Hospitals set up an uninvited stall and participated in workshop. Audience confusion over the workshop implications of the consultation proposals for their healthcare. Member of the board heard to say in an aside to a colleague about their understanding and confusion, " It doesn't matter. We just have to be seen to be consulting."

- 19th Sept 2012 - Concurrent SaHF Meeting at Fulham Broadway Church Hall, next to Chelsea football ground. Hard copy consultation docs available. Save our Hospital reps visited throughout day. Attendance very poor. (See scripted notes p.13 -)

- Timing and location of meeting open to challenge. Organised for the same day and time as major international football match, Chelsea vs Juventus. Poorly advertised, (notice only on SaHF website)

- Only 6 people attending when I went. Stopped from photographing display and attendance. Two crucial questions about Charing Cross and Chelsea Westminster asked. (See attached scripted notes from the meeting - Witness, Anabela Hardwick)

- Save our Hospitals regular stalls continue in Hammersmith and Fulham.

- NW London NHS Joint Primary Care Trusts Public Meeting- Westminster Methodist Hall – The SaHF board shown a copy of Chelsea Westminster Hospital *Trust News.*

- Questioned about why and how such open, active electioneering could be allowed when there were media embargos and blackouts in all the Option B (Charing Cross and Hammersmith) and C Hospitals.

- Unsatisfactory, unacceptable response by representatives responsible for ensuring democratic procedures are followed. - Informed us that "Foundation Trust Hospitals (eg.CWH) were independently funded so could do what they liked". This effectively condoned unmonitored, unequal 3rd world election voting.

- Emailed LBHF Council members with requests for help informing residents and vulnerable community groups in Fulham. A struggle for volunteers informing people in such a short time frame.

- Wrote to local Council again requesting help. No response from LBHF until pleading on behalf of the Borough's electorate. (forwarded & attached email 25th Sept) Consultation deadline fast approaching.

- Cllrs from Fulham Reach ward responded by leafleting the ward about the consultation. Other wards in Fulham did not. No mention the actual threat of closure of Charing Cross in choice of Options.

October 2012

- SaHF public meeting Phoenix School, Hammersmith

- Dr. Tim Spicer, when asked by Doctor why GPS had not been balloted as they had been in Kingston. Replied that it was not necessary as "the PCTS knew what doctors involved thought. Open to question how and who they were.

- Request to Marcus Ginn, LBHF Communications Councillor on Health and Scrutiny committee for help leafleting to reach people before the end of the Consultation. Told too expensive. £43,000 already spent. Question how spent in relation to duty to inform and represent their electorate.

- Consultation closed.

- 80,000 petition submitted to Downing Street

December 2012

- SaHF JPCT meeting at Westminster Methodist Hall – *legal cogency* regarding the public and patients' response to the consultation defined. Dismissive of petition. Only written evidence to be taken account of.

- Save our Hospitals letters written- based on residents and patients' concerns, questions and alternative suggestions (eg. Charing Cross merger with Chelsea Westminster under one management) These were then personalized to make it easier to express concerns.

- Letters printed and handed out with envelopes to all without computer access at stalls. Others sent them in online. (see attached example.)

- Sent to Cllr Lucy Ivimy LBHF Health and Scrutiny committee chair & Jeff Zitron, SaHF Chair.

- Letters prompt limited alteration to original plans. Demolition and destruction of main teaching hospital included.

January / February 2013

- 15th January JPCT meeting – discussion with Daniel Elkeles, Jeff Zitron and and Cllr Peter Graham after overhearing them talking about the closure of CX as a foregone conclusion. Told them not to be so hasty.
- Approx 1000 letters sent in.
- Campaigning at Barons Court - Stopped by Daniel Elkeles from SaHF saying the board had listened to us. Changes not in consultation made in response to letters
- Outpatients Specialist Health and Social Care Centre with 60 day beds and no A&E to replace major teaching hospital with a loss of 500 acute inpatient beds.
- LBHF Council placed two page misleading spread in Fulham Chronicle announcing hospital *SAVED,* Friday prior to SaHF announcement.
- 15th February
- Open to question why a full page misleading image of Charing Cross with SAVED across was in the newspaper when it was to be demolished and replaced by a 16,000 ft Outpatients Centre on the site of the Medical Staff accommodation blocks. It gave impression the hospital was saved when it only meant saved from original plans that no one knew about.
- LBHF leafleting the Borough twice, once with an expensively produced booklet with the same misleading information thus giving the impression the hospital had been saved.
- Taxpayers' money used in publicity used to misinform. Cllr Graham, however said it was funded by the Conservative party, not by the taxpayer.
- SaHF official announcement 19th February, 2013

Shaping a Healthier Future Consultation Flaws
Role of NW London NHS Trust; London Borough of Hammersmith &Fulham Council

Timing

- Timing of the consultation announcement was extremely poor. The dates had been agreed on by the local Council.
- Announced during school exams, just prior to summer holidays and the onset of the Olympics
- Announcement only in the news. Not publicised anywhere in Hammersmith and Fulham other than in the local papers and online on the Council website (dependent on having a

computer and being a regular visitor to the website)

Informing and consulting the public and GPs

- Seriously inadequate public engagement, engagement with doctors and medical students at Charing Cross. All those to be most seriously impacted.
- Little awareness of the Consultation throughout the Borough but particularly in Fulham.
- No attempt to contact vulnerable community groups, patients or residents to be impacted and seriously affected by the proposed major reconfiguration of healthcare in Hammersmith and Fulham by either LBHF or SaHF.
  (*Evidence -LBHF Health and Scrutiny Committee Draft report)*
- No attempt to openly engage with clinicians over concerns in Hammersmith and Fulham. Doctors reluctant to speak out publically.
- (*Evidence – Draft report- Inadequate key engagement with the public and GPs, which they contributed to - 4.2- 4.5, scripted meeting notes)*
- No information in GP surgeries.
- No leafleting of residents in the borough by the Council.
  (*Evidence – letters from residents, emails to the Council and Consultation board, scripted public meeting notes, Draft report*)

Obstacles to taking part in the consultation

- No access or awareness of either the consultation itself or where and how to obtain the hard copy consultation documents.

- No attempt to ensure they were available to the public to enable people to participate. (except at poorly advertised public meetings…Fulham Chronicle Newspaper with limited uneven distribution and LBHF website)

- Hard copy unavailable. To be ordered online. Telephone number only available online. Participation dependent on awareness and computer access and knowledge. Excluded thousands without either.

- The document itself was ridiculously long for a public document, 88 pages.

- Length and being online made it difficult to read without taking notes to be able to answer the questions. A daunting task.

- Its design meant questions were at the end. Not possible to answer without constantly referring back. Answering questions was reliant on content detail so juggling act. Very difficult to do without hard copy.

- Questions were leading questions without genuine choice. Aimed at achieving prescribed answers.

- Options were not consulting or providing genuine choices for beneficiaries of care or to enable them to be participants in of design (Andrew Lansley's first test)

- Options were aimed at closing hospitals and selecting which to close. Patients use both Charing Cross and Chelsea Westminster for different reasons.
- Nowhere was it made clear that voting for Option a and 'saving' Chelsea Westminster meant 'closing' Charing Cross and reducing it to an Urgent Care Centre, the size of a football pitch.

- 4 hours to complete. Daunting and confusing. Leading questions to 'railroad desired answers. Validity open to serious challenge under Trades Description Act.

- It gave the impression that hospitals would be little affected by the closure of A&Es. Reality…Closing of A&Es, when hospitals become local hospitals or specialist hospitals, in reality this means a loss of the hospital to the public.

- Calling them *Specialist or Local* is euphemistic for major downgrading by either limiting hospital accessibility to patients through referral only or complete loss of a 'hospital to be replaced by a 24 hour GP led Urgent Care Walki-in Centre.
  This euphemistic labelling gave the impression they would all continue to be hospitals with inpatient / outpatient treatment. It is effectively a lie.

- The document was written in carefully chosen misleading marketing speak. Misrepresenting the reality of healthcare in hospitals so that what will effectively be a major reduction in healthcare is being sold as a promise of a model of perfection. Glossy Estate agents euphemistic language. Eg. A *'local hospital' with 24 hour care* is a 24 Hour GP led Urgent Care Centre, not a hospital at all. Validity, therefore, open to question.

The consultation process itself

- The choices and configuration do not stand up to the key 4 test criteria laid down by Andrew Lansley, the former Secretary of State, nor do they meet their own criteria. They fail completely on the first that "*patients must be at the heart of everything from beneficiaries of care to participants of design.*"

- This is financially driven, as a business case (profit and loss) and is not about a health service (treatment and standards of care.) Healthcare is not business, it is a service. There is little consideration of what is involved in providing effective a good health service, i.e. investment in the medical workforce *and* its support staff, not corporate business managers with vested interests. This is how medical ***services*** need to be delivered to achieve good outcomes. Cost cutting measures like those proposed by Bruce Keogh, to follow a PC World /Curries model of success of 'less is more' is ludicrous.

- The criteria of 'Value for money' and 'Education' in the options is seriously open to challenge. There is no mention of the cost or consequences of dismantling the major world renowned medical School at Charing Cross nor how this is in the interests of Education. None of the other hospital options could possibly replace it and it would have to be divided between hospitals piecemeal. Doing so would be extremely costly, disruptive and counter productive as it would destroy the medical school. *(Evidence Attachments- 1. Draft report 2. Freedom of information letter from the CEO of Imperial College)*

- No consultation with student body of Medical students.

- No risk assessment done on effect of impact of closing Charing Cross Hospital and A&Es in Hammersmith and Fulham (*Evidence –notes from December 6th public meeting; see Risk assessment documents from SaHF)*

Key questions patients and medical students regularly asked campaigners and in the letters sent in.

These questions were not answered and could not be answered satisfactorily.

Q 1. Why and how are the specialties at Charing Cross to be dismantled in patients' interests?
Q.2 Where are they to go that will be in the interests of patients and medical staff?
Q.3 Charing Cross Hospital is a major teaching hospital and medical school, as is Chelsea

Westminster. How can dismantling them be in the interests of future consultants, medical students and doctors of the future, nurses, medical staff and improving healthcare? How is this meeting the best 'Education' provision, one of the key criteria in the consultation?

Q.4 How will this provide 'Value for money', one of the key criteria in the consultation?

We would like answers to questions asked, including questions of Transparency sent to the consultation board and the local Council. (see Attached)

How were the choices of hospitals to pit against one another chosen? It was not based on the Kings Fund or patient consultation. What was the motivation?

The suggestion of merging Chelsea Westminster and Charing Cross as one major acute hospital on two sites under one management put forward in letters to Lucy Ivimy, the Chair of the Health and Scrutiny Committee and SaHF JPCT Chair, Jeff Zitron, were dismissed by Dr. Tim Spicer at Fulham Broadway public meeting as it '*was not in the brief*'.

Decisions and concerns

- Seriously open to challenge through lack of genuine consultation and resulting poor response.
- Open unmonitored electioneering allowed and encouraged while other hospitals kept in the dark.
- Hard copy Consultation documents delivered throughout Chelsea.
- Lack of public engagement and consultation in Hammersmith and Fulham by either LBHF and SaHF
- Transparency regarding consultation with the public, medical practitioners and staff at Charing Cross and Hammersmith Hospitals.
- Voiced concerns that NW London JPCTs making decisions would be disbanded and no one would be accountable for decisions.
- Website for NW London NHS no longer active (www.northwestlondon.nhs.net) Crucial information to be replaced by NHS Central London CCG, NHS Hammersmith and Fulham CCG; NHS West London CCG, now the joint CWHH CCG, Accountable Chief Officer, Daniel Elekeles (cwhh.complaints@nhs.net) this was not set up until after decisions were made. Many of the board members are the same as those on the JPCT SaHF board.
- Concerns about conflicts of interest in private companies. (*Evidence mail from Stephen Duckworth, Rainsberry Freedom of information letter)*

Hammersmith and Fulham Council approved the Consultation dates, dismissed the findings of their own Draft report on the Consultation to support the decision regardless of major concerns, misled their electorate and finally denied us the right to a judicial review.

There are many questions regarding transparency both NW London NHS and LBHF must answer. The UK is meant to be a democratic country but the processes followed.

LBHF Select Health and Social Care Scrutiny Committee and Shaping a Healthier Future Meetings

Monday 17 September 2012

LBHF Select Health Committee Meeting -Scripted notes

Council Questioning - Steve Mc Manus -

Interim Imperial College Trust Chief Operations (5 weeks)

Cllr Q: *Has Imperial indicated its preferences to the consultation committee?*

SM: *Paper sets out options of sites internally and College on academic study and research. Imperial Trust and College are separate. We are the Academic Health and joint executive between the two.*

Council Q on waiting lists, treatment records for arthritis and cancer patients
Challenge on lost data and waiting lists.

SM: *Still a backlog of 243 patients on lost or incomplete records.*
86 at risk patients not traced.
Referral of arthritis/ orthopaedic and cancer patients not addressed.
Admitted using private sector to shorten waiting times as these were far in excess of 18 week waiting list recommended.
time. Highlighted that it was not a site issue. Trust vague abt position n CXH

Cllrs questioned SM on what was actually doing about the Trust Corporate reputation. - i.e. what led to problems with data entry.

SM: admitted very poor reputation. *Need to do a lot to rebuild. Need to communicate with patients and all relevant bods and organizations.*

Cllr LI -LBHF summary: - *Imperial College needs to be investigated*
A lot of highly paid executives.

- *Council lacks trust in ICT*
- *Requires a page by page analysis of exactly what went wrong*
- *Want to know how far up the management chain / ladder problems went.*
- *Call for an independent review of the government of the Trust; a report and precise analysis to clarify vagueness.*

A. Preferred option -
Council Q: *Is Imperial supporting Option A?*

SM avoided answering the questions. Talked about out of hospital care. Stated the issue around CH is very complex. Not clear whether supporting the proposal of CXH being downgraded to local hospital status. Said 'debate will be had on Weds' 19th Sept.

Cllr. Stephen Cowen (SC): *I'm concerned abt the vagueness of the answer.*

Cllr Peter Graham (PG): Challenging the Trust on their agenda for Weds. (Looked up agenda on phone.) Q. *How can a verbal update lasting 10 minutes be devoted to a decision that will have profound consequences? The paper going to the board for discussion is not on the agenda. This beggars belief.*

Cllr Marcus Ginn (MG): *Imperial have a clear position on this but are not being open about it.*

Cllr PG: *It is reasonable that the board make a copy of the paper available.*

Shift attention to Chelsea Westminster representatives.

Sir Christopher Edwards (CE) – Chair of Trust Govs at CWH and Head of College of Emergency Medicine – role of A&E at CWH:

"Junior doctors are being put off medicine. They do not feel they are properly exposed. There is a30% drop out rate. End up with only 40% that might lead to consultancies."

"This is what this is really about."

Cllr Q: *How on a very constrained site would CWH cope?*

Sir CE: *Current A&E would expand on the ground floor and sideways. Paediatric A&E and oncology The adjacent space opposite could be used.*
What's worrying is when you say 100,000, but this is not real. Blue light ambulances is what we should be talking about.

Cllr Stephen Cowen (SC): Question about outright campaigning on behalf of CWH

Sir CE: *It's not surprising people support their own hospital. It's rather different consequences for CXH.*

Cllr SC*: You are a very successful Foundation Trust Hospital. You have demonstrated you can manage things well.*

Sir CE*: In cash strapped NHS we believe we can invest funds. If we didn't there would be catastrophic consequences. We would have to move Paediatrics and Maternity, our core business, with knock on effects on emergency services We wouldn't have need for specialist surgery.*

Becoming a local hospital means becoming a non-viable hospital. CWH is one of the last new hospitals built.

Cllr Q: Questioning the level playing field: *Do you think it would be inappropriate if you didn't put it in the public domain?*

Sir CE: *Yes, but..... CXH is part of this very large group. They have to look at siting. CWH is compared with Imperial Trust not CXH. The Board of CWH is a Foundation Trust with an independent budget set aside for governors on how to use.*

In the past it was said that Brompton and Marsden should move to CXH. Is it the best thing for the patient? Poorly staffed?
There is an amazing lack of clarity of precisely what will happen if it is downgraded to a local hospital.

We are supportive of Imperial College Trust becoming a Foundation Trust. The main problem with running a three hospital site is almost becoming financially viable.

Cllr SC: *How many services are being duplicated? Could there be a merger with CXH?*

Sir CE: *I have a vested interest in Imperial Trust's success. Could we have a closer link to CXH? That would be entirely up to Imperial Trust. CWH is open to all sorts of options. That's not on their agenda. It's not what they are trying to do.*
We want the best possible outcome for patients and have to put resources to the best use.

Cllr Q*: Are there better solutions?*

Sir CE: *If they split up too much, it won't work. St. Mary's Renal merged to meet patients' needs.*

Cllr SC: - summarising the uneven playing field: *There is no independent objectivity pitting one hospital against another. It isn't going to end well if they are pitted against one another. The critical test will be what NW London NHS does about Imperial Trust. The key issue of 'site' is allotted 10 minutes to the ICT agenda. NW London has to address this. It is side tracking real issues in our community.*

Sir CE: *If there are other options, we would find it very useful if alternatives could be put forward and we would consider.*

NW London NHS representatives - Dr.Tim Spicer; Daniel Elkeles

Responding to the Rideout report and discussion. They believe they corrected the inaccuracies regarding the pre-consultation, present consultation, methodology of choice and addressed the issue of 'not taking the special needs of Hammersmith and Fulham into account , particularly with regard to the specific specialties at CXH and the effect.

Cllr SC: *We do not accept the case for this change. The reasons for solutions are good but the solutions are not. The issue of 'work force for example. How would you solve the issues of workforce.?*

Cllr L.I. (Chair): *We agree with the principles but not the solutions*

Cllr PG: *We were talking about land value the last time you were here. Value across the sites (p.50 Appendix 3)*
At any time have Imperial expressed their opinions?

DE: *When the Trust come to a final decision. Told NW London Imperial are supporting Option A It is what he (CEO) told us He did not want to pre-empt the meeting and decision. There is a debate. I know Mark Davis will discuss this at the meeting on Wednesday.*

Cllr (Joe Carlbach JC?) : *This gives the impression one bit doesn't know what the other is doing. That he hasn't had a discussion yet and there is no firm Trust position on this, implying the opposite of what NW London NHS are saying. I think there is an on going dialogue.*

DE: *Mark Davis said the joint committee preference is for Option A. this does not mean he has made his mind up. There is the option to changeAll Trusts were finally aware shortly before the consultation went out. The Trust Board is having the debate.*

Cllr JC: *This is becoming a farce. We will refer this to the Secretary of State for proper investigation. What exactly is going on here?*

Comment- *Consultees with vested interests - Daniel E passed a note to CWH. What was that about? CWH have a vested interest in outcomes.*

Cllr LI: *would expect having a dialogue with all the major hospitals - but not with CXH, says risks are in a public document in the public domain. All risks PCT has to deal with but.....*

Cllr SC: *p 7 - £1bn savings.*

DE: *We've identified issues and should have gone to NW NHS but only now looking at them.*

Cllr LI: *Not having looked at these risks is astonishing (all the things that could go so wrong)*

Cllr SC: *This is intrinsic to the case of change you are making. This has never been updated. Looks like the cart before the horse.*

Cllr LI: *Are you saying you have a list of mitigating factors considered?*

DE: *Correct. The next report will be in November.*

Cllr SC: *Why have you not been able to say how GPs have responded? CCGs. Considering the four Langley tests.*

DE: *NW never claimed unanimous support.*

Cllr SC: *We would like a percentage.*
Cllr PG: *Land value - You lambasted Tim Rideout about land valuation. You said you had done valuations. Misled the committee twice - led to the wrong page in the document - differentiated between sites.*

Cllr LI - CCGs -GP Surgeries: *Even if H&F doctors disagree, in other words the Shadow or non statutory doctors have no say because they are not in the CCG, the four tests have to be applied.*

DE: *They agreed to the consultation.*

Cllr LI: *That is very different from agreeing to the proposals.*

Dr Tim Spicer (TS): *We want to protect the trust of patients.*

Cllr LI: *They will have to make a decision. What will the decision process be?*

Dr TS: *We have to continue to take soundings of our members.*

Cllr PG: *(ref-Langsley)You must have support of GP commissions - the Secretary of State looks for / reviews the support of practices or commissions.*
The decision is to be made in February He has to consider the 4 tests. Do not believe the decision is in the best interest of local NHS. Is there a better way than A /B/ C?

Dr TS?: *That is the joint committee decision. The Secretary of State does not have to take the decision they have recommended.*

Cllr PG: *If the 4 tests are not met, it will not go ahead. One of the tests is that it must have the support of GP commissions.*

DE: *We will take soundings from the members of the CCG.*

Cllr Q: *Why not a ballot?*

Dr TS: *One of the functions is not just your opinion in order to have confidence in what we can deliver/ can do.*

DE: *True consultancy is not just about counting heads, it's considering best solutions.*

Cllr SC: *What if 60/ 80% of doctors were against the proposals; that makes the position untenable.*

NW NHS: *A majority of colleagues are against Option A (members of CCG but not all doctors.) Dr TS: As clinicians, we have concerns about all the options.*

Cllr LI: *The committee would like a clear understanding of what GPs think. All. Whether these proposals have the support of the GPs. Tim Rideout. (will be polled online) If there is no way of balloting GPs, the Council will make its own decisions.*

LBHF Scrutiny committee's Draft report on consultation
September 2012

Concerns not addressed but Council chose to disassociate, dismiss as if never drawn attention to and sing the unchanged SaHF mantra

The local Council drew up a damning draft report of the consultation in Sept 2012 but then dismissed all the risks they highlighted and singing the same mantra as SaHF. All the concerns have not been resolved and now in January 2015 are proving to be genuinely putting lives at risk. This is gambling with our lives. They knew the risks and decide to go ahead regardless. No one voted for these changes. Risks and concerns are unchanged.

Councillor Lucy Ivimy admitted they had fought hard for the ***non-acute*** services at Charing Cross but said little about the much needed acute services, loss of 500 beds or A&E.

Below was the response the LBHF Conservative Council Health and Scrutiny Committee's response to the SaHF Consultation at the time. (Committee chaired by Lucy Ivimy) Highlighted in blue and yellow are the key concerns made. Once the SAHF reconfiguration was 'approved', given full support, the opposite stance was taken, overiding concerns expressed prior to approval.

All concerns expressed here, then were no longer deemed to be flaws and were either dismissed with the same marketing language used by SaHF or ignored. This was a shock to all who had trusted and believed the Council had supported them in the campaign to Save our Hospitals,

Charing Cross and our A&Es. This however can be used to look back at what was said then and subsequently ignored leading us to where we are now in January 2015. Key questions:

- How many of these concerns and risks are proving to be a reality now?
- Why did the Conservative Council then dismiss these concerns and unquestioningly support Shaping a Healthier Future's arguments, thereby accepting that risk assessments would be done but after decisions to go ahead with major reconfiguration of our NHS hospitals and healthcare rather than before?

I have a file with evidence of how the consultation was mismanaged to ensure the outcomes that the Government wanted. The concerns highlighted below will provide a benchmark for comparison of what is actually happening now and the full impact of these changes.

London Borough of Hammersmith and Fulham **11 September, 2012**
'Shaping a Healthier Future' Consultation Response **v.1 Draft 21**

1. Introduction

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

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

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

2. Context

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

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

2.3 The proposals represent a radical reconfiguration of local health services, with an increased emphasis on out of hospital care and a reconfiguration of NW London's hospitals. For Hammersmith & Fulham, this means a reduction in the *scope and breadth of services provided at Charing Cross Hospital (most notably including a downgrading of the Hospital's A&E and the removal of complex medicine and surgery services) and, to a significantly lesser extent, at Hammersmith Hospital (both hospitals are currently managed by Imperial College Healthcare NHS Trust).*

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

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

3. The Council's position

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

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

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

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

- The objectives of "Shaping a healthier future" are appropriate (i.e. of improving service quality and reducing unwarranted variation, improving the health of local people through the provision of better care, and ensuring that organisations are financially viable for the long term);
- *The* current provision of local healthcare is not acceptable, as it is too often characterised by unacceptable levels of quality and service and unwarranted variation, substantial health inequalities, and an unsustainable financial position;
- The adequacy of the pre-consultation engagement of key stakeholders, notably patients, public, clinicians and the Council itself is open to challenge;
- The extent to which the requirements of the 2010 Equality Act have been met in determining the impact of proposals on protected groups at a borough level is open to challenge;

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

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

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

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

4. The pre-consultation and consultation process

- **Engagement**

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

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

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

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

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

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

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

4.8 The statements made in the **business case relating to wider engagement** and involvement in shaping the proposals are **also open to challenge**. While sound, the stakeholder engagement principles do not address the apparent democratic deficit in the process. It is

difficult to see how such proposals can be legitimised democratically without both the active engagement and support of local government. Currently, significant aspects of the proposals do not have the support of the Council.

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

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

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

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

- **The "Four Tests"**

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

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

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

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

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

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

- **Equalities Impact Analysis**

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

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

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

- **Timing and decision-making**

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

4.22 Further, the proposals have been developed during a time of major organisational change within the NHS. The 2012 Health Act abolishes Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) from 1 April 2013, replacing them with local CCGs and the NHS Commissioning Board. The business case states that all NW London CCGs have been established. This is not strictly true. The current PCT and SHA structures are still in place (albeit on a clustered basis) and are still statutorily responsible for local health services until 31 March 2013. "Shadow" CCGs have been set up as sub-committees of PCTs and are currently participating in a formal assessment process to support their eventual establishment and authorisation by early 2013 for them to "go live" on 1 April 2013.

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

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

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

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

- **Programme assurance**

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

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

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

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

5. Methodology

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

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

- Insufficient exploration of alternatives to hospital reconfiguration;
- The absence of any detailed independent verification of the baseline financial model provided by local NHS Trusts to support the proposals; and

- The unnecessary combining of much needed proposals to strengthen primary and community services with proposals to reconfigure local hospitals.

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

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

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

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

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

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

- The patient experience assessment, driven by an inappropriate use of estates indicators;
- The patient choice assessment, driven by a spurious argument about the number of NHS Trusts managing Major Hospitals;

- The financial surplus assessment, that has not been subject to verification and the materiality of which is subject to challenge;
- The Net Present Value calculation, that double counts previous measures and is subject to challenge; and
- The workforce assessment that inappropriately underrates Imperial Trust compared with Chelsea & Westminster.

5.7 In more detail:

- **The case for change**

5.8 The proposals are predicated on the need for substantial change that must start now. Included is an assessment of the changing demands on the NHS in NW London but it is not clear if the business case takes account of the fact that more than 20,000 extra homes are planned for Hammersmith & Fulham in the next 10 to 15 years.

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

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

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

- **Principles and objectives**

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

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

5.14 One of the key arguments for hospital reconfiguration and rationalisation is that the limited availability of senior medical personnel (particularly at weekends) has a detrimental impact on clinical outcomes. There are clear indications in fact that many of the current outcomes are satisfactory, notwithstanding the limited availability of senior medical personnel and

specialist teams. The business case does not explore other ways of securing sufficient cover that are not dependent on service rationalisation.

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

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

- **The financial model**

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

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

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

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

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

viable. The differences between Trusts are in reality marginal and subject to significant change depending on changes in the underlying assumptions and actual delivery.

- **Clinical model**

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

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

NB

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

5.25 **The principles and standards proposed for Out of Hospital care are sound.** *However, the practical development of this model for Hammersmith & Fulham should be developed with the full involvement of all parties, including the Council, and should be developed to specifically meet the needs of local people. Currently the eight CCG level strategies appear somewhat generic and lack sufficient detail to support implementation.*

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

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

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

care. This does not require formal consultation and should be decoupled from the case for reconfiguration and implemented as a matter of urgency.

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

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

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

- **Options appraisal**

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

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

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

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

5.36 For example, clinicians concluded that "their desired clinical standards could not be met if all nine current NW London acute sites ... were to become major hospital sites". The business case does not provide the evidence for this conclusion. Given its importance in underpinning

the proposal to reduce services provided at four of the nine sites, including Charing Cross and Hammersmith Hospitals, this is a significant omission.

5.37 The clinicians considered evidence about factors that were judged to contribute to high quality clinical care. The business case states that as a result of this consideration clinicians "identified that there should be between three to five major hospitals in NW London to support the projected population of 2 million", with a view that more than five major hospitals leading to sub-optimal care. The proposals centred on five as the proposed number, primarily in light of current capacity constraints. The detailed evidence base for this decision to propose five major hospitals is not provided with the business case and is therefore open to challenge.

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

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

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

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

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

5.43 In order to evaluate the options, a number of criteria were developed. Some suggested by clinicians and patients were not accommodated, including integration of services, health equality across NW London, and support for preventative care and help for patients to manage their own conditions. These exclusions are open to challenge. Their inclusion would go some way to addressing the inadequate population focus of the current proposals.

5.44 On the clinical quality criterion (the highest ranked by clinicians and patients), the position has been adopted that "current clinical quality at Trust level was not a useable proxy for

future clinical quality at site level after reconfiguration was complete". This is a contentious statement and is open to challenge. It was proposed because the assessment used current mortality rates at Trust rather than site level. Given the importance of the quality aspect of the option appraisal, site level information should have been secured in order to allow for appropriate and necessary comparisons. The management teams of a number of the respective trusts have indicated that this information is available at site level. Regarding distance and time to access the service (again a highly important criterion for patients and the public), the business case places much less emphasis on this issue given that the criterion was a fundamental part of the basis for identifying the eight options. This is open to challenge. A much more detailed analysis on a more granular individual population and group basis should have been used to inform the options appraisal.

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

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

5.47 The patient experience element of the quality criteria includes an assessment of the quality of the respective estates across the nine sites, based on the assumption that there is a correlation between the quality of the hospital or clinic where a patient is treated and their experience (although only very limited theoretical evidence is explicitly quoted to support this statement and it is contrary to local evidence). In order to use this as a comparative measure of patient experience the business case uses nationally collected site level information (from ERIC returns) in terms of the proportion of space deemed to be not functionally suitable as NHS space and the age of the estate. This makes a large assumption that there is direct correlation between the age and the quality of the estate and it does not take into account in any way current patients' views of the respective sites. Therefore the information's use in this way is open to challenge.

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

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

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

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

5.52 In terms of value for money, the evaluation uses a number of criteria. In terms of the estimated capital cost of the additional capacity required by the reconfiguration the only real difference highlighted is between those options that include Hammersmith Hospital as a Major Hospital (Options 1 to 4) and those that don't (Options 5 to 8). In terms of relocating maternity and other services, this has a significant impact on any option where Charing Cross Hospital is designated as a Major Hospital, as it currently has no maternity services at present. If the capital cost of such a relocation is truly prohibitive, this element of the model could be looked at again.

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

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

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

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

challenge, as further more detailed work should be done to secure a better estimate of likely transition costs.

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

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

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

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

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

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

- Changes to the designation of the Major Trauma Centre at St Mary's;
- Current location of stroke units;
- Changes to the location of the Hyper Acute Stroke Unit (HASU) at Charing Cross.

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

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

(DD note: research is one aspect of medical training and education for doctors. Charing Cross is the largest medical school for undergraduates in the UK)

NB

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

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

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

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

- **Readiness**

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

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

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

5.71

6. Clinical outcomes

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

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

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

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

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

7. Impact

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

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

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

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

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

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

7.6 Furthermore, these changes would have a detrimental impact on the new Hammersmith & Fulham CCG's ability to influence the care commissioned for local people. Effectively the proposals fragment Hammersmith & Fulham's health care across many different providers. It is unlikely in consequence that Hammersmith & Fulham will be a major commissioner of any of the receiving NHS Trusts.

8. Additional issues

- **Implementation**

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

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

- **Benefits and disbenefits**

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

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

- **Clinical outcomes**: the potential for these to be adversely affected by increased travel time and delayed access to emergency services, and the impact on the population of the other proposed changes (e.g. to maternity services);
- **Primary care development: the impact of services not being improved** as proposed, whilst hospitals proceed to reduce their capacity;
- **Equality and human rights: the impact on the most vulnerable groups of people (particularly children and** older people) in Hammersmith & Fulham's diverse population;
- **Increased complexity**: the establishment of a new "tiered" system of local healthcare (including "local" and "major" hospitals) has the potential to significantly confuse patients and the public; and
- **Loss of expertise: the potential significant loss of clinical expertise and excellence at Charing Cross Hospital which has established a world-class reputation**

- **Motivation**

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

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

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

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

9. Next steps

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

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

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

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

– ENDS –
LBHF-FCS: CPD-Policy
11 September 2012
Amendments and additions from Draft v1.1

"DRAFT" watermark added
1 Introduction – new three-paragraph section with one each on context, concerns and next steps
3.3 (ex 2.3) first bullet, fourth line – organisations are…
3.4 (ex 2.4) second line – paragraph ~~1.8~~ 3.3 and in…
4.16 (ex 3.16) fifth line – business case ~~to~~ states…
7.2 (ex 6.2) rewritten – Analysis of the preferred option indicates that currently each A&E in NW London serves an average population 5% less than the national average. If the preferred option is implemented the cuts will result in each remaining A&E serving an average population that is 52% larger than the national average.
9.2 The Council, through its Scrutiny committee, will therefore ~~seek~~ decide whether to refer…
9.3 The Council, again through its Scrutiny committee, will therefore ~~seek~~ decide whether to refer…
9.4 New paragraph

Approvals process

05/09/2012 – Draft v1.0 – circulated to Peter Smith and David Evans for comments
06/09/2012 – Draft v1.1 – sent to Cllr Ginn for review
10/09/2012 – Draft v1.1 – sent to Sue Perrin for Cllr Ivimy to review ahead of HHASC dispatch
10/09/2012 – Draft v1.1 – Cllr Ginn forwarded for inclusion on Cabinet Briefing agenda
11/09/2012 – Draft v1.2 – incorporating Cllr Ginn's amends and additions
11/09/2012 – Draft v1.21 – incorporating rewritten paragraph 7.2

Fulham Broadway – Fulham Methodist Church - Wednesday 4 pm September 19th
***Shaping a Healthier Future* open meeting** - Summary and scripted notes.

Held the same day as a Chelsea-Juventus match. Football fans flooding the area. It was not advertised. Few people knew about it. 6 attending – 4ish. Small numbers earlier in the day.

Present Daniele Elkeles (DE) and Dr. Tim Spicer (TS), NW NHS rep, Andrew Pike

I was the only person there for a long time. I spoke to Dr. Spicer informally one to one. Opportunity to tell him there were no real options in the consultation. Suggested that a merger of Charing Cross and Chelsea Westminster Hospitals under one management would have saved money and made much more sense. (Took a picture of the display to catch the atmos and they told me I needed permission.)

He *agreed* but said it couldn't happen "as it *was not in the brief. There are workforce issues where they are seriously undermanned. Increasing specialisation brought better outcomes but then it is harder to run services on local sites."*

Discussion called once 6 people , including myself and Anabela Hardwick) 4pm.

QUESTIONS
I bought up the point about the discrepancy between the Option A hospitals electioneering and the other hospitals being prevented from publicising the proposed changes in the consultation. Chelsea Westminster had been campaigning while Charing Cross and Hammersmith Hospitals had a media embargo imposed on them. Confidentiality clauses prevented staff from talking about the consultation or proposed changes. Residents in Fulham and patients in Charing Cross were unaware. There is no publicity or information available in the hospital. There were about 6 copies of the consultation document in the PALS office on a small table, not easily visible.

I held up a copy of the Chelsea Westminster hospital broadsheet, *Trust News* August / September. I said I had collected copies at hospital on several occasions. I pointed to where it clearly explained how to vote Option A to save the hospital. In addition to some of the tick box blue cards held up, I showed the three pages devoted to helping people vote fro CWH. I pointed out that nowhere did it explain that voting Option A would close the A&Es of Hammersmith and Charing Cross Hospitals or effectively reduce CHX to a nothing more than an outpatients, local Urgent Care Centre as a local hospital.

I have copies of all of these as evidence.

I said I had gone into all the departments and on every reception desk there were '*Safe in our Hands'* blue cards for patients and visitors to pick up to tick box option A. I then said this led to 3rd world electioneering tactics and asked what they were going to do about it.

Dr. Spicer tried to be reassuring and replied, "*When it comes to counting the votes, the blue cards will be discounted."*
I said I would remember that when it came to the counting of the votes.

Other questions of concern from the audience were about:

- difficulty of patient transport to hospitals and accessibility
  TS: Patients can book an NHS taxi.
- what will happen to CXH. It has 800 beds – *DE: In the interests of consultants being present more of the time, traded off clinical benefit to 'do- ability'.*
- what is meant if it becomes a local hospital
  TS: Local hospitals will not have an acute side. They will still have outpatients with urgent and social care integrated. Seen as a community facility

Exchange between LBHF resident and Cllr Lucy Ivimy's response to his Open letter

The exchange of emails between Cllr Lucy Ivimy, Ken Bromfield, a resident and patient at Charing Cross, myself, Una Hodgekins, a resident and Jeff Zitron from SaHF consultation below took place shortly after the 'news' of the closure and downgrading of CX hospital. It highlights the depth of feeling at the betrayal. The Council's pre-empted full page SAVED spreads across a picture of Charing Cross before the official announcements shocked the community and prompted this open letter and subsequent exchanges:

To the Editor of the Fulham Chronicle
Please publish the article below! It will redress a depressing imbalance in the HF paper.

The issue of the fate of Charing Cross hospital towers over everything in my 70 plus years as a Hammermith resident. I should be grateful if you would publish the open letter below.
Ken Bromfield MBE. Chartered FCIPD. FIScT

An open letter to Hammersmith Council

When our Council announced to its electorate that it was joining the fight to save Charing Cross Hospital , was its campaign objective for us to end up with Charing Cottage Hospital, with a massive reduction in beds and other services? If this was the case, the Council's was disingenuous, deceitful and utterly opaque, to say the least.

On the other hand, if the Council's campaign purpose was in line with the thousands of concerned residents, to maintain a world class hospital facility in Hammersmith, then its 'efforts' have been a failure. How Councillors can claim victory is beyond me.

What exactly were the success criteria in the Council's exalted 'battle' to save Charing Cross Hospital . Where were they published?

I was a Charing Cross Hospital inpatient for 10 weeks. A vital part of my healing process was the stream of visitors whose love and encouragement helped me out of a dark place. As you know, public transport, including the tube is excellent to our hospital. By comparison, Chelsea Westminster is nowhere near the tube. Parking is nigh on impossible in that area. Councilors should ask themselves whether this will discourage visitors, and if so, what are the consequences?. Should this issue have been put into the decision making process about our NHS medical care?

One bright spark Councillor pointed out to me that A&E doesn't attract visitors. Even if this was so, people do visit patients in the 500 or so beds currently at CHX. When the beds go, the visitors will obviously have to troop off to wherever they are replaced.

We have a rising population in our borough. Even our Council should be able to work out that healthcare needs will rise. If the Council fails to care about this issue for our people, then it leads one to suspect they have alternative health arrangements for themselves or they live in districts unaffected by the debacle.

The public anger at our Council is palpable. The Council should hang its heads in shame, or apologise to people like me who were born, raised, still live, and would be content to die in Hammermith.

Ken Bromfield MBE. Chartered FCIPD. FIScT

[redacted]

[redacted]

Hi Dede

This is the note that I sent to the H&F article comments.

Perhaps the most striking aspect of the Hammersmith Council's treachery when it announced that it was instrumental in "saving" Charing Cross Hospital, was its utter disregard of its electorate's savoir faire and political judgement. Did our Council really believe that we would be taken in? What an insult to us all!

The Councillors are in a hole. Guess what? They are still busy with their shovels. They are tring to justify their deceit with arguments such as "The hospital will continue to treat at least 85% of H&F patients who are currently seen at CXH." This spurious statistic misses the point. We are concerned about the people who need more serious treatment as in-patients. There will be 440 bed losses in the CHX "plan for the future". At only 80% occupancy that's 128,460 in-patient days. Assuming an average stay of 6 days, that's 25,692 patients and their vital visitors, who will have to go elsewhere, probably Chelsea Westminster with its poor access by tube and car. Whatever the vacuous spin churned out by our Council, Charing Cross Hospital has been hugely diminished. *It has not been saved.* The Council's affront to us all needs urgent redress.

Cheers, Ken

Ken Bromfield MBE. Chartered FCIPD. FIScT

[redacted]

Lucy's Reply
What is Charing Cross Social Care Hospital?

Dear Mr Bromfield
Thanks for your email. In summary, original Option A proposals for Charing Cross were for a Local Hospital of 4,000 square feet costing £15m, giving no beds, having no specialisms, and having standard Urgent Care Centre facilities unable to take ambulances.

The new proposals are for a *Specialist Health and Social Care Hospital* of 16,000 square feet costing close to £100m, with 60 beds, retaining all the current **outpatient** specialisms **plus an enhanced Urgent Care Centre** with full diagnostics and able to take some ambulances. It will therefore be four times the size of original proposals.

The NHS announced this substantial u-turn in a presentation to members of the eight borough Joint Health Overview and Scrutiny Committee which I chair. I made a note of what is proposed, but full details in written form will not be available until the agenda for the formal JCPCT meeting next week is published.

Under the new proposals the following specialisms have been saved:
- Oncology - specialist ambulatory cancer care including the cutting edge radiotherapy and chemo treatment
- West London Sexual Health clinic
- Mental Health facility
- Renal care
- Research and teaching in conjunction with Imperial College
- Full range of diagnostics

- An ante and post natal clinic will be added
- The UCC will be enhanced so that it will take ambulances (though **not** blue light emergencies) and be able to treat 70% of all patients who currently present to the A&E
- All current specialist out-patients will continue to be treated under the new proposals
- In total, about 90% of patients currently treated at Charing Cross will still be treated there (As outpatients only)

What will, however, still be lost is:
- Blue light life threatening A&E
- Stroke unit
- Complex acute surgery
- Beds will reduce to 60...only used as day beds

Serious injuries or emergencies such as a stroke, and acute complex surgery are the dramatic aspects of a hospital and take up a large part of the bed space, but actually involve a very small proportion of all patients.

SOH Comment (500 beds being used regularly for inpatient care will be lost)

These patients want to receive and should receive the best treatment, which means a full team of A&E / trauma and stroke specialists should be on hand 24 hours a day, 7 days a week.

Comment - (Because CEO Mark Davis has split up consultancy- specialist teams. He moved and sent them to SMH as with specialties below. Forcing patients from LBHF to go to Westminster for life threatening treatment)

This is not currently the case at Charing Cross, which is why an ambulance with a severe multiple trauma victim will today go to St Mary's Paddington where there are such facilities. Imperial currently has plans to move the stroke unit from Charing Cross to St Mary's in order to co-locate it with the trauma unit where there is a brain surgeon always on hand, as some stroke victims require emergency brain surgery to remove a clot.

SoH NOTE
(Charing /Cross has the best neuroscience and neurosurgical unit in the country at present. A long established team preforming brain surgery and spinal surgery)

This type of organisation saves lives and reduces the degree of permanent disability suffered by patients.

The downside of the additional time in the blue light ambulance (where a patient has already been stabilised) is hugely outweighed by the benefits of immediate specialist treatment once in hospital.

For this reason, I feel that carrying on the battle in order to try and save a full range of A&E at Charing Cross would actually be, from a clinical viewpoint, a mistake.I hope this helps.

Kind regards
Lucy Ivimy, Chair, Joint Health Overview

.....

Subject: 1) Lucy Ivimy's letter and (2) PFI at West Middlesex
Date: Fri, 15 Feb 2013 13:06:08
From: Una Hodgkins [redacted]

To: dede wilson [redacted]
CC: Carlo Nero [redacted] 'Jasmine Pilgrem (Ashchurch Residents Association)" [redacted]

Dear Dede,

I live In Hammersmith, in Ravenscourt Ward, which is Lucy Ivimy's!
(1) Thank you for forwarding Ken Bromfield's letter and Lucy's reply. Her letter contains statements, which even she could not possibly believe.
For example it will be impossible to continue training doctors at Charing Cross when the number of beds has been cut from 500 to just 60. I spoke yesterday outside Charing X with a consultant . He said in a bemused tone - they are so weary of change - that transitional arrangements while they split teaching between St Mary's Paddington and Hammersmith Hospital would be "very testing" and would be disruptive to teaching. They would not be staying at Charing Cross with no patients....
(2) While I was outside Turnham Green station last night I spoke with someone who works for West Middlesex hospital. He told me that this hospital was built fairly recently with PFI money, and that it was paying £5M pa in interest payments to the consortium which built it, and because of this it was in a perilous financial position. But it was locked in to paying and keeping the hospital open for years ahead!

So we are in the same mad position as Lewisham of being forced to keep open small financially imperiled small hospitals while closing financially and clinically successful, large ones!!!! Someone, somewhere MUST make a fuss about this total absurdity.

Best wishes,
Una

On 15/02/2013 11:07
From: Cllr IVIMY <cllr.ivimy@btinternet.com>
To: "cllr.ivimy@btinternet.com" <cllr.ivimy@btinternet.com>
Sent: Monday, 18 February 2013, 12:49
Subject: Fwd: NW London NHS Joint Primary Care Trusts
Fwd: (1) Lucy Ivimy's letter and (2) PFI at West Middlesex
Sent from my iPad

Begin forwarded message:
Resent-From: <Lucy.Ivimy@lbhf.gov.uk>**From:** Una Hodgkins [redacted]**Date:** 16 February 2013 09:50:24 GMT**To:** Ivimy Lucy COUNCILLOR <Lucy.Ivimy@lbhf.gov.uk>, <consultation@nw.london.nhs.uk>**Subject: NW London NHS Joint Primary Care Trusts Fwd: (1) Lucy Ivimy's letter and (2) PFI at West Middlesex**

Dear Lucy and Mr Zitron,

I have been talking to various professionals employed in the NHS while I distribute leaflets for Save Our Hospitals (Charing Cross, Hammersmith and Ealing). Can you please note the comments in my e-mail below from (1) the consultant in charge of post-graduate medical training at Charing Cross and (2) an employee at the West Middlesex hospital. The comments of the latter are extremely worrying: we could be closing large, clinically and financially viable hospitals like Charing Cross and Hammersmith in favour of clinically and financially weaker and smaller units. This is crazy!

The NHS consultation should focus EXCLUSIVELY on the provision of hospitals on a medical and geographic basis. The NHS should not take into consideration the value of the land in "North Fulham" for redevelopment - particularly as redevelopment means ADDING more residents, not reducing them in some of London's most densely populated, yet very accessible boroughs.

I propose the following, rational solution to cutting hospitals in NW London: create one "super hospital" with stroke, cardiac and "major trauma" (brain and lung surgery) outside the "nucleus" of Central London, either at Charing Cross or at Hammersmith. These two sites have all the advantages required for larger,

more intense hospitals: existing large buildings, room to expand on nearby car park or Wormwood Scrubs, existing landing space for helicopters, close to M4 and Heathrow, good access by public transport.

Retaining three A &Es in central London (Chelsea and Westminster, University College Hospital and St Mary's) makes no sense, as these are sites which are each deficient in several respects. And we should buy out nonsensical PFI deals before they cripple the NHS. Now is the time to tackle this very poor budgeting.

Yours sincerely (Mrs) Una Hodgkins Save Our Hospitals campaign (http://www.saveourhospitals.net/) [redacted]

----- Forwarded Message -----
From: Lucy Ivimy <cllr.ivimy@btinternet.com>
To: Cllr IVIMY <cllr.ivimy@btinternet.com>
Cc: [redacted]
"consultation@nw.london.nhs.uk" <consultation@nw.london.nhs.uk>;
[redacted]
Sent: Monday, 18 February 2013, 15:24
Subject: Re: Fwd: NW London NHS Joint Primary Care Trusts Fwd: (1) Lucy Ivimy's letter and (2) PFI at West Middlesex

Dear Una and Dede,

Thanks for your emails. Please note that neither Charing Cross nor Hammersmith hospitals will close. Hammersmith Hospital is a large specialist hospital, which has a small and under-utilised A&E. The A&E does not take serious trauma cases as Hammersmith Hospital does not have the facilities to deal with this sort of work, and blue light ambulances seldom take patients there. The A&E functions more like a UCC, so downgrading it to that will have minimal impact on the hospital.

Charing Cross will lose its acute specialisms but retain its other specialisms..
It will become a Specialist Hospital – like Hammersmith – but with a different range of specialisms. All the outpatients that it currently treats will continue to be treated there.

(DD: It already is an acute major hospital. The specialisms at Charing Cross are what make it a world renowned centre of excellence. The specialist teams are known for their high quality of care.(see attached article) They are unique and irreplaceable. This is being disregarded and so are the patients receiving their specialist care.

These long established teams are being systematically broken up. This is not in the interests of patients' care or doctors of the future. In fact, in complete contradiction of the need for restructuring as stated in the consultation,.. ' for the best care -to have key acute specialty teams under one roof. " They already are. eg. Neuroscience, neurosurgery with brain and spinal treatment specialties, orthopaedics and complex reconstruction/ kidney and renal surgery/ cancer surgery/ ENT.

The total number of patients at Charing Cross will increase, although they will primarily be outpatients rather than in beds. For example, the stroke unit, which takes relatively few patients but uses a lot of bed space, will go, but specialist ante and post natal clinics will be added, which will treat many patients but take up little, if any, bed space. Charing Cross will therefore continue to function as a teaching hospital.

(DD How can it function as a teaching hospital without any inpatients or genuine overall treatment essential for learning? A&E is crucial for doctors of the future to learn emergency medicine and see how patients are treated from start to finish. It cannot be done piecemeal. This is cosmetic. I am an education consultant and teacher trainer. In educational terms this does not make sense.

Patients at the hospital at present are both inpatient and outpatient, needing acute treatment,

beds and follow up treatment. There needs to be continuity and clear effective teamwork from start to finish. This is what students learn from. Ante natal and post natal also require 'birth' experience for doctors to learn about delivering babies and the potential complications. Crucial confidential data also is less likely to get lost as it stay where patients are treated.)

The NHS is indeed proposing a small number of 'super hospitals', to be called 'major hospitals', with the ability to deal with stroke, cardiac, major traumas and acute complex surgery.
and Chelsea West Charing Cross should be one of them

It proposes five such across the North West London area, each with a fully functioning A&E. Two of these are Chelsea & Westminster and St Mary's and the others out of the town centre.
(DD - But none in our borough.)

Kind regards
Lucy Ivimy

From: dede wilson

To: lucy.ivimy@lbhf.gov.uk; consultation@nw.london.nhs.uk; mark.davis@imperial.nhs.uk

1 **Attachment** 4.2MB
Report praises under-threat Charing Cross and Hammersmith hospitals - Local News - News - Fulham Chr.webarchive Save

Dear Lucy and all concerned,

I'm afraid this does not answer Una's questions. Saying Charing Cross is SAVED as a hospital is disingenuous. It won't be a hospital. We know the plan is to demolish Charing Cross and replace it with a smaller building with the loss of 500 beds. These are to be replaced by 60 day beds but no beds that require acute specialist care as at present.

All should re-read the article attached about the hospital as a reminder of precisely what the Council has said, how Charing Cross is regarded in the Foster report and what the NHS is proposing to dispose of. Consider what was said then and what is being said now.

English language is being played with here to 'manipulate and railroad residents' into thinking they will have a hospital. We won't. It'll be a a glorified specialist polyclinic.

LBHF will have no beds for residents who need acute A&E care and follow up treatment, (unless the specialty exists at Hammersmith Hospital). Only day care. eg. Cancer patients will have radiotherapy and chemo at CXbut have to travel to St Mary's for surgery.

Effectively, it has been assumed that 90% of us in H&F will never need acute medical care and that it is not needed at present. Residents will not need A&E, acute surgical treatment or hospital beds because we will not have accidents or serious health problems. SaHF, NWLondon NHS and LBHF must consider us to be a uniquely healthy borough with a very small population.

These are peoples' lives, not chess pieces to be moved around on the board. They are real people. We must not to be considered dispensable as is happening at the moment. (Our treatment is to be dispersed around NW London, out of borough far from family and friends.)

Save our Hospitals volunteers are outside the hospital regularly. We talk to patients and people in hospital. We know what is going on and how it is affecting everyone. How many of you have done that?

In your reply below, I have commented on the replacement of our hospital by a this proposed specialist clinic.

Peoples' lives in LBHF are being put at risk. NHS cost cutting compromises care as has been shown at Stafford Hospital. Doctors have been mislead into believing the choices in the consultation were the best solutions to the problems facing the NHS. Alternatives were not considered as both Una and I mentioned

If Chelsea Westminster and Charing Cross were to have merged under one management, but on 2 sites, all the best specialty treatment imaginable would have been under one umbrella with a teaching hospital that would be the envy of the rest of the UK. When I asked Dr. Spicer why this was not an option at the meeting at the Methodist Church Hall in Fulham in September, he responded that it wasn't in the brief. It should have been.

We have one MP who has one leg in Chelsea and one leg in Fulham, the other MP represents the other half of Fulham and Hammersmith. Those of us in Fulham have been split down the middle when we should have been united. Just as those two hospitals should have been.

I have a file with evidence on the mismanagement of the consultation. Tactics used to ensure the outcomes that the Government wanted.

Dede Wilson,
English and Foreign Language Teaching Consultant and Trainer
Save our Hospitals Hammersmith and Fulham
Fulham Reach resident and patient at Charing Cross since 1972.
[redacted]

SUBMISSION TO:-
INDEPENDENT HEALTHCARE
COMMISSION PANEL
FROM MRS. ANNETTE CHAMBERS
MS. DÉSIRÉE CRANENBURGH
AND LBH+F COMMUNITY

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TO THE INDEPENDENT
HEALTHCARE
COMMISSION PANEL
ROOM 39
HAMMERSMITH TOWN HALL

MRS. ANNETTE CHAMBERS
MS. DÉSIRÉE CRANENBURGH
[redacted]

17TH FEBRUARY - 27TH FEBRUARY 2015

DEAR INDEPENDENT HEALTHCARE COMMISSION PANEL + TEAM,

HOPE YOU ARE ALL KEEPING WELL. THANK YOU FOR YOUR CARE AND TIME GIVEN IN READING THROUGH SUBMISSIONS AND LISTENING TO OUR VIEWS AND CONCERNS AT PUBLIC MEETINGS. IT IS PAINSTAKING AS IT CONCERNS PEOPLES HEALTH AND LIFE STORIES. IT IS EMOTIONALLY DRAINING AND HUMBLING. SADLY, MOST OF WHAT WE'VE WRITTEN IS FAMILIAR TO YOU.

WE APOLOGISE FOR LENGTH OF SUBMISSION. IT'S BEEN COMPILED AT REQUEST OF OUR LOCAL COMMUNITY. THEY HAVE ALLOWED US TO INCLUDE THEIR STORIES. HOPEFULLY, ONE DAY THEY'LL FEEL CONFIDENT TO DO THIS THEMSELVES. OUR LOCAL ESTATE REFUSE COLLECTORS HAVE ASKED ME TO INCLUDE A LETTER I WROTE TO LOCAL PRESS. RECENTLY WE ENCOURAGED OTHERS TO WRITE AS WELL.

THE IMPACT OF LOSS OF OUR A+ES AND HOSPITAL CLOSURES WILL CAUSE SEVERE DAMAGE TO THE HEALTH OF OUR MOST VULNERABLE. MANY HAVE CUTBACK ON FOOD + HEATING. SOLD THEIR CLOTHES FOR 55P A KILO. SUPERGLUE THEIR FILLINGS IN. WEARING POUNDLAND GLASSES. HALVING PRESCRIPTION DOSES. G B - 2015! IT'S SADDENING AND SHAMEFUL.

MOST OF OUR COUNCIL HOUSING ESTATES ARE IN CLOSE PROXIMITY TO BOTH OUR HOSPITALS. HOUSING OUR MOST VULNERABLE. MANY OF US USE G.P. SERVICES AT CXH + H'SMITH. PLUS A+ES ON MANY LIFE SAVING OCCASIONS.

MY MOTHER IS 80 YRS OLD WITH ASTHMA + BRONCHIECTASIS. I'VE INHERITED HEALTH CONDITIONS. WE'RE EACH OTHER + EXTENDED FAMILY'S CARERS. WE'VE LIVED IN + AROUND H'SMITH ALL OUR LIVES. WERE 5TH GENERATION IMMIGRANTS. WERE IN/OUTPATIENTS

P.T.O.

WE'VE ALSO WORKED IN AND VOLUNTEERED IN MOST LONDON HOSPITALS. MUM HAS BEEN A LEAGUE OF FRIENDS VOLUNTEER AND A FOUNDER VOLUNTEER OF OUR BROADWAY HOMELESS PROJECT.

I'VE WORKED FOR FORTY YEARS FOR FRONTLINE SOCIAL SERVICES, NHS + DWP COVERING POSSIBLY EVERY LIFE ISSUE AS A FAMILY OUTREACH KEYWORKER. WE KNOW AND FEEL FIRST HAND HOW LOCAL HEALTH SERVICES SAVE LIVES AND PROMOTE HEALTH TO BENEFIT OUR DIVERSE COMMUNITY.

WE'RE SADDENED THAT I.F.S.A.H.F (MIS-SHAPING A HEALTH (LESS) FUTURE) GOES THROUGH IN ITS ENTIRETY IT WILL RESULT IN A HEAVY TOLL ON PRESENT AND FUTURE HEALTH. OUR HOSPITALS ARE A PART OF OUR COMMUNITY - HEALTH, EMPLOYMENT, LOCAL SERVICES AND SHOPS.

WE KNOW SERVICES AT OTHER HOSPITALS ARE GOOD BUT WE DON'T WISH TO OVERWHELM THEM WHEN THEY'RE STRUGGLING TO COPE. ACCESS + TRAVEL MUST BE CONSIDERED, TOO.

FOR 2½ YEARS (PRIOR TO ILLNESS DEC. 2014) EVERY SATURDAY AFTERNOON MUM DELIVERS LEAFLETS, 'CALL OUT' IN LYRIC SQUARE. MIDWEEK WE'RE TALKING TO COMMUNITY. WE RUN A TABLE "THE 2 SILK LADIES OF H+F TOGETHER TO SAVE OUR NHS" OUTSIDE SCHOOLS, CHILDREN + ELDERCARE COMMUNITY CENTRES. WE GIVE INFORMATION PACKS. WE NEED TO GET THE MESSAGE ACROSS. SOME HAVE FORMED NOW LITTLE GROUPS OF THEIR OWN.

WHAT FOLLOWS IS ANECDOTAL/OBSERVATIONAL. HOPE IT EXPRESSES OUR NEED TO KEEP OUR NHS LOCAL. THOSE DETAILED ARE NOT IN ANY PARTICULAR ORDER. ALL BEING PENSIONERS, LOW WAGE EARNERS, UNEMPLOYED, NO TRANSPORT HAVING SOCIAL ISSUES AND WELFARE CUTS AS A DENOMINATOR.

THANK YOU. ANNETTE + DESI

CONCERNS OF OUR COMMUNITY

OUR ELDERLY.

SOME ISOLATED CARERS FOR THEIR PARTNERS, CHILDREN GRANDCHILDREN · WORN DOWN BY LONG-TERM ILLNESSES AND CARE RESPONSIBILITIES. CONCERNS ABOUT FALLS AT NIGHT. SHORTAGE OF MONEY FOR EXTRA TRAVEL TO REVIEWS TREATMENTS APPOINTMENTS. SOME POOL RESOURCES TO HELP EACH OTHER (MINICAB) EASIER IF HOSPITAL'S LOCAL.

IT'S CONFUSING GETTING AROUND ONE HOSPITAL DEPT WITHOUT NAVIGATING AN UNKNOWN HOSPITAL + AREA. WHEELCHAIRS, MOBILITY AIDS TO BE CONSIDERED ON PUBLIC TRANSPORT TRAVEL AT NIGHT, RUSH HOUR, BAD WEATHER.

SOME ELDERLY BLAME THEMSELVES FOR CLOSURES IT'S UPSETTING THE REPETITION THAT THEIR AGE GROUP IS RESPONSIBLE FOR GROWING BURDEN ON NHS SO THEY NEGLECT THEIR HEALTH. THEY'RE CONCERNED ABOUT ELDER/SOCIAL/AFTER CARE.

LONE PARENTS

CARING FOR YOUR SICK/INJURED CHILD ON YOUR OWN IS A WORRY. WHAT IF YOU'RE ILL YOURSELF? TRAVEL TO HOSPITALS LATE AT NIGHT, FEARFUL AS A WOMAN · ONCE YOU'VE RECEIVED TREATMENT, NO LONGER AN EMERGENCY HAVE A CHILD WITH YOU - HOW DO YOU GET HOME SAFELY SOME HAVE SLEPT ON HOSPITAL BENCH OVERNIGHT. FOR A HOSPITAL STAY, CHILDCARE ARRANGEMENTS, VISITS EASIER IF SERVICES LOCAL · WE ENCOURAGE CHILDREN/PARENTS CARERS TO BECOME INVOLVED IN COMMUNITY HEALTH PROGRAMMES - THE WIDER SERVICES OF OUR NHS MORE LIKELY TO BE USED IF LOCAL · SOME PARENTS/CARERS SAY "LIFE IS ONE BIG APPOINTMENT."

YOUNG PEOPLE OUT OF CARE

THEY ARE TAKING CONTROL OF THEIR HEALTH CARE FOR FIRST TIME. THEY NEED ADVICE, SUPPORT ON HEALTHY EATING, HEALTH CHECKS, TEEN PREGNANCY, SUBSTANCE

P.T.O.

ABUSE, COUNSELLING AND MENTAL HEALTHCARE.
THEY MAY BE LOW WAGED, UNEMPLOYED, IN WORK EXPERIENCE EDUCATION SOME MAY BE PARENTS AND OR HAVE LEARNING DIFFICULTIES SOME SERVICES RECEIVED AS RESULT OF A+E VISITS. HEALTHCARE MUST START YOUNG TO BENEFIT WELLBEING AND LESSEN HEALTHCARE ISSUES AND COSTS.

THOSE LIVING WITH DISABILITIES OUR DISABLED ARE MORE LIKELY TO HAVE MULTIPLE HEALTH CONDITIONS. THEY AND CARERS NEED SUPPORT TO LIVE IN THEIR COMMUNITY TRANSPORT IS DIFFICULT - STAIRS, LACK OF RAMPS LIFTS NOT WORKING (IF THEY'VE GOT THEM!) STAFF SHORTAGES. LONG WAIT FOR HOSPITAL TRANSPORT. THIS COMMUNITY DOESN'T NEED MORE ISOLATION.

YOUNG CARERS

THESE CHILDREN HAVE LOST THEIR CHILDHOOD SCHOOLING/SOCIAL LIFE HAMPERED DUE TO HEAVY CARERS RESPONSIBILITIES. THEY'LL HAVE TO MAKE DECISIONS ON TRANSPORT TO HOSPITALS FURTHER AFIELD. A+E OR U.C.C? DIFFICULT FOR AN ADULT. LET ALONE A CHILD. THEY HAVE TO CONSIDER CARRYING MEDICATION, WHEELCHAIRS ETC AND OVERNIGHT STOPS.

CHILD ABUSE AND DOMESTIC VIOLENCE

SADLY, THIS EXISTS. FOR BABIES, CHILDREN AND ADULTS ALIKE, A+E, IS THEIR FIRST PORT OF CALL (NOT ALWAYS G.P. IF FAMILY, FRIENDS ETC DO THIS) AND HOW MANY TIMES DO YOU SEE THE SAME (OR?) FOR THEIR EMOTIONAL WELLBEING, HEALTH AND PERSONAL SAFETY AND A SAFE PATH TO LIVING AS

PART OF THEIR COMMUNITY WITH FAMILY CARERS/SUPPORT SURVIVOR SUPPORT KEYWORKERS · I'VE ATTENDED CXH CHILD PROTECTION TRAINING IT IS SENSITIVE + INFORMATIVE

ADDICTIONS, ALCOHOL, MISUSE OF DRUGS

IT'S A SUPPORT KNOWING A + E, HOSPITAL IS LOCAL IN REMISSION CASES. PEOPLE HAVE SAID "IT'S THEIR ROCK" PEACE OF MIND FOR CARERS. SERVICES CAN BE LINKED POLICE, SOCIAL SERVICES CAN DIRECT THOSE IN NEED TO LOCAL HOSPITAL + SERVICES (A POLICE CELL IS NOT A HOSPITAL WARD) PEOPLE WHO ARE VULNERABLE CAN'T WANDER ABOUT CONFUSED.

NON COMMUNICABLE DISEASE SUFFERERS.

THESE AFFECT OTHERS BUT SPECIFIC TO OUR DIVERSE B.M.E. COMMUNITY - SICKLE CELL, DIABETES, VIT D CALCIUM DEFECIENCIES HEART DISEASE HIGH B.P. THESE CONDITIONS INCLUDE REGULAR HOSPITAL VISITS + TREATMENTS AND CAN BECOME EMERGENCIES · LOCAL SERVICES NEEDED. AS A CARER YOU CAN GET TO APPOINTMENTS AND STILL BE NEAR YOUR WORK PLACE. MANY WITH NCDS ARE CONCERNED ABOUT LOSS OF BEDS.

MENTAL HEALTH DEMENTIA/ALZHEIMERS.

SOME ALONE ON ESTATES FORGET TO TAKE THEIR MEDICATION · A RESIDENT ON OUR ESTATE HAD HIS MEDICATION LEFT ON THE DOORSTEP · WE WERE ABLE TO GET HIM TO HOSPITAL - A MAPPED JOURNEY HE KNEW

WE KNOW THERE IS A RISE IN DEMENTIA - OUR LOCAL CARE HOMES/SHELTERED/NEED HEALTH SERVICES LOCAL MEDICATION TRIGGERS CHEMICAL CHANGES AND HOSPITAL CARE IS NEEDED IMMEDIATELY.

G.Ps, LOCUMS 111, PHARMACISTS

WITH BEST INTENTIONS AND EXPERTISE GPS ETC CAN'T PERFORM SURGERY TREATMENTS THAT NEED TO BE CARRIED OUT, IN HOSPITAL

P.T.O.

AS FOR 111, ITS TIME CONSUMING, AND WE DONT TRUST THOSE OPERATORS.. PHARMACISTS ARE RELUCTANT TO GIVE ADVICE IF YOU'VE EXISTING HEALTH CONDITIONS OR IF THEY'RE UNSURE OF WHAT YOU'RE SAYING OR SYMPTOMS SO UNDERSTANDABLY TRY ADVISE YOU TO GO TO YOUR G.P OR A+E. NO ONE WILL PUT THEIR JOB ON THE LINE

WIDER SUPPORT IN COMMUNITY/NETWORKS/ CARE LIAISON/SOCIAL SERVICES/CHILDRENS CENTRES/SCHOOLS.

PATIENTS, CARERS, RESIDENTS CAN ACCESS SERVICES LOCALLY MORE LIKELY TO USE THEM FORM A RAPPORT WITH KNOWN STAFF ALDING BETTER OVERALL COMMUNITY HEALTH + INVOLVEMENT. HOSPITAL STAFF MORALE IMPROVES WHEN YOU'RE HOSPITAL HAS A FUTURE. MANY SERVICES ARE USED MAINLY BY THOSE WITH LEARNING DIFFICULTIES OR SPECIFIC NEEDS IT'S PEACE OF MIND FOR THEM.

PATIENT CARER WELLBEING

SHORT OR LONG STAY, IT'S LESS ISOLATING IF FAMILY/FRIENDS VISIT REGULARLY. THEY HELP WITH GENERAL CARE, OVERNIGHT STOPS, LONGER VISITS, BRING IN CARE BAGS LESSEN PATIENT CARER STRESS ESPECIALLY IF ENGLISH ISN'T A FIRST LANGUAGE. TRAFFIC JAMS, COST MAKE FOR SHORTER VISITS. PATIENTS ARE DISTRESSED IF THEIR VISITORS LEAVE EARLY. IN RELAPSE CASES YOU NEED TO GET BACK TO HOSPITAL QUICKLY.

TRANSPORT

A MAJOR ISSUE/OPPOSITION TO HOSPITAL CLOSURES. IT'S COSTLY, CRAMMED, LACK OF ACCESSIBILITY - WHEELCHAIRS, BUGGIES DAILY

3/3

A TON CAN BE LET ON. TIMETABLE CHANGES DEPENDING ON TIME OF TRAVEL. TFL SAY "DON'T BOARD IF YOU'RE UNWELL" THEY ARE NOT AN ARM OF AMBULANCE PARAMEDIC SERVICE. WITH TFL STAFF SHORTAGES UNSTAFFED STATIONS, AND EXTRA BUSES AND TUBES WON'T BE PUT ON FOR HOSPITALS – PASSENGERS WILL BE RESPONSIBLE FOR PATIENTS.

WE KNOW OUR LOCAL ROADS, JAMS, FOOTBALL GROUNDS AND TRAVEL IN HTF. BY THE TIME WE GET TO CHELWEST ST MARYS 'OUR GOLDEN HOUR' WILL BE TICKING AWAY.

HAMMERSMITH HOSPITAL A+E CLOSURE

THIS HOSPITAL IS VITAL FOR WHITE CITY/OLD OAK RESIDENTS ISOLATED AREAS OF HTF. THEY RELY ON GP SERVICE. MANY ELDERLY AND YOUNG FAMILIES LIVE THERE. THERE IS A NEW HEALTH CENTRE BUT IS IT FULLY FUNCTIONING IT'S NOT AN A+E

TWO YOUNG CARERS SAID "WE HAVE 10 CHICKEN SHOPS HERE IF THEY CLOSE 2 DOWN THAT'S GOOD FOR OUR HEALTH BUT WE'VE ONLY GOT 2 A+ES AND YOU CLOSE BOTH DOWN MAN, THAT'S NOT GOOD FOR YOUR HEALTH!"

AN ELDERLY LADY SAID "IS IT TOO MUCH TO ASK FOR TO BE CARED FOR + DIE IN COMMUNITY AND HOSPITAL I WAS BORN IN?"

FOR ALL THAT'S SAID ON STATISTICS, FACTS, 0% FIGURES HOW WE ANSWER AND PLAN FOR THE ABOVE IS WHAT COUNTS.

A

OUR PERSONAL HEALTH EXPERIENCE
BUT COULD BE THAT OF MANY OF OUR NHS PATIENTS.

DEAR INDEPENDENT HEALTHCARE PANEL AND TEAM.

WHAT FOLLOWS IS A PERSONAL ACCOUNT OF ONGOING HEALTH EXPERIENCE ITS THE REASON I'M WRITING IN UPPER CASE. I APOLOGISE IF OUR SUBMISSION IS LATE AS WE WERE GIVEN THE WRONG CLOSING DATE. IF WE'VE PASSED THIS NEVER MIND WE'VE TRIED OUR BEST. WE KNOW YOU'RE DOING ALL YOU CAN TO HELP OUR NHS CARE. THAT'S THE MOST IMPORTANT TASK.

THANK YOU.

ON 24TH DEC 2014 MY MOTHER (80YRS) AND I, (57YRS) WERE TOO ILL TO GET TO A&E AND WORRIED WE'D INFECT OTHERS.

26TH DEC. MUM RANG CXH FOR GP APPOINTMENT, AVAILABLE 29TH DEC ON THAT DAY (HOPING 6TH FLOOR LIFTS WORKED!) GP DIAGNOSED MUM WITH A DEEP LUNG INFECTION ADDING TRIGGER TO HER ASTHMA + BRONCHIECSTASIS. I HAD SHINGLES RIGHT SIDE HEAD, EYE, NOSE, FACE, NECK. GP SAID "YOU MUST GET TO WESTERN EYE HOSPITAL ASAP" WE'D NO CHOICE WE CALLED A MINI CAB CXH TO N.E.H £18.00 AND W.E.H TO KING ST. £14.00

N.E.H WAS PACKED THE STAFF WERE BRILLIANT CALM + PROFESSIONAL. I WAS DIAGNOSED WITH UVEITIS (RIGHT EYE.) I ATTEND BOTH HOSPITALS FOR EACH CONDITION FROM DECEMBER ONGOING - I'VE HAD PRESCRIPTIONS FOR 18 MEDICINES (AND OVER THE COUNTER) COST SO FAR £156.00. SOME PATIENTS WERE WATERING DOWN EYE DROPS, TAKING HALF DOSES BECAUSE THEY DIDN'T HAVE ENOUGH MONEY. ALTHOUGH HOSPITAL PHARMACISTS DO TRY BY EXPLAINING WHAT YOU CAN DO TO GET HELP AND ADVISE ON WHAT YOU CAN GET OVER THE COUNTER.

THE EYE TEST NURSE TOLD ME SHE UNDERSTOOD WHY SOME OUT PATIENTS WERE WEARING POUNDSHOP GLASSES POUNDLAND STAFF SAY 3-SO SPECS SELL FASTEST.

P.T.O.

FOR 4 WEEKS MEDICINES WERE 1½-2HRS OVER 24HR INTERVAL. SO NO SLEEP! I MADE MY OWN CHART SOME HAD TO BE KEPT IN THE FRIDGE AN ELDERLY LADY AT WEH SAID "IT'S SO FRIGHTENING. I WAS SCARED OF FALLING, IT'S DARK AND COLD." ANOTHER ELDERLY MAN SAID "IT'S HARD SORTING IT ALL OUT. HOW'S 15 MINUTES OF HOME HEALTH CARE GOING TO HELP US?"

DUE TO INHERITED HEALTH CONDITIONS I WAS UNABLE TO TAKE ORDINARY PAINKILLERS. VARIOUS ONES PRESCRIBED, MY SYSTEM REJECTED. DUE TO THAT I NOW HAVE POST HERPETIC NEURALGIA (PHN.) THE HEADACHES ARE UNBEARABLE 24/7 SINCE DEC'14 THE MEDICS CALL THEM "THE SUICIDE HEADACHES" THE STAFF HAVE HELPED ALL THEY CAN. I SUSTAINED ON-GOING NERVE DAMAGE. MY MUM HAS CATARACTS SO IT'S TAKEN TIME TO WRITE THIS. MY EYE ONLY OPENED ½ THROUGH FEBRUARY THE OTHER EYE IS STRAINED BALANCE (DUE TO FLUID AROUND NERVES) HAS IMPACTED ON MY WALKING. SOME OF US AT HOSPITAL LIKE ME, ARE 8 HRS. CONTRACTED, LOW WAGE EARNERS AND DON'T QUALIFY FOR SICK PAY.

W.E.H SENDS GUIDE NOTES PRIOR TO APPOINTMENTS REGARDING HELPFUL HINTS TO SAVE MONEY ETC ON MEDICINES AND TRANSPORT AND BRING SOMEONE WITH YOU.

1. <u>PRESCRIPTIONS</u>

HOSPITAL PHARMACY CAN ONLY GIVE TWO MEDICINES OF EACH I NEEDED 4/6. SO YOU'RE GIVEN THE PRESCRIPTION TO GIVE TO YOUR G.P SO YOU BOOK A VALID G.P. APPOINTMENT WITH FEELS LIKE TIME WASTING TO GET YOUR MEDICATION. AN EXTRA JOURNEY OUT AS WELL WHEN YOU'RE NOT WELL AND NEITHER IS THE PERSON LOOKING AFTER YOU.

3/ TRANSPORT

WITH CERTAIN TYPES OF ILLNESS YOU CANNOT TRAVEL ON TFL (OUR NEW AMBULANCE SERVICE.)
W.E.H. MOST OF US HAVE HAD DROPS THEY AFFECT YOUR SIGHT FOR 6 HRS APPROX.

BAKER ST TUBE - WAS PACKED I WAS AFRAID I'D GET A BACKPACK IN MY EYE (I'M 4'9") WHEN W.E.H MOVES TO ST MARYS PADDINGTON STN. WILL BE THE SAME.

BUS 27 1½ HRS FROM H'SMITH WE COULDN'T GET A SEAT AND HUNG ON FOR DEAR LIFE. THE MOTION MADE ME NAUSEOUS. IT WAS A NIGHTMARE

AFTER EYE DROPS AT W.E.H PATIENTS WERE SITTING AND THINKING HOW TO GET HOME/BUS STOPS. ONE LADY HAD COME WITH HER DAD WHO HAD DEMENTIA (HOSPITAL STAFF HELPED) YOUNG MUM SAID "HER FRIEND DIDN'T HAVE FARES TO COME WITH HER" ANOTHER SAID "SHE'D ONLY MONEY FOR HER OWN FARE." ANOTHER PATIENT SAID I'VE GOT TO KEEP COMING AND MY DAUGHTER CAN'T ALWAYS GET TIME OFF WORK"

THIS IS WHERE S.A.H.F FALLS DOWN. PEOPLE WHO AREN'T WELL AND VULNERABLE TRAVELLING OUT OF AREA SHUNTING AROUND WHEN YOU JUST WANT TO LIE DOWN.

IT'S CREATING HARDSHIP FOR THE VERY PEOPLE OUR NHS WAS CREATED FOR WHILE IN WAITING AREAS YOU COULD SENSE POVERTY AND DEPRIVATION. THE WORRY ABOUT HOW YOUR GOING TO MANAGE YOUR MEDICATION AND FINANCES. AS FOR MUM AND I AND ALL OF US INVOLVED IN THIS SUBMISSION WE'RE CARRYING ON AS BEST WE CAN. IT'S PEOPLE LIKE US WHO REALLY FEEL THE TRUE VALUE OF OUR NHS - YOU CAN'T MAKE SOMETHING BETTER IF IT'S NOT THERE. WE ALL SAID HOW

P.T.O.

LUCKY WE ARE TO HAVE IT AND WE'RE DEEPLY CONCERNED ABOUT IT'S FUTURE. WE'LL DO ALL IT TAKES TO SAVE IT.

OPINION

Letters should be 300 words maximum. The editor reserves the right to edit letters. Anonymous letters will not be considered but names and addresses can be withheld

LETTERS AND COMMENTS>>

HAMMERSMITH FULHAM CHRONICLE 5.07.2013

Help celebrate health service's 65th birthday

HEALTHCARE: Pre-July 1948.

A rabbit's foot, a dog's lick, snake oil wagon, old wives' tale, penny dispensary – the goodwill of others as poor. The vulnerable, disabled and those with mental health issues consigned to institutions. People born with treatable illnesses, living in sufferance, dying in pain.

Community nursing, medical information on healthy diets and check-ups negligible. Nearly every vulnerable family lost a loved one as they could not afford doctors' fees or private sanitariums – heartbreaking.

Healthcare: July 5, 1948.

The most important life-changing moment for us all. The birth of The National Health Service for all people young and old, from maternity care to health centres. Dentistry, eye care, children's health, monitoring for NCDs (non-communicable diseases), treatment for STDs (sexually transmitted diseases), mental health care, blood transfusions, operations, medicines, transplants and organ donorship, medical research, scans and medical pioneers.

Access to GPs and hospitals with trained medical staff free at the point of delivery. The best healthcare ever. Can you imagine how each person felt on that day? A call to life.

Healthcare: Post-July 2014.

Back to the bad old days? Privatisation full on? Private healthcare insurance? Cherry picking of easier delivered services? Low staff morale? Fewer hospital beds, wards, and A&Es? Neglecting our health? Loved ones not being able to afford their healthcare?

So many thought-provoking questions – please let our answer to them all be 'no way'.

Let's work together to improve our NHS where needed. Build on what we have, keep the caring constant for all people. Let us care for our NHS, let's celebrate its very special 65 years of life.

Join us at Charing Cross Hospital today (Friday) for an all-day celebration with our community and in Lyric Square tomorrow between noon and 4pm.

Happy 65th birthday NHS, may you never retire. The best present given to our past, present and future generations.

DESIREE CRANENBURGH
King Street
Hammersmith

NEWS

>> TELL US YOUR COMMUNITY NEWS

www.getwestlondon.co.uk/send-your-story

by Alix Culbertson
alix.culbertson@trinitymirror.com

Warnings over patient safety

Fears for care quality spark nurses to call for a halt to reorganisation

FRONTLINE nurses have called for the suspension of the west London hospital reorganisation programme until further guarantees can be given about out-of-hospital care.

The Royal College of Nursing is asking Imperial College Healthcare NHS Trust to suspend its Shaping a Healthier Future programme which has seen Hammersmith Hospital's A&E being closed and more changes are to come.

Members are worried patients will suffer from a lack of investment in out of hospital care to make up for the closures as they believe it is currently not at a level where patients are safe.

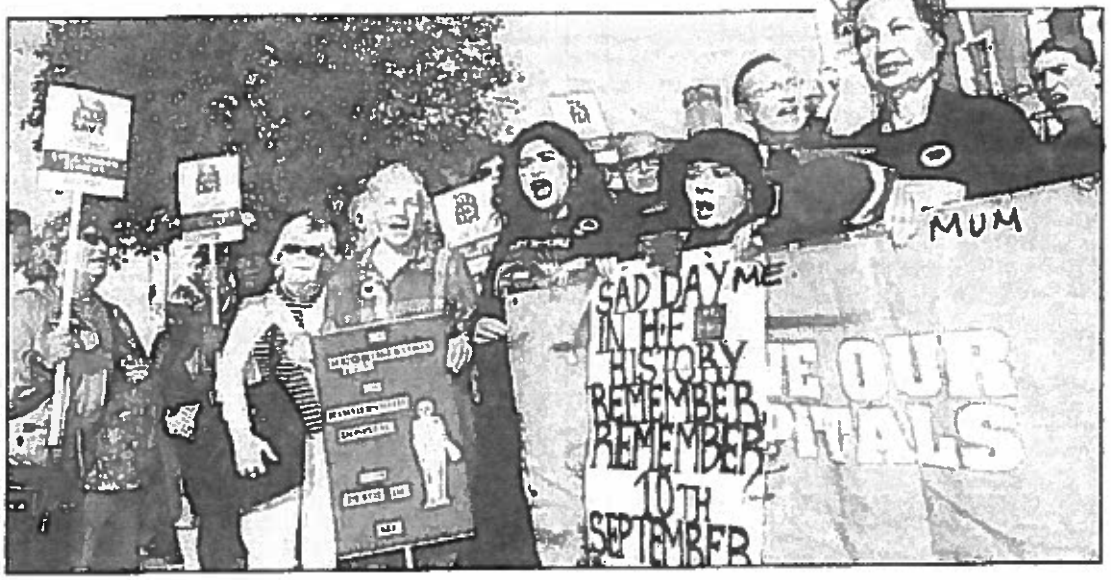
The RCN, which focuses on patient needs, on Tuesday submitted evidence based on local frontline members' feedback to a review being held by Michael Mansfield QC on behalf of Hammersmith and Fulham, Brent, Ealing

Local nurses told the Gazette there were increased waits for ambulances outside hospitals in the area and dangerous diversions were being made due to capacity problems

They also said patients and carers do not understand the new Urgent Care Units which have replaced A&Es at Hammersmith and Central Middlesex Hospitals. One member said: "Patients and particularly their carers are frightened and confused about the A&E closures."

Members added that pressure on GP services means practice nurses cannot carry out preventative health interventions meaning people are going to A&E who should have been kept well earlier in the system.

As well as patien becoming frustrated



■ CAMPAIGN: Protesting against the closure of the A&E department at Hammersmith Hospital last year
Photo by Grant Humphreys NL201410535

out, tired and frequently unable to get their time for the next study days"

RCN London Regional Director Bernell Bussue said: "The RCN will always support service reorganisation which delivers improvements in the quality of patient care. However it is just not clear that patients have seen any benefit from these changes so far.

"The positive case for 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 practice, little seems to have been done to boost capacity elsewhere in the system to make up for the closures.

Proper replacement services, transition arrangements, funding and a workforce plan should have been in place before the existing units were cut.

"Nursing staff working in the area have told us the closures have damaged patient care. The remainder of the Shaping a Healthier Future closures should be suspended until out of hospital capacity is properly expanded."

The RCN has also cited health secretary Jeremy Hunt as saying Shaping a Healthier Future would give north west London 'probably the best out-of-hospital care anywhere in the country' but this winter west London's remaining A&E units have experienced some of the longest waiting times in the country.

DEAR INDEPENDENT HEALTHCARE PANEL/TEAM.
THANKYOU FOR GETTING THROUGH ALL THIS. WE THANK YOU ALL FOR YOUR ENDEAVOURS ON BEHALF OF ALL OUR COMMUNITIES. WE'VE ALL GOT TO EMPOWER EACHOTHER

WE DO HOPE TO GET TO HAMMERSMITH TOWN HALL 14TH MARCH. MUM TAKES ME FOR WALKS! I WORRY ABOUT THE TOLL ON HER I'M SO GLAD SHE HAD THE SHINGLES JAB

DO TAKE VERY GOOD CARE OF YOURSELVES.

LOVE AND GOD BLESS

ANNETTE, DES I AND ITF COMMUNITY

A Chambers / D. Crone.

Smith Peter

From: Rob Sale [redacted]
Sent: 10 March 2015 07:59
To: Smith Peter
Subject: Evidence to the NW London Healthcare Commission - Harrow Patients Participation Network
Attachments: HPPN Evidence.9.3.2015 Final.docx; Appendix 1.pdf; Appendix 2.pdf; Appendix 3.pdf; Appendix 4.pdf

Peter,

Please find attached our evidence to the Commission which has been signed off by our Committee. Given the very tight time limit for submission and discussion with our full membership (as Harrow didn't sign up to the Commission we only found out about it recently by chance on the Hillingdon Healthwatch website) we have limited our evidence to work we have done to challenge the inequitable funding arrangements for our health services in Harrow which I am sure has resonance with other areas too.

There are other issues that are giving rise to concern around the implementation of the Shaping a Healthier ıture programme which, to be honest, like so much of what is happening now in our NHS, is couched in such impenetrable 'consultant (not the medical variety) speak' that as ordinary people we find it really hard to catch up and there is a fear that once we have it will be too late to have any meaningful say because the decisions will have already been made. We have touched on the question of the failure to provide out of hospital services, in particular in the East and Centre of Harrow. There is also the apparent lack of accountability of the whole process to patients and the public (for example we only found out about the 'Patient and Public Representative Group' - which, somewhat bizarrely, is apparently not open to said 'patients and public' - a couple of weeks ago when it was referred to under the heading of 'Patient and Public Engagement Input' in a CCG Board Meeting report on 'Co Commissioning', . The move to co commissioning and provision of Primary Care services by 'GP Networks' appears to be a very big change in the way services are delivered which will have a major impact on our surgeries and how they operate and yet there has been practically no public debate.

Hopefully by the time the day for oral evidence comes up on May 9th we will have had more time to discuss these and other issues in our wider group and may have further comments to make then.

ob Sale
Committee Member
Harrow Patients Participation Network

Evidence to the North West London Healthcare Commission

Harrow Patient Participation Network

9th March 2015

Introduction

The Harrow Patient Participation Network is an umbrella organisation made up of the Chairs/nominated representatives of most of the local surgery Patient Participation Groups in the Borough, broadly answerable to some 200,000 patients. We are an independent non-party political organisation which exists both to sustain and encourage existing and emerging PPGs by sharing of knowledge and experience and to influence, where appropriate, decision makers such as the CCG and NHS England by representing the interests of our surgery members and their patients.

We are accountable to our member PPGs and take up issues as necessary which are referred up by them.

The issues facing patients of primary care in Harrow are similar to those experienced in many of the other NW London CCG areas, all affected by the implementation of the Shaping a Healthier Future Programme. Difficulty getting appointments with GP of choice, long waits for appointments, increasing number of locum doctors due to pressure on resources and difficulties in recruitment. A significant factor in this, in addition to perilous financial situation of the CCG and the massive increase in bureaucracy brought about by the Health and Social Care Act 2012 is the combined effect of the closure of nearby acute services and the failure to provide the enhanced services in the Community promised by the SaHF project.

Our evidence relates primarily to the financial crisis facing our local health services, made worse by a funding formula which fails to recognise the current population or health needs of our community in Harrow. We emphasise that we do NOT support the view that Harrow should be bailed out by neighbouring Boroughs who may on paper be above their 'fair share target'. As we explain below an area can be over its 'fair share target' but still struggling to meet the health care needs of the community. This is because the financial 'pie' is not based on the health needs of the population but on the funds 'made available' by Government.

The Financial Position in Harrow and the Potential for Challenge

Like many other areas of the country both our NHS and local authority services are being subjected to unsustainable, ideologically driven cuts in funding

For the last ten years both the NHS and the Council have said that the formulae used to determine government grants for the borough have been 'unfair' in that they do not recognise the demographic changes that have taken place over the last 20 years or so. This has been constantly referred to in the local press and by politicians of all parties. In the current crisis we have said both to the CCG and the council it is time to step up to the mark, which should include a robust and expert (legal and financial) investigation and challenge, if possible a legal one. We urged both bodies at every opportunity to pool their resources in what should be a common interest in the health and welfare of the community they serve. To date there is little evidence of anything other than lip service from either party or politicians of any hew, now busily chasing votes in what is, of course, a marginal constituency.

We therefore decided to investigate the possibility of a legal challenge ourselves and on 19th September 2014 submitted a brief to Leigh Day Solicitors concerning the possibility of:

Challenge by way of judicial review or otherwise any or all of the following:

- *Determination of overall grant allocation for Harrow by Government*
- *NHS England allocations to CCGs for hospital, community and mental health services*
- *NHS England allocations to area teams for Primary care*
- *DoH allocations to local authorities for public health*

This may include a challenge of inadequate or absence of consultation on the methods used for any of the above

We were inspired to take this step after hearing from a GP at the Jubilee Practice in Tower Hamlets which had recently brought a successful action against NHS England in defence of their surgery was threatened with closure.

Suggested basis for challenge to Health Services Funding Allocation in Harrow

In support of our case we referred to four documents, the first two of which are National Audit Office reports, submitted as appendices:

Appendix 1: 'Funding Healthcare: Making allocations to local areas' – Report (National Audit Office, HC 625 Session 2014-15 11th September 2014)

Appendix 2: 'Funding Healthcare: Making allocations to local areas - Allocations to local commissioners' (National Audit Office, 11th September 2014)

Appendix 3: 'Harrow CCG financial position - overview'. A paper provided to HPPN by the CCG which is essentially reprinted from pages 13 and 14 of the CCG Annual Report.

(Link to Annual Report:

http://www.harrowccg.nhs.uk/publications?media_item=1933&media_type=10#file-viewer

Appendix 4: House of Commons Committee of Public Accounts report, 'funding healthcare: making allocations to local areas', 9.1.2015

The first report is a summary of the NAO review of the formula in action (in the context of the major changes in the NHS) with some key comments and observations

The second report gives the actual allocations to every area in the Country under 3 headings:

- NHS England allocations to CCGs for hospital, community and mental health services (Figure 1) - 81% of the total
- NHS England allocations to area teams for Primary care (Figure 2)
- DoH allocations to local authorities for public health Figure 3)

From the point of view of the CCG it is the first one that is relevant but all are relevant if you are looking at the overall health needs of our borough.

This shows that out of 211 CCGs Harrow's per capita funding of 922 puts it 4th from bottom (208/211) nationally. There is only one CCG in the Country which is further away than Harrow (-9.8%) from its 'fair share' Funding Target - Oxfordshire (-10.8%)

The Primary care allocation (Figure 2 is only given for London as a whole, £206 per person, 2.2% above the fair share target - this does not say how individual areas like Harrow are doing in that respect - we did not know if a more detailed breakdown was available.

Another illuminating statistic can be seen in the allocations to Local Authorities for Public Health (smaller figures as this only makes up 4% of the total health funding). You will see that Harrow comes in at £36 per person, 4.9% short of its target. The City of London on the other hand comes in at £156 per person, some 528.7% above its 'fair share' Funding Target!

Setting the Scene - the Actual Financial position in Harrow

(NB since our submission there has been a slight improvement in Harrow's allocation. With the new allocation the updated Distance From Target reduces to 5.04% (£13.7m) from 8.8% at the end of 2015/16. However the underlying principles remain unaddressed and Harrow CCG still struggles to set a legal budget and is reliant on 'bail out' funding from the other CCGs in the North West London Collaboration

On top of this there is a (one off) £18m debt inherited from the PCT.

On top of this, even after making QIPP savings of 19m in 2013/14 - part of the three year target of cuts of £43m, the CCG still has a year on year unfunded deficit of £10m.

At the time of our submission the CCG paper (Appendix 3) says that Harrow CCG has 'prepared a balanced budget' for 2014/15 but that this 'assumes agreement to additional funding from other North West London CCGs to the tune of £34.9m (see table on page 2).

There is a very important point on page 5 of the first NAO summary report (Appendix 1) - see point 3 where it says '**...target funding allocations are intended to represent local areas' fair share of the available funding, rather than the amount of money that might be required to meet their health care needs in full**'. And of course when we are talking about the cost of the health care needs in full we mean the aggregate of all three of the allocation heads referred to in the report (CCGs, Primary care, and Public Health) each allocation determined by the same formula.

We were reliably informed that in order to get a true picture of the real health needs of the people of Harrow (and elsewhere) what you would do is a 'zero based budgeting exercise' and this would give a very much higher figure than the current so called 'fair share targets' under the current exercise. It is for this reason that another CCG can be technically above this arbitrary 'fair share target' but still be desperately underfunded in terms of actual health needs. This will particularly apply to areas of 'high deprivation' which are already hit by the Government's decision to phase out the Minimum Practice Income Guarantee which gave additional weighting to such areas. It is for this reason that we do not support the 'Rob Peter to pay Paul' divisive approach adopted by the CCG. The fundamental problem is '...the mismatch between resources and patient needs of nearly £30 billion a year by 2020/21' identified in the NHS Five Year Forward Review – it is this that needs to be addressed by whichever Government is in power.

The 'Key Findings' and 'Balancing fairness and financial stability' sections of the NAO Summary report (Appendix 1 pp7-10) possibly give some good pointers to a robust challenge of the formula for Harrow:

- Despite professions of greater local control, the 2013 changes have actually '...brought greater central control over the division of funding between primary care, hospital, community and mental health services and public health, but removed a degree of local discretion and flexibility' **(para 8)**

- NHS England has increased funding for primary care slower than for hospital care despite the stated aim of moving services from hospital into the community **(para 9).**

  Specifically under 'Shaping a Healthier Future' the enhanced 'Out of Hospital Services' were supposed to be in place before the closing/reconfiguring of A&Es took place. This happened in September and yet there is still no progress on the provision of the New Primary care 'Hubs' to serve the East and centre of the Borough that are promised in the 'Out of Hospital Strategy. At a recent meeting we had with the Local medical Committee it appears that due to uncertainties surrounding the funding arrangements it is very unlikely the CCG will receive any viable bids for these HUBs in the form that residents have been led to understand; there is already talk of providing a 'virtual' HUB whatever that means instead.

- The Department of health did not initially consult on changes to the formula in the light of the NHS reforms. When this was pointed out in another NAO report apparently the DoH and NHS England did consult 'publically' on changes. How 'public' this was, what was Harrow's response, what were the details of the consultation (how long, who was consulted, when carried out, what responses did they get etc.) have never been provided to us **(para 10)**

- Decisions about how quickly to move commissioners towards their 'target funding allocations ('pace of change policy') are not based on evidence and are therefore a matter of judgement' **(para 12)**

- Progress in moving towards targets is slow **(para 13).**

- Changes in population are supposedly taken into account in calculating funding targets. Places like Harrow do not see the benefit of this due to slow 'pace of change policy' (para 14). In 2014/15 NHS introduced a rule to try and mitigate this for CCGs but has not applied this to area teams (Primary Care) nor has the DoH for public health allocations to local authorities.

- The DoH and NHS England decide current funding allocations without fully considering the combined effect on the local area **(para 16)**

- Weighting for relative need for healthcare can change target funding allocations significantly but progress in improving measures of need has been mixed. **(para18)**

With all these concerns the conclusion that '...the Department and NHS England's approach to allocating funding for healthcare is generally sound' seems wide of the mark. Situations where conclusions/recommendations of a report are at variance with the main body of evidence are not unheard of in public life and can indicate a higher political agenda – we are left wondering whether this is the case here.

The overall outlook for Harrow is not encouraging, particularly when we consider the massive 82m cuts that are proposed in Council services. Recommendation 'e' of the NAO report emphasises the interrelation of health care and social care funding allocations. As the

recently concluded Take Part 'consultation' carried out by Harrow Council revealed the level of engagement and exchange of information between the Council and Health Service partners was very poor. For example the Council made strong representations to the CCG in November 2014 that the CCG had published its final version of its Commissioning Intentions the day before the Board meeting at which they were to be approved with no opportunity for them to be considered by the council's Health and Social care Scrutiny Subcommittee. Again, Harrow CCG in its response to the Consultation submitted on 7th November 2014, only 4 days before it was due to close stated that when they had met the council on 7th October '...the CCG was not in a position to support the proposals in the consultation due to the very limited information made available to the group'. The CCG compiled a list 13 areas where they had asked for more information; by 7.11.2014 this had still not been provided.

In January this year a House of Commons Committee of Public Accounts report, 'Funding healthcare: making allocations to local areas', 9.1.2015 further undermines the formula used for allocation of funding. Its conclusions (pp 4-6) include:

- The slow progress towards target funding allocations means the Government has not fulfilled its policy objective of equal access for equal need.
- Decisions about funding for the different elements of healthcare and social care have been made without fully considering the combined effect on local areas.
- There is a lack of evidence to underpin the adjustment that is made for health inequalities.
- The primary care funding formula was developed with limited input from the advisory body and remains an interim approach.
- The proportion of total funding devoted to primary care has fallen, even though primary care is an important way of tackling health inequalities.

On 28th January we received a reply form Leigh Day Solicitors stating '...we shared the documents you provided with a barrister who has vast expertise in this area. He has responded to say that although it seems extremely unfair, he struggles to see merits upon which a successful judicial review could be mounted'. Given the very limited information that is available to us as members of the public, we feel that had those in the positions of responsibility including the CCG and the Local Council pooled their resources, expertise and access to key information as we had urged the outcome may have been different, to the benefit of patients and our NHS in Harrow. In any event the 'extreme unfairness' has been recognised and should be addressed but not at the expense of our neighbouring boroughs as indicated above.

Robert Sale
Committee Member
Harrow Patients Participation Network

9th March 2015

National Audit Office

Report
by the Comptroller
and Auditor General

Department of Health and NHS England

Funding healthcare: Making allocations to local areas

HC 625 SESSION 2014-15 11 SEPTEMBER 2014

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National Audit Office

Department of Health and NHS England

Funding healthcare: Making allocations to local areas

Report by the Comptroller and Auditor General

Ordered by the House of Commons
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This report has been prepared under Section 6 of the National Audit Act 1983 for presentation to the House of Commons in accordance with Section 9 of the Act

Sir Amyas Morse KCB
Comptroller and Auditor General
National Audit Office

9 September 2014

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This report examines how the Department of Health and NHS England allocate funding to the local commissioners of healthcare.

10509 09/14 NAO

Contents

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Key facts

£79.1bn

total funding allocated to local healthcare commissioners, 2014-15

£1,371

average funding per person for locally commissioned healthcare, 2013-14

-£137 to +£361

range in how far clinical commissioning group allocations are from their fair share of funding per person, 2014-15

1.2%	annual increase in funding for health after inflation in the four years to 2014-15
£64.3 billion	funding allocated to clinical commissioning groups, 2014-15
£1,076 to £1,845	estimated range in funding per person for locally commissioned healthcare, 2013-14
£0.37 billion	used to move under-target commissioners towards their fair share of funding, 2014-15
19	of the 20 clinical commissioning groups with the tightest financial positions at 31 March 2014 had received less than their fair share of funding

Summary

1 Each year the Department of Health (the Department) receives over £110 billion to fund health services in England. It passes around 90% of this money to NHS England. NHS England is the Department's largest arm's-length body and is responsible for the system of commissioning healthcare.

2 The Department is ultimately responsible for the system for allocating funding for healthcare. It and NHS England make annual allocations to local commissioners. These bodies commission healthcare from NHS bodies and other providers on behalf of their local populations. The amount of funding that individual commissioners are allocated is calculated using 'funding formulae' that apportion the total funds available. In 2014-15, £79.1 billion was allocated in this way:[1]

- NHS England allocated £64.3 billion (81% of the total) to 211 clinical commissioning groups to commission hospital, community and mental health services.
- NHS England allocated £12.0 billion (15% of the total) to its 25 area teams to commission primary care.
- The Department allocated £2.8 billion (4% of the total) to 152 local authorities to commission public health services, such as smoking cessation programmes.

3 The first step in allocating funding involves the Department or NHS England calculating a 'target funding allocation' for each local commissioner. In calculating target allocations, the Department and NHS England aim to give those local areas with greater healthcare needs a larger share of the available funding. Target funding allocations are intended to represent local areas' fair share of the available funding, rather than the amount of money that might be required to meet their healthcare needs in full. In deciding actual funding allocations, the Department and NHS England seek to ensure that local health economies are not destabilised. They therefore move local commissioners gradually from their current funding levels towards their target allocations.

1 This total does not include funding that NHS England manages centrally, including for commissioning specialised services, or the separate allocations that NHS England gives to clinical commissioning groups and area teams for their administration costs.

Our report

4 Given the amount of money involved – equivalent to nearly £1,400 per person each year – the way in which the Department and NHS England allocate funding to local commissioners is a crucial part of the way the health system works. These decisions are complex, involving mathematical formulae and elements of judgement.

5 The need for decisions to be robust is even more important at times, as now, when funding is tight. Although health has been protected compared with most other areas of government spending, funding increased by an average of just 1.2% a year in real terms in the four years to 2014-15. At the same time the demand for healthcare continues to grow. As a result, local commissioners, and in turn their providers, face challenges in remaining financially sustainable. The level of funding they receive in the first instance is one factor in sustainability, along with others such as how well organisations manage their costs, how efficient they are and whether they receive additional non-recurrent financial support during the year.

6 In 2011, we reported on the formula funding of local public services, including the Department's allocations to primary care trusts.[2] Since then, the government has reformed the health system through the Health and Social Care Act 2012. Most of the changes took effect in April 2013. They included new structures for the commissioning of healthcare with the abolition of primary care trusts and the creation of NHS England and clinical commissioning groups. The current arrangements for allocating funds to local commissioners are therefore relatively new.

7 This report examines how the Department and NHS England allocate funds to the local commissioners of healthcare. We set out our audit approach in Appendix One and our evidence base in Appendix Two. We analysed the arrangements against a range of criteria including policy objectives and recommendations made by the Committee of Public Accounts in 2011.[3,4] We compared the three approaches in place now and also compared them with the approach previously used for primary care trusts. Key elements from this comparison are summarised in Appendix Four.

2 Comptroller and Auditor General, *Formula funding of local public services*, Session 2010–2012, HC 1090, National Audit Office, July 2011.
3 HC Committee of Public Accounts, *Formula Funding of Local Public Services*, Fifty-fifth Report of Session 2010–2012, HC 1502, November 2011.
4 A summary of the government's response to the Committee's recommendations is set out in Appendix Three.

Key findings

The funding framework

8 **The reforms of the health system in 2013 brought greater central control over the division of funding between primary care, hospital, community and mental health services, and public health, but removed a degree of local discretion and flexibility.** The Secretary of State now decides how much of the Department's total budget should be allocated to the NHS and to public health; and NHS England decides centrally how much should be allocated to primary care and how much to hospital, community and mental health services. Previously, primary care trusts received a unified allocation. They decided locally how to split this between the different funding streams and had flexibility to shift funding in-year to respond to developments. Under the new arrangements, the commissioning bodies in each local area have different geographical boundaries and receive separate allocations to commission services for their local population (paragraphs 1.9 to 1.11).

9 **Since 2013 the Department has directed funding to support its policy objectives to some extent.** The split of funds between primary care, hospital, community and mental health services, and public health is a matter of judgement, informed by previous spending patterns and policy priorities. In the two years to 2014-15, the Department demonstrated the importance it attaches to public health by increasing funding, which now goes to local authorities, by a total of over 10%. NHS England has increased funding to clinical commissioning groups for hospital, community and mental health services faster than to area teams for primary care, despite the long- standing aim of moving care out of hospitals. Clinical commissioning groups decide locally how much of their budget to commit to community health services; however, there are no current data on this (paragraphs 1.12 to 1.14).

10 **The new funding arrangements are more transparent and continue to use expert, independent advice.** In our 2011 report, we highlighted that the Department had not consulted publicly on changes to the formula it used to set target allocations. Since then, the Department and NHS England have consulted publicly on changes. NHS England also decided funding allocations at a public board meeting. The Department and NHS England are advised by the independent Advisory Committee on Resource Allocation in developing and applying the funding formulae (paragraphs 1.4 and 1.15).

Balancing fairness and financial stability

In allocating funding to the local commissioners of healthcare, the Department and NHS England aim to balance fairness (that is, allocation based on need) with the aim of not destabilising the financial position of local health economies.

11 **There is wide variation in the extent to which the funding that local commissioners receive differs from their target allocations.** In 2014-15, over three-quarters of local authorities, and nearly two-fifths of clinical commissioning groups, are more than 5 percentage points above or below target. Funding for clinical commissioning groups varies from £137 per person below target to £361 per person above target (paragraphs 2.3 to 2.5).

12 **Decisions about how quickly to move commissioners towards their target funding allocations are not based on evidence and are therefore a matter of judgement.** The Department and NHS England do not consider that there is objective evidence on which to base decisions about the most appropriate 'pace of change'. Therefore, decisions are based on judgements about the changes in funding that local health economies can tolerate without being financially destabilised and about the effects of organisations not receiving their target allocations. Our exploratory analysis suggests that local bodies may be able to tolerate changes in funding that are more significant than those currently provided for (paragraphs 2.15 to 2.17).

13 **Progress in moving commissioners towards their target funding allocations is slow.** It is harder to make progress towards target allocations when the financial position is tighter and there is less money available to give larger increases to those bodies that are furthest away from target. For 2014-15, the Department and NHS England used £1.61 billion of the £1.98 billion available to increase funding for all commissioners by a minimum level. The remaining £0.37 billion was used to move under-target commissioners towards their target allocations. As a result, the total amount that commissioners were below target fell by 5% from £1.97 billion to £1.87 billion. In contrast, had the Department and NHS England used all the available funding to move under-target commissioners towards target, the total amount that commissioners were below target would have fallen by 39% to £1.20 billion (paragraphs 2.6 to 2.14).

14 **NHS England has taken steps to address the risk that changes in local populations may jeopardise financial stability.** Changes in local populations are accounted for in calculating target funding allocations. But a slow pace of change towards target allocations limits how far actual allocations reflect the changes, and funding per person may not be stable. For example, in 2011-12 the 20 primary care trusts that had the largest increases in population all received less funding per person than they had in the previous year (by an average of 2.2%). NHS England mitigated this risk for 2014-15 by introducing a rule to increase every clinical commissioning group's allocation by at least as much as its population, unless they were already considerably over target. NHS England has not adopted this approach for its area teams, nor has the Department for local authorities (paragraphs 2.18 to 2.20).

15 There is an association between the financial position of clinical commissioning groups and whether they receive less or more than their target funding allocation. We found:

- The 20 clinical commissioning groups with the tightest financial positions received, on average, 5.0% less than their target funding allocation. Of these 20 groups, 19 received less than their target allocation.
- The 20 clinical commissioning groups with the largest surpluses received, on average, 8.8% more than their target funding allocation. Of these 20 groups, 18 received more than their target allocation.
- The 107 under-target clinical commissioning groups received a total of £1,606 million less than their target allocations and had a combined deficit of £165 million. The 104 groups that received funding above their target allocation had a combined surplus of £547 million (paragraphs 2.21 to 2.23).

16 The Department and NHS England decide current funding allocations without fully considering the combined effect on local areas. For 2014-15, NHS England considered the aggregate funding position at the level of the 25 area teams. We aggregated funding for primary care, hospital, community and mental health services, and public health at a more local level, based on clinical commissioning group geographical areas. This exploratory analysis suggests that in 2013-14, on average, local areas received £1,371 per person for locally commissioned healthcare, ranging from £1,076 in Oxfordshire to £1,845 in Knowsley. The funding received ranged from £186 per person (12.8%) below target (in Corby) to £508 per person (39.3%) above target (in West London) (paragraphs 2.25 to 2.27).

Setting target funding allocations based on need

In calculating target funding allocations, the Department and NHS England aim to give those local areas with greater healthcare needs a larger share of the available funding.

17 NHS England's use of GP lists to estimate clinical commissioning group and area team populations makes target funding allocations more responsive to changing needs, although there is limited assurance around the reliability of these data. Compared with Office for National Statistics projections, GP list data are updated more frequently and allow need to be assessed better. However, there are known concerns about the accuracy of GP list data, including the tendency for lists to be inflated. NHS England has published guidance for tackling list inflation but centrally has limited ongoing assurance that area teams are following the guidance. The Department's allocations to local authorities for public health continue to be based on Office for National Statistics projections (paragraphs 3.4 to 3.8).

18 Weighting for relative need for healthcare can change target funding allocations significantly but progress in improving measures of need has been mixed. NHS England's approach to assessing need in calculating allocations for clinical commissioning groups is better than the previous approach at predicting relative need because it uses more detailed data. In contrast, its approach for area teams for 2014-15 was heavily based on the primary care component of the previous primary care trust formula, and is regarded as an interim solution. For 2014-15, the adjustments for relative need ranged from a 27.9% increase to a 25.0% decrease in the target allocations for clinical commissioning groups, compared with the position had funding been distributed based on population size alone (paragraphs 3.9 to 3.16).

19 NHS England makes a smaller adjustment to funding allocations to support the government's objective to reduce health inequalities, but the evidence for basing this adjustment on life expectancy is unclear. Target allocations for clinical commissioning groups and area teams include an adjustment that moves money towards areas with lower life expectancies. However, the evidence is unclear on the extent to which increasing funding can help to reduce health inequalities. The Advisory Committee on Resource Allocation plans to do more work on this area. For 2014-15, the adjustments for health inequalities ranged from a 7.3% increase to a 4.1% decrease in the target allocations for clinical commissioning groups. Broadly, the adjustment moves money towards parts of London and the north-west of England (paragraphs 3.17 to 3.25).

Conclusion

20 The Department and NHS England's approach to allocating funding for healthcare is generally sound. There have been some improvements since 2011, including greater transparency, and decisions continue to be informed by independent, expert advice. However, the evidence supporting some aspects of funding allocations, such as financial stability, is limited and these factors have a significant impact on the amount of money each local area receives.

21 The low real-terms growth in total funding for the health system in recent years has made it difficult for the Department and NHS England to allocate funding in a way that achieves the twin aims of fairness and financial stability. The concern of the Department and NHS England not to destabilise local health economies has resulted in them making very slow progress in moving local areas towards their target allocations, which are intended to represent fair funding.

Recommendations

22 Our recommendations are designed to support an objective approach to balancing fairness and financial stability and to strengthen the evidence base for funding decisions:

a **The Department and NHS England should develop an evidence base to inform their decisions about how quickly to move commissioners towards their fair share of funding.** This 'pace of change' has a significant impact on the funding for each local area and there is a clear relationship between distance from target allocation and financial position. In making decisions about pace of change, the Department and NHS England should take account of: previous changes in local spending patterns, evidence on the effect of distance from target and the views of local commissioners.

b **The Department and NHS England should gain appropriate assurance over the quality of all data used to set target funding allocations.** A priority for NHS England should be GP list data as they are central to calculating allocations for clinical commissioning groups. There are benefits to using GP lists but there are known concerns over the reliability of these data.

c **The Department and NHS England should use emerging data to develop their evidence base on how best to use funding allocations to reduce health inequalities.** Currently the evidence is unclear about the best way for allocations to support this objective.

d **The Department and NHS England should set out how the funding framework supports their key policy objectives.** While there is now greater central control over the distribution of funding between primary care, hospital, community and mental health services, and public health, at local level funding is now more fragmented than under primary care trusts, meaning there is less flexibility to move resources between settings. In particular, NHS England should further explore how funding can support the provision of more care outside hospitals.

e **The Department and NHS England should consider the combined effect of their different allocations as part of the process of making funding decisions.** In particular, they should work with the Department for Communities and Local Government to take account of funding for social care, given the impact it may have on the need for healthcare. They should also publish data on aggregate local funding to help local commissioners plan services and understand better the financial position of local health economies.

f **NHS England, working with the Advisory Committee on Resource Allocation, should develop the approach for allocating funding to its area teams for primary care.** NHS England has refined the approach for funding clinical commissioning groups for hospital, community and mental health services, but has made less progress on primary care.

Part One

The framework for funding healthcare

1.1 This part of the report covers the system for allocating funding for healthcare, the total funding available, the relevant objectives of the Department of Health (the Department) and NHS England, and the impact of the 2013 reforms to the health system.

The system for allocating funding

1.2 The Department is ultimately responsible for the system for allocating funding for healthcare. In 2014-15, it received £113.0 billion in funds voted by Parliament (**Figure 1**). Of this, it allocated:

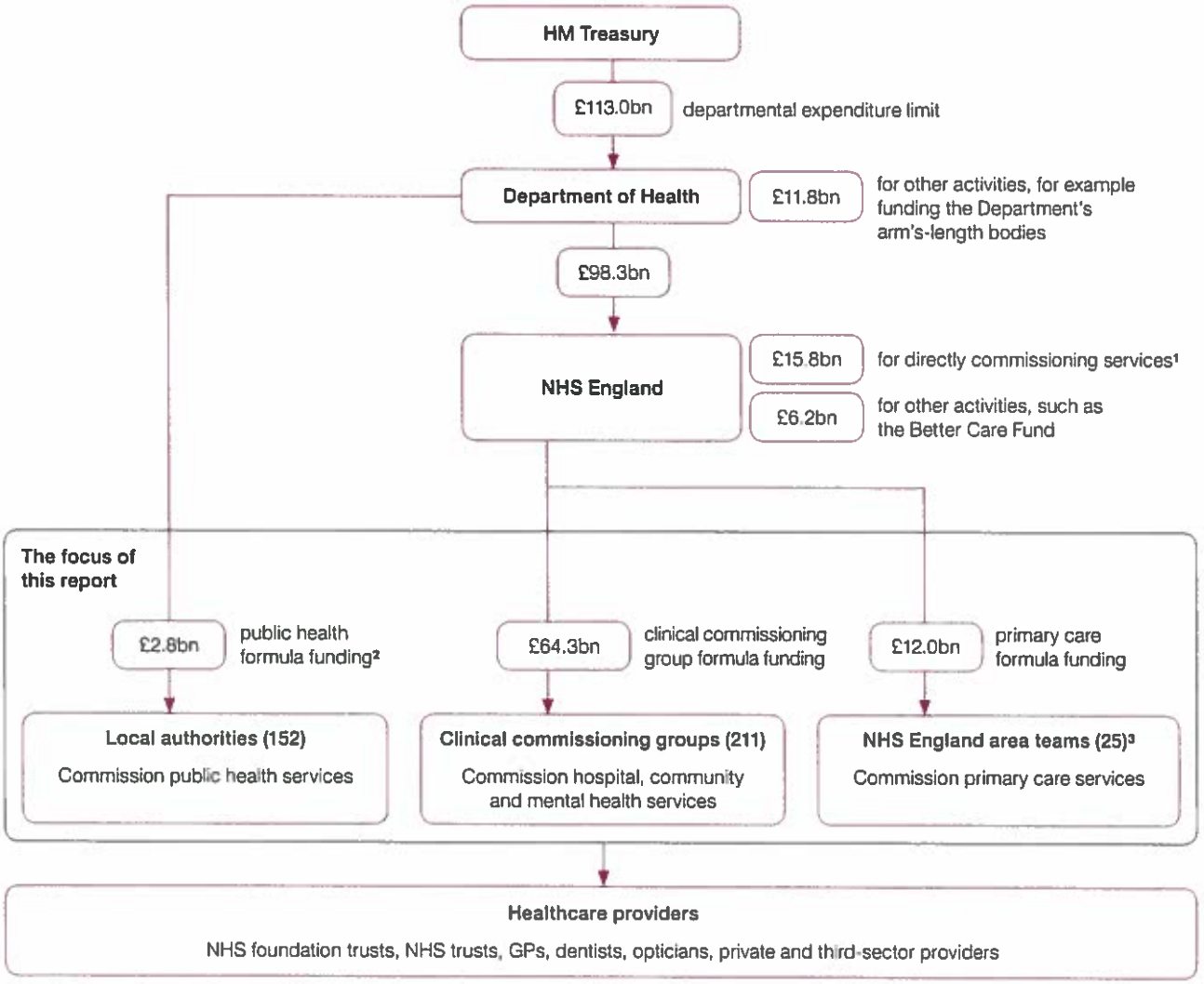
- £98.3 billion to NHS England; and
- £2.8 billion to 152 local authorities to commission public health services.

1.3 NHS England is the Department's largest arm's-length body and is responsible for the system for commissioning healthcare. In 2014-15, it allocated:

- £64.3 billion to 211 clinical commissioning groups to commission hospital, community and mental health services; and
- £12.0 billion to its 25 area teams to commission primary care.

1.4 The Department and NHS England use 'funding formulae' to allocate the total money available under each funding stream between the local commissioners of healthcare. These bodies commission services on behalf of their local populations from NHS and other providers. As was the case when we reported in 2011, the Department and NHS England are advised by the independent Advisory Committee on Resource Allocation and its Technical Advisory Group in developing and applying the funding formulae.

Figure 1
Funding streams in the health system, 2014-15



Notes

1 The £15.8 billion for direct commissioning covers 'specialised services' (such as child heart surgery), healthcare for those in prison or custody and in the armed forces, and NHS England's public health responsibilities, such as immunisation. These services are generally commissioned through the area teams but at a national rather than local level.

2 The £2.8 billion of public health formula funding is distributed on behalf of the Department by Public Health England.

3 NHS England has 27 area teams but the 3 teams in London receive a single allocation for primary care, meaning there are 25 allocations in total.

4 Figures may not sum due to rounding.

Source: National Audit Office

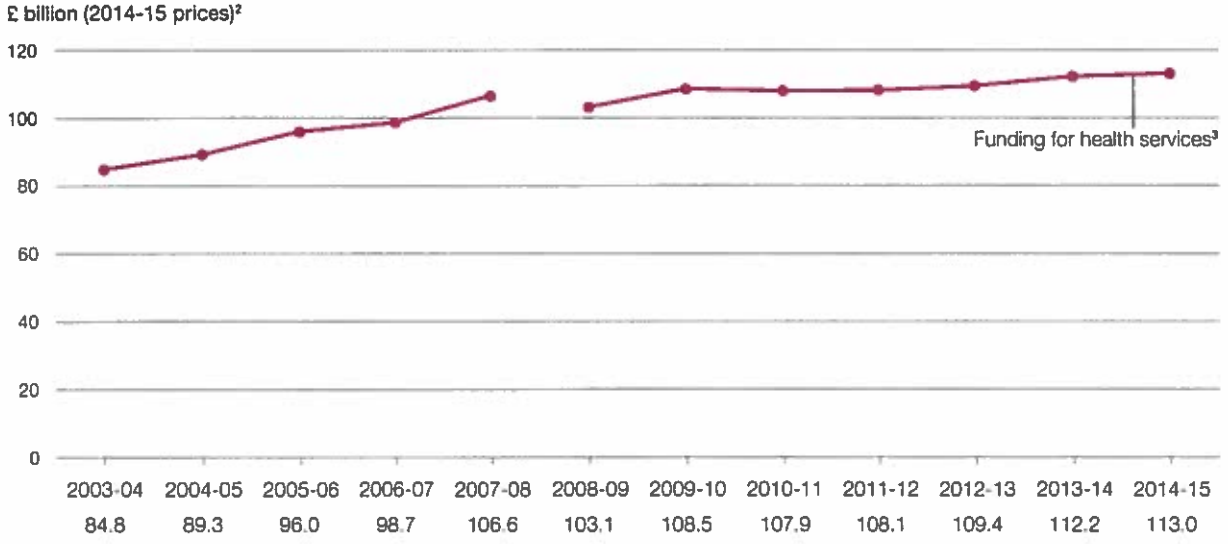
Total funding

1.5 There was sustained and significant growth in the funding available for health services in England in the early part of the last decade, but the increase has slowed in recent years (**Figure 2**). In the four years to 2007-08, the Department's budget for healthcare grew by 5.9% a year on average in real terms. In the four years to 2014-15, funding increased by 1.2% a year in real terms.

1.6 Therefore, while health has been protected compared with most other areas of government spending, the financial position is increasingly tight. At the same time, the demand for healthcare continues to grow, partly because of the ageing population and developments in drugs and medical technology. This puts NHS commissioners and providers under increasing financial pressure.

Figure 2
Funding for health services, 2003-04 to 2014-15[1]

The increase in funding available for health services in England has slowed in recent years



Notes
1 Figures from 2003-04 to 2007-08 are not fully comparable with figures from 2008-09 onwards, due to changes in the Department's responsibilities.
2 We have adjusted figures to 2014-15 prices using HM Treasury's gross domestic product (GDP) deflators.
3 'Funding for health services' is the total departmental expenditure limit for the Department of Health.

Source: HM Treasury, Public Expenditure Statistical Analyses 2009; Department of Health Resource Accounts 2013-14; and HM Treasury June 2014 GDP deflators

Objectives for allocating funding

1.7 In 2014-15, the Department and NHS England allocated £79.1 billion to local commissioners using funding formulae. The Department has long-standing, transparent objectives for allocating funding. These objectives have been re-stated recently. The Health and Social Care Act 2012 gave both the Department and NHS England a legal duty to have regard to the need to reduce health inequalities between people. The Department's annual mandate to NHS England has confirmed the objective of equal access for equal need. The Department has also set NHS England the objective of ensuring that changes in funding allocations do not destabilise local health economies.

1.8 These are high-level objectives, which are not precise or time-bound. This means that, while they provide a useful broad enduring framework, they are less helpful for informing specific judgements about allocations in practice, such as the balance between responding to needs and providing funding stability.

Impact of the 2013 reforms to the health system

1.9 The reforms to the health system in April 2013 provided greater central control over the division of funding between: primary care; hospital, community and mental health services; and public health, by removing a degree of local discretion. Funding is now split between these three funding streams centrally:

- The Secretary of State for Health, advised by the Department, decides how much of the Department's total budget should be allocated to the NHS and how much to public health.
- NHS England decides how much of its total budget should be allocated to primary care, hospital, community and mental health services, and the other health services that it commissions directly. This arrangement is intended to prevent any perception of political interference in the way that money is distributed.

1.10 Before the reforms, the system for allocating funding was less fragmented. The 151 primary care trusts received one unified allocation from the Department. They decided locally how to split this between the three funding streams. As a result, the split varied between local areas. In addition, primary care trusts had flexibility to shift funding in-year between funding streams to reflect developments or changing priorities.

1.11 The reduced local discretion will have an uneven impact, depending on the starting position of local areas. It is likely to reduce geographical variation in the split of funding. For example, our exploratory analysis suggests that in 2012-13 there was a 10 percentage point range in the proportion of funding allocated to hospital, community and mental health services. Under the new arrangements, this range will narrow over time to 7 percentage points.

Allocating funding to support policy objectives

1.12 Given the amount of money involved, the split of resources between the three funding streams is a crucial part of the way the health system works. Decisions on allocating funding are a matter of judgement, informed by previous spending patterns and policy priorities. The Department has started work to develop an analytical framework for assessing the benefits of re-allocating resources within and between sectors.

1.13 In practice, the degree of flexibility that the Department and NHS England have in making funding decisions is constrained by a number of factors, such as financial controls imposed by HM Treasury in agreeing NHS England's budget. Also, to protect financial sustainability, the Department and NHS England consider the cost pressures in different sectors and reflect these in the way they share funding between primary care, hospital, community and mental health services, and public health.

1.14 Against this background, we examined the extent to which recent funding decisions have supported two of the Department's key policy objectives:

- **Protecting spending on public health** – In 2010, the Department committed to protect funding for public health services. In the two years to 2014-15, it increased allocations to local authorities for public health by a total of over 10%. It did not routinely collect data on this area before 2012-13, so we could not analyse the trend in public health spending over a longer period.

- **Supporting the provision of care outside hospital** – NHS England does not decide how much funding is allocated to each of hospital care, community health services and mental health services, because it provides a combined allocation to each clinical commissioning group. Decisions about the distribution of funding between these three settings therefore rest with clinical commissioning groups. There are currently no data on how much of each clinical commissioning group's budget was allocated to community services. From 2003-04 to 2012-13 primary care trusts increased the proportion of total spending committed to community services (from 6.8% to 10.7%) by more than for core hospital services (from 45.6% to 48.3%).[5]

  NHS England does decide how money should be divided between area teams for primary care and clinical commissioning groups for hospital, community and mental health services. For 2014-15 it increased funding for primary care by less than for hospital, community and mental health services (2.1% compared with 2.5%). Under primary care trusts, which received a combined allocation for all care, the proportion of total spending committed to primary care fell from 29.1% to 23.4% between 2003-04 and 2012-13.

  The 2013 Spending Review announced the creation of the Better Care Fund to increase integration between health and social care with the aim, for example, of reducing emergency hospital admissions. In 2015-16, the Fund will comprise at least £3.8 billion of pooled local budgets shared between the NHS and local authorities.

5 Data from NHS (England) Summarised Accounts. Core hospital services defined as general and acute services and A&E.

Transparency

1.15 Transparency has improved under the new funding arrangements. In our 2011 report we highlighted that, in contrast to other funding formulae, the Department had not consulted publicly on changes to its formula. Since then, the Department and NHS England have consulted on changes made as part of the reforms to the health system. Both organisations also continue to publish key documents and data, and NHS England decided funding allocations at a public board meeting.

Predictability

1.16 The Department and NHS England have sought to give commissioners more notice of their funding allocations to help them plan. For example, NHS England's most recent allocations to clinical commissioning groups and its area teams covered two years, and it is considering giving allocations that cover between three and five years in future.

1.17 Allocations were subject to considerable change during the course of 2013-14 following the reforms to the health system. For example, NHS England adjusted clinical commissioning group allocations during the year by up to 9%. This was to correct for inaccuracies in the data provided by primary care trusts, which underpinned the allocations for 2013-14.

Part Two

Balancing fairness and financial stability

2.1 In allocating funding to local commissioners of healthcare, the Department of Health (the Department) and NHS England seek to balance fairness with the requirement not to destabilise the financial position of local health economies. This part of the report covers how these two objectives have been balanced, including the factors affecting allocation decisions and the effect of these decisions.

Distances from target funding allocations

2.2 The first step in allocating funding to local commissioners involves the Department or NHS England estimating the needs of each commissioner. They use this information to calculate a 'target allocation' for each body, equivalent to their fair share of the available resources. Part Three of this report covers the calculation of target allocations.

2.3 So as not to destabilise local health economies, the Department and NHS England have moved commissioners gradually from their current funding levels towards their target allocations. The difference between a commissioner's target allocation and its actual allocation is known as the 'distance from target'. In 2014-15, distances from target vary widely (**Figure 3**):

- Nearly two-fifths of clinical commissioning groups are more than 5 percentage points above or below target. Funding per person ranged from £137 under target to £361 over target.
- Over three-quarters of local authorities are more than 5 percentage points above or below target.
- NHS England's area teams are, in general, closer to their target allocations than clinical commissioning groups and local authorities. This is partly due to increased aggregation as the area teams cover larger geographical areas.

Figure 3
Distances from target funding allocations, 2014-15

			Range in distances from target[1,2]		Commissioners over 5 percentage points from target (above or below)	
	Commissioners	Average target allocation per person (£)	Percentage (%)	Per person (£)	Number	Percentage (%)
Hospital, community and mental health services	211 clinical commissioning groups	£1,133	-12.0 to +33.9	-£137 to +£361	83	39.3
Primary care	25 area teams	£211	-3.8 to +4.3	-£8 to +£9	0	0
Public health	152 local authorities	£51	-43.0 to +529.7	-£28 to +£156	118	77.6

Notes

1 Negative numbers are for commissioners that receive less than their target funding allocations.

2 Throughout the report, 'distance from target' refers to the position after commissioners have received their funding increase for the year. This is also known as the 'closing distance from target'.

Source: National Audit Office analysis of Department of Health and NHS England data

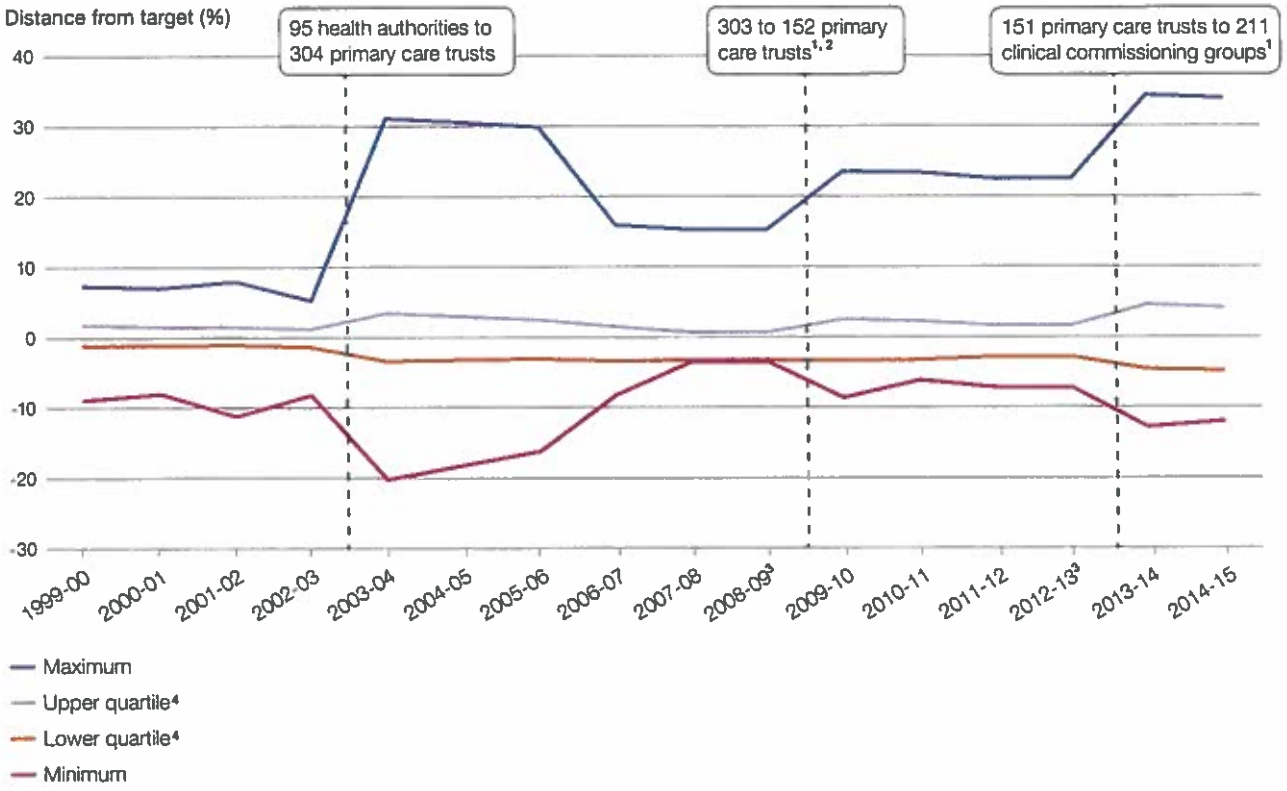
2.4 Commissioners' distances from target change from year to year. The Department and NHS England aim to reduce distances from target over time so that, ultimately, bodies reach their target allocations. Our analysis shows that distances from target have tended to increase following significant structural changes in the health system (**Figure 4** overleaf), and have narrowed during periods of stability. For example:

- In 2011-12, when targets were last calculated for primary care trusts, the range in primary care trusts' distances from target was 30 percentage points (with an interquartile range – within which half of commissioners fall – of 4 percentage points).
- In 2013-14, following the most recent reforms under the Health and Social Care Act 2012, the range in clinical commissioning groups' distances from target was 46 percentage points (with an interquartile range of 9 percentage points).

Figure 4

Distances from target funding allocations, 1999-2000 to 2014-15

As with previous reforms, distances from target funding allocations increased following the reforms to the health system in 2013



Notes

1 Two primary care trusts merged between 2003-04 and 2008-09, causing the total to fall from 304 to 303, and between 2009-10 and 2012-13, causing the total to fall from 152 to 151.

2 The number of primary care trusts changed from 303 to 152 in October 2006. However, funding allocations for 2007-08 had already been announced, and the Department then spent time developing a new funding formula. The new funding was applied from 2009-10.

3 The Department did not estimate target funding allocations in 2008-09 or 2012-13. Instead, it gave all commissioners a uniform increase. We have therefore assumed that distances from target in those years were the same as distances from target in the previous year.

4 Half of commissioners fall between the upper quartile and lower quartile.

Source: National Audit Office analysis of Department of Health and NHS England data

2.5 This increase in distance from target following the reforms in April 2013 may have been caused by various factors, including changes to the formulae used to calculate target allocations. Because the reforms introduced new structures for commissioning healthcare, the Department and NHS England had to develop new formulae for estimating the needs of the new commissioners. These estimated target allocations in a different way from the previous formula used for primary care trusts. They also had to divide funding in a different way geographically. Since funding had been moving towards the previous targets, changing the target allocations was likely to increase the average distance from target and this proved to be the case.

Progress towards target funding allocations

2.6 The framework for the extent to which each commissioner's funding moves towards its target allocation is known as the 'pace of change' policy. It usually includes a minimum level of growth for all commissioners and larger increases in funding for those bodies that are furthest away from target.

Recent progress

2.7 Over the last two years, progress in moving towards target allocations has been fastest for local authorities for public health, where the distances from target were the highest. For 2013-14 and 2014-15, the Department awarded local authorities increases of up to 10% (**Figure 5**). For 2013-14, NHS England increased funding for clinical commissioning groups and area teams by a flat rate, as the Department did for primary care trusts for 2012-13; therefore no progress was made in reducing distances from target for these bodies.

Figure 5
Recent pace of change levels, 2013-14 and 2014-15

	Commissioners	Increases in allocations		Distances from target
		2013-14[1] (%)	2014-15 (%)	2014-15 (%)
Hospital, community and mental health services	211 clinical commissioning groups	+2.3 (flat rate)	+2.1 to +4.9	-12.0 to +33.9
Primary care	25 area teams	+2.6 (flat rate)	+1.6 to +3.0	-3.8 to +4.3
Public health	152 local authorities	+2.2 to +10.0	+2.8 to +10.0	-43.0 to +529.7

Note

1 No targets were calculated for clinical commissioning groups or area teams in 2013-14, and each area was given a flat rate of growth. The pace of change in 2013-14 was therefore nil.

Source: National Audit Office analysis of Department of Health and NHS England data

2.8 We identified that some of the commissioners that are furthest below their target allocations have in fact received smaller increases in funding per person than those commissioners that are above their target allocations. This is a result of applying percentage uplifts where there are large differences in starting allocations. For instance, analysis of the Department's allocations for local authorities in 2014-15 shows that:

- Surrey, which was 43% below target at £20 per person, received the maximum 10% uplift in allocations, equating to an increase of £2 per person; whereas
- City of London, which was 513% above target at £180 per person, received the minimum 2.8% uplift, equating to an increase of £5 per person (over double that of Surrey).

Effect of tighter financial position

2.9 The Department has been able to increase the rate of progress towards target allocations when the total funding for health has grown significantly in real terms. At these times more money is available for redistribution, even after all local areas have received real-terms growth in funding. For example, in 2006-07 funding increased by 9.2% and the most under-target primary care trusts received a 15.7% increase. In contrast, in 2011-12 funding increased by 2.2% and the most under-target primary care trusts received a 4.2% increase (**Figure 6**).

2.10 It is more difficult to make progress towards target allocations when the overall financial position is tighter. In 2014-15, NHS England's total funding increased by 0.2% above inflation. NHS England increased funding for its local commissioners by 0.4% above inflation, by reducing funding for its other activities.

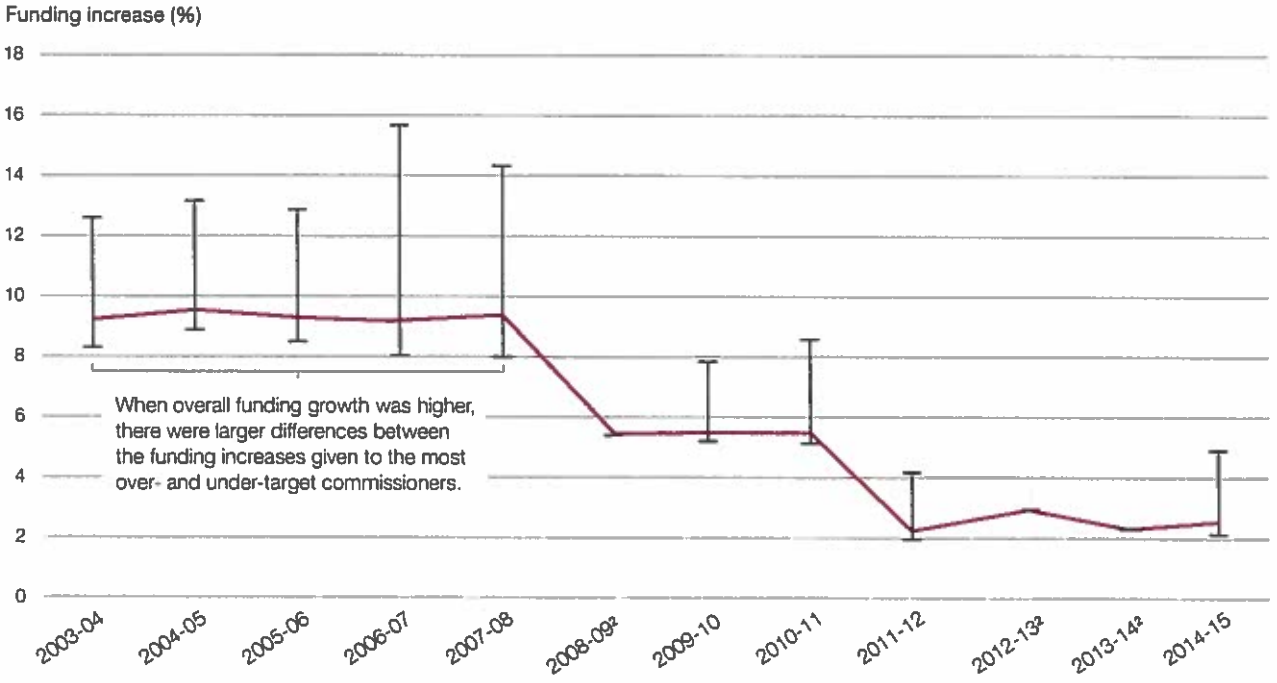
2.11 In total, the Department and NHS England made £1.98 billion available to increase funding for local commissioners in 2014-15. They used this total in the following ways:

- **Giving all commissioners a minimum funding increase, at a cost of £1.61 billion.** They increased allocations for clinical commissioning groups and local authorities by at least inflation, continuing the long-standing approach that no commissioner's budget should be reduced in real terms. However, the minimum increase for area teams was 1.6%, with 9 teams receiving increases below inflation.
- **Using the remaining £0.37 billion to move under-target commissioners towards their target allocations.** As a result, the total amount that commissioners were below target fell by 5% from £1.97 billion to £1.87 billion. It left 222 commissioners below target and the remaining 166 commissioners above target.

Figure 6

Progress towards target funding allocations, 2003-04 to 2014-15[1]

Progress towards target funding allocations has increased when total funding has grown significantly



Notes

1 Data to 2012-13 are for primary care trusts, and from 2013-14 are for clinical commissioning groups.

2 In 2008-09, 2012-13 and 2013-14 all commissioners received the same increase.

Source: National Audit Office analysis of Department of Health and NHS England data

2.12 Had the Department and NHS England used all of the £1.98 billion to move under-target commissioners towards target, the total amount that commissioners were below target would have fallen by 39% to £1.20 billion. The remaining commissioners would have been above target by the same amount. In this scenario, above-target commissioners would have received no increase in funding (that is, a real-terms reduction).

Future distance from target

2.13 If the Department and NHS England maintain their current pace of change policies, some local commissioners will continue to receive funding that is a considerable distance from their target allocations. In 2011, the Committee of Public Accounts recommended that departments should commit to giving the right funding for an area's needs within a set time period. The government disagreed with this recommendation because it did not consider it was practical due to target allocations constantly changing.[6]

2.14 The Department and NHS England have not announced allocations beyond 2015-16.[7] As noted earlier, it is more difficult to make progress towards target allocations when the overall financial position is tighter. Were the current pace of change and tight financial position to continue, it would take approximately 6 years before no clinical commissioning group was below its target allocation by more than 5%. For local authorities for public health, this would take 10 years. As some commissioners currently receive considerably more than their target allocations, the time taken before no commissioner was above target by more than 5% would be much longer: approximately 60 years for clinical commissioning groups and 80 years for local authorities.[8] All of NHS England's area teams are already within 5% of target for primary care funding.

Factors affecting pace of change policies

2.15 The Department and NHS England do not consider that there is objective evidence on which to base decisions about the most appropriate pace of change for moving local areas towards their target allocations. Therefore, decisions about pace of change are a matter of judgement relating to the changes in funding that local health economies can tolerate without being financially destabilised and about the effects of organisations not receiving their target allocations.

Capacity to tolerate changes in funding

2.16 Local bodies may be able to tolerate changes in funding that are more significant than those allowed under current pace of change policies. Using data from 2009-10 to 2012-13, we calculated the average year-on-year change in the amount that each primary care trust chose to spend on hospital, community and mental health services. We compared these figures to NHS England's pace of change policy for 2014-15 for clinical commissioning groups, which now commission most hospital, community and mental health services and so are the nearest proxy.[9] This exploratory analysis suggests that an estimated:

6 HM Treasury, *Progress on implementing recommendations on 19 Committee of Public Accounts reports (Session 2010-12)*, Cm 8539, February 2013.
7 NHS England has published indicative allocation growth assumptions for 2016-17 to 2018-19 to help clinical commissioning groups to plan.
8 Appendix Two outlines how we estimated these figures.
9 The data for primary care trusts and clinical commissioning groups are not completely comparable. For example, the former are spending data and the latter are allocations data. Appendix Two provides more details of this analysis.

- 27 primary care trusts (18% of the total) had changed the amount spent on hospital, community and mental health services by less than the minimum change in allocations to clinical commissioning groups; and
- 27 primary care trusts (18%) had changed by more than the maximum change for clinical commissioning groups.

2.17 Despite limitations, this analysis indicates that some primary care trusts changed the amount they spent on hospital, community and mental health services by more or less than the changes allowed under NHS England's current pace of change policy. More work is needed to understand the effect of such changes on the financial stability of commissioners and their local providers, and the delivery of services and outcomes for patients. All these factors need to be considered in deciding an appropriate pace of change policy.

Impact of local population changes

2.18 In considering what is an appropriate pace of change, the Department has focused on ensuring stability of funding at local area level. This approach does not, however, take account of the fact that changes in population may cause funding per person to rise or fall significantly regardless of stability in total funding. Each year, local populations may change due to high rates of births and/or deaths, or cross-boundary migration. These changes in population are accounted for in calculating target allocations. But a slow pace of change policy limits the extent to which actual funding reflects the changes.

2.19 To quantify this risk, we investigated local areas that have previously experienced significant changes in their populations. The most recent available data, for 2011-12, show that:

- The 20 primary care trusts that had the largest increases in population all received less funding per person than they had in the previous year (by an average of 2.2%).
- The 20 primary care trusts that had the largest falls in population all received more funding per person than they had in the previous year (by an average of 5.3%).
- One of the largest changes in population was in Kensington and Chelsea primary care trust, which fell by 6.4%, while in nearby Wandsworth the population rose by a similar percentage. Both primary care trusts received a funding increase of around 2%. As a result, funding per person rose by 9.0% in Kensington and Chelsea but fell by 4.2% in Wandsworth. Therefore, despite the stability in total funding, funding per person changed significantly in both areas.

2.20 NHS England has recognised this risk, and has mitigated it in its pace of change policy for clinical commissioning groups. For 2014-15 it introduced a rule to increase the funding for every clinical commissioning group by as much as its population had increased, or by inflation, whichever was greater.[10] Taking the example in paragraph 2.19, this policy would have ensured that funding per person in Wandsworth at least stayed the same, rather than falling by £78. NHS England has not adopted this approach for its area teams, nor has the Department for local authorities.

Effect of commissioners not receiving their target funding allocations

Financial position

2.21 The financial position of individual commissioners is affected by a range of factors, including how well they manage their costs and whether they have received any additional non-recurrent financial support during the year. We found evidence suggesting an association between clinical commissioning groups receiving funding that is above or below their target allocation and their financial position.[11] Our analysis showed that at 31 March 2014:

- The 20 clinical commissioning groups with the tightest financial positions received, on average, 5.0% less than their target funding allocation.[12] Of these 20 groups, 19 received less than their target allocation.
- The 20 clinical commissioning groups with the largest surpluses received, on average, 8.8% more than their target funding allocation. Of these 20 groups, 18 received more than their target allocation.
- The 107 under-target clinical commissioning groups received a total of £1,606 million less than their target allocations and had a combined deficit of £165 million. The 104 groups that received funding above their target allocation had a combined surplus of £547 million.

2.22 While the relationship between financial position and distance from target allocation is likely to be complex and vary from area to area, we carried out analysis to investigate the association. This exploratory work, which assumes a constant effect between the two factors, suggests that, on average, for every £100 a clinical commissioning group is below target its financial position worsens by around an estimated £10 to £17. The actual effect may be smaller or larger than this for any individual clinical commissioning group and, as shown in **Figure 7**, some groups that received substantially less than their target allocation were in surplus at the end of 2013-14. Distance from target allocation explains around 23% of the variation in clinical commissioning groups' financial position. More work is needed to understand the effect of funding on the financial position of commissioners and their local providers.

10 This rule was supplemented by a further rule that clinical commissioning groups who were more than 5% over target could not receive more than the minimum increase. This affected one area, Tower Hamlets, which received the minimum 2.14% increase despite its population increasing by 2.47%.

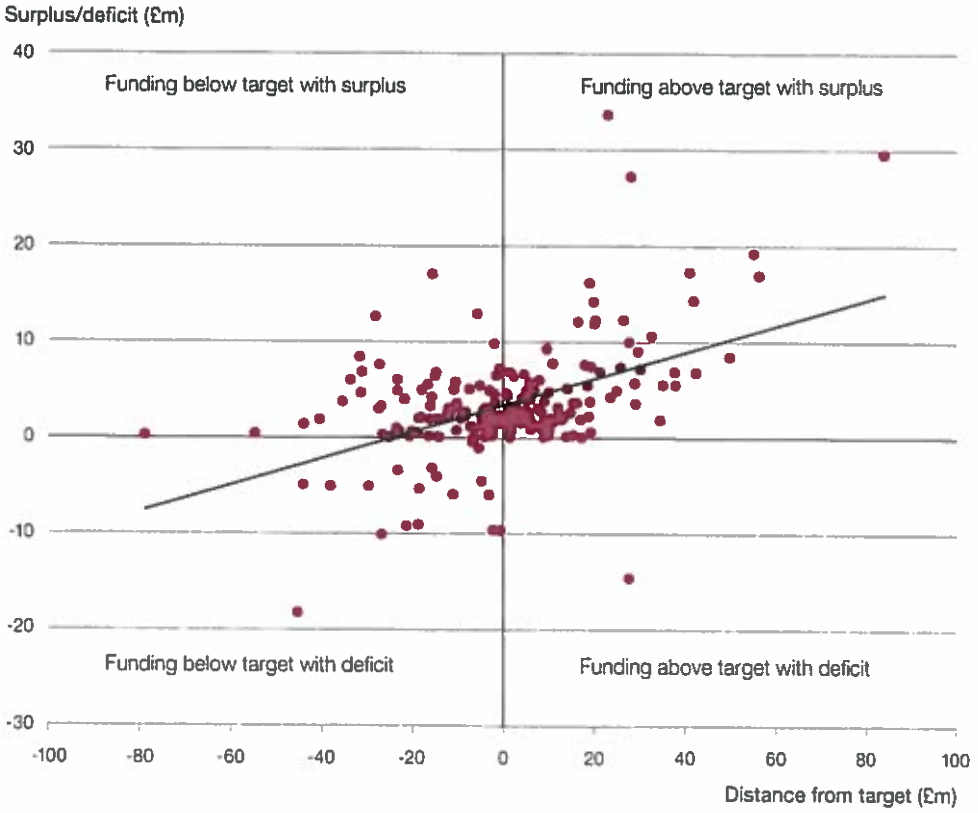
11 Similar analysis was not possible for either area teams or local authorities because a substantial proportion of these organisations' funding – which will affect their financial position – is provided outside of the funding formula for other services.

12 Of these clinical commissioning groups, 19 had a deficit and one had a surplus of 0.01%.

Figure 7

Relationship between distance from target funding allocation and financial position by clinical commissioning group, 2013-14

Areas with lower levels of funding, relative to target, are more likely to report a financial deficit



Note

1 The trend line is the straight line that best represents the data on the scatter plot.

Source: National Audit Office analysis of NHS England data

2.23 We identified a weaker relationship between distance from target allocation and financial position for primary care trusts at 31 March 2013. Distance from target explained 8% of the variation in financial position.

Provision of health services

2.24 We also sought to investigate whether receiving funding that is above or below target allocation appears to affect a local area's health services or outcomes.[13] Given the multiple factors that affect health outcomes, we explored the relationship between distance from target at a local level and measures of how health services are provided, namely the number of GPs, hospital beds and hospital-based NHS staff. Our exploratory analysis did not identify any significant associations between the resourcing of health services by NHS providers and commissioners' distances from target allocations.

Balancing fairness and financial stability across different funding streams

2.25 The challenges of meeting the complex care needs of the ageing population and addressing the public health problems associated with unhealthy lifestyles require a more transparent and integrated approach to commissioning across the health system and more widely. To balance fairness and financial stability, the Department and NHS England need to consider the aggregate funding position of local areas, rather than making allocations in isolation. Knowledge of the overall funding position would also help local commissioners better plan their services.

Across the health system

2.26 Creating an aggregate position of health funding is more challenging following the reforms to the health system. Money is provided in three separate allocations and the geographies used for the different allocations vary. In setting primary care and hospital, community and mental health services allocations for 2014-15 in December 2013, NHS England considered the combined effect of the three health allocations at the level of the 25 area teams. It did not calculate the combined effect at a more local level until June 2014. The Department did not provide us with any evidence that it has considered the wider funding position when deciding its public health allocations.

2.27 We investigated combined health funding at the local level – based on clinical commissioning group areas – by mapping allocations across different geographical boundaries and using primary care funding patterns from 2012-13, when such data were last collected at this level (**Figure 8** on page 30). The lack of data on, for example, local primary care funding meant that we had to make several broad assumptions in order to do this mapping.[14] We estimate that in 2013-14:

13 Appendix Two provides more details of this analysis.
14 Appendix Two provides more details of this mapping and the assumptions we made.

- On average, local areas received £1,371 per person for funding healthcare, ranging from £1,076 (Oxfordshire) to £1,845 (Knowsley).[15]
- The most under-target area (Corby) was below target by £186 per person (12.8%), while the most over-target area (West London) was above target by £508 per person (39.3%).
- 18 areas received at least £100 more per person than their target allocation while 20 areas received at least £100 per person less.
- There were positive relationships between distances from target at a local level across the three separate funding allocations. While these associations were generally weak, this suggests that in 2013-14 the Department and NHS England were over- or under-funding the same areas to some extent.

Healthcare and adult social care

2.28 Given the link between healthcare services and social care, we also explored the relationship between the two. Local authorities receive funding for providing a range of local services, including social care.[16] The funding allocations are based in part on an estimate of the relative need for social care within each area. However, this funding is not ring-fenced and local authorities decide how much of their total budget to spend on social care.

2.29 Many people receive both healthcare and social care and, therefore, lower spending in one of these sectors might be expected to cause additional costs in the other. A recent survey found that nearly a third of clinical commissioning group chief finance officers considered that cost pressures in social care were causing cost pressures in their clinical commissioning group.[17] Our exploratory analysis supports this view. In local areas where aggregate health funding is below the target allocations, local authorities tend to spend more than expected – based on relative need – on adult social care. More work is needed to understand the extent of, and causation in, this relationship.

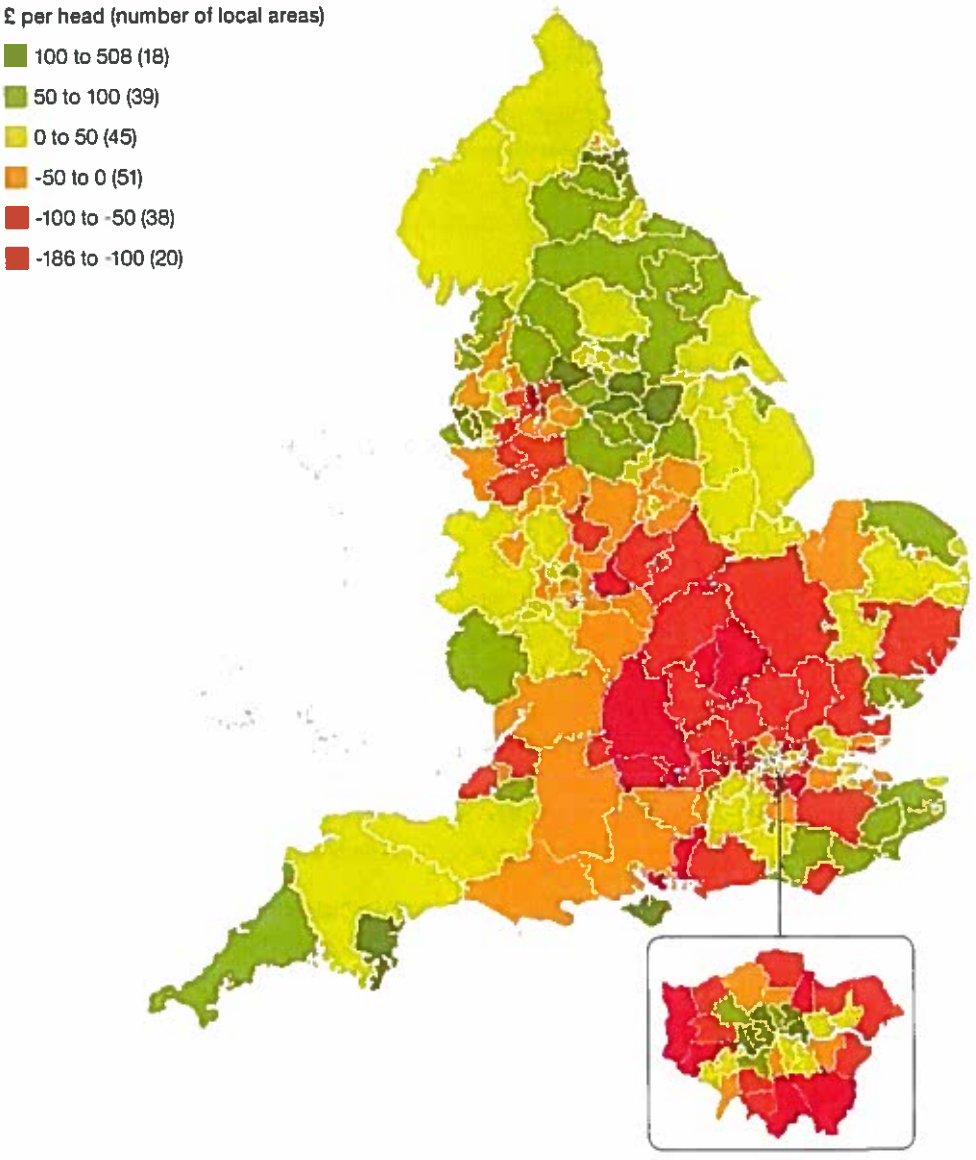
2.30 The apparent association between health funding and social care spending suggests that decisions about each should not be made in isolation. NHS England has recognised the need to analyse social care funding in assessing the local impact of its funding decisions. However, in making decisions about 2014-15 health funding allocations, neither the Department of Health nor NHS England took account of local authority spending on social care or the Department for Communities and Local Government's plans for funding local authorities. In June 2014, NHS England calculated total levels of local funding, covering both health and social care.

15 These per person estimates use NHS England's estimates of the population covered by each clinical commissioning group.
16 Social care comprises personal care and practical support for adults with physical disabilities, learning disabilities or physical or mental illnesses, as well as support for their carers.
17 Healthcare Financial Management Association, *NHS financial temperature check*, June 2014. Based on 63 responses.

Figure 8

Aggregated distances from target funding allocations for healthcare by local area, 2013-14

Eighteen local areas received at least £100 more per person than their target funding allocation, while 20 received at least £100 per person less



Source: National Audit Office analysis of Department of Health, NHS England and Office for National Statistics data

Part Three

Setting target funding allocations

3.1 This part of the report covers how the Department of Health (the Department) and NHS England set target allocations for each local commissioner of healthcare. Specifically, we examine how they estimate population size and adjust for relative need and health inequalities.

3.2 The target funding allocations are intended to represent local areas' fair share of the available funding, rather than the amount of money that might be required to meet their healthcare needs in full. The allocations are based on predictions of need, taking account of the size and characteristics of local populations. They are not designed to cater for unpredictable events, such as sudden outbreaks of infectious disease, which can be costly for the local areas affected. The new structures for commissioning healthcare are intended to reduce unpredictability by centralising the commissioning of specialised services needed by relatively small numbers of people in any local area.

Overall approach

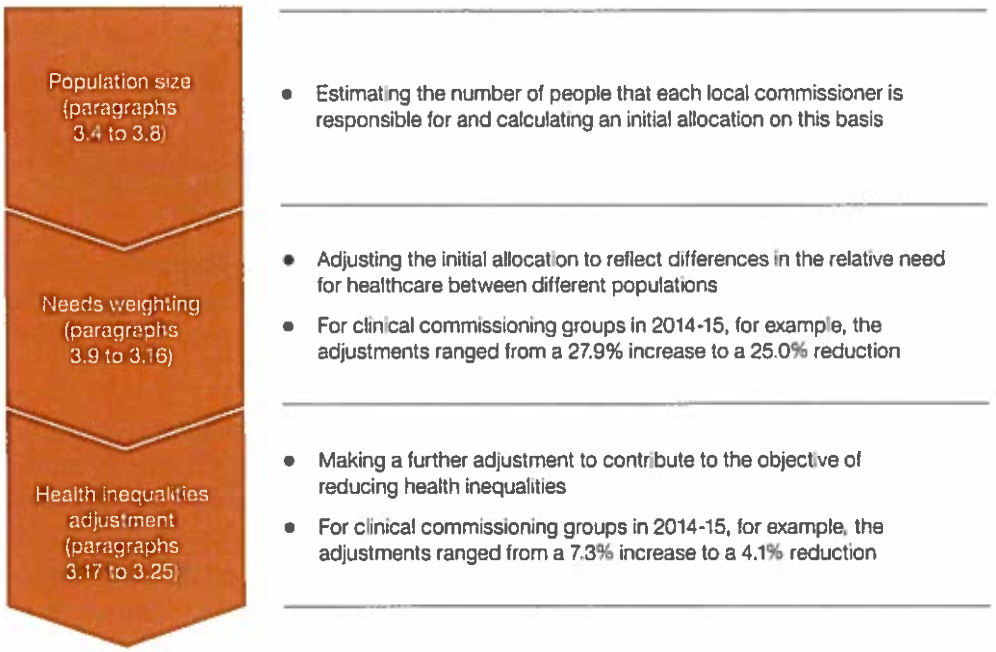
3.3 The principles underpinning the approach of the Department and NHS England are that local areas with higher healthcare needs should get a larger share of NHS resources and that allocations should be used in support of the aim of reducing health inequalities. The overall approach that both organisations adopt involves calculating funding allocations based on population size and then adjusting them for relative needs and health inequalities (**Figure 9** overleaf).

Estimating population size

Data sources

3.4 Population size is the factor that has the most significant effect on each commissioner's target funding allocation. It is important that, where possible, the data used are responsive to changes in the size of local area populations and their need for healthcare. Any large inaccuracies in population estimates would lead to inequitable target allocations.

Figure 9
Approach to calculating target funding allocations



Note

1 The Department and NHS England make a further adjustment to reflect unavoidable differences in costs due to location alone, for example higher staff or buildings costs. These calculations are made at provider level, and the allocations of commissioners are then adjusted to reflect the providers from which they purchase healthcare.

Source: National Audit Office

3.5 Before April 2013 the Department used population projections from the Office for National Statistics to calculate funding allocations for primary care trusts. The Department continues to use these projections to estimate local authority populations and calculate allocations for public health. Its approach is consistent with how the Department for Communities and Local Government allocates grant funding to local authorities. In contrast, NHS England uses data from GP lists to calculate population estimates for clinical commissioning groups and area teams.

Data quality

3.6 Compared with Office for National Statistics projections, GP list data offer benefits including:

- **More responsive to changes in population.** Office for National Statistics projections are based on the census, which is carried out every 10 years. They are therefore less responsive to changes in population than GP list data, which are updated more frequently.
- **More detailed understanding of relative need.** Data from GP lists allow need to be assessed more precisely, at the level of individual patients rather than local areas (paragraph 3.14).

3.7 There are, however, known concerns about the accuracy of GP list data. In 2012, a report commissioned by the Advisory Committee on Resource Allocation[18] noted several issues affecting accuracy including:

- **'List inflation'.** GP lists tend to be inflated (6% higher on average than Office for National Statistics projections). Areas with more transient populations tend to have more inflated GP lists. This is because, for example, patients who move may not tell their GP, and may remain on the GP's list after they have left the area. NHS England adjusts allocations for clinical commissioning groups to reduce the effect of list inflation to some extent.
- **Unregistered patients.** GP lists do not include unregistered patients, such as homeless people. Providing healthcare for such patients costs an estimated £240 million per year. These costs are not distributed evenly across the country, and are highest in London, Birmingham and Southampton.

3.8 The Department previously estimated that changing from Office for National Statistics projections to GP list data could affect a local area's estimated population by up to a 12.6% increase or 4.0% fall.[19] In its 2011 report on formula funding, the Committee of Public Accounts recommended that, working with HM Treasury, departments should set standards for the accuracy and timeliness of the data sources they use, focusing in particular on strengthening data where it will be central to proposed new arrangements. The Department accepted this recommendation, and undertook an exercise to consolidate the two data sources and clean the new GP list data. However, assurance that the data are accurate remains limited:

- All 8,000 GP practices are responsible for maintaining their own lists. The Advisory Committee on Resource Allocation has noted that GP practices have an incentive to over-state their lists, because the funding they receive is directly related to list size.

18 Nuffield Trust, *Updating and enhancing a resource allocation formula at general practice level based on individual level characteristics*, January 2012.

19 Analysis underlying Advisory Committee on Resource Allocation, *The comparative performance of the PCT and CCG allocation formulae*, June 2013.

- NHS England published guidance on 'tackling list inflation' in June 2013.[20] This noted that some degree of list inflation was inevitable, but that current trends of inflation were excessive with regional variation. NHS England's area teams are expected to work with GP practices to manage lists. NHS England centrally does not routinely assure itself that the guidance is being followed but collected evidence for us of the work that most area teams have done.

Adjusting for relative need

3.9 Estimates of the relative healthcare needs of local populations also have a significant impact on target funding allocations. The Department and NHS England adjust allocations on this basis which is intended, for example, to reflect the additional demand for healthcare in areas with higher proportions of elderly people.

3.10 NHS England adjusted 90% of each clinical commissioning group's target allocation for 2014-15 for relative need. The adjustments ranged from a 27.9% increase to a 25.0% decrease, compared with what target allocations would have been based on population size alone. The adjustment increased the target allocations by at least 15% for 26 clinical commissioning groups and reduced them by at least 15% for 18 clinical commissioning groups (**Figure 10**). The needs adjustment also changed area teams' allocations by up to 18%, and local authorities' allocations for public health by up to 79%.

Approaches to assessing need

3.11 Given the lack of consensus on the best way to measure need, we do not offer judgement on which is the most appropriate method. Both approaches currently used in England have strengths and limitations:

- NHS England's utilisation-based approach (paragraphs 3.13 to 3.15) benefits from drawing on comparatively rich data on past consumption of health services. However the calculations do not account for need for healthcare that is not currently being met, where this unmet need is distributed differently to met need.
- The Department's outcomes-based approach (paragraph 3.16) uses a measure of the actual health of the population. However, it is difficult to establish what resources should be used to meet this need.

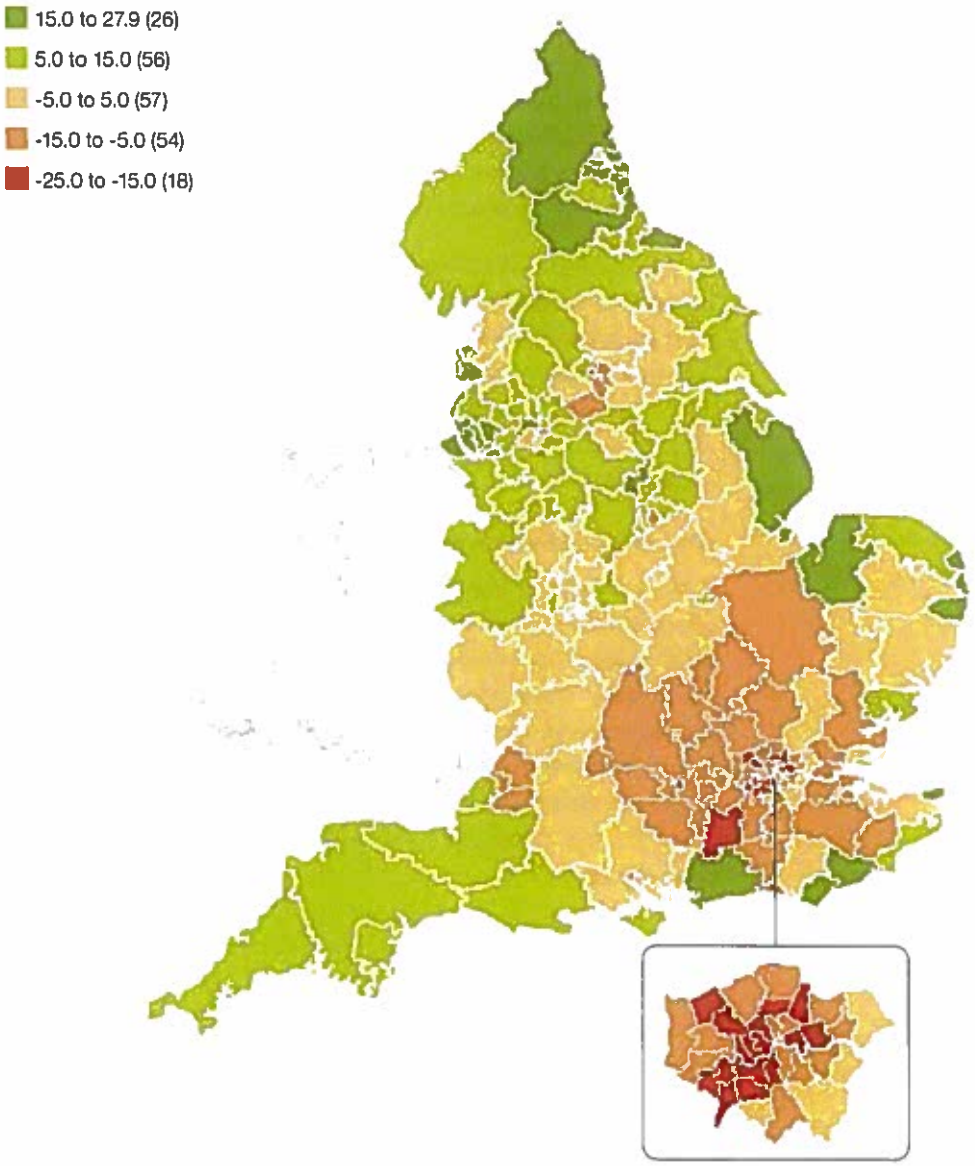
3.12 The Advisory Committee on Resource Allocation plans to investigate the approaches to assessing need used in other countries, including Wales. The Welsh Government uses a formula based on population and health need for allocating funding to local health boards. The main data source for measuring need is self-reported information on illness from the Welsh Health Survey. This is supplemented by other data on specific conditions.

20 NHS England, *Tackling list inflation for primary medical services*, June 2013.

Figure 10

Impact of adjusting for relative need by clinical commissioning group, 2014-15

The needs-adjustment changed clinical commissioning groups' target funding allocations by up to a 27.9% increase or a 25.0% decrease



Source: National Audit Office analysis of NHS England data

Utilisation-based approaches for allocations to clinical commissioning groups and NHS England's area teams

3.13 NHS England uses proxy indicators, such as age, gender and previous diagnoses, to estimate the relative healthcare needs of different local areas. It bases the estimate on the indicators' association with variations in service use or spending. For example, if the analysis suggests that spending on healthcare tends to be higher for elderly people then, all else being equal, NHS England assesses local areas with a larger proportion of elderly people as having higher relative need.

3.14 The Department adopted a similar approach in calculating funding allocations for primary care trusts until 2012-13. NHS England refined the approach for allocations to clinical commissioning groups for 2014-15. By using newly available data at the level of individual patients to create a more detailed model of healthcare utilisation, NHS England's new approach is better at predicting relative needs.

3.15 In contrast, NHS England's approach for primary care allocations for area teams for 2014-15 was heavily based on the relevant component of the previous primary care trust formula. It did not seek the Advisory Committee on Resource Allocation's views until three months before the primary care allocations were announced. As a result, the Advisory Committee did not have time to develop an alternative approach. NHS England regards the current approach as interim and intends to refine how it assesses need for future years.

Outcomes-based approach for allocations to local authorities for public health

3.16 The Department adopted a new approach to assessing need in calculating funding allocations to local authorities for public health for 2013-14. This involved estimating relative need based predominantly on a measure of life expectancy, a proxy for health inequalities. The Advisory Committee on Resource Allocation advised that, given the pivotal role of public health in supporting the objective of reducing health inequalities, this formula would benefit from being based on a measure of health status. As a result, target allocations were increased in local areas with lower life expectancies (broadly parts of London and the north-west of England) and reduced where life expectancies were higher.

Adjusting for health inequalities

Approach to assessing health inequalities

3.17 Since 1999 health funding formulae have included adjustments to move money towards areas with lower life expectancies, with the aim of reducing health inequalities (paragraph 1.7). In its 2010 report on tackling inequalities,[21] the Committee of Public Accounts recommended that in allocating funding the Department and NHS England[22] should consider how to correct funding shortfalls in the most deprived areas.

3.18 NHS England uses a measure of life expectancy as the basis for adjusting for health inequalities in calculating target allocations for clinical commissioning groups and its area teams.[23] This approach is based on the rationale that moving money towards areas with lower life expectancies will reduce health inequalities and allow unmet need to be addressed.

3.19 NHS England has improved the basis for adjusting for health inequalities, although the approach remains an interim measure. Compared with the measure used previously (disability-free life expectancy), the current indicator (standardised mortality ratios) is updated more often. It is also better at detecting small pockets of ill-health in otherwise healthy areas as it is calculated for smaller areas. The Advisory Committee on Resource Allocation considers that, while the current measure is an improvement, it is only an interim approach. It plans to conduct further work on estimating unmet need for health services.

Effect of health inequalities adjustment

3.20 The adjustment for health inequalities is less than the adjustment for relative need. NHS England adjusted 10% of the target allocation for each clinical commissioning group for 2014-15 for health inequalities. The effect of the adjustment ranged from a 7.3% increase to a 4.1% decrease (**Figure 11** overleaf). The range in adjustments (11.4 percentage points) is around a fifth of the range for the relative needs adjustment (52.9 percentage points).

3.21 Broadly, the adjustment for health inequalities moves funding towards parts of London and the north-west of England. For 2014-15, it increased the target allocations of 25 clinical commissioning groups by more than 3%, and decreased the target allocations of 9 clinical commissioning groups by more than 3%.

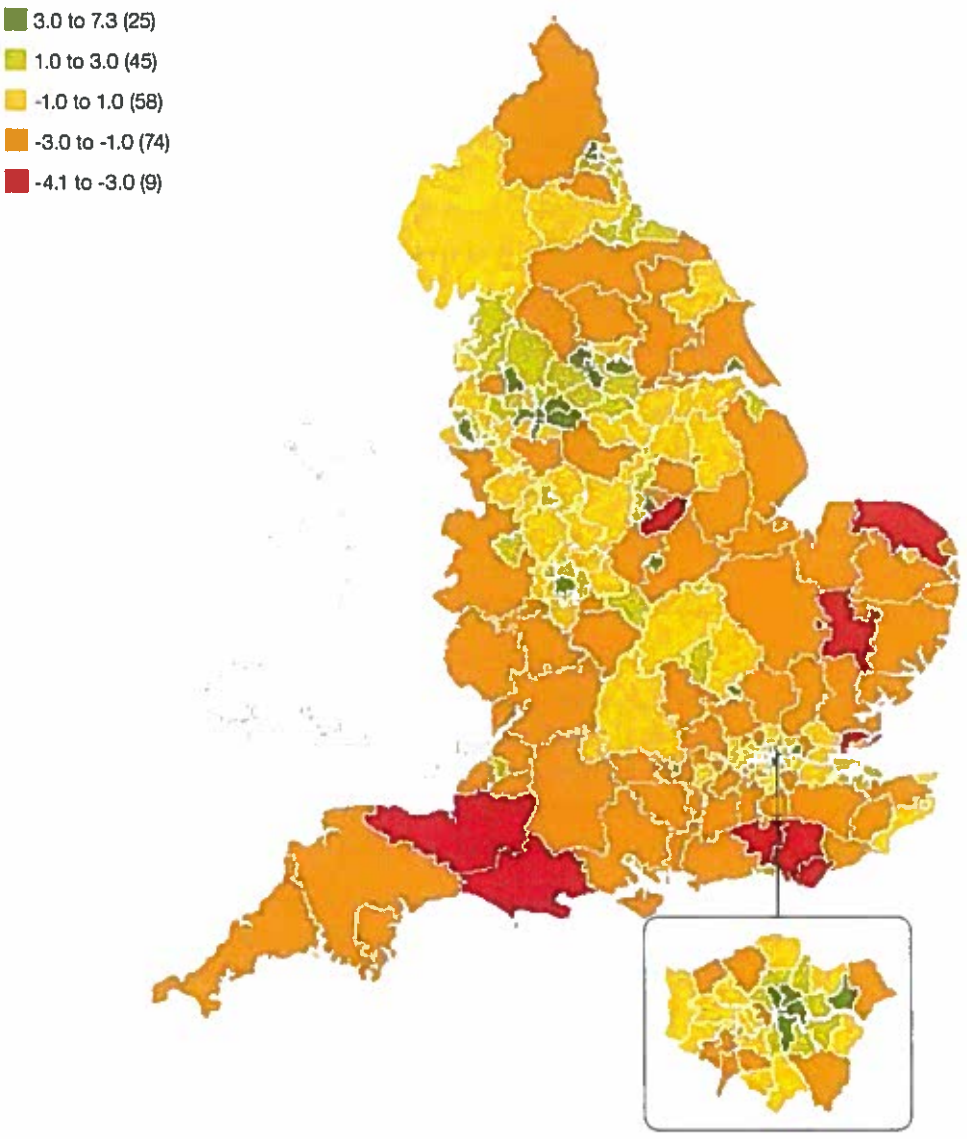
3.22 NHS England adjusted 15% of the target allocation for each of its area teams for health inequalities. This larger amount reflects NHS England's view that improving primary care will have more impact on reducing health inequalities.

21 HC Committee of Public Accounts, *Tackling inequalities in life expectancy in areas with the worst health and deprivation*, Third Report of Session 2010-11, HC 470, November 2010.
22 Then known as the NHS Commissioning Board.
23 The Department does not adjust for health inequalities since its allocations to local authorities for public health already reflect a measure of life expectancy (paragraph 3.16).

Figure 11

Impact of adjusting for health inequalities by clinical commissioning group, 2014-15

The health inequalities adjustment changed clinical commissioning groups' target funding allocations by up to a 7.3% increase or a 4.1% decrease



Source: National Audit Office analysis of NHS England data

3.23 The evidence is unclear on the extent to which increasing funding can help to reduce health inequalities. For example, it is uncertain how far health inequalities reflect the provision of health services, rather than other social factors such as income, education and child welfare. And while there is evidence of some benefits, the cost-effectiveness of previous funding adjustments has not been demonstrated. The Advisory Committee on Resource Allocation also does not consider there is any evidence about the appropriate weight to give to any health inequalities adjustment.

3.24 In funding primary care trusts, the Department applied a weighting of 15% in 2009-10 and 2010-11, and a weighting of 10% after that. For 2013-14, the Department initially commissioned the Advisory Committee to develop a formula with no health inequalities adjustment.[24] However, NHS England considered that the proposed formula risked increasing health inequalities by awarding more money to areas with better health outcomes. It therefore commissioned the Advisory Committee to propose a health inequalities adjustment for clinical commissioning groups. NHS England adopted this adjustment for 2014-15. It also applied it in calculating primary care allocations for area teams.

Addressing health inequalities and the needs of ageing populations

3.25 In allocating funding, NHS England faces a particular challenge in addressing health inequalities and meeting the complex care needs of the ageing population at the same time. Areas with low life expectancy (which tend to be deprived) tend to have fewer elderly people. For example, in the 20 clinical commissioning groups with the lowest life expectancy, on average 3.4% of the population was aged over 80, compared with 4.5% in the 20 groups with the highest life expectancy. As a result, increasing funding for areas with low life expectancy will tend to reduce funding in areas with more elderly people. In other words, there appears to be a trade-off between addressing health inequalities and not reducing funding in areas with ageing populations.

24 The Department initially commissioned the Advisory Committee to advise on allocations for 2013-14, because NHS England was not established until October 2012.

Appendix One

Our audit approach

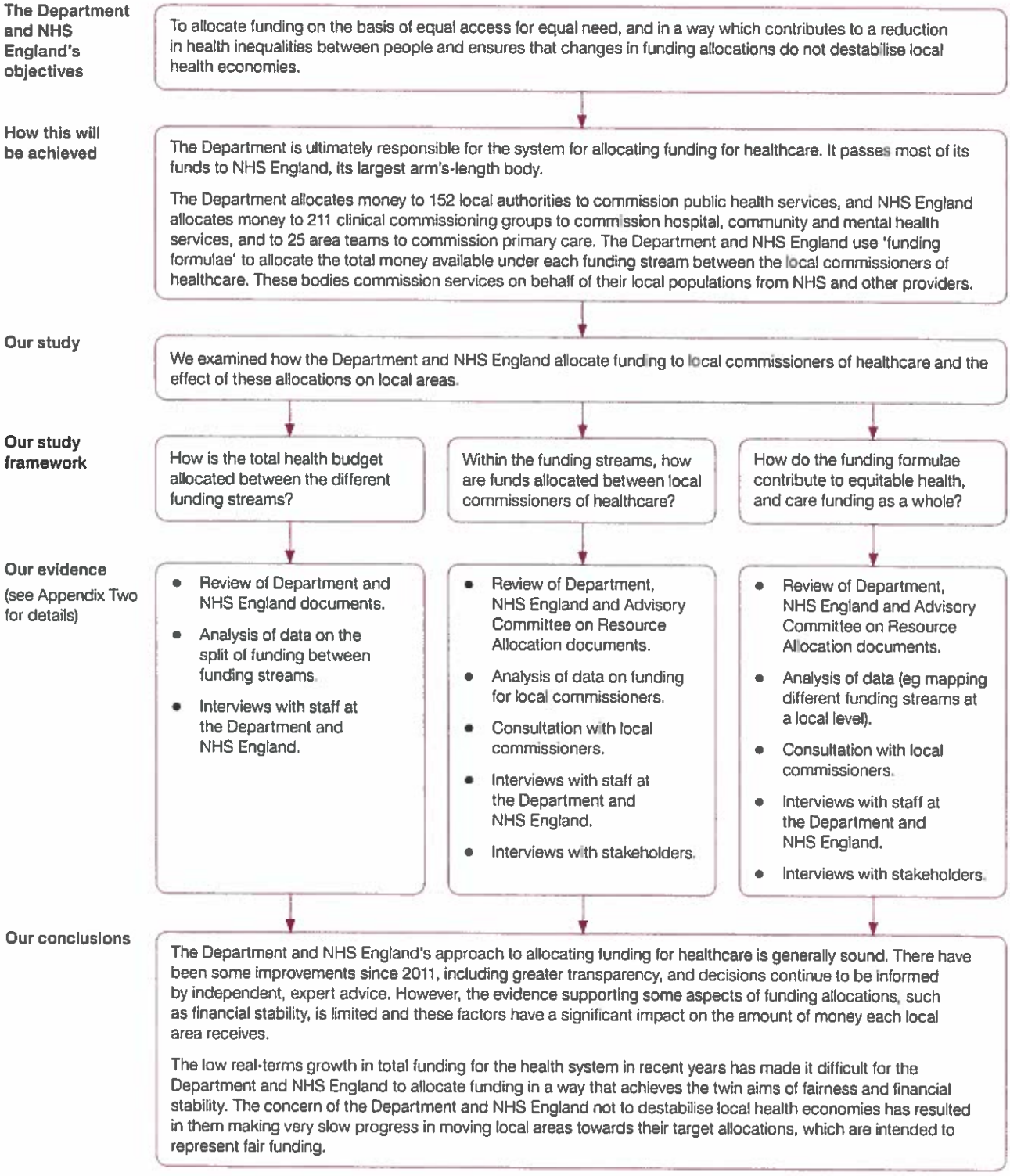
1 This report examines how the Department of Health and NHS England allocate funding for healthcare to local areas. In particular, we reviewed how the Department and NHS England:

- allocate funding between the different funding streams (hospital, community and mental health services, primary care, and public health);
- balance fairness and financial stability when making allocations to local areas; and
- calculate each local commissioner's fair share of the available funding.

2 To support accountability and transparency, we examined how allocations are made. In reviewing these issues we also, where appropriate, drew conclusions by applying an analytical framework based on: policy objectives; comparing the three approaches now in place with each other and with the approach previously used for primary care trusts; and relevant recommendations made by the Committee of Public Accounts in 2011.

3 Our audit approach is summarised in **Figure 12**. Our evidence base is described in Appendix Two.

Figure 12
Our audit approach



Appendix Two

Our evidence base

1 We reached our independent conclusions on how funding for healthcare is allocated to local areas after analysing evidence collected between March and July 2014. Our audit approach is outlined in Appendix One.

2 **We reviewed key documents.** These covered the arrangements currently in place for allocating funding to local commissioners, and the approach previously used for primary care trusts. The documents included: Department of Health, NHS England and Advisory Committee on Resource Allocation documents; academic articles; and previous National Audit Office and Committee of Public Accounts reports.

3 **We interviewed staff from a range of organisations.** The interviews were designed to help us understand the technical detail of the funding formulae and the effect of key decisions. The organisations included: the Department of Health; NHS England; the King's Fund; the Nuffield Trust; the University of Liverpool; the University of Manchester; the University of Plymouth; the Association of Directors of Public Health; NHS Clinical Commissioners; and the Healthcare Financial Management Association.

4 **We consulted clinical commissioning groups.** This exercise was designed to help us understand the effect of funding allocations on commissioners and on local health economies. We spoke to the chief finance officers from four clinical commissioning groups, and received written submissions from four others.

5 **We analysed existing data.** The analysis was designed to understand: how funding is distributed between local commissioners; how this has changed over time; and the effects of the current funding distribution. We analysed data including: total Department of Health budget from 2003-04 to 2014-15; actual allocations and target allocations for local commissioners from 1999-2000 to 2015-16; primary care trust spending from 2009-10 to 2012-13; clinical commissioning groups' financial position; adult social care need (from formula grant) and spending (from personal social services expenditure data); and hospital bed numbers. Details of some of the key pieces of analysis are described below:

- **Estimating the time required for all local commissioners to be within 5% of their target funding allocations** (paragraphs 2.13 to 2.14). We estimated how long it would take for all commissioners to be within 5% of their target allocations if current pace of change policies continued. In practice the time will depend on many factors, such as the total funding available and the way commissioners' target allocations change. Our analysis therefore made several broad assumptions, including that overall funding growth, commissioners' population sizes and relative needs, and the minimum funding growth which commissioners can receive all remain the same as for 2014-15 for local authorities and for 2015-16 for clinical commissioning groups (the most recent years for which the decisions have been made). Our calculation also assumed that all commissioners that are more than 5% above target receive the minimum funding increase, and all commissioners that are more than 5% below target receive the maximum funding increase.[25] Within the constraints of the minimum and maximum funding increases, this is the pace of change policy which would move all commissioners to within 5% of their target allocations most quickly.

- **Assessing the pace of change policy by comparing it with primary care trust spending patterns** (paragraphs 2.16 to 2.17). We examined whether primary care trusts had previously changed how much they spent on hospital, community and mental health services more quickly than current pace of change policies allow. To do this, we calculated the average annual change between 2009-10 and 2012-13 in the amount that each primary care trust spent on these services, based on financial data provided by the Department. After adjusting for inflation, we compared these figures with NHS England's pace of change policy for 2014-15 for clinical commissioning groups. Clinical commissioning groups now commission most of these services and so are the closest proxy to primary care trusts. However, as clinical commissioning groups and primary care trusts cover slightly different services, the comparison should be treated with caution. For example, only the primary care trust figures include specialised services. Spending on these services is less predictable, which potentially increases the variation from year-to-year. We used the average annual change in spending on hospital, community and mental health services over a three-year period, rather than just a single year, to mitigate this risk.

25 For clinical commissioning groups we assumed that each year the maximum funding growth percentage would increase. This is because each year there will be fewer commissioners significantly under-target, so these can receive a greater share of additional funding. NHS England confirmed that this assumption is in line with its pace of change policy. Data did not exist to conduct a similar analysis for local authorities, so for them we assumed that maximum growth remained the same as in 2014-15.

- **Investigating the effect of commissioners not receiving their target funding allocations** (paragraphs 2.21 to 2.24). We would have liked to understand the relationship between commissioners' 'distance from target' and patient outcomes. However, the limited data available meant that we could not carry out this analysis. Instead, we used a mathematical technique called linear regression analysis to explore the relationship between distance from target and various proxy measures. We looked at the relationship between clinical commissioning groups' distance from target and: clinical commissioning groups' financial surplus/deficit;[26] average hospital bed numbers (adjusted for relative need); and hospital staffing[27] levels (adjusted for relative need). We also looked at the relationship between NHS England's area teams' distance from target and GP numbers, again adjusted for relative need.

- **Combining different funding streams at a local level** (paragraphs 2.25 to 2.27). We estimated the funding received by each local area for locally commissioned healthcare, based on clinical commissioning group areas. We also calculated aggregate target funding allocations for each local area. For this analysis, we had to estimate how current and target levels of funding for primary care (allocated to 25 area teams) and for public health (allocated to 152 local authorities) are divided between the 211 clinical commissioning group areas. Our approach was:

    - For **primary care targets** we used the data that NHS England had used to calculate targets for area teams, as most of these data were available at clinical commissioning group level. Data on dentistry targets were not available. However, as dentistry is a relatively small proportion of spending, we assumed that need for dentistry is distributed between clinical commissioning group areas in the same way as need for other primary care services.

26 We carried out this analysis both including and excluding the effects of non-recurrent financial support given to clinical commissioning groups.

27 Comprising nursing, midwifery and health visiting staff, scientific, therapeutic and technical staff, ambulance staff, clinical support staff and infrastructure support staff.

- For **primary care allocations** we used data on how much primary care trusts planned to use to fund primary care in 2012-13, the last year these data were collected at a local level, and projected it forward to 2013-14. We divided each primary care trust's planned primary care spending between its 'Lower Layer Super Output Areas'.[28] We then summed these Output Area level estimates to clinical commissioning group level. Finally, we increased the estimated spending for each clinical commissioning group by 2.6%, in line with the overall growth in primary care funding between 2012-13 and 2013-14. This analysis makes several significant assumptions including that all primary care trusts divided their funding equally across their population. It also depends on data on primary care trusts' planned spending, which are known to contain errors. While we attempted to cleanse these data, some inaccuracies are likely to remain.
- We mapped **local authority targets and allocations for public health** to clinical commissioning groups by attributing them to Lower Layer Super Output Areas, using the same approach as described above for primary care allocations.

28 The Office for National Statistics divides England into 32,844 'Lower Layer Super Output Areas', which are small geographical areas with populations of between 1,000 and 3,000.

Appendix Three

The government's response to the recommendations made by the Committee of Public Accounts in 2011

1 In July 2011 we published a report on formula funding of local public services which covered – among other things – the formula used at that time by the Department of Health to allocate funds to primary care trusts.[29] This report formed the basis of a hearing of the Committee of Public Accounts. The Committee then produced its own report in November 2011,[30] with recommendations to which the government responded in February 2012. **Figure 13** shows the recommendations and the government's assessment of progress against them.

2 As shown, the government disagreed with two of the Committee's recommendations. One of these recommendations – that departments should use independent advisory groups to provide technical expertise – was aimed at other departments covered by our 2011 report, as the Department of Health already used the Advisory Committee on Resource Allocation. The government's reason for disagreeing with the other recommendation – that departments should commit to giving the right funding for an area's need within a set time period – was as follows: "While the Government welcomes the Committee's support for the aim of ensuring stability of funding, it does not believe it is practical to set a time limit by which the needs-assessed levels should be achieved. The needs-assessed level of funding, for instance due to demographic changes, is constantly changing. This would risk destabilising some organisations and jeopardises the sustainability of funding systems."

29 Comptroller and Auditor General, *Formula funding of local public services*, Session 2010–12, HC 1090, National Audit Office, July 2011.

30 HC Committee of Public Accounts, *Formula Funding of Local Public Services*, Fifty-fifth Report of Session 2010–2012, HC 1502, November 2011.

Figure 13
Progress against previous recommendations made by the Committee of Public Accounts

Recommendation	Current status
Departments should identify the primary objective for formula funding models, and design their models to establish transparent, equitable allocations which achieve that objective.	Implemented
Departments should commit to giving the right funding for an area's needs within a set time period.	Disagreed
Departments should set out publicly the basis for their judgements, and how they affect the distribution of funding relative to their primary objective.	Implemented
Working with the Treasury, departments should set standards for the accuracy and timeliness of data sources they use, focusing in particular on strengthening data where it will be central to proposed new arrangements.	Implemented
Departments should use independent advisory groups to provide technical expertise.	Disagreed
The Treasury should report back to the Committee to explain how each of our recommendations is incorporated within new funding arrangements.	Implemented

Sources:
HM Treasury, *Treasury Minutes: Progress on implementing recommendations on 19 Committee of Public Accounts reports (Session 2010–2012); 3 National Audit Office reports; 12 updates from Treasury Minute progress reports (January 2012); and a progress report on Government Cash Management*, Cm 8359, February 2013; and
HM Treasury *Progress report on the implementation of Government accepted recommendations of the Committee of Public Accounts – Sessions 2010–2012 and 2012-13*, Cm 8899, July 2014

Appendix Four

Key elements of the three funding streams, 2014-15

	Hospital, community and mental health services	Primary care	Public health
Local commissioners	211 clinical commissioning groups	25 NHS England area teams	152 local authorities
Total funding allocation (£bn)	64.3	12.0	2.8
Average allocation, per person (£)	1,133	211	51
Basis for estimating population size	GP lists	GP lists	Office for National Statistics population projections, based on the census
Adjustment for relative need			
Approach to estimating relative need	Mainly utilisation-based, using data on past spending on healthcare	Mainly utilisation-based, using data on past GP workload	Mainly outcomes-based, using a measure of life expectancy
Effect on target allocations[1] (%)	-25.0 to +27.9	-16.2 to +17.6	-53.9 to +79.2
Adjustment for health inequalities			
Approach to adjusting for health inequalities	A measure of life expectancy, given a 10% weighting[2]	A measure of life expectancy, given a 15% weighting[2]	No separate adjustment – the needs adjustment for public health is largely based on a measure of life expectancy
Effect on target allocations[3] (%)	-4.1 to +7.3	-2.0 to +2.5	
Range of allocations, by local commissioner			
Actual allocations, per person (£)	878 to 1,517	181 to 249	22 to 185
Target allocations, per person (£)	960 to 1,434	185 to 250	23 to 105
Distance from target, per person (£)	-137 to +361	-8 to +9	-28 to +156
Distance from target (%)	-12.0 to +33.9	-3.8 to +4.3	-43.0 to +529.7

Notes

1 Amount by which target allocations adjusted for relative need would differ from target allocations based simply on population size.

2 Proportion of each commissioner's target allocation that is adjusted for health inequalities.

3 Amount by which actual target allocations (which include adjustments for health inequalities, relative need and unavoidable cost differences) differ from target allocations adjusted only for relative need and unavoidable cost differences.

Source: National Audit Office analysis of Department of Health, NHS England and Office for National Statistics documents

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Department of Health and NHS England

Funding healthcare: Making allocations to local areas

Allocations to local commissioners 2014-15

11 SEPTEMBER 2014

Allocations to local commissioners 2014-15

1 On 11 September 2014, we published a report on *Funding healthcare: Making allocations to local areas* (HC 625, Session 2014-15). This document sets out the level of funding and distance from target at a local level in 2014-15, covering:

- NHS England allocations to clinical commissioning groups for hospital, community and mental health services (**Figure 1**);
- NHS England allocations to area teams for primary care (**Figure 2**); and
- Department of Health allocations to local authorities for public health (**Figure 3**).

Figure 1
NHS England allocations to clinical commissioning groups for hospital, community and mental health services, 2014-15

Clinical commissioning group	Allocation	Distance from target	
	Per person (£)	Per person (£)	Percentage (%)
Airedale, Wharfedale and Craven	1,189	+50	+4.4
Ashford	1,048	+47	+4.7
Aylesbury Vale	979	-50	-4.8
Barking and Dagenham	1,159	+21	+1.8
Barnet	1,016	-52	-4.8
Barnsley	1,366	+129	+10.4
Basildon and Brentwood	1,136	+35	+3.2
Bassetlaw	1,269	+52	+4.2
Bath and North East Somerset	1,063	+36	+3.6
Bedfordshire	979	-90	-8.4
Bexley	1,110	-57	-4.9
Birmingham CrossCity	1,154	-12	-1.1
Birmingham South and Central	1,079	-38	-3.4
Blackburn with Darwen	1,174	-27	-2.2
Blackpool	1,313	-23	-1.7
Bolton	1,142	-58	-4.8

Figure 1 *continued*
NHS England allocations to clinical commissioning groups for hospital, community and mental health services, 2014-15

Clinical commissioning group	Allocation	Distance from target	
	Per person (£)	Per person (£)	Percentage (%)
Bracknell and Ascot	969	-67	-6.4
Bradford City	952	-7	-0.8
Bradford Districts	1,182	-2	-0.2
Brent	1,051	+64	+6.5
Brighton and Hove	1,123	+67	+6.3
Bristol	1,032	-42	-3.9
Bromley	1,088	-97	-8.2
Bury	1,087	-115	-9.6
Calderdale	1,213	+114	+10.4
Cambridgeshire and Peterborough	978	-50	-4.9
Camden	1,275	+197	+18.2
Cannock Chase	1,133	-16	-1.4
Canterbury and Coastal	1,119	+53	+5.0
Castle Point and Rochford	1,115	-42	-3.6
Central London (Westminster)	1,261	+276	+28.0
Central Manchester	1,088	+7	+0.6
Chiltern	928	-74	-7.4
Chorley and South Ribble	1,225	+25	+2.1
City and Hackney	1,219	+93	+8.3
Coastal West Sussex	1,213	-67	-5.2
Corby	1,070	-137	-11.3
Coventry and Rugby	1,091	-21	-1.9
Crawley	1,115	+61	+5.8
Croydon	1,030	-108	-9.5
Cumbria	1,299	+102	+8.5
Darlington	1,250	+11	+0.9
Dartford, Gravesham and Swanley	1,094	-15	-1.4
Doncaster	1,329	+100	+8.2
Dorset	1,173	-40	-3.3
Dudley	1,179	-16	-1.3
Durham Dales, Easington and Sedgefield	1,398	+64	+4.8

Figure 1 *continued*
NHS England allocations to clinical commissioning groups for hospital, community and mental health services, 2014-15

Clinical commissioning group	Allocation	Distance from target	
	Per person (£)	Per person (£)	Percentage (%)
Ealing	1,011	-66	-6.2
East and North Hertfordshire	1,040	-53	-4.9
East Lancashire	1,314	+77	+6.2
East Leicestershire and Rutland	988	-77	-7.2
East Riding of Yorkshire	1,173	+50	+4.4
East Staffordshire	1,019	-44	-4.2
East Surrey	1,033	-23	-2.2
Eastbourne, Hailsham and Seaford	1,252	-64	-4.8
Eastern Cheshire	1,073	-71	-6.2
Enfield	1,052	-76	-6.7
Erewash	1,180	-37	-3.0
Fareham and Gosport	1,005	-92	-8.4
Fylde and Wyre	1,316	+39	+3.0
Gateshead	1,391	+120	+9.4
Gloucestershire	1,061	-27	-2.5
Great Yarmouth and Waveney	1,269	+46	+3.8
Greater Huddersfield	1,119	+66	+6.3
Greater Preston	1,156	+5	+0.4
Greenwich	1,178	-8	-0.7
Guildford and Waverley	1,028	+34	+3.4
Halton	1,380	+30	+2.2
Hambleton, Richmondshire and Whitby	1,211	+75	+6.6
Hammersmith and Fulham	1,216	+137	+12.7
Hardwick	1,303	+38	+3.0
Haringey	1,040	-27	-2.6
Harrogate and Rural District	1,096	+38	+3.6
Harrow	922	-100	-9.8

Figure 1 *continued*
NHS England allocations to clinical commissioning groups for hospital, community and mental health services, 2014-15

Clinical commissioning group	Allocation	Distance from target	
	Per person (£)	Per person (£)	Percentage (%)
Hartlepool and Stockton-on-Tees	1,245	-5	-0.4
Hastings and Rother	1,363	+59	+4.5
Havering	1,142	-45	-3.8
Herefordshire	1,138	+42	+3.8
Herts Valleys	1,033	-53	-4.8
Heywood, Middleton and Rochdale	1,222	-64	-5.0
High Weald Lewes Havens	1,121	+34	+3.1
Hillingdon	974	-93	-8.7
Horsham and Mid Sussex	1,024	-21	-2.1
Hounslow	951	-129	-12.0
Hull	1,244	+106	+9.3
Ipswich and East Suffolk	1,019	-52	-4.9
Isle of Wight	1,402	+247	+21.4
Islington	1,309	+69	+5.6
Kernow	1,212	+71	+6.2
Kingston	972	-23	-2.3
Knowsley	1,517	+83	+5.8
Lambeth	1,113	-13	-1.1
Lancashire North	1,213	+80	+7.0
Leeds North	1,116	+61	+5.8
Leeds South and East	1,271	+71	+5.9
Leeds West	1,043	+42	+4.2
Leicester City	1,026	-65	-5.9
Lewisham	1,199	-11	-0.9
Lincolnshire East	1,258	+40	+3.3
Lincolnshire West	1,124	+9	+0.8
Liverpool	1,446	+95	+7.0
Luton	1,012	-76	-7.0
Mansfield and Ashfield	1,242	-13	-1.0
Medway	1,084	+5	+0.5
Merton	940	-78	-7.7

Figure 1 *continued*
NHS England allocations to clinical commissioning groups for hospital, community and mental health services, 2014-15

Clinical commissioning group	Allocation	Distance from target	
	Per person (£)	Per person (£)	Percentage (%)
Mid Essex	1,014	-52	-4.9
Milton Keynes	916	-78	-7.9
Nene	1,021	-77	-7.0
Newark and Sherwood	1,137	-9	-0.8
Newbury and District	964	-100	-9.4
Newcastle North and East	1,093	-19	-1.8
Newcastle West	1,360	+25	+1.9
Newham	1,070	+39	+3.8
North and West Reading	1,008	-74	-6.9
North Derbyshire	1,270	+103	+8.8
North Durham	1,249	+26	+2.2
North East Essex	1,211	+47	+4.0
North East Hampshire and Farnham	1,025	-39	-3.7
North East Lincolnshire	1,246	+53	+4.4
North Hampshire	965	-34	-3.4
North Kirklees	1,169	+102	+9.6
North Lincolnshire	1,202	+32	+2.7
North Manchester	1,303	+1	+0.0
North Norfolk	1,247	+62	+5.2
North Somerset	1,117	-59	-5.1
North Staffordshire	1,184	-19	-1.6
North Tyneside	1,323	+63	+5.0
North West Surrey	1,085	+42	+4.0
North, East, West Devon	1,162	+28	+2.5
Northumberland	1,297	+51	+4.1
Norwich	1,016	-23	-2.2
Nottingham City	1,090	+9	+0.9
Nottingham North and East	1,109	-43	-3.7
Nottingham West	1,108	-63	-5.4
Oldham	1,222	+3	+0.3
Oxfordshire	878	-106	-10.8

Figure 1 *continued*
NHS England allocations to clinical commissioning groups for hospital, community and mental health services, 2014-15

Clinical commissioning group	Allocation	Distance from target	
	Per person (£)	Per person (£)	Percentage (%)
Portsmouth	1,120	-19	-1.6
Redbridge	993	-64	-6.0
Redditch and Bromsgrove	1,054	+10	+1.0
Richmond	997	+5	+0.5
Rotherham	1,289	+80	+6.6
Rushcliffe	1,011	-38	-3.7
Salford	1,275	-65	-4.8
Sandwell and West Birmingham	1,100	-32	-2.9
Scarborough and Ryedale	1,270	+86	+7.3
Sheffield	1,186	+63	+5.6
Shropshire	1,172	+42	+3.7
Slough	1,029	-80	-7.2
Solihull	1,107	-13	-1.1
Somerset	1,164	+2	+0.2
South Cheshire	1,114	-74	-6.2
South Devon and Torbay	1,296	+123	+10.5
South East Staffs and Seisdon Peninsular	1,036	-24	-2.3
South Eastern Hampshire	1,044	-101	-8.8
South Gloucestershire	946	-82	-7.9
South Kent Coast	1,271	+76	+6.4
South Lincolnshire	1,137	+23	+2.1
South Manchester	1,212	-29	-2.3
South Norfolk	1,051	-8	-0.7
South Reading	907	-84	-8.5
South Sefton	1,460	+130	+9.8
South Tees	1,317	+35	+2.7
South Tyneside	1,467	+129	+9.6
South Warwickshire	1,056	-13	-1.2
South West Lincolnshire	1,124	+40	+3.7
South Worcestershire	1,040	-9	-0.9
Southampton	1,035	+14	+1.4

Figure 1 *continued*
NHS England allocations to clinical commissioning groups for hospital, community and mental health services, 2014-15

Clinical commissioning group	Allocation	Distance from target	
	Per person (£)	Per person (£)	Percentage (%)
Southend	1,142	-76	-6.2
Southern Derbyshire	1,113	-49	-4.2
Southport and Formby	1,331	+52	+4.0
Southwark	1,165	+12	+1.0
St Helens	1,374	+46	+3.5
Stafford and Surrounds	1,058	-6	-0.5
Stockport	1,132	-54	-4.5
Stoke on Trent	1,229	-27	-2.1
Sunderland	1,469	+150	+11.4
Surrey Downs	1,089	+54	+5.2
Surrey Heath	1,159	+95	+8.9
Sutton	1,087	-88	-7.5
Swale	1,126	-27	-2.4
Swindon	997	-54	-5.1
Tameside and Glossop	1,271	-12	-0.9
Telford and Wrekin	1,068	+7	+0.6
Thanet	1,353	+61	+4.7
Thurrock	1,090	+11	+1.0
Tower Hamlets	1,151	+51	+4.6
Trafford	1,120	-22	-1.9
Vale of York	1,062	+36	+3.5
Vale Royal	1,135	-37	-3.1
Wakefield	1,268	+105	+9.0
Walsall	1,265	+109	+9.4
Waltham Forest	995	-70	-6.5
Wandsworth	1,023	+63	+6.6
Warrington	1,120	-86	-7.1
Warwickshire North	1,084	-128	-10.6
West Cheshire	1,183	-6	-0.5
West Essex	1,072	-55	-4.9
West Hampshire	1,048	-23	-2.1

Figure 1 *continued*
NHS England allocations to clinical commissioning groups for hospital, community and mental health services, 2014-15

Clinical commissioning group	Allocation	Distance from target	
	Per person (£)	Per person (£)	Percentage (%)
West Kent	1,006	-58	-5.5
West Lancashire	1,215	+6	+0.5
West Leicestershire	994	-54	-5.2
West London	1,426	+361	+33.9
West Norfolk	1,271	-2	-0.1
West Suffolk	1,109	+20	+1.8
Wigan Borough	1,275	+12	+0.9
Wiltshire	1,065	-25	-2.3
Windsor, Ascot and Maidenhead	951	-99	-9.4
Wirral	1,372	+36	+2.7
Wokingham	938	-69	-6.9
Wolverhampton	1,211	+38	+3.3
Wyre Forest	1,118	+20	+1.9

Source: National Audit Office analysis of NHS England, Technical Guide to Clinical Commissioning Group and Area Team allocations 2014-15 and 2015-16, *J-CCG pace of change options*, March 2014

Figure 2
NHS England allocations to area teams for primary care, 2014-15

Area team	Allocation	Distance from target	
	Per person (£)	Per person (£)	Percentage (%)
Arden, Herefordshire and Worcestershire	208	+1	+0.5
Bath, Gloucester, Swindon and Wiltshire	193	+1	+0.4
Birmingham and the Black Country	216	-8	-3.8
Bristol, North Somerset, Somerset and South Gloucestershire	206	+2	+0.9
Cheshire, Warrington and Wirral	225	+1	+0.6
Cumbria, Northumberland, Tyne and Wear	228	-6	-2.5
Derbyshire and Nottinghamshire	212	-3	-1.4
Devon, Cornwall and the Isles of Scilly	219	+9	+4.3
Durham, Darlington and Tees	244	+4	+1.8
East Anglia	202	-1	-0.3
Essex	194	-6	-3.1
Greater Manchester	233	-2	-0.8
Hertfordshire and the South Midlands	195	-4	-2.0
Kent and Medway	199	-2	-1.2
Lancashire	223	-6	-2.5
Leicestershire and Lincolnshire	203	-1	-0.6
London	206	+4	+2.2
Merseyside	249	-1	-0.4
North Yorkshire and Humber	225	+9	+4.1
Shropshire and Staffordshire	213	-2	-1.0
South Yorkshire and Bassetlaw	237	+4	+1.6
Surrey and Sussex	197	-1	-0.3
Thames Valley	181	-4	-2.3
Wessex	199	-2	-0.9
West Yorkshire	224	+6	+2.7

Source: National Audit Office analysis of NHS England, Technical Guide to Clinical Commissioning Group and Area Team allocations 2014-15 and 2015-16, *K-Primary Care*, March 2014

Figure 3
Department of Health allocations to local authorities for public health, 2014-15

Local authority	Allocation	Distance from target	
	Per person (£)	Per person (£)	Percentage (%)
Barking and Dagenham	71	-5	-6.7
Barnet	38	-2	-5.0
Barnsley	60	-3	-5.2
Bath and North East Somerset	41	+1	+1.4
Bedford	45	-4	-8.1
Bexley	32	-10	-24.7
Birmingham	73	-1	-1.3
Blackburn with Darwen	88	+6	+7.8
Blackpool	126	+43	+51.5
Bolton	67	-4	-5.1
Bournemouth	44	-15	-25.7
Bracknell Forest	26	-15	-37.0
Bradford	65	-5	-6.5
Brent	59	-0	-0.0
Brighton and Hove	67	-2	-2.9
Bristol, City of	66	-4	-5.5
Bromley	40	+4	+10.8
Buckinghamshire	33	-3	-9.5
Bury	51	-3	-5.2
Calderdale	51	-3	-5.9
Cambridgeshire	35	-2	-5.2
Camden	112	+33	+42.3
Central Bedfordshire	38	-0	-1.0
Cheshire East	38	-2	-5.0
Cheshire West and Chester	42	-2	-5.0
City of London	185	+156	+529.7
Cornwall	33	-1	-2.7
County Durham	88	+37	+72.5
Coventry	59	-10	-14.9
Croydon	50	-1	-2.4
Cumbria	31	-14	-30.6

Figure 3 *continued*
Department of Health allocations to local authorities for public health, 2014-15

Local authority	Allocation	Distance from target	
	Per person (£)	Per person (£)	Percentage (%)
Darlington	67	+7	+11.6
Derby	56	-10	-14.5
Derbyshire	46	+5	+11.3
Devon	29	-2	-5.4
Doncaster	66	+5	+9.1
Dorset	31	+1	+4.7
Dudley	60	+13	+28.8
Ealing	63	+4	+6.4
East Riding of Yorkshire	27	-7	-20.9
East Sussex	46	+10	+27.6
Enfield	43	-7	-13.6
Essex	35	-2	-4.9
Gateshead	78	+15	+22.9
Gloucestershire	36	-2	-5.0
Greenwich	73	-4	-5.1
Hackney	117	+27	+29.3
Halton	69	-2	-3.4
Hammersmith and Fulham	114	+48	+72.3
Hampshire	30	-4	-10.5
Haringey	68	-4	-5.0
Harrow	36	-2	-4.9
Hartlepool	91	+17	+22.2
Havering	39	-4	-9.7
Herefordshire, County of	42	+6	+16.1
Hertfordshire	33	-7	-17.0
Hillingdon	54	-0	-0.8
Hounslow	52	-7	-11.7
Isle of Wight	43	+7	+20.6
Isles of Scilly	31	+5	+20.8
Islington	116	+21	+22.3
Kensington and Chelsea	133	+87	+190.7

Figure 3 *continued*
Department of Health allocations to local authorities for public health, 2014-15

Local authority	Allocation	Distance from target	
	Per person (£)	Per person (£)	Percentage (%)
Kent	36	-4	-10.6
Kingston upon Hull, City of	87	+8	+10.0
Kingston upon Thames	54	+13	+30.6
Kirklees	55	-3	-5.1
Knowsley	111	+34	+44.1
Lambeth	84	-4	-5.0
Lancashire	50	-3	-5.0
Leeds	52	-9	-14.4
Leicester	66	-12	-15.7
Leicestershire	33	-2	-5.8
Lewisham	69	-1	-1.3
Lincolnshire	39	-2	-5.0
Liverpool	89	-4	-4.5
Luton	61	-9	-13.0
Manchester	86	-19	-18.3
Medway	52	-3	-5.8
Merton	43	+2	+5.3
Middlesbrough	117	+31	+35.6
Milton Keynes	33	-15	-31.5
Newcastle upon Tyne	74	+0	+0.6
Newham	81	-10	-10.9
Norfolk	35	-1	-3.0
North East Lincolnshire	62	-1	-1.0
North Lincolnshire	49	-3	-5.2
North Somerset	36	-2	-4.9
North Tyneside	53	-3	-5.0
North Yorkshire	32	-2	-5.0
Northamptonshire	41	-4	-9.1
Northumberland	42	+0	+0.7
Nottingham	89	+3	+3.9
Nottinghamshire	45	-0	-0.8

Figure 3 *continued*
Department of Health allocations to local authorities for public health, 2014-15

Local authority	Allocation	Distance from target	
	Per person (£)	Per person (£)	Percentage (%)
Oldham	65	-9	-11.9
Oxfordshire	39	-2	-5.0
Peterborough	48	-12	-20.0
Plymouth	47	-11	-19.6
Poole	40	+4	+11.3
Portsmouth	77	+9	+13.7
Reading	52	-15	-22.5
Redbridge	38	-9	-18.8
Redcar and Cleveland	81	+25	+46.0
Richmond upon Thames	40	+6	+18.1
Rochdale	69	-4	-5.0
Rotherham	54	-1	-1.9
Rutland	28	+4	+17.2
Salford	77	-5	-6.2
Sandwell	69	-4	-5.2
Sefton	73	+18	+33.0
Sheffield	54	-3	-5.0
Shropshire	32	-3	-9.1
Slough	37	-28	-43.0
Solihull	47	+7	+17.9
Somerset	29	-4	-11.9
South Gloucestershire	27	-7	-20.8
South Tyneside	86	+27	+44.4
Southampton	62	-3	-5.2
Southend-on-Sea	45	-6	-12.0
Southwark	74	-4	-5.2
St. Helens	74	+13	+21.9
Staffordshire	39	-2	-4.9
Stockport	45	-2	-5.0
Stockton-on-Tees	67	+6	+9.3
Stoke-on-Trent	80	+8	+11.1

Figure 3 *continued*
Department of Health allocations to local authorities for public health, 2014-15

Local authority	Allocation	Distance from target	
	Per person (£)	Per person (£)	Percentage (%)
Suffolk	35	+3	+8.0
Sunderland	76	+15	+24.5
Surrey	22	-13	-36.8
Sutton	43	-1	-3.1
Swindon	40	-9	-19.1
Tameside	56	-13	-18.9
Telford and Wrekin	64	+12	+21.9
Thurrock	46	-1	-2.9
Torbay	55	+12	+29.1
Tower Hamlets	116	+16	+16.2
Trafford	45	-1	-1.7
Wakefield	62	+2	+3.7
Walsall	58	-3	-5.3
Waltham Forest	45	-23	-33.6
Wandsworth	80	+20	+32.5
Warrington	50	-3	-5.0
Warwickshire	39	-1	-1.5
West Berkshire	30	-5	-14.1
West Sussex	33	-1	-4.1
Westminster	133	+74	+127.3
Wigan	73	+12	+18.8
Wiltshire	30	-2	-7.3
Windsor and Maidenhead	23	-15	-38.4
Wirral	82	+18	+28.0
Wokingham	26	-4	-13.1
Wolverhampton	76	+9	+13.3
Worcestershire	46	+9	+23.0
York	36	-8	-17.6

Source: National Audit Office analysis of Department of Health, *Exposition book public health allocations 2014-15*, January 2013

National Audit Office

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Harrow CCG financial position – overview

Background to Harrow CCG's finances

From April 2013 Harrow Clinical Commissioning Group (CCG) has been responsible for commissioning (planning and purchasing) local health services (excluding primary care and specialised services, which are commissioned by NHS England. Examples of specialised services include services for patients with cystic fibrosis and services for some cardiology treatments). Previously Primary Care Trusts (PCTs) had responsibility for the full range of services.

Harrow CCG inherited from the PCT an ongoing shortfall of c£18m (this is the ongoing difference between the CCG's income – the money the CCG receives - and expenditure – the money the CCG needs to spend on healthcare for its residents' needs).

To address this shortfall, Harrow CCG agreed a three year recovery plan to restore the CCG to an overall balanced financial position (money CCG receives equalling the spend needed for local health services) and as part of this a deficit plan was agreed with NHS England of £10.4m for 2013/14.

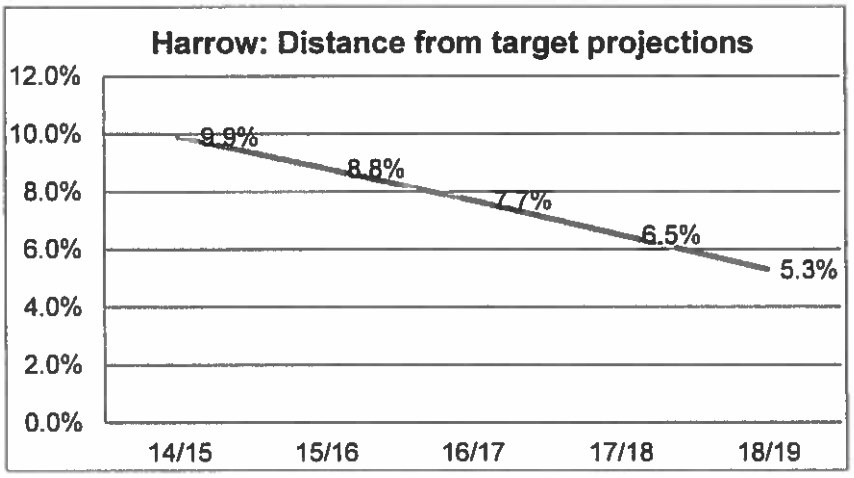
CCG funding allocation

The 2012 NHS act requires NHS England to look at reducing inequalities in access to, and outcomes from, healthcare. The new funding calculations for the CCG allocations (the money the CCG receives from NHS England for its local health services) includes population growth – based on 2011 census information and GP patient list sizes, the effect of relative deprivation and poverty on health need, the impact of an ageing population and geographical cost differences across England.

All CCGs received an increase of 2.14% on their 2013/14 funding. CCGs judged to be under their target allocation funding received more funding than the national average increase in recognition of the additional health need of their populations. Harrow is currently assessed as receiving £24.7m (9.9%) less funding than its target share.

Harrow CCG therefore received one of the highest increases in the country, amounting to 4.2% on the 2013/14 funding baseline of £224.7 million. This means the CCG receives just under £9.5million growth funding in 2014/15.

Despite this additional funding, the graph below shows how far Harrow CCG is estimated to be from its target allocation (as a percentage) for years 2014/15 to 2018/19.



2014/15 financial plan

After CCGs have received their confirmed funding allocations, each CCG prepares a financial plan for the next year. For 2014/15, the CCG has prepared a balanced budget.

This plan however assumes agreement to additional funding from other North West London CCGs to cover:

Funding for the non-repayment of 13/14 deficit	£10.4m
Funding to support 14/15 planned budget shortfall	£9.4m
Retain 2.5% funding from joint CCG fund	£5.8m
Funding to support Out of Hospital investment	£4.3m
Further funding to achieve balanced budget	£5.0m

NB. All aspects of the NWL financial strategy are dependent on NHS England agreement as part of their review and sign-off of 14/15 Operating Plans for all CCGs, and as part of this, ensuring consistency to statutory and other requirements on CCGs.

House of Commons

Committee of Public Accounts

Funding healthcare: making allocations to local areas

Twenty-fifth Report of Session 2014–15

Report, together with the formal minutes relating to the report

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Report

Summary

The Department of Health (the Department) and NHS England have changed the way that they allocate health funding to local commissioners. The Department and NHS England have prioritised maintaining the financial stability of local health economies, but this means they have made only very slow progress towards ensuring that all areas receive their fair share of the available funding. Around two-fifths of clinical commissioning groups and three-quarters of local authorities are receiving allocations more than 5% above or below what would be their defined share. This has consequences for financial sustainability—of the 20 clinical commissioning groups with the tightest financial positions at 31 March 2014, 19 had received less than their defined share of funding. One of the main objectives of the funding formulae is to support the reduction of health inequalities, yet the Department and NHS England have only limited evidence on how best to make adjustments for this purpose. NHS England also has more work to do on tackling inaccuracies in GP list data, which are a key determinant in calculating an area's fair share of funding.

Conclusions and recommendations

1. In 2014-15, the Department and NHS England allocated a total of £79 billion to local commissioners of healthcare, equivalent to £1,400 per person. Following the reforms to the health system in 2013, there are three separate funding allocations. In 2014-15, NHS England allocated £64.3 billion to 211 clinical commissioning groups for hospital, community and mental health services and £12.0 billion to its 25 area teams for primary care; and the Department allocated £2.8 billion to 152 local authorities for public health services. The amount of funding that individual commissioners are allocated is calculated using 'funding formulae' that apportion the total funds available. In calculating target funding allocations, the Department and NHS England aim to give those local areas with greater healthcare needs a larger share of the available funding. In deciding actual funding allocations, the Department and NHS England consider that they should only move local commissioners gradually from their current funding levels towards their fair shares, to ensure that local health economies are not destabilised.

2. **The slow progress towards target funding allocations means the Government has not fulfilled its policy objective of equal access for equal need.** In 2014-15, nearly two-fifths of clinical commissioning groups and over three-quarters of local authorities remain more than 5 percentage points above or below their target funding allocations. Funding for clinical commissioning groups varies from £137 per person below target to £361 per person above target. This has important implications for the financial sustainability of the health service as underfunded clinical commissioning groups are more likely to be in financial deficit: 19 of the 20 groups with the tightest financial positions at 31 March 2014 had received less than their target funding allocation. The Department and NHS England explained that there are trade-offs between moving commissioners more quickly towards their target funding allocations and safeguarding the stability of local health economies, and that making quicker progress would involve real-terms reductions in funding for some areas. However, the National Audit Office calculated that, if the slow pace of change were to continue, it would take around 80 years for all local commissioners to get close to their target funding allocations. NHS England said that it wanted to make faster progress and that it aimed to move all clinical commissioning groups to within 5 percentage points of their target allocations within around two years. For public health allocations to local authorities, the Department said that decisions, including the pace of change, were a matter for the government of the day.

   Recommendations: ***NHS England should confirm its commitment to move clinical commissioning groups to within 5 percentage points of their target allocations and set out a precise timetable. NHS England should also better understand the correlation between funding allocations and poor performance among clinical commissioning groups.***

   The Department should develop an evidence base to inform government decisions on how quickly public health allocations to local authorities should move towards their target allocations.

3. **Decisions about funding for the different elements of healthcare and social care have been made without fully considering the combined effect on local areas.** NHS England accepts that decisions on the three separate health allocations have, to date, been made in isolation of each other. It wants to move towards 'place based' funding formulae, whereby allocations for clinical commissioning groups and primary care, and potentially the Department's funding to local authorities for public health, are combined. In addition, local authorities receive funding which covers social care from the Department for Communities and Local Government. Many people need both healthcare and social care, and lower spending in one sector may cause additional costs in the other. There is growing understanding of the interdependence of health and social care funding but the causal relationship between the two is not understand, and the Department and NHS England did not take account of local authority spending on social care or the Department for Communities and Local Government's funding for local authorities in making decisions on health funding.

   Recommendation: ***The Department and NHS England, working with the Department for Communities and Local Government, should carry out work to understand the interaction between the funding of healthcare and social care, and use this information to inform funding decisions.***

4. **There is a lack of evidence to underpin the adjustment that is made for health inequalities.** NHS England adjusts target allocations by 10-15% to move funding towards areas with lower life expectancies, with the aim of reducing health inequalities. The current indicator is better able than the past methodology to detect small pockets of ill-health in otherwise healthy areas. However, there is no clear health justification for deciding what weighting should be given to the inequality indicator. The Advisory Committee on Resource Allocation, which advises the Department and NHS England, does not consider there is any evidence that the current health inequalities adjustment is appropriate. NHS England stressed the importance of retaining the health inequalities adjustment as a matter of principle, while acknowledging the lack of supporting evidence on what weight to give it.

   Recommendation: ***The Department and NHS England should improve the evidence base for the health inequalities adjustment, including collecting evidence on whether their approach is fair and cost-effective and properly meets the objective of reducing health inequalities.***

5. **The proportion of total funding devoted to primary care has fallen, even though primary care is an important way of tackling health inequalities.** NHS England told us that primary care is expected to have more impact than clinical commissioning group spending on reducing inequalities. However, between 2003-04 and 2012-13, the proportion of total spending committed to primary care fell from 29% to 23% as a consequence of the NHS prioritising hospital initiatives such as reducing waiting times. NHS England said it planned to reverse this trend and increase the proportion of healthcare funding being spent on primary care. It would also like to bring together the budgets for clinical commissioning groups and primary care to increase local flexibility with the intention of better targeting local priorities.

Recommendation: ***The Department and NHS England should set out the rationale for decisions about how funding is split between different funding streams, including assessing the implications of any changes in the distribution of funding.***

6. **The primary care funding formula was developed with limited input from the advisory body and remains an interim approach.** NHS England has improved the funding formula for clinical commissioning groups, which is now based on more detailed data. However, these improvements have not been made for primary care. NHS England did not seek input from the Advisory Committee on Resource Allocation until three months before it had to make decisions about primary care allocations and there was insufficient time to improve the formula. As a result, NHS England's approach for primary care allocations to area teams for 2014-15 and 2015-16 was heavily based on what the Department had done previously for primary care trusts and is regarded as interim.

Recommendation: ***NHS England should improve the primary care funding formula in time for the next round of funding allocations for 2016-17, with early input from the Advisory Committee on Resource Allocation.***

7. **The target funding allocations may be unreliable in some areas due to shortcomings in the GP list data which are used to estimate population size.** Population size is the factor that has the most significant effect on funding allocations. While there have been some improvements to the population data, GP list numbers still tend to be inflated as people may remain on lists after they have moved out of an area. This is a particular issue in areas with more transient populations. At the same time, GP lists do not include unregistered patients which may affect areas with high levels of inward migration. Most of NHS England's area teams have done some work to validate GP lists, but NHS England accepts that it needs to do more. It told us that its area teams will be required to implement detailed guidance on validating GP lists so that it has more assurance about the data. It also intends, from spring 2015, to procure a new primary care services 'back office' that should make GP list validation consistent across the country.

Recommendation: ***NHS England should take immediate action to ensure that all area teams are complying with its guidance on GP list validation, at the same as taking forward its longer-term plans to gain greater assurance over the data.***

1 Fairness of funding allocations

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health (the Department) and NHS England about how funding is allocated to local healthcare commissioners in England.[1] Following the reforms to the health system in 2013, there are now three separate funding allocations.[2] In 2014-15, a total of £79 billion was allocated to local commissioners of healthcare, equivalent to £1,400 per person. The Department allocated £2.8 billion to 152 local authorities to commission public health services, such as smoking cessation programmes. NHS England, the Department's largest arm's-length body, allocated £64.3 billion to 211 clinical commissioning groups to commission hospital, community and mental health services; and NHS England also allocated £12.0 billion to its 25 area teams to commission primary care.[3]

2. The first step in allocating funding involves the Department or NHS England calculating a 'target funding allocation' for each local commissioner. This represents their fair share of the money that is available. The Department of Health and NHS England have changed the way that they allocate health funding to local commissioners. The aim is to give those local areas with greater healthcare needs—defined in the main by population age with some weighting for health inequalities—a larger share of the available funding.[4] In deciding actual funding allocations, the Department and NHS England seek to ensure that local health economies are not destabilised. They therefore move local commissioners gradually from their current funding levels towards their target allocations.[5]

3. In 2014-15, nearly two-fifths of clinical commissioning groups and over three-quarters of local authorities remain more than 5 percentage points above or below their target funding allocation.[6] This means that these areas are receiving substantially more or less than their fair share. For clinical commissioning groups, funding varies from £137 per person below target in Corby to £361 per person above target in West London; for local authorities, funding varies from £28 per person below target in Slough to £156 per person above target in the City of London.[7]

4. Whether or not local commissioners receive their target funding allocations is one of the factors that may affect their financial sustainability, and there is a clear link between the financial positions of clinical commissioning groups and whether they are under- or over-funded. For example, of the 20 groups with the tightest financial positions at 31 March 2014, 19 received less than their target funding allocation; whereas, of the 20 groups with the largest financial surpluses, 18 received more than their target allocation. The National Audit Office's exploratory work suggested that, on average, for every £100 a clinical

1 C&AG's Report, *Funding healthcare: Making allocations to local areas*, Session 2014-15, HC 625, 11 September 2014

2 C&AG's Report, paras 8, 1.9-1.10

3 C&AG's Report, paras 2, 1.2-1.3

4 Qq 88-89, 90-92

5 C&AG's Report, paras 3, 2.1-2.3

6 Qq 7, 34; C&AG's Report, paras 11, 2.3

7 Q 14; C&AG's Report, paras 11, 2.3, *Allocations to local commissioners* online appendix Figure 1

commissioning group was below target its financial position worsened by around an estimated £10 to £17.[8]

5. Progress in moving commissioners towards their target funding allocations has been very slow. NHS England highlighted that it is more difficult to move allocations towards the shares determined by the formula when, as now, the overall financial position is tight and there is less money to go around.[9] The National Audit Office calculated that, at the current pace of change, it would take approximately six years before no clinical commissioning group remained below its target allocation by more than 5%. For local authorities and the expenditure on public health, this would take 10 years. However, it would take much longer before no commissioner remained above its target allocation by more than 5% (60 years for clinical commissioning groups and 80 years for local authorities).[10]

6. The Department and NHS England told us that there are trade-offs between moving commissioners more quickly towards their target funding allocations and maintaining the stability of local health economies. NHS England said that making faster progress would mean real-term reductions in funding in some parts of the country, which has not happened in the past. The Department told us that it had decided that it should not reduce the amount of money that had previously been spent on public health by local NHS bodies, at the point it transferred responsibility for these services to local authorities.[11]

7. NHS England said that it would like to make faster progress in moving areas towards their target funding allocations. Specifically, it would like to get to a position within a year or two where no clinical commissioning group was more than 5% from its target allocation, although this would depend, to some extent, on the size of the total health budget.[12] The Department also said that it hoped to move local authorities' public health allocations to within 5% of target more quickly. However, it said it could not commit to a timetable because decisions about public health allocations and the pace of change were a policy matter for the government of the day.[13]

8. Whereas previously primary care trusts received a unified allocation for local health services, since the reforms to the health system in 2013 funding has been fragmented into three pots with separate allocations for clinical commissioning groups, primary care and public health.[14] Addressing the needs of local populations requires an integrated approach to commissioning healthcare. However, the Department and NHS England decided current funding allocations without fully considering the combined effect on local areas.[15] NHS England accepted that the separate health allocations had been made in isolation of each other but said that it wanted to move towards 'place-based' funding formulae,

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8 Q 96, C&AG's Report, paras 15, 2.21-2.22

9 Q 3, C&AG's Report, paras 13, 2.9-2.10

10 Q 2, C&AG's Report, para 2.14

11 Qq 3, 4, 7

12 Qq 5, 13-15, 37

13 Qq 34-36, 39-40

14 C&AG's Report, para 8, 1.9-1.10

15 C&AG's Report, paras 16, 2.25-2.26

incorporating its allocations for clinical commissioning groups and primary care and, potentially, the Department's allocations to local authorities for public health.[16] The Department, however, did not think it would necessarily be appropriate to have a single formula, citing the different nature of public health funding, which largely concerns the population's health in the future while the funding allocated by NHS England is largely intended to meet current healthcare needs.[17]

9. The National Audit Office report highlighted an association between health funding and social care spending. Many people receive both healthcare and social care, and lower spending in one of these sectors might be expected to case additional costs in the other. A survey in June 2014 identified that nearly a third of clinical commissioning group chief financial officers considered that cost pressures in social care were causing cost pressures in their organisation.[18] The Department acknowledged that there was a clear link between health and social care but said that the causal relationships between the two were not clear. However, in making decisions about 2014-15 health funding allocations, neither the Department of Health nor NHS England took account of local authority spending on social care or the Department for Communities and Local Government's plans for funding for local authorities.[19]

10. The Department and NHS England also referred to the Better Care Fund which will help to test how the NHS and local government can pool funding. They told us that the Fund is intended to increase integration between health and social care, help services deal with the pressures they are facing and improve understanding about the interaction between the two sectors.[20]

16 Qq 53-54, 93

17 Q 76

18 Q79, C&AG's Report, para 2.29

19 Q 79-80, C&AG's Report, paras 2.30

20 Qq 12, 79-81

2 Using funding to tackle health inequalities

11. The health funding formulae include adjustments to move money towards areas with lower life expectancies, with the aim of reducing health inequalities. The Department and NHS England have improved how they make these adjustments, with the current indicator better able to detect small pockets of ill-health in otherwise healthy areas.[21] NHS England adjusts 10% of target allocations for clinical commissioning groups and 15% for area teams. The Department adjusts the whole of the public health allocations to local authorities on the basis of a measure of life expectancy—a proxy for health inequalities.[22]

12. We asked NHS England whether it knew if the current adjustments were applied at the correct level.[23] NHS England explained that it relied on advice from the Advisory Committee on Resource Allocation on how to adjust allocations to reflect health inequalities. However, it acknowledged that the Advisory Committee did not consider there was any evidence about the appropriate weight to give to any adjustment. Nevertheless, NHS England considered that retaining the health inequalities adjustment was important as a matter of principle.[24] It expected the Advisory Committee to advise further on the health inequalities element of the funding formulae in time for the 2016-17 allocations.[25]

13. NHS England explained that it adjusts a higher proportion of area team allocations for health inequalities, compared with those for clinical commissioning groups, because it considers that improving primary care will have more impact on reducing health inequalities.[26] However, the National Audit Office found that between 2003-04 and 2012-13, primary care trusts reduced the proportion of total spending committed to primary care from 29% to 23%.[27] NHS England thought this trend was a consequence of the NHS focusing on hospital activity during this period, such as initiatives to reduce waiting times. It said that it planned to reverse the trend and devote an increased proportion of funding to primary care in future. In addition, it would like clinical commissioning groups and local authorities to have more flexibility to move money to where they think it will have the biggest impact.[28]

14. NHS England also highlighted the impact that other parts of government have on health inequalities.[29] The Department said that it had regular contact with other government departments about these issues, in particular with the Department of

21 Q 61; C&AG's Report, para 3.17

22 Qq 42, 87; C&AG's Report, para 3.16

23 Qq 43, 61-63

24 Qq 41, 63-64; C&AG's Report, para 3.23

25 Q 65, 70-73

26 Qq 43-44

27 Qq 48-49; C&AG's Report, para 1.14

28 Qq 45, 50, 55

29 Qq 43, 67

Communities and Local Government about housing and local government, and with the Department for Work and Pensions about the benefits system, and that it sought to encourage other departments to take account of health inequalities in their policies.[30]

3 Calculating target funding allocations

15. The Department and NHS England set target funding allocations for each local commissioner by predicting healthcare needs, taking account of the size and characteristics of local populations.[31] There have been some improvements since we reported on formula funding in 2011.[32] There is more transparency around key decisions, with, for example, NHS England deciding its funding allocations at a public board meeting. The Department and NHS England continue to be advised by the independent Advisory Committee on Resource Allocation in developing and applying the funding formulae.[33]

16. In addition, NHS England's approach to setting clinical commissioning groups' target allocations is better at predicting need because it is based on more detailed data. However, NHS England acknowledged that its formula for primary care funding remained an interim approach. It did not seek the views of the Advisory Committee on Resource Allocation until three months before the primary care allocations were announced. The Advisory Committee, therefore, did not have sufficient time to develop an alternative approach.[34] As a result NHS England's approach for primary care allocations for 2014-15 and 2015-16 was heavily based on what the Department had done previously for primary care trusts.[35]

17. Population size is the factor that has the most significant effect on target funding allocations. The accuracy of population data is therefore a key factor in ensuring that target allocations are right.[36] NHS England uses data from GP lists to calculate local population estimates. The National Audit Office found that such data are more responsive to changes in population and enable a more detailed understanding of relative need than the Office for National Statistics projections which were used previously. However, GP list numbers tend to be inflated as people remain on lists after they have moved out of an area, although NHS England told us that list inflation is a third less now than five years ago. Inaccuracies in GP lists are a particular issue where there are transient populations, such as those areas with high levels of migration and unregistered patients.[37]

18. NHS England said that some of the bias caused by shortcomings in GP list data was mitigated by other data used in calculating target funding allocations, such as benefit claimant rates. However, it recognised that there had been little consistency in how GP lists

30 Qq 74-77

31 C&AG's Report, paras 3.1-3.2

32 Q 2; C&AG's Report, para 20

33 Qq 2, 17; C&AG's Report, para 10, 18, 1.4, 1.15, 3.14

34 Qq 17-18; C&AG's Report 3.14

35 C&AG's Report, paras 18, 3.15

36 Q 105; C&AG's Report, para 3.4

37 Qq 10, 16, 24, 33; C&AG's Report, paras 3.5-3.7

were validated in the past, and in the current year a third of its area teams had not undertaken list validation exercises.[38] NHS England has published guidance on tackling list inflation but the National Audit Office found that there was little routine assurance that this guidance was being followed by area teams. NHS England plans to require all area teams to implement the detailed guidelines on validating GP lists by the end of 2014-15. It also said that it intended, from spring 2015, to procure a new primary care services 'back office' that would make GP list validation more consistent across the country.[39]

38 Qq 16, 22-23, 33

39 Qq 16, 20; C&AG's Report, paras 17, 3.8

Formal Minutes

Monday 8 December 2014

Members present:

Mrs Margaret Hodge, in the Chair

Guto Bebb	Austin Mitchell
Mr David Burrowes	Stephen Phillips
Meg Hillier	John Pugh
Stewart Jackson	Nick Smith
Anne McGuire	

Draft Report (Funding healthcare: making allocations to local areas), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 18 read and agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

Resolved, That the Report be the Twenty-fifth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Wednesday 10 December at 2.00 pm

Witnesses

Monday 20 October 2014 *Question*

The following witnesses gave evidence. Transcripts can be viewed on the Committee's inquiry page at www.parliament.uk/pubaccom.

Paul Baumann, Chief Financial Officer, NHS England; **Richard Douglas CB**, Director General of Finance and NHS, Department of Health; and **Simon Stevens**, Chief Executive, NHS England Q1–122

List of printed written evidence

The following written evidence was received and can be viewed on the Committee's inquiry web page at www.parliament.uk/pubaccom. fhm numbers are generated by the evidence processing system and so may not be complete.

1 NHS CCGs (fhm0001)

List of Reports from the Committee during the current Parliament

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2014–15

First Report	Personal Independence Payment	HC 280
Second Report	Help to Buy equity loans	HC 281
Third Report	Tax reliefs	HC 282
Fourth Report	Monitor: regulating NHS Foundation Trusts	HC 407
Fifth Report	Infrastructure investment: impact on consumer bills	HC 406
Sixth Report	Adult social care in England	HC 518
Seventh Report	Managing debt owed to central government	HC 555
Eighth Report	Crossrail	HC 574
Ninth Report	Whistleblowing	HC 593
Tenth Report	Major Projects Authority	HC 147
Eleventh Report	Army 2020	HC 104
Twelfth Report	Update on preparations for smart metering	HC 103
Thirteenth Report	Local government funding: assurance to Parliament	HC 456
Fourteenth Report	DEFRA: oversight of three PFI waste projects	HC 106
Fifteenth Report	Maintaining strategic infrastructure: roads	HC 105
Sixteenth Report	Early contracts for renewable electricity	HC 454
Seventeenth Report	Child maintenance 2012 scheme: early progress	HC 455
Nineteenth Report	The centre of government	HC 107
Twentieth Report	Reforming the UK Border and Immigration System	HC 584
Twenty First Report	The Work Programme	HC 457
Twenty Second Report	Out-of-hours GP services in England	HC 583
Twenty Third Report	Transforming contract management	HC 585
Twenty Fourth Report	Procuring new trains	HC 674

NW London Joint Health Overview and Scrutiny Committee

March 2015

RESPONSE TO HEALTH COMMISSION CALL FOR EVIDENCE ON SHAPING A HEALTHIER FUTURE

The North West London Joint Health Overview and Scrutiny Committee (JHOSC) was formed by the London Boroughs of **Brent, Ealing, Hammersmith and Fulham, Harrow, Hounslow, Kensington and Chelsea, Richmond and Westminster** in July 2012. The Committee was founded at the request of NHS North West London as part of a statutory consultation process for *Shaping a Healthier Future (SaHF).* The statutory role of the JHOSC was completed in November 2012 when it submitted its final report following its review of the hospital reconfiguration consultation to the NHS.

However, in November 2013, following the final decision on the structure of the reconfiguration setting out which hospitals would be developed as major and local hospitals, the North West London Collaboration of Clinical Commissioning Groups (CCGs) requested that the JHOSC continued to provide a cross-borough forum for discussing and scrutinising issues relating to SaHF.

The JHOSC has subsequently met on 6 further occasions with its latest meeting held on 3 March 2015 at which this response was considered.

REMIT OF THE JHOSC

The JHOSC has three main functions:

- To **scrutinise the SaHF reconfiguration of health services in North West London**: focusing on implementation plans, actions by North West London Clinical Commissioning Groups (NWL CCGs)
- To **make recommendations to NWL CCGs, NHS England** and any other appropriate external body; and to monitor the outcomes of these recommendations
- To require the provision of **information from, and attendance before the Committee of, any such person or organisation under a statutory duty to comply with the scrutiny function** of health services in North West London.

The JHOSC takes **a wider view** than individual Local Authorities might normally take, and it is intended that **cross-borough** implications arising from the SaHF reconfiguration are the focus.

Individual member authorities of the JHOSC maintain their own scrutiny of health services in and affecting their own boroughs. This will not be precluded by

participation in the JHOSC. This Committee is a discretionary joint Committee, **without the delegated powers of the Local Authorities.** In accordance with the local authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 and subsequent non-statutory guidance, the power of referral to the Secretary of State is not delegated to the JHOSC but is retained by the individual boroughs.

It should be noted that the approach of the JHOSC has changed over time. When originally set up, it met largely at the behest of the Shaping a Healthier Future team as part of their consultation process. Over the past year the JHOSC has taken a more pro-active stance, setting out its own work programme and meetings schedule. This reflects a shared determination to increasingly drive the scrutiny agenda.

THE JHOSC'S POSITION ON SAHF

In its response to the SaHF consultation, the JHOSC outlined its overall acceptance of the case for change noting that these changes are necessary to addressing long-standing quality and patient safety issues, although some boroughs still had serious reservations and so did not support the case for change. It also welcomed the focus on addressing problems with quality and performance across sites, services and providers as referenced by the programme and supported by evidence presented to the JHOSC. The Committee also noted its agreement with the underlying principles and building blocks which SaHF suggested as the basis for future emergency care.

The JHOSC suggested that the case for change would be stronger, better understood and have a greater chance of success if it were part of a clear and agreed strategy on integrated health and social care for North West London.

However, the following concerns were raised:

- The readiness and capacity of the out of hospital services and how the proposals would work in practice
- How A&Es and Urgent Care Centres will work together
- The financial viability of the acute reconfiguration options and whether the financial motivation behind these changes is to move the burden from the NHS to other agencies or the public themselves
- 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
- The retention of skilled staff
- How progress on ensuring and improving quality and safety will be measured
- How well the public understands the changes and has confidence in them

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 recommendations put forward by the JHOSC in response to the SaHF consultation were as follows:

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.
2. More information is produced on how patient flows will change in the new system and what will happen to patients borough by borough.
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.
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.
5. Joint commissioning between local authorities and CCGs and between the CCGs themselves should be strengthened to deliver better coordinated care.
6. Measurable standards and outcome measures are developed
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.
8. Detailed equalities impact assessment is developed and also plans for mitigation are developed.
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.

See the JHOSC's full response at Appendix 3.

ONGOING CHALLENGES

Financial Viability and Business Cases

There have been delays around the sharing of the SaHF business case, which has been pushed back on several occasions and there remains a lack of clarity about what stage this is at and when it will be available. There are concerns that developments which are dependent on SaHF are going ahead before the appropriate bodies, including the JHOSC, have had the opportunity to review the business case.

There has also been confusion around which business cases will be shared. Initially the expectation was that individual hospitals' business cases would be shared, later it was expected that individual Clinical Commissioning Groups' (CCGs) business

cases would be shared and in more recent meetings members have been told that the Shaping a Healthier Future business case would be shared.

Specific examples of seeking to obtain an understanding of the financial aspects of SaHF include:

- At the December 2013 meeting, the Committee was informed that the hospitals' business cases were being considered together and would be signed off in early 2014. Daniel Elkeles (Senior Responsible Officer for SaHF) was given an action to re-send a link to the Decision Making Business Case. This was outstanding in February 2014.
- At the February 2014 meeting Members asked about the costs of extended consultant cover as part of the seven day services programme. They were advised that these costs would be available in the Outline Business Case (OBC), which was still not available at this time.
- At the same meeting Members also queried when the OBC would be available to scrutinise. They were advised that it was expected to be ready by the end of March 2014.
- In response to a query, the Committee was advised that it would be impossible to write up the issue of capacity vs population growth vs cuts until the hospitals' business cases were finalised. This issue is to be discussed once the necessary information is in place.
- At the August 2014 meeting, Mr Elkeles was actioned to share the West Middlesex University Hospital business case with the JHOSC. The SaHF OBC had still not been received by the October 2014 meeting.
- At the October 2014 meeting the Committee sought clarification on the source of funding for improvement of the NHS estate. The Committee noted that £250m was being sought for spending on GP surgeries.
- At the March 2015 meeting the Committee once again requested the Implementation Business Case and was told that is still in draft form and will be shared as soon as possible but no timetable was indicated.

Out of hospital (OOH) services

There have been numerous discussions about ensuring the sufficient out of hospital services are in place before A&Es are closed. Members have felt that they have not received sufficient guarantee that the good work that is taking place around out of hospital services funded through the Better Care Fund will be sufficiently embedded to support reconfiguration.

At the December 2013 meeting, Dr McGoldrick presented 'Developing OOH services' which outlined the common features for each CCG. IT and the sharing of information in a safe way was noted as a key enabler. Where patients gave consent, information would be shared across UCCs, and community services including mental

health services. The CCG also gave an update on OOH progress, informing the board that between April and December three GP practices had opened at weekends and that this would be further extended. Extended hours services were being offered in Brent and were shortly to be offered in Ealing. The Committee expressed concern that the variety of services was too confusing. They were assured that the 111 number as a single point of contact would simplify this.

At the February 2014 meeting, the Committee was reminded that NW London had successfully applied to be an 'Early Adopter' for the Seven Day Services Improvement Programme. This meant that NW London is expected to become expert in delivering seven day services within five years. Members requested that the Committee see a progress update related to Out of Hospital workforce when one was available. The Committee reiterated its concern that the variety of OOH services was confusing for patients.

At the August 2014 meeting, Members raised the issue of lack of join up between OOH services, and that IT was still not in place to allow services to share information. The Committee reiterated its belief that out of hospital services must be in place before any reconfiguration of major hospitals were implemented, and stated that they had asked these questions a number of times without satisfactory answers. They were advised that at a future the programme team would share what they were doing in each borough, and the Committee resolved to receive regular updates on OOH strategy at future meetings.

During the October 2014 meeting, the Committee reiterated concerns that two A&E departments had been closed and that OOH services should have been in place before these closures went ahead. They highlighted a Care Quality Commission report which supported their claim that Central Middlesex had been closed too soon.

A&E waiting times

An update was provided at the JHOSC meeting on 3 March. The JHOSC was informed that there had been a dip in performance in autumn 2014, which the NHS believes is in line with the same trend across London and nationally, and is not a direct result of the closure of Hammersmith or Central Middlesex A&E departments..

In December 2013, the JHOSC was told that NW London's A&E performance against the 95% target was the highest in London, at 96.92% in the week ending 17 November 2013.

In October 2014 the Committee received a presentation from Daniel Elkeles on A&E performance, during which he reported that performance in NW London has continued to improve, with no reported issues resulting from the A&E closures.

A&E and Urgent Care Centres (UCC) working together

At the December 2013 meeting, there was a discussion around the changes to Ealing and Charing Cross A&Es. The Committee was informed that following the changes to these departments, they would no longer take blue light patients. The Committee asked that they be provided with the capacity and beds figures for the existing and new A&E at Northwick Park.

At the February 2014 meeting the Committee queried the operating hours of UCCs. They were assured that UCCs would operate at all times.

At the August 2014 meeting Councillors expressed concerns about the public information campaign informing patients of the changes. Dr Spencer advised that the public information campaign period would continue past the closure dates as they would continue educating the public about using the UCCs. Councillors also expressed concern that closing Central Middlesex and Hammersmith A&Es at the same time without leaving A&E staff in place in case of any transition issues was dangerous. They were assured that much consideration had been given to the timing and that this was the safest way.

Retention of skilled staff

At the February 2014 meeting the Committee was informed that SaHF had held a workshop with Health Education NW London for over 100 stakeholders. The outputs of this session had laid the foundations of the workforce workstream's focus for the following 12-18 months. The areas of focus included workforce HR transition, achieving acute clinical standards, primary care workforce transformation, developing the workforce for integrated care. Councillors queried whether the capacity and skills needed were already available or would need to be recruited. The Committee were advised that modelling of this was ongoing.

Little further detail has been given on how skilled staff are to be retained.

Ensuring quality of services

At the August 2014 meeting Members asked how they would measure whether the 10 September changes had worked and what types of performance indicators they would be looking at to ensure that the message had got through. Dr Spencer responded that they had detailed patient trackers monitoring the number of people at each site and how they got there, and a centralised tracking database, and that they did a huge amount of monitoring in each A&E and this would continue. It includes waiting times and access to diagnostics.

At the October 2014 meeting the Committee expressed concern that the high number of Policy Indicators could lead to targets becoming diffuse and unfocused. Mr Elkeles responded that the list has been shortened and targets are being prioritised.

Transport and access

At the meeting on 3 March 2015 the JHOSC requested that TAG share their work programme and provide further information on some of the specific potential changes that they are discussing with Transport for London (TfL).

At the February 2014 meeting the Committee requested that once a travel strategy was in place that the Committee should have sight of it. At the August 2014 meeting the Committee raised the issue of vulnerable patients being reliant on public transport to get to and between services. The Committee were assured that an Equalities Impact Assessment had taken the needs of the most vulnerable into account.

At the October 2014 meeting the Committee raised this issue once again, but specifically relating to pregnant women. They were told that ante-natal care should be provided in their own borough and so they would only need to travel for scans. Cllr Byrne reiterated the Committee's need to be reassured that hospital transport plans are supported by TfL.

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

Written submissions of Andy Slaughter, MP for Hammersmith, to the North West London Health Care Commission:

1. I am the MP for Hammersmith, a position held since 2010. Prior to that I was MP for Ealing, Acton & Shepherds Bush 2005-10. I served as a councillor in Hammersmith & Fulham 1986-2006, and as Leader of the Council 1996-2005. I am very familiar with the structure and operation of the NHS in north-west London and the Shaping a Healthier Future (SaHF) proposals.

2. My principal concerns arising from SaHF relate to hospital services. These include the closure of Hammersmith Hospital Emergency Department in September 2014 and the proposals for Charing Cross, namely the demolition and clearing of the entire 16 acre site, with a sale of approximately half the site for residential use and the retained NHS facilities being directed in the main to primary care, treatment and minor elective surgery. This will result in the removal of 93% of inpatient beds and all consultant emergency medicine, including the hyper-acute stroke unit, intensive treatment, and type 1 accident and emergency.

3. The loss of both A&E departments in the borough is part of a wider loss of four of the nine A&E departments in NW London proposed by SaHF. Already the intense pressure on A&E, inpatient beds and the London Ambulance Service has increased following the Hammersmith and Central Middlesex closures. Targets are regularly missed by wide margins and the pressure on staff and patients is intolerable. There is already insufficient capacity in the system.

4. A secondary concern is travel. This affects both patients and visitors, in particular those who do not have access to cars, who are elderly or disabled. Much of the borough has high levels of deprivation and chronic ill health and low car ownership.

5. There is a lack of new provision of alternative services. Despite the advocacy of alternatives to relieve pressure on A&Es from the integration of social care to diverting patients to primary and community care services, few additional services have so far been put in place ahead of the A&E closures. However, most west London hospitals already have triaging between GPs, urgent care and A&E services all of which are available, for example, on the Charing Cross site. As such, it is difficult to say that A&Es are overloaded because of a lack of primary care alternatives. The College of Emergency Medicine has recently expressed the view that most people who go to A&E need A&E care.

6. There is little evidence to suggest that the type of reorganisation proposed is sound in clinical terms. Whereas the changes to date – such as the centralisation of specialisms on a particular site – have had merit, in the context of general emergency medicine there is no particular evidence to say that having fewer larger units is going to prove beneficial in terms of the quality of care or the saving of lives. In contrast, the downside is obvious: fewer centres and further to travel. There is a difference, as the College of Emergency Medicine has stated, between the centralisation of major trauma and stroke services on the one hand and the pooling of emergency services generally.

7. It appears therefore that the sole benefits of SaHF are cost savings, or generating capital receipts by land disposal.

8. From the time the SaHF proposals were put forward in June 2012 consultation, justification and implementation have been equally poor. There has been no genuine attempt to engage with the public or to talk with the users of the services in an open way, which would engage their actual opinions. Rather, there has been an attempt to divert public opinion down the route already envisaged by the proposers. Allied to this is the lack of independent clinical evidence put forward. Many independent clinicians and professional bodies doubt whether this is the right approach.

9. As such, it cannot be said that due process has been followed in terms of establishing a case, or in terms of consulting with the public, a point which my constituents frequently mention to me. Despite SaHF affecting two million people in west London, most feel they have no ownership of the proposals and that their views are disregarded.

10. The quality of management and in some cases the quality of service in the acute sector is unsatisfactory, and yet the cuts and closures are going ahead oblivious to that. In the last year, the Care Quality Commission reports for most of the major hospitals in west London, including those managed by Imperial Healthcare Trust, have found that they require improvement, and that the existing standards of emergency care are not good enough.

11. We are trying to implement major change on a system that is currently broken, and on organisations which, in many cases, have gone through repeated management change, and which suffer from high staff turnover and low staff morale. Whilst staff are doing an extremely good job under very difficult circumstances, they are not getting the support they need from the organisations themselves. It is a bad way to introduce major change.

Dated 11 March 2015.

I confirm that this statement is true to the best of my knowledge and understanding.

Andy Slaughter MP

Written Submissions of Dr Onkar Singh Sahota to the North West London Health Care Commission:

1. I am Dr Onkar Singh Sahota and have been a GP in Hanwell in Ealing since 1989. I head a group of three practices that provide general medical services to around 11,000 patients. In 2012, I was elected to the London Assembly and represent the boroughs of Ealing and Hillingdon. I am now chair of the Health Committee of the London Assembly.

2. In my many years of practice I have seen numerous attempts at service reconfiguration, but the scale and depth of these changes are unprecedented. Currently there are 9 A&E Departments (as defined currently) in North West London and as outlined in the "Shaping a Healthier Future (SaHF) Strategy Document there are plans to close 4 of them along with a reduction of 900 inpatient beds. In my opinion, this is an experiment in service closures at this scale as it has not been tested anywhere else in the country.

3. It is extremely ambitious to attempt to close inpatient services at this scale and say that care will instead be moved to the community. Community care services are already stretched and there has been no investment in developing community services to take over the transferred patient care workload. We need resilience and capacity in the community services before attempting to close down hospitals. More care in the community and nearer the patient's home is an objective that I support but it does require infrastructure and human resources to deliver it. Both of these are lacking and there is no coherent plan to deliver it currently.

4. The SaHF plans have failed to take into account the impact on the local population and West London has pockets of population that is one of the most socially deprived in the country. Southall is particularly deprived and has worryingly high morbidity rates related to cardio-

vascular disease and diabetes which are above the national average. Further, London Borough of Ealing has the second highest rate of Tuberculosis in London (and London itself is the Tuberculosis capital of Western Europe).

5. This is an area where the population is expanding rapidly. Everybody is surprised how quickly London has grown and it is anticipated that by 2020 the population of London will be 9 million, increasing to 10 million by 2030.

6. A point that particularly concerns me is the plan to close the A&E at Ealing Hospital but still maintain the Urgent Care Centre (UCC) there. Currently, 28,000 patients a year are transferred by the UCC to Ealing A&E department, which is on the same site. I am extremely concerned as to where those 28,000 patients will go if the A&E is closed. The very reason somebody is transferred from UCC to A&E is because they are in need of more expert emergency care and it is therefore necessary for them to be seen on the same site. In many cases time to treatment will be critical to the outcome. We don't know of any example in the country where an urgent care centre has operated without a corresponding A&E on the same site. This proposal is very worrying.

7. I am also very concerned about the increased travel time for patients as a result of these A&E closures. If a patient lives in Southall or Hanwell and needs to get to Northwick Park hospital, it would take about 1 hour 40 minutes on buses. This would be particularly problematic for the elderly and young mothers. There seems to have been consideration of blue light travel times, but there has been no thought at all as to the impact on public travel times and, importantly, there has been no consultation with Transport for London before SaHF went out to consultation.

8. Since the A&E at Hammersmith and Central Middlesex hospitals closed, there has been an impact on others hospital in West London. The Central Middlesex closure has had a particular impact on Northwick Park. We know that since the closure has taken place, the waiting times in Northwick Park have become one of the worst examples in the country. The department isn't coping and the four-hour waiting target is being broken every week. There has already been one occasion where the hospital had to stop accepting ambulance patients.

9. In January 2015, we heard evidence at the London Assembly Health Committee about the impact of the A&E crises over the winter months. Amongst others, the Chief Operating Officer of Northwick Park Hospital gave evidence to the Committee as well as Dr Anne Rainsberry, the Director of NHS London. The Committee was informed that Northwick Park Hospital was under stress as there were more sicker patients coming to the hospital and that the impact of the closure of Central Middlesex A&E and Hammersmith Hospital A&E was "as planned". I cannot accept that the Management had planned for Northwick Park Hospital to fail its targets.

10. I have reviewed the NHS Statistics that shows that the number of type one cases (seriously ill) attending Northwick Park has not increased. It's not that there are more sick patients, it's that the patients who previously attended Hammersmith and Central Middlesex now have to go to Northwick Park and that is causing chaos, which the system isn't able to cope with. Please find exhibited to this statement relevant A&E statistics [OS1].

11. In terms of the consultation: it was extremely limited in scope. Only a few copies of documents were sent to a small number of places. There were no documents produced in local languages (which would have been particularly appropriate in the Borough of Ealing) and libraries didn't seem to have any. Further, the response questionnaire was 15 pages long with 50 questions designed to frustrate and exhaust the

responder. The questions were framed in a way to lead to the conclusion that the proposed A&E closures was based on sound science. The response document was not designed to get genuine feedback from the local population. Further, one NHS Trust (and its local population) was set to compete with the neighbouring trust, a tactic to "divide and rule".

12. Ealing CCG surveyed all its GPs but the patients being looked after by GPs in Hanwell & Southall would be most affected by the closure of Ealing Hospital. The GPs in Southall and Hanwell did come out very strongly against the closures of Ealing hospital.

13. Staff morale is extremely low at the moment, there are real problems with recruitment and retention in the NHS at present. Across London we are short of 8,000 nurses and 400 paramedics. London's NHS is under stress but I am particularly worried about how, in light of the proposals of SaHF, the local health system will cope in North West London.

Dated 12 March 2015

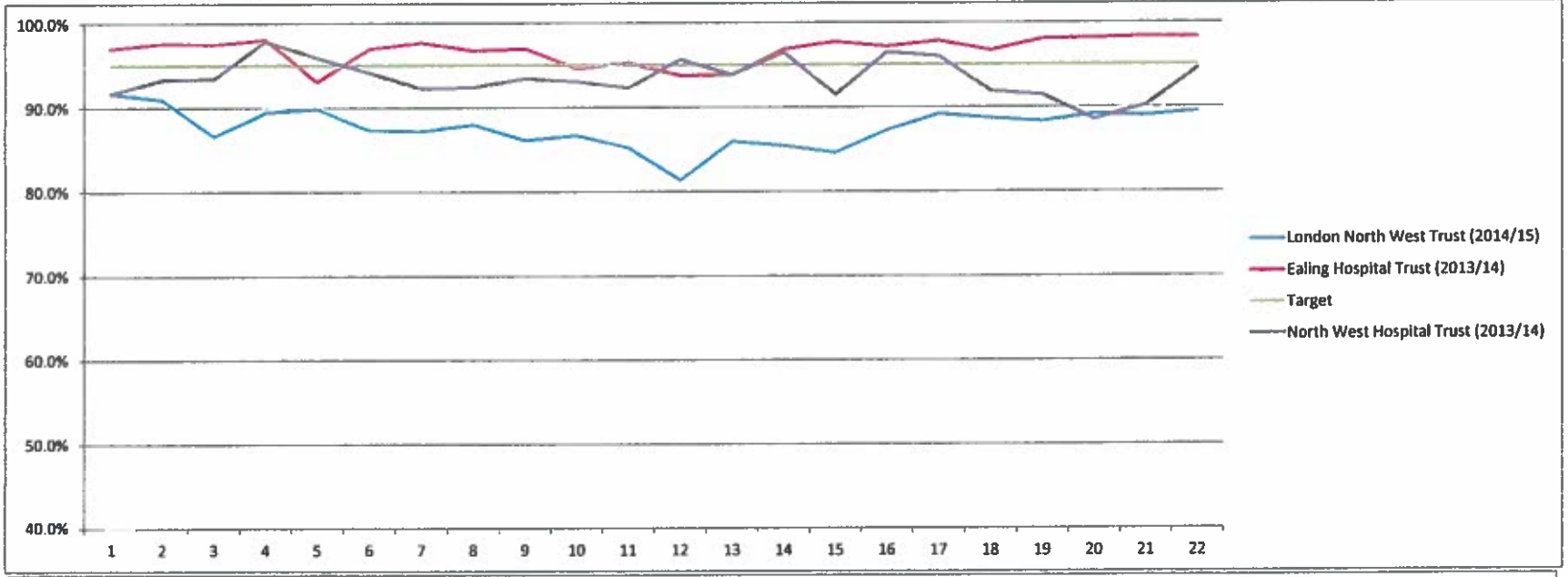
I confirm that this statement is true to the best of my knowledge and understanding.

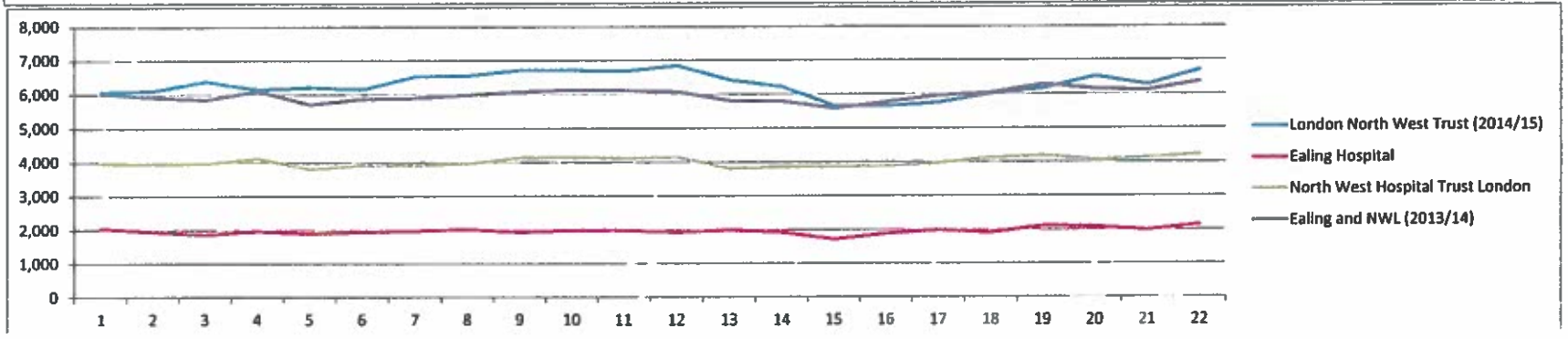
Dr Onkar Singh Sahota

NHS England http://www.england.nhs.uk/statistics

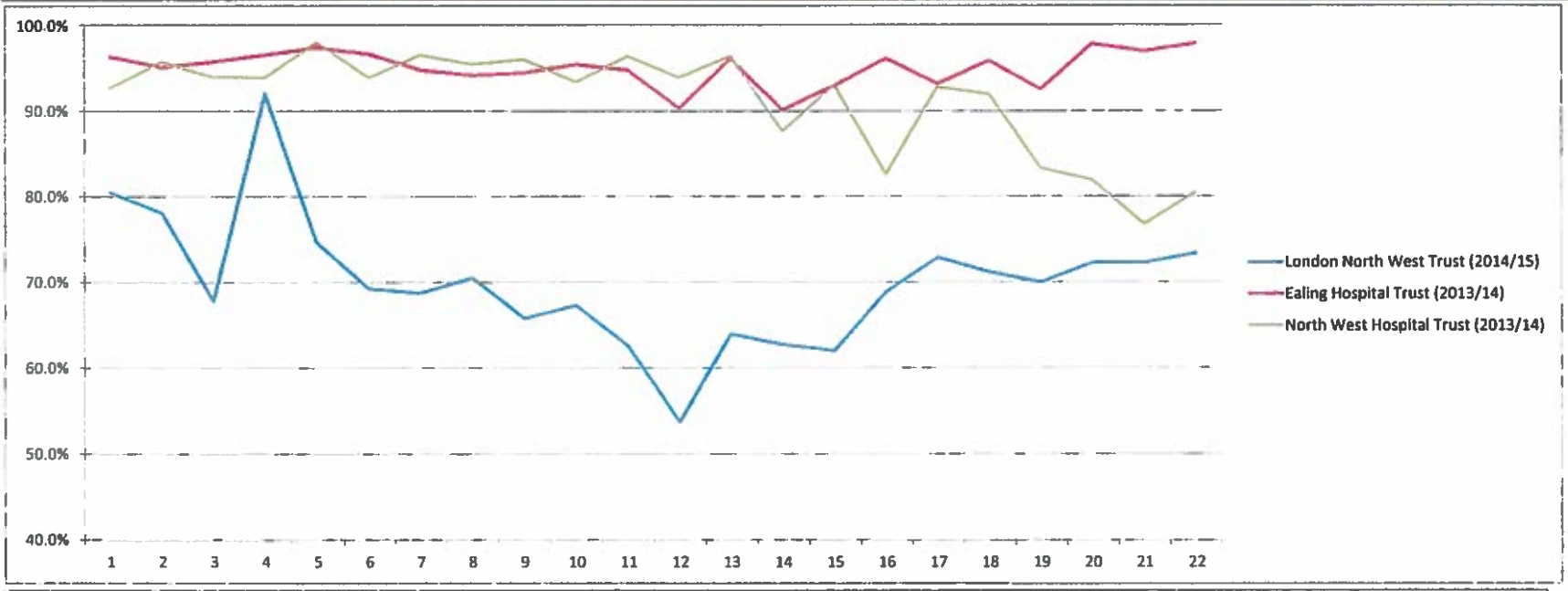
A&E Statistics (October - March 2013/14 and 2014/15)

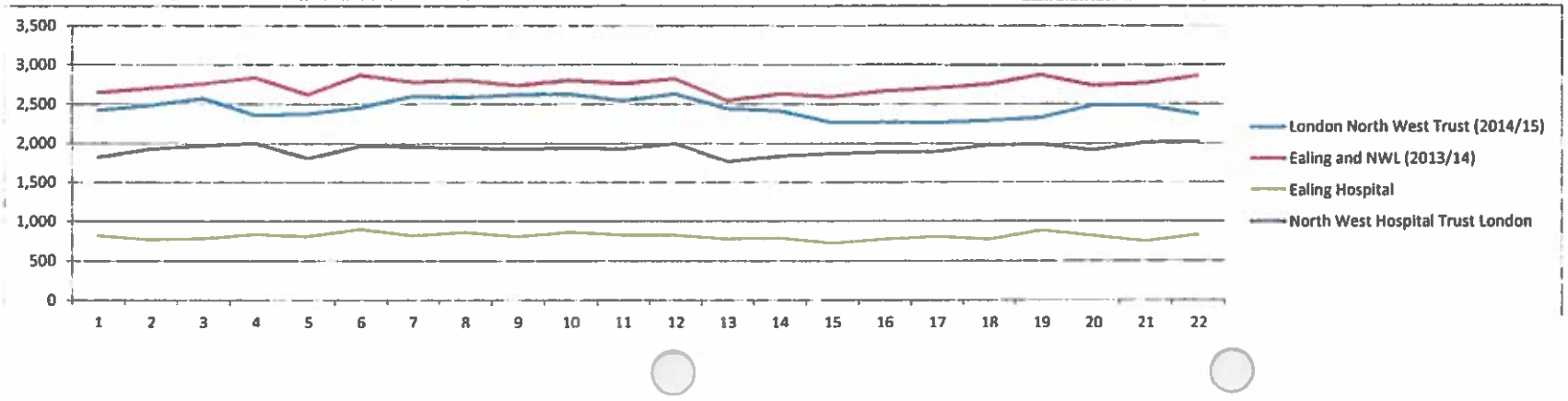
% over four hours (All Types)	Week 40	Week 41	Week 42	Week 43	Week 44	Week 45	Week 46	Week 47	Week 48	Week 49	Week 50	Week 51	Week 52	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9
London North West Trust (2014/15)	91.7%	91.0%	86.6%	89.5%	89.9%	87.3%	87.2%	88.0%	86.1%	86.7%	85.2%	81.4%	85.9%	85.4%	84.6%	87.3%	89.2%	89%	88%	89%	89%	89%
Ealing Hospital Trust (2013/14)	97.0%	97.6%	97.5%	98.1%	93.1%	97.0%	97.7%	96.8%	97.0%	94.6%	95.3%	93.8%	93.9%	96.9%	97.8%	97.2%	97.9%	96.7%	98.1%	98.2%	98.4%	98.3%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
North West Hospital Trust (2013/14)	91.7%	93.3%	93.5%	97.9%	95.9%	94.2%	92.3%	92.4%	93.4%	93.1%	92.3%	95.6%	93.8%	96.4%	91.5%	96.4%	96.0%	91.9%	91.4%	88.5%	90.2%	94.5%
Attendances (All Types)																						
London North West Trust (2014/15)	6,074	6,118	6,401	6,149	6,221	6,158	6,538	6,558	6,719	6,710	6,680	6,842	6,421	6,223	5,655	5,647	5,738	6,008	6,171	6,514	6,278	6,607
Ealing and NWL (2013/14)	6,028	5,919	5,844	6,101	5,702	5,867	5,891	5,989	6,085	6,136	6,113	6,074	5,801	5,735	5,583	5,763	5,955	6,041	6,295	6,139	6,105	6,359
Ealing Hospital	2,049	1,960	1,871	1,978	1,896	1,950	1,974	2,024	1,939	1,991	1,991	1,926	1,995	1,924	1,718	1,883	1,987	1,910	2,107	2,082	1,983	2,139
North West Hospital Trust London	3,979	3,959	3,973	4,123	3,806	3,917	3,917	3,965	4,146	4,145	4,122	4,148	3,806	3,861	3,865	3,880	3,968	4,131	4,188	4,057	4,122	4,220





% over four hours (Type-1)	Week 40	Week 41	Week 42	Week 43	Week 44	Week 45	Week 46	Week 47	Week 48	Week 49	Week 50	Week 51	Week 52	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9
London North West Trust (2014/15)	80.5%	78.1%	67.8%	92.0%	74.6%	69.2%	68.7%	70.5%	65.7%	67.3%	62.6%	53.7%	63.9%	62.7%	62.0%	68.8%	72.8%	71%	70%	72%	72%	73%
Ealing Hospital Trust (2013/14)	96.4%	95.1%	95.8%	96.5%	97.4%	96.7%	94.8%	94.2%	94.5%	95.4%	94.8%	90.3%	96.1%	90.1%	93.0%	96.1%	93.2%	95.9%	92.5%	97.8%	96.9%	97.8%
North West Hospital Trust (2013/14)	92.7%	95.7%	94.0%	93.9%	97.9%	93.9%	96.5%	95.4%	96.0%	93.4%	96.4%	93.9%	96.4%	87.6%	93.0%	82.6%	92.8%	91.9%	83.3%	81.9%	76.7%	80.5%
Attendances (Type-1)																						
London North West Trust (2014/15)	2,423	2,481	2,570	2,356	2,374	2,453	2,599	2,583	2,616	2,623	2,540	2,626	2,440	2,412	2,264	2,264	2,264	2,288	2,826	2,481	2,481	2,370
Ealing and NWL (2013/14)	2,646	2,702	2,758	2,837	2,619	2,867	2,777	2,798	2,733	2,802	2,758	2,819	2,544	2,626	2,592	2,663	2,703	2,750	2,870	2,733	2,765	2,852
Ealing Hospital	822	774	788	836	811	899	821	861	807	864	828	824	779	791	726	775	810	773	882	820	753	834
North West Hospital Trust London	1,824	1,928	1,970	2,001	1,808	1,968	1,956	1,937	1,926	1,938	1,930	1,995	1,765	1,835	1,866	1,888	1,893	1,977	1,988	1,913	2,012	2,023





Written Submissions of Stephen Pound to the North West London Health Care Commission:

1. I am Stephen Pound and have been the Member of Parliament for Ealing North since 1997. I served as a Councillor for the London Borough of Ealing from 1982-1998 and as Mayor of the Borough 1995-1996. I have lived in North West London since the NHS and I were both born in July 1948.

2. I strongly associate myself with the concerns expressed by Ealing Council and detailed in appendices 1, 2 and 3 of their submission to this enquiry.

3. In particular, my constituents have expressed their concerns in relation to the changes to acute provision and the diminution of locally responsive emergency care. I have also been contacted by nursing staff, who support the comments of Dr Peter Carter, Chief Executive and General Secretary of RCN, in relation to increasing pressure on nursing staff and the increasing reliance on agency staff and those from overseas.

4. The loss of four out of nine A & E departments in North West London is a source of considerable anxiety to my constituents and the impact of the closure of A & E Services at Hammersmith and Park Royal is causing particular concern and increasing pressure on staff in the acute hospitals and the London Ambulance Service.

5. From having three maternity hospitals in Ealing, including the very large facility at Perivale, there is now only the maternity service at Ealing Hospital. The potential loss of this provision will not only severely affect constituents who will have to travel further to give birth, but will also have an impact on ante natal and post natal care. As the population of Ealing rises (its current level is in excess of 342,000), the demand for maternity services is increasing and shows no sign of diminution. Although centralisation of some provisions, such as stroke services, can be

successful, the absence of any local maternity service is another source of considerable anxiety to my constituents.

6. Anyone unfamiliar with the geography and demographics of Ealing might assume that the proximity of other facilities beyond the borough makes them easily available to local residents. However, I can attest from my own experience that while public transport does provide an excellent service from the north and north west of the borough to Ealing Hospital, the prospect of my constituents travelling to Northwick Park, St Mary's, or West Middlesex is extremely daunting and another source of anxiety.

7. In addition to the strategic objectives of "Shaping a Healthier Future", the current state of the NHS provision in North West London causes utter mind-numbing confusion to my constituents and me, resulting in further anxiety. I propose to mention some specific cases, with the agreement of the constituents, which illustrate the chaotic consequences of disaggregation and a lack of common standards and service levels.

8. I have to concur with the statement made in Parliament by Angie Bray MP for Ealing Central and Acton that this process is "all about money".

9. Since the proposals first being made in the summer of 2012, there has been a uniformly negative response from my constituents. The extent and strength of marches, meetings, and demonstrations – including one of several hundred people at Hammersmith Town Hall last week – show that this is not an alarmist response, but a fundamental fear of what is seen as a centralisation of health services in North West London to the detriment of local communities.

10. I strongly support the statement of Andy Slaughter MP for Hammersmith given in evidence and referring to the complete

lack of ownership amongst both our constituents and the utter failure of SaHF to engage with our constituents at any meaningful level.

11. It is now universally recognised that the creative destruction of the Health and Social Care legislation passed earlier by this Parliament has had a catastrophic impact on service provision, staff morale, patient confidence, and the ability to consider future provision objectively. The near universal perception among my constituents is of an NHS close to collapse and suffering shock treatment, which offers no hope of improvement but only further disruption and division.

STEPHEN POUND MP
17th March 2015

North West London Collaboration of Clinical Commissioning Groups

15 Marylebone Road
London NW1 5JD

By Email

Mr Mansfield QC
c/o Peter Smith
Room 39
Hammersmith Town Hall
London
W6 9JU

18 March 2015

Dear Mr Mansfield,

I am writing to you on behalf of the Shaping a Healthier Future Programme Board, in response to the evidence that has been submitted to the Commission from the chairs of a Brent CCG locality patient participation group, which the group was kind enough to share with us.

We were deeply concerned by many of the factually inaccurate comments made within its submission, and feel strongly enough to respond directly to some of these below. We would be grateful if you would consider our response in relation to the evidence the group has submitted.

The Brent participation group said:

- *"This policy was promulgated in the name of the 8 Clinical Commissioning Groups (CCG) (then in formation) for these boroughs, but was clearly backed at national level by the NHS and the Department of Health… Many regard the consultation exercise as deeply flawed and the strategy has never had whole-hearted community support."*

We strongly refute this claim. This was a policy developed by the clinicians working in the eight CCGs along with the clinical leaders in all the trusts in North West London. We were pleased that our compelling clinical case had the subsequent support of NHS London. Furthermore, we carried out an extensive public consultation, during which we:

- Attended more than 200 meetings which included running two roadshows in each of the eight North West London boroughs, as well as additional roadshows in the neighbouring boroughs of Camden, Richmond and Wandsworth, public meetings and debates, GP and hospital site events and engagement with hard to reach groups. These were attended by more than 5,000 people
- Printed around 100,000 full consultation documents and response forms in 10 languages
- Uploaded an online response form and questionnaire to the Shaping a Healthier Future website. The website received nearly 20,000 hits during the consultation period

- Distributed more than 555,000 summary leaflets, factsheets, postcards, posters which were made available for display in libraries, GP practices, pharmacies, hospitals and town halls, as well as in newspapers in North West London
- Produced a range of additional materials to provide additional public information about the planned changes, including factsheets, postcards, posters, videos, exhibition boards, FAQs and slide decks

More than 17,000 people provided written responses to the consultation. All responses to the consultation were received and analysed independently by Ipsos MORI and its report can be found on the Shaping a Healthier Future website at www.healthiernorthwestlondon.nhs.uk.

The consultation was independently reviewed by the Consultation Institute, a not-for-profit organisation, who endorsed the exercise and awarded it a certification of good practice.

The feedback from the consultation indicated support for the proposals and the need to change the way health services are delivered in North West London. Furthermore, we responded to this feedback, carrying out significant additional work in terms of analysis of clinical recommendations, options evaluation (including finance), travel, equalities and implementation planning.

The proposals were subject to further assessment after Ealing Council applied for a Judicial Review, but the High Court found there were no grounds for this and that the consultation exceeded the standards required. Ealing Council Health Overview and Scrutiny Committee also referred the programme to the Secretary of State for Health, and he in turn referred the matter to the Independent Reconfiguration Panel (IRP), who supported the proposals.

The Brent participation group said:

- *"as early as 2006 severe staffing and financial cuts were made to the establishment of Central Middlesex Hospital... several commentators saw this as a cynical attempt to induce poor performance at the hospital, so that at a later date it could be characterized as failing and unsafe and then planned for downgrading. In our view this is exactly what happened under SaHF."*

It is important to note that the multi-million pound Brent Emergency Care and Diagnostic Centre (BECaD) opened at Central Middlesex Hospital in 2007. Why would the local health economy build a new hospital with a new A&E, if it was planning to 'downgrade' the service?

With regard to the changes at Central Middlesex Hospital in 2014 – which saw the closure of its A&E department – it is incorrect to label this a 'downgrade'. The changes were made as part of a wider strategy to provide better, more accessible care in the community and more specialised care in our hospitals. These changes will help to achieve better patient outcomes and save lives.

Specifically, it will enable Central Middlesex Hospital to specialise in elective, or planned, care, ensuring:

- It provides safe, clean and modern facilities for planned operations like hip replacements and other orthopaedic surgery and pre-planned procedures
- Reductions in the number of cancellations of planned operations due to facilities no longer having to be shared with potential emergency cases
- Improved infection levels due to better, more modern buildings and no risk of cross-contamination from unplanned emergency cases
- Continued provision of a 24/7 Urgent Care Centre on site

On a strategy of more centralised A&E services, the Brent participation group said:

- *"it does not follow that other common conditions needing urgent admission to hospital will benefit from some form of concentration"*

Investment in out-of-hospital services to allow more centralised acute care will help ensure more specialist consultants are on hand to treat seriously ill or injured patients in our A&Es. This will enable us to have more centres of excellence in emergency care in the same way that stroke and trauma services have been centralised across London. This was something which was controversial at the time but which is now acclaimed by clinicians and politicians alike as being a remarkable innovation that saves hundreds of lives every year. We estimate that with more consultants on duty at all major hospitals at the weekend, made possible by concentrating staff on fewer sites, we can save at least 130 lives per year.

This move will also provide additional benefits for all patients requiring acute healthcare services, including:

- Hitting the four-hour A&E waiting time targets consistently at all major hospitals across North West London, throughout the year
- More critical care consultants on duty 24/7 (168 hours per week), so that seriously ill patients always get the best expert care
- Consultants in other specialties such as paediatrics on duty between 12-16 hours per day, seven days per week, providing much more cover than at present
- More trained and experienced emergency doctors on site 24/7 in A&E departments ensuring patients are seen by senior specialist staff early in their treatment
- More investment in mental health so that psychiatric liaison services can better co-ordinate 24/7 care for vulnerable, mentally ill people

The Brent participation group said:

- *"Many who responded to the SaHF consultation argued that no acute hospitals should lose their A&E departments or be downgraded to elective or local hospital status until the community facilities and treatment arrangements were put in place. The NHS gave assurances that this would be the case."*

The closure of the A&E departments at Central Middlesex Hospital and Hammersmith Hospital were brought forward due to clinical safety risks. Alternative capacity was arranged through the 24/7 urgent care centres remaining on both sites and other A&Es across North West London.

This has included substantial investment in improved urgent care centres at Central Middlesex Hospital and Hammersmith Hospital, A&E departments at Northwick Park and St Mary's Hospital and four out-of-hospital hubs now operational. As a result of this, we have improved capacity in North West London.

Further improvements to out-of-hospital services continue, with an additional 19 out-of-hospital hubs being developed and a further four hubs to deliver out-of-hospital services being developed on hospital sites, while there are no plans to close any more A&E departments.

The Brent participation group asked:

- *"what progress has been made in providing specific new facilities outside hospitals as described in the table and how many hospital stays and appointments have been avoided as a result of them. We cannot find this information on the SaHF website and we have had no reply to our email to the SaHF team asking these questions."*

Under the programme, local CCGs have made significant strides in developing out-of-hospital services in order to reduce the need for emergency care and unplanned admissions. In Brent alone it has:

- Established ***GP Access Hubs*** in each of the five localities within Brent, beginning as a pilot in November 2013. These hubs provide evening and weekend GP and nurse appointments until 9pm Mondays to Fridays, and 9am to 9pm on Saturdays. Following evaluation of the pilot, the service has recently been extended to provide access to primary care services from 6am to 9pm Mondays to Fridays and 9am to 3pm on Saturdays, Sundays and Bank Holidays. Brent CCG also commissions a Walk in Centre, which is open from 8am to 8pm every day, 365 days a year, as well as an Urgent Care Centre which is open twenty four hours a day, seven days a week (24/7). These have provided more than 70,000 additional GP and nurse appointments in primary care and rapid access out of normal GP practice opening times, providing the opportunity to intervene earlier and reduce reliance on walk in, urgent and emergency care services.
- Implemented consultant led ***Community Ophthalmology Services*** into community sites across Brent to improve patient experience of care, waiting times for referral to treatment and accessibility through provision in community settings. Feedback from patients and referring clinicians has been positive.
- Extended its ***Brent Short-Term Assessment Rehabilitation and Reablement Service (STARRS)*** to include a social worker to enable better links with the Local Authority. Brent STARRS further provides "in reach" services to other acute hospitals with the aim of preventing hospital admissions as well as enabling early supported discharge and preventing possible re-admissions. STARRS has been in operation since 2011 and was expanded by the CCG in 2014. This service has demonstrated year-on-year improvements in preventing admissions and has been recognised as an exemplar of integrated care for an ageing population that requires support to remain at home during an acute illness. To date, the service is on track to prevent almost 2,800 admissions in 2014-15 against a target of 2,300. In the nine month period from April to December 2014, 2,206 admissions were avoided through intervention by the STARRS team.
- Introduced the ***Integrated Care Programme (ICP)*** through multidisciplinary meetings (including the patient) to develop personalised care plans, and recruited Health and Social Care Co-ordinators to liaise with patients, the NHS and social care to improve patient care.
- Launched ***Brent Integrated Diabetes Services (BIDS)*** in October 2014 to improve services for patients with type 2 diabetes. The new service offers multi-disciplinary diabetes care in primary and community settings and an extended patient education programme to help patients understand, manage and control their diabetes. This service is designed to improve patient satisfaction by reducing the number of emergency admissions to hospital for diabetic patients and increasing patient attendance at the Diabetes Education and Self-Management for On-going and Newly Diagnosed (DESMOND) programme.
- Is piloting a service for patients with ***Sickle Cell*** to improve care through an education and support programme. This service is being provided by the Sickle Cell Society to provide pre-admission and post admission intervention and support. The anticipated impact is a reduction in A&E attendances and admissions due to early intervention and support, leading to better clinical outcomes for patients.
- Extended its ***Looked After Children and Child and Adolescent Mental Health Services (CAMHS)*** to improve service provision for this specific group of vulnerable children with complex mental health needs in August 2014. Following Brent Council's decision on 9 December 2013 to commission a reduced mental health service for Looked After Children, arrangements were made to safely transfer the care of 51 Looked After Children, and 86 children with developmental progress difficulties to

other services. Brent CCG invested an additional £220k (recurrent full year effect) into the existing Central North West London Foundation NHS Trust (CNWL) CAMHS service to provide dedicated resources for Looked After Children, and children with developmental progress difficulties.

- Established ***Primary Care Dementia Nurses*** for each locality within Brent to increase capacity for early diagnosis and provide early intervention. In addition, the CCG and Brent Council jointly commission a Dementia Café for patients and carers with dementia. Brent CCG invested £397k in specialist dementia services made up of five specialist mental health nurses to support carers and patients after a diagnosis of dementia. The nursing team works as a bridge for patients between primary care services and the specialist Memory Clinic dementia service. All patients now receive support and advice following specialist diagnosis at the memory clinic, thus improving the quality of life for patients and their carers. From April to December 2014, the new Primary Care Dementia Nursing Service worked with 238 newly diagnosed patients and their carers.

Finally, we feel it is important to emphasise the fact that the Shaping a Healthier Future programme, through Brent CCG, has a longstanding history of communicating and engaging with the patient participation group and has actively engaged with and provided the group with information in the past.

We hope that in responding to the inaccuracies laid out in the group's submission, we can help the Commission reach a clear and well informed assessment of the programme.

Yours sincerely,

Dr Mark Spencer
Deputy Regional Medical Director, NHS England (London)
Clinical Lead, Shaping a Healthier Future
GP at Hillcrest Surgery, W3

Smith Peter

From: Andrew Pike [mailto:Andrew.pike@nw.london.nhs.uk]
Sent: 19 March 2015 15:31
To: Andrew Pike
Subject: Changes to maternity and interdependent services at Ealing Hospital

Sent on behalf of Dr Mohini Parmar, Chair, Ealing CCG

Dear Colleague,

In 2013 as part of the "Shaping a Healthier Future" programme it was decided to improve maternity services in NW London by consolidating maternity services onto six hospital sites and cease maternity deliveries at Ealing Hospital.

Ealing Hospital maternity unit is currently a safe place for women to give birth. However, the standards for maternity units are changing and we know that in future Ealing may struggle to meet those standards. This could lead to an unplanned closure which could increase clinical risk for women and is not fair on women or staff. The London Clinical Senate has recently endorsed the clear need for these changes to maternity services to occur as soon as it is safe to do so.

A significant amount of work has been undertaken to progress the improvement plans and the assurance of this work is still underway. Ealing CCG Governing Body met on the 18 March 2015 and has confirmed that further work needs to be done on operational readiness before a decision on timing of the closure of Ealing maternity unit is made.

We expect that Ealing CCG will discuss maternity again at the next scheduled meeting of their Governing Body, but it will not be discussed at the extraordinary meeting on 25 March.

The planned changes will improve care for women across NW London by:

- Continuing to deliver antenatal and postnatal care locally in Ealing
- Ensuring that for most women the care they receive before and after the birth is provided by a midwife from the same hospital as where they give birth.
- Expanding the number of community midwives and investing in the home birth team
- Having more senior consultant cover in maternity units
- Improving the midwife-to-birth ratio
- Providing a midwife-led unit alongside every maternity unit in North West London
- Upgrading facilities at all six hospital sites

For further information please contact Andrew Pike: andrew.pike@nw.london.nhs.uk.

Andrew Pike
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15 Marylebone Road
London NW1 5JD

CWHHE Central London. West London. Hammersmith & Fulham. Hounslow. Ealing. Clinical Commissioning Groups

Smith Peter

From: Phillip Brownley Eldridge MA [redacted]
Sent: 24 March 2015 01:06
To: Katy Rensten; Smith Peter
Subject: Submission to North West London Health Commission

Submission to North West London Health Commission for London Borough of Hounslow.

My name is Phillip Brownley Eldridge,a resident of the London Borough of Hounslow.

My submission covers my own experiences of local NHS services and a series of examples from my role as a Patient representative.

My personal experience of both Primary and Secondary care is as follows.

I am a Type 2 Insulin Dependent Diabetic with Diabetic Neuropathy,Chronic Kidney Disease and I am registered with Social Services as a person who has severely impaired vision.

Last June,I underwent a Blood test as part of my treatment by the Renal Clinic at West Middlesex University Hospital. The sample,when analysed showed a high level of lipids.My Specialist renal Nurse made connections with the Lipid Clinic and my GP. At the beginning of September 2014, I had still to receive any follow up procedures. To ease my concerns,I flew to Spain and underwent a further Blood Test.This showed no signs of a Lipid problem.

The above experience shows
a continuing lack of co-ordination between Primary and Secondary Care despite the alleged adoption of strategies to produce an integrated health care system.

Since 2011 I have set on a series of Tender Committees for the London Borough of Hounslow and Hounslow Clinical Commissioning Group. During this period I served on Panels that covered Public Health provision,the Urgent Care Centre, Diabetic Intermediate Care service and Out of Hours GP services.

The last two panels were carried out by the HCCG during the period November 2013 thru to December 2014.I served on these two panels as the Patient Representative for the London Borough of Hounslow.

Having observed two cycles of a commissioning process I would like to make the following comments in note form.
(1).That the HCCG was staffed by individuals who had no prior experience of Purchasing goods and/or services.
(2).In evaluating submitted tenders the Panel was never shown any facility operated by the Tenderer.There was no systematic review of Tenderers capabilities.
(3).One of the potential bidders for Diabetic Intermediate Care was an Industrial Gases supplier.
(4).There was an extensive use of Consultants.In particular with regard to Finance and Contract Mediation.In some instances,one firm of Consultants was representing two CCGs.The issue of conflict of interest was never raised.
(5).The quality of advice was never a concern. During the Diabetes Intermediate Care,we had to abort the initial PQQ and ITT phases.This was solely due to the failure of a Financial Consultant to specify the Tender document correctly.The Tender was so designed so as to make it impossible for any non incumbent to win the Tender.
(6)The Clinicians on the Panel only raised concerns about adherence to the known policies that were specified in the Tender Document.

(7).Those sections of the Tender covering Staff,IT Systems,Finance were restricted to certain members of the Panel.
(8).That Patient Representatives,contrary to the Francis Report and Patients,First and Foremost,were removed from Panels.I was removed from the Ambulatory Care programme and from the OOH GP service. In both cases the HCCG took a conscious decision to exclude.

I would like to draw the NWL Health Commissions attention to the outcomes of any system of internal markets within the NHS.
These points shall be in note form:
(1).That the fragmentation of the market and the consequential need for potential service providers.Has led to additional costs in providing the same level of Patient Care.Taking a local firm, Hounslow and Richmond Healthcare,they need to retain additional staff to provide a facility to Tender.They have a need to retain Estates,Finance,Human Resources staff so as they can tender and re-tender for contracts.Therefore,the NHS has a higher cost base for the same level of activity.
(2).The NHS does not make effective use of the Clinicians that it currently employs.Its latest figures show a total of 148,450 Clinicians yet we have queues at Accident and Emergency departments.This inefficiency is further compounded by the use of Clinicians in the management of CCGs.In fact NHS England employs more Clinicians from Malawi than does the state of Malawi.Patients die in Malawi so as Clinicians can work a 5 day week.
(3).The policy document Shaping a Healthier Future is prayed in aid of the changes that will occur for the better. In reality it is an example of a Utopian policy.For it projects a better series of outcomes in the future.Yet it does not reflect the concrete realities of the Health Economy in the present.These are a failed Primary Care system,a Secondary Care system that still receives over seventy percent of the NHS budget.
(4).A continuing failure by National and Local Politicians to state the simple truth "Swedish healthcare cannot be paid for by Texas Tax rates".And more importantly can a structurally imbalanced economy continue to finance the NHS at its current levels?
(5).The need for users to recognise that change will occur and the blind refusal to adapt led to the continuing use of Hammersmith A&E at a huge cost for "2.7 bluelights a night" only.This facility could not be staffed with a fulltime Clinical lead,so locums were used at a cost of £800,000 per annum for the Clinical lead.
(6).The need to re arrange primary care from 54 GPs surgeries in the LBH into 5/6 Health Centres that would operate on a 24/7 basis.People prefer A&Es because they are open 24/7 and have car parking.So many surgeries are poorly served by Public transport and have limited parking facilities.
The current system worked when Doctors Finlay and cameron had Janet to both man the reception and prepare lunch in Tannochbrae.But its continuance only serves the interests of GPs and not Patients.

in closing my submission I would like to conclude with a suggestion that the monolith of NHS England be broken down into 8/9 regional unitsmwuth an application of Morrisonian principles with regard to "local health under local
control".A policy of returning to a local orientation of health policy with a framework of Health Centres
and the return of smaller local hospitals with a core of specialisms at a central location.

Sent from my IPad Air
Phillip Brownley Eldridge MA.

Smith Peter

From: John McNeill [redacted]
Sent: 18 March 2015 18:30
To: Smith Peter
Subject: Submission to the Commission

Hi Peter,

You suggested that my prepared oral submission can now be included in evidence to the Commission. That would be great.

My prepared statement was as follows. Hope you can copy it into your rmat. Please let me know if I need to re-send it in any other form.

B/W John.

ORAL EVIDENCE TO COMMISSION – 14 March 2015

Introduction

With permission, I would wish to briefly reiterate the main points I raised in my written submission, then to focus on the main topic I asked the Commission to consider – patient hospital transport and the effects of the 'Shaping the Future' plan on that aspect of the patient experience.

Generally

The consultation on "Shaping a Healthier Future" was a total sham. It soon became obvious that the proposals for re-organisation of services for NW London had been pre-planned and agreed. The consultation exercise was just putting a 'tick in the box' that a consultation process had taken place.

I was told at a public event to promote it back in 2011 that nothing would happen without full consultation and public consent. That was, at the very least, misleading.

A&E Services

The A&E closures have been severely detrimental to the health, welfare and service accessibility for residents of NW London. People experiencing major illness or requiring emergency injury treatment are now taken miles from their homes or incidents to already overcrowded A&E units. The evidence of A&E unmet targets has been well publicised. If I'm taken ill at home, or involved in a serious Road Traffic Accident in Ealing, I'm told I would not now be treated locally but taken to a distant location. That loses valuable time in medical attendance and treatment plus causing major inconvenience to any friends and family wishing to visit me.

May I take this opportunity to highlight a major omission in public information about A&E services. The Risk Register for the Health and Social Care Act 2011 predicted all this, but the government unsurprisingly refused and still refuses its publication. That Risk Register MUST be published. May I ask the Commission to press for that to happen. The warnings given at the time about the effects of the Act must be put in the public domain.

Difficulties for patients accessing GP appointments plus the volume of referrals from the 111 service call centres have both added to A&E pressures. I've had to use the 111 service as an 'out of hours' GP service and I can confirm that non-medical staff using algorithms for diagnoses will naturally be risk-averse and will send callers to A&E for self-protection. This just adds to the pressure on remaining A&E units.

Hospital Closures

With the impending closure of Ealing Hospital, there will no longer be any inpatient beds in the whole of the London Borough of Ealing. Other hospitals in neighbouring Boroughs, including much of Charing Cross, are facing cuts and closures despite past promises. This is bad for patient care. For families and friends visiting inpatients this will be difficult, costly and extremely inconvenient. Parking is limited and expensive in and around hospitals and public transport services are difficult for the elderly and disabled.

NHS Fragmentation and Privatisation

The introduction of the internal market and privatisation of NHS services has led to the fragmentation and segmentation of service provision. 'Shaping a Healthier Future' is only making this worse. Putting distance between remaining hospitals and centres just makes joined up healthcare more difficult to achieve. Another £780m NHS privatisation package has just been announced – this will lead to further fragmentation of services and will only make matters worse for patient understanding of how to access services.

Hospital Patient Transport Services for the Elderly and Disabled

I would ask the Commission to particularly focus on this topic.

This is a very relevant topic for the Commission in its consideration of the effects of the "Shaping a Healthier Future" process. With hospital cuts and closures, hospital transport will have an increasing role in the patient experience with more and longer journeys. Our ageing population and longer life expectancy will put an ever-growing demand on transport services. Longer journeys to more distant locations will require more vehicle miles per journey and longer time commitment per journey for drivers and staff.

Just a few years ago, hospital patient transport was directly provided by directly employed and trained NHS staff using NHS ambulances and purpose-built passenger vehicles. With fragmentation and privatisation, hospital transport has become a LOTTERY for patients in timing comfort and care. I chose the word 'lottery' very carefully as it perfectly describes my experiences. Sometimes you win and get good service, other times you lose and receive terrible service. I'll probably repeat it as we make progress.

Over the years, I've had excellent service from some providers and very poor service from others. I'm here today to promote at least an **adequate** service for all patients in the light of forthcoming hospital closures.

Hospital Transport is now being regularly provided by private companies often using drivers on minimum pay and untrained in dealing with needs of patients. The vehicles may carry the NHS logo, but are run by profit-motivated companies where money is more important than patient care.

I've also been taken to & from hospital by minicab companies. The untrained and low-paid drivers often have no idea of patient care and can be uncaring and impatient if their passengers are difficult to deal with. I've had drivers who have had

to ask me for directions to get to and from hospitals. That is an unacceptable service, unfit for purpose.

There are three main issues that need to be addressed if patients are to have confidence in safe and secure transport over longer distances.

1 Vehicles

Purpose built ambulance transport is generally satisfactory. It provides reasonable, if not great, comfort and the vehicles are safe and secure. Ramps for wheelchair and walking frame access are usually available. The problem is with minicabs and small passenger-only vehicles. I've had occasions where the vehicle sent for me has not been accessible and I've had to wait for an alternative. The use of standard saloon cars provided by local cab companies is totally unsuitable for patients with walking aids, restricted movement and who may be in pain.

I recently was put into a saloon car with my walking frame which hardly fitted into the vehicle. I was then joined by two other passengers who both had large pairs of crutches – the driver spent ages to try and fit us all in with our equipment. One of the patients had just been discharged from the hospital following a knee operation. She was in some pain and was unable to stretch her leg to get comfortable as there was no room to move the front passenger seat forward. It was a very bad experience for her and for us.

If providers cannot provide suitable vehicles, they should not be used for hospital patient transport.

The longer journeys which will be undoubtedly occur under the 'Shaping the Healthier Future' hospital arrangements must be carried out in suitable vehicles to accommodate the needs of patients with a variety of needs for an accessible and pain-free service. I'm not asking for luxury limousines, just vehicles that are fit for purpose.

Having a suitable vehicle arriving to take a patient to and from hospital is currently a 'lottery'. I never know what type of vehicle will arrive, whether I can even get into it and what sort of journey I'll have.

2 Drivers and staff

Untrained minicab drivers are not acceptable in providing patient hospital transport. They work to priorities set by their employers which is usually to get the job done as

quickly as possible so as to get back on the road. They are unable to properly care for disabled passengers and those in pain. They are not trained to cope with anything urgent or emergency en route. They are not kitted out to deal with incontinence and any other patient needs. They should not be used for hospital patient transport services.

Again, patients often don't know which type of drivers and staff will turn up. It's a 'lottery' which cannot continue with the longer journeys that will be inevitably be required as a result of 'Shaping a Healthier Future'.

3. Timing

In my experience, again it's a lottery as to when patients are picked up and what time they'll arrive at their destinations.

For journeys into hospital for appointments and admissions, we're asked to be ready 2 hours before our allotted time. It's only anecdotal evidence, but from my experience and talking with other patients on board, I would suggest that approximately 50% of us arrive on time. That's not only a difficult situation for anxious patients worried about arriving too late but also for the clinics and receptionists who then have to re-organise appointments for late arrivals. I've been told to say **'Hospital Transport'** to receptionists as my excuse for lateness – they raise their eyes to the ceiling and forgive me. One of my clinics had closed by the time I arrived and I was sent home without being seen. On occasions, it has taken up to 4 hours from the time I was told to be ready until my arrival at the hospital. That can be a very stressful experience.

Obviously there are occasions when traffic conditions interfere with transport plans, but this should be the exception if sufficient time is allowed for timely arrival for appointments. Timing is a 'lottery'.

For journeys home, I've waited for up to 4 hours for transport following clinical appointments Add to that a long journey delivering several patients to various locations on the way makes for a very poor patient experience.

To sum up, If NHS services continue to be centralised and local facilities closed under 'Shaping a Healthier Future', hospital transport for elderly and disabled patients will become a growing and key part of patient care. Longer life and increasing demand for treatment will put even more pressure on transport services. If the current service levels continue, there is no way that patient needs can be met.

At the moment it's a 'lottery', the future looks bleak.

Issues of vehicles, drivers and timing must be addressed and major improvements put in place. The cheap options must be stopped.

Hospital transport provision must become **much better regulated** and monitored. Vehicles must be fit for purpose, drivers must be qualified to at least a minimum care standard and patient care must take precedence over operational profit. Currently, the opposite seems to prevail on many occasions. This must change as more patients will have to rely on these services in order to be able to attend their hospital appointments and admissions at more distant locations due to the 'Shaping a Healthier Future' plans.

I don't see a 'healthier future' – I just see cuts, closures and poorer patient experience, including failing hospital patient transport services.

Thank you for the opportunity for me to provide my evidence and for your attention. I'm happy to take any questions.

John McNeill 14.3.2015

From: [redacted]
Subject: FORMAL COMPLAINT 19 October 2012 Ambulance Service CONFIDENTIAL
Date: 25 October 2012 14:12
To: ped@londonambulance.nhs.uk

Dear Sirs

This complaint is made because it took so long to collect me to go to A&E Ealing hospital

Friday 19 October at 1735 hours 999 call made, by ex wife now onsite, to Ambulance Services, It was a wet rainy miserable evening. I was in very severe pain and starting to shout on account of it. Around 1815 hours 999 called again . They say they had to re-triage the call for help.

By now I am non stop shouting and swearing due to pain. At some point, we think, at 1830 hours, a paramedic arrives and tries to give me gas. The pain is so very great that drawing in gas through the mouth is agony, and I cannot do it. So I get no relief from the gas. Am given Paracetomol which starts to work. I arrive 2 ¼ hours later into A&E Ealing Hospital in a yellow ambulance..

It takes 15 MINUTES to walk from my front door to the A&E front door.

1. Why did this appalling delay happen?
2. Why don't you call patients when an ambulance is designated to your home and is on the way?
3. Why does the Boston Manor Ambulance station have so few vehicles? Please increase them.
4. Why can one of the stationary ambulances on the A&E ramp at Ealing Hospital not be called out to very local people in need of urgent transport? How will you improve co-ordination of knowledge regarding ambulance location and ambulance availability?
5. What specific improvements will you make to avoid this happening again?
6. I have never shouted in pain for 90 minutes or more - non stop. How will you compensate me for the very real physical suffering - and the mental shock.?

Yours sincerely

Richard HERING
[redacted]

To Peter Smith Clerk to Commissioner and
Michael Mansfield QC Chair of Commission 25th Feb 2015

I am not sure if this is now too late for your Inquiry but I wanted to say what wonderful treatment I received yesterday from the NHS in Ealing

I experienced chest discomfort and rapid heart beat aound 4.00PM Tuesday 24th Feb and as I was worried I went to my GP at Bramley Rd Surgery Ealing W13
I was seen almost immediately

I was given a thorough examination and questioning by a GP. In front of me he rapidly typed a lengthy report including past history and details from my electronic file .

I was told to go immediately to A&E Ealing Hospital and present the report to the Medical Team. My husband took me in the car. The machines in the car park were broken so free parking! (Why isn't it always like that? Awful to have to scrabble around to find appropriate change when you're under pressure ...then worry that, as time goes by in hospital you may be FINED!)

With almost no waiting after arriving at A & E at 5.00PM I was taken in to the Department, a nurse checked out some details and I was given a bed. Then a succession of tests were applied: Blood Test, Blood Pressure/temp/heart, Urine test, ECG, XRay and then a thorough examination by a Dr.
Everything was spotless, staff were efficient, reassuring, charming, helpful and although there were many other patients it was a model of peaceful calm. I was even brought a cup of tea and offered sandwiches.

After a final detailed Q&A and examination by a charming female Dr (who looked the age of someone just out of school!) I was told they could not find anything wrong but I was quite right to go to my GP and he was quite right to send me in. They would refer me to a Cardiologist and I will receive invitation for more heart checks just to be sure! Finally, the chief Dr came to see me and said I could go home! It was, by then 8.15PM

I could not fault anything and felt so proud of all of the staff, our wonderful NHS and Ealing Hospital!
I do not think Ealing Hospital should be closed down! It is great!

Judith Breens
[redacted]

NHS
Ealing
Clinical Commissioning Group

Professor Lowy

[redacted]

3rd Floor
Perceval House
14/16 Uxbridge Road
Ealing
W5 2HL

Tel: 020 3350 4366
Email: andrew.pike3@btinternet.com

13 February 2015

Dear Professor Lowy

US Study tour

Many thanks for your letter dated 22 January 2015 regarding the US study tour.

In North West London we have listened to patient frustrations about difficulties in finding their way through the system and repeating their story multiple times. The visit was part of a national initiative, funded by the Department of Health through the Pioneer whole system programme to foster innovation and drive forward more joined up health and social care.

The US was chosen for the visit as it allowed participants to visit several locations that are using a different approach to care, performance systems and capitation especially in relation to elderly care which is a key focus of the NW London early adopters.

McKinsey & Co successfully bid to provide consultancy support to the NWL Pioneer work and this included facilitating a study tour of US sites. McKinsey have previously helped arrange study tours for other parts of the NHS and were asked to use their experience in organising the programme and travel logistics.

The visit allowed 23 people: clinicians, officers and lay people from health and social care organisations across NWL to learn about how they can improve care for their patients and gain a better understanding of how others are approaching integrated care, share that with others and be better informed to lead the improvements to care for our 2 million residents across North West London. During the visit participants were able to:

- See innovative care first hand
- Learn how key elements of Whole Systems have been successfully implemented in practice
- Excite and inspire a coalition of leaders

On their return participants are in effect expected to become the leaders for health and social care integration and share their learning during a variety of ways. In the coming months we will also be looking at how we can share the learning with a wide audience.

I trust this answers your questions.

Yours sincerely,

Andrew Pike
Assistant Director of Communications

cc Suzanne Lyn Cook

Hillcrest Surgery 337 Uxbridge Rd London W3 9RA

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Partners:-

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[redacted]

Dear Dr Lowy

Thank you for your letter. I hope to answer some of the points you raise:-

A&E waiting times in Ealing are being met, and we have no plans to close the department. In September 2014 the departments at Central Middlesex and Hammersmith were closed on the advice of the Independent Reconfiguration Panel chaired by Lord Ribeiro (previous president of the Royal College of Surgeons). because of safety concerns in accordance with the work that had been undertaken by a large number of clinicians across the region.

It is correct that performance in A&E across the country were poor compared to the 95% standard over the winter period and this was reflected in North West London. However performance across the area was better compared to other parts of London or the country, and have recovered more quickly. Ealing Hospital in particular is now meeting the 95% target of being assessed, investigated and either admitted or discharged within 4 hours, in part because of the support from the Urgent Care Centre which runs alongside the A&E. In addition to this the remaining A&Es (including Ealing) have been able to increase their medical and nursing teams so that there is on-site consultant delivered care for 16 hours a day. At Central Middlesex prior to closure it was less than 8 hours a day and at Hammersmith there were no A&E trained consultants. I've attached a couple of sheets that give the details.

I'm afraid that, other than being an advisor to the Ealing CCG, I am not part of the management structure within the CCG so can't answer your comments regarding the trip to the USA in any detail. Certainly I went on a similar trip some years ago and did find it useful. The American health care system is

much less efficient than the NHS and has great inequalities in access with many people not accessing basic care - but some parts of the system were instructive. Highlights included meeting the clinician who was advising President Obama on the proposed health care reforms; visiting ChenMed where high input to frail elderly patients was having a great impact on patient satisfaction and the proactive planned care was reducing costs by reducing unplanned admissions; integrated care in Geisinger Health Care in Philadelphia showed the use of integrated care, supported by informatics which were possible when the artificial primary-secondary care division was overcome.

Audiology is now provided by a wide range of providers (introduced by the last government), including Boots, SpecSavers and the local hospitals. The referral is not reviewed or vetted as you suggest, but administrators ensure that the referral and appointment is arranged where the patient wants. This is to reduce the work in individual practices and help patients choice. There are other specialities where a specialist reviews all referrals (e.g. cardiology, gastroenterology) as we found there were some routine referrals that should have been sent urgently or where physiotherapy could hasten recovery whilst waiting to see an orthopaedic surgeon. The system remains under review, but regular audit shows that it doesn't add any significant delay and has sped up care in a significant number of high risk referrals.

I'm very sorry that you have found the medical expertise at Hillcrest to be unsatisfactory. As you may know I am no longer a partner at the practice, but attend most days to run an early morning commuter clinic. I would be very pleased to investigate and seek to address any specific problems you've encountered. but I hope that you find your new practice meets your needs.

Yours sincerely

Mark Spencer

Performance in North West London has been above the rest of London

- Across Q3 the North West London sector was the highest performing for all type A&E performance and therefore above the London average performance for the quarter. Performance at London North West Healthcare was 6.82% above the lowest performing Trust in London across the whole of the third quarter.

	Q3 2014/15 All-type performance	Q3 Admissions 13/14	Q3 Admissions 14/15	Increase in admissions in 2014/15	Q3 Attendances 13/14	Q3 Attendances 14/15	Increase in attendances in 2014/15
North West London Area	92.87%	47,508	47,648	0.29%	307,269	327,683	7.65%
North East London Area	92.01%	72,071	73,446	1.91%	427,310	460,014	6.64%
South London Area	92.27%	68,084	72,859	7.01%	370,368	371,375	0.27%
London	92.34%	187,663	193,953	3.35%	1,104,947	1,159,072	4.90%
England	92.56%						

- Admissions have been broadly flat year on year in North West London area compared to an average rise of 3.35% in London. However, attendances have increased in North West London area by over 123 per day compared to the previous year, with this equating to a 7.65% increase in attendances in Q3 14/15 compared to 13/14. The performance position has been secured despite this increase.

- Length of stay has reduced by 9% at Northwick Park site (Oct 2014 compared to October 2013) meaning that patients are not having to spend as long in hospital and resources are being used more effectively.

- The North West London area had the highest A&E performance of the three London sectors in 10 of the 13 weeks of Quarter 3. There was only one week in quarter 3 where London North West Healthcare had the lowest all type performance in London. The North West London sector has continued to out perform other sectors at the start of Q4.

- Performance at North West London has continued to be well above the lowest performing organisations and provisional performance for 14th January at 89.83%. This was the 11th highest performance out of the 20 trusts that reported.

- For elective care North West London has the lowest number of 52 week waiters across London, is second of the three areas in terms of admitted performance (during this period of backlog clearance) and highest performing against the 62 day cancer standard.

	November RTT 52 week waiters	November RTT admitted performance	Cancer 62 day performance Q2
North West London Area	4	85.60%	83.46%
North East London Area	6	86.80%	79.28%
South London Area	26	83.10%	77.31%
London	36	85.60%	79.20%

...And the clinical model has improved due to the reorganisation of A&E

- The sector now has a more clinically sustainable and safe service, with patients having access to consultant led emergency care and primary care led urgent care in ways not possible before the changes.

- There are:
  - A further 6 A&E consultants at Northwick Park compared to last Winter enabling increased hours of consultant cover to 3 A&E consultants 8am to 10pm and at least 1 consultant up to midnight.
  - Weekend consultant cover at Northwick Park has moved from 9am-5pm to 8am-midnight
  - A further 6 A&E consultants across Imperial Healthcare Trust's A&E sites
  - 6 additional core medical trainees in emergency care at Imperial
  - Additional emergency department flow co-ordinator at Imperial

- Overall the bed numbers for the North West London Sector are up by 39 in 2014 compared to 2013, with Northwick park having an increase of 37 beds.

- All 9 urgent care centres in NW London are now open 24/7. The UCCs at Hammersmith and Central Middlesex are working to the new enhanced UCC model and achieved the 95% target throughout the quarter.

- 291 practices across North West London are now offering evening and weekend appointments which are accessible for 1,729,612 patients

- Delayed Transfers Of Care at North West London Healthcare have reduced from 5.50% of beds being unavailable due to delayed transfers of care in November down to 1.52% on January 14th.

BOARD ASSURANCE FRAMEWORK

CCG Objective	Risk
Objective 1: Empowering patients to take more control of their health and wellbeing through delivery of the 'whole systems integrated care' programme.	**1** – Engagement with patients is not adequate to enable them to make informed choices about their care.
Objective 2: Securing high quality services and improved outcomes for patients	**2** - Inability to specify outcomes that we want to see providers deliver leading to reduced impact of commissioning.
	3 - Safeguarding Children – failure to meet statutory responsibilities leading to poor quality care
	4 - Safeguarding Adults – failure to meet statutory responsibilities leading to poor quality care primarily in care homes but also other providers
	5 – Imperial not delivering services to the agreed standard and lack of alignment between their strategy and our operational delivery
	6 –Chelsea & Westminster do not deliver services to agreed standard
	7 – Inability of West Middlesex to deliver services to agreed standard and impact of the transaction with Chelsea and Westminster
	8 – Inability of Ealing Hospital to deliver services to agreed standard
	9 – Inability of Central London Community Healthcare to deliver services to agreed standard
	10 – Inability of West London Mental Health Trust to deliver services to agreed standard and to deliver elements of the out of hospital strategy
	11 – Inability of Central & North West London Trust to deliver services to agreed standard and to deliver elements of the out of hospital strategy
Objective 3: Putting in place the infrastructure to deliver high quality commissioning	**12** – Failure to put systems in place to deliver improvements in commissioning support.
	13 – Not managing the relationship between CCGs and member practices effectively
Objective 4: Building relationships with local authorities and Health and Wellbeing Boards to deliver the Better Care Fund plan, and developing and delivering joint plans with other CCGs across North West London.	**14** - Lack of alignment between approaches taken by CCGs and Local Authorities means that the benefits set out in the Better Care Fund workstreams are not realised and unmanageable cost pressures in 2015/16.
Objective 5: Delivering the Out of Hospital Strategy and acute hospital changes as set out in the Shaping a Healthier Future Strategy.	**15** - Through unsustainable demand, uncontrolled delays to the delivery timelines and an inability to deliver the required clinical workforce Shaping a Healthier Future delivers precipitate, poorly planned change, which adversely impacts quality and safety
	16 – Through an inability to meet the clinical standards, deliver the requisite workforce, deliver behavioural change, sustain expected patient experience and unsustainable demand on the system Shaping a Healthier Future does not deliver the planned benefits to improve quality and safety of health and care across NW London
	17 - Primary care and community care providers are not able (due to organisational and workforce issues) to deliver the increase in activity required to deliver services as described in the Out of Hospital Strategy
Objective 6: Delivering our statutory and organisational duties	**18** - Failure to deliver IT systems which can deliver data CCGs need
	19 - Failure to operate in a way that meets required Information Governance standards
	20 - Failure to meet in year financial targets and to deliver the planned underlying surplus that underpins longer term financial sustainability

Addendum to the Submission to the Independent Healthcare Commission for North West London by Eve Acorn

Community Centres

In November 2014 the Ealing Council Cabinet decided to remove all subsidies from all 8 of their Community Centres.

The subsidy last year for Perivale Community Centre was £38,000. This means the Centre will have to find an extra £38,000 for day to day running plus an unknown amount for increased rent and other increased expenses. The Centre Management Committee is relying on the groups which hire the facilities to find the money. However they are fearful of pricing themselves out of the market because they will have to increase the rent by at least 33% and possibly by 50%.
I am fearful that users faced by such a large increase at Perivale, will leave and finding similar increases at the other centres, will simply cease their activities altogether.
At Perivale Community Centre, there are many clubs beneficial to physical health and mental wellbeing. (See some examples in Appendices (a) and (b) below).
I personally play table tennis and short (indoor) tennis there. Hence my knowledge of the above through attending the Management Committee Meeting today 20th March 2015.

Ealing Mental Health Services

This is an update of the information given in attachment (1) in my original submission - 'Letter to local newspaper.'

Solace: Is still under threat but may be saved at a cabinet meeting on Tuesday 24th March 2015. Under the proposals, users would have been given personal budgets to buy alternative support services once the centre shut. The centre may be funded in the short term by the council until alternative arrangements have been evaluated.

John Conolly Unit: This building on the St Bernards Mental Hospital site has been demolished. The patients have been moved to the main building.

Lammas Centre: This has been sold.

Manor Gate and Cherrington House: The recovery teams have closed. There are now just two teams covering Ealing - East and West recovery teams. The East one is located in Acton and West in Southall. The Southall one has a satellite service in Northolt 3 days a week to cover those living in the North. Cherrington House now houses an assessment team that take referrals from the GP.

Carlton Road Day Centre: This is still under threat of closure as is Elm Lodge.

Appendix (a)

Perivale Community Centre

Toddlers / Pre-School Activities
- Pre-school
- Parent and Toddlers

School Age Activities
- Ballet
- French
- Bulgarian Language
- Bulgarian Dance
- Futsal (Football)
- Disabled Children's Christmas Party
- Beavers Easter Egg Hunt

Youth Activities
- Aikido
- Archery (2 clubs)
- Swimming (2 clubs - theory, first aid)
- Kung Fu
- Athletics

Disabled Activities
- Disabled Bowmen of Perivale
- MENCAP
- Disabled Children's Christmas Party

We also have disabled users in:
- Bowls
- Bowls League
- Creative Crafts
- Bingo
- Painting and Drawing
- Pins and Needles (craft)

Appendix (b)

MANAGER'S ANNUAL REPORT 2014/15

Centre Events

The Association held a table top sale in May 2014 to raise funds.
There are plans to hold a Christmas Raffle in December 2014 to raise funds.
The Association held a Christmas Craft Fair in November 2014 to raise funds.

This year (April 2014/March 2015) we have raised £2,751.45, from the table sale, craft fair, raffle, donations and the honesty box.

The following groups have joined Perivale Community Centre

Archery Gold – have increased their sessions on Saturdays.

Greenford Northolt and Perivale (GNP) Community Federation - have used the Centre three times during the past year. A Dr. Bike session, where people can bring their bikes to the centre for a service and advice free of charge. A Healthy living? session where people were advised on how to change their eating habits and eat? healthily free of charge. A health screening session – nurses to check their blood pressure etc. and give advice free of charge.

Defensive Driving Training – this is a morning course in March 2015.

Kick Boxing will hopefully re-start their sessions in April 2015.

Group Updates

Friday Bingo –Since the Centre took over the running of this group, the numbers are averaging 25 each Friday and the members are enjoying their sessions.

I would like to take this opportunity to thank Vic, Donna & Matt for all their hard work on behalf of the Association. I would also like to thank Garry for her continued support and guidance.

March 2015

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 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

Lewisham Hospital and the TSA proposals to downgrade it.

In the summer of 2012 the Government appointed a Trust Special Administrator using for the first time ever the Unsustainable Provider Regime legislation. The South London Healthcare Trust was in severe financial difficulties, mainly due to excessive PFI repayments, and it was decided to send in a TSA to "find a solution". As well as recommending the break up of the SLHC Trust and the takeover of its constituent parts by other bodies, the TSA recommended the downgrade of Lewisham hospital which was in a separate neighbouring trust and, importantly, not the trust to which he had been appointed. This was a replay of proposals several years before under the Picture of Health plan which had proposed downgrading Lewisham Hospital and which failed, partly because it could be shown that the patient flow estimates were wrong. Indeed several of the protagonists who supported the TSA proposals for Lewisham including senior people in NHS London talked of this as "unfinished business". The Picture of Health did lead to the downgrade of Queen Mary's Hospital in Sidcup and its incorporation into the new South London Healthcare Trust, with significant implications for healthcare in the area which still affect us today.

The proposed Lewisham Hospital downgrade would have closed it as a District General Hospital. The A+E was to close and be replaced by something referred to as an "Urgent Care Centre Plus" or "small A+E". Exactly what it would offer was not specified but it would not qualify as a major A+E by the standards of the College of Emergency Medicine. The hospital would lose all acute medical, surgical and paediatric beds and its ICU. The initial proposals included either the complete closure of the maternity unit or a "freestanding" obstetric led unit – i.e. one without any emergency ICU, medical, surgical, paediatric or blood bank back up. The site would have retained the UCC, some rehab beds, some out patient clinics. And an elective surgical centre was planned. The final proposal also included a midwife led birthing unit. 60% of the site would have been sold off. The fate of the in-patient psychiatric unit in the Lewisham hospital site, run by South London and Maudlsey NHS trust was not even mentioned.

The basic reason for this proposal was financial but the TSA tried to use clinical justifications. All clinical groups in Lewisham not only opposed these plans but also submitted detailed critiques of the justifications, showing them to be without foundation and full of errors.

The clinical groups who contributed to the critique were:
Emergency Department consultants and matrons
Obstetricians
Paediatricians
Anaesthetists
Intensive care consultants
ENT consultants
General physicians
General surgeons

General practitioners and Lewisham CCG
Director of children's services
In addition there was a detailed 23 page critique by Lewisham Public Health department. There were also detailed criticisms by Lewisham Children's Service Manager for health visiting and safeguarding and the Lewisham Local Safeguarding Children Board.

Lewisham people fight back

There was a massive campaign of resistance to these plans supported by all sections of the community and culminating in a demonstration of 26,000 on 26 January 2013. This was not enough to convince Jeremy Hunt to reject the TSA proposals. There then followed a judicial review by both the Save Lewisham Hospital Campaign and Lewisham Council which was successful in the summer of 2013 and again at appeal in November 2013.

It's important to state that Lewisham won the JR because of an interpretation of the law. It's of note that there is no mechanism in the consultation process for such fact-based critiques to lead to corrections or the removal of erroneous or unwarranted assertions or arguments.
The fact that the consultation, evidence and arguments that were put forward by the TSA to justify the Lewisham downgrade were full of errors, flaws and inadequacies should by rights have mean the proposal was rejected. But there is no mechanism to do so. JRs only deal with points of law. There is no forum, no "court" for evidence and critique. No matter how sound the criticisms were, no matter how many errors we identified, none of that was taken into account, let alone even acknowledge or answered by the TSA. I believe this is a fundamental flaw in the so-called consultation process.

If you look at the Save Lewisham hospital Campaign website you will see each of the detailed evidence based critiques by clinicians and others. It makes one want to weep to think how much effort went into all that and how it counted for absolutely nothing in the decision making process. Luckily we had the law on our side but not everyone has that.

The TSA proposals were erroneous, lacked sound evidence or failed to take account of reality. The final proposals failed to take account of the criticisms or correct errors and inaccuracies.

1. Impact of closure of the A+E and its replacement with an "Urgent Care Centre Plus" model.

The suggested use of a 'UCC plus' model was criticised by Lewisham clinicians - ED doctors, other hospital doctors and GPs. These were some of the points they made:

- Under TSA plans, 77% of ED (A+E) patients were expected to attend the future UCC. This would rely on paramedics, ambulance technicians and GPs being able to determine before sending patients to the UCC that they will

not require admission. These practitioners send their patients to an ED precisely because they cannot make this determination beforehand.

- At the present time approximately 7 in 10 patients referred by GPs to the ED are managed by the emergency doctors who utilise hospital systems and services in such a way that they can be discharged home. This ability would be lost in a UCC of any variety.
- A 'UCC plus' would still be deprived of a Resuscitation room; this would present a major risk to patient safety, given that a significant number of ED patients deteriorate after initial presentation to the GP/London Ambulance Service.
- The proposed 'UCC plus' would have to function in the absence of a HDU/ITU; critical patients who deteriorate after initial assessment will therefore require transfer to another trust, yet another (unnecessary) risk to patient safety.
- A 'UCC plus' is an untested model that shows no real advantage over other models in the absence of the other acute services you propose to cut.

The figures used by the TSA to say that 77% of those attending Lewisham A+E could be managed in an UCC Plus were challenged. Lewisham ED consultants looked at the evidence and stated that only 30% of attendances could be managed in a standalone UCC and that 70% would have to be seen in a neighbouring A+E – almost the exact opposite of the TSA estimates. The Lewisham ED consultants however provided detailed evidence for how they came to that conclusion; the TSA by contrast used a crude simplistic method that did not stand up to clinical scrutiny. The TSA estimated that because only 23% of A+E attendees were admitted to hospital then the other 77% didn't need to be in an A+E. That totally fails to understand the nature of an A+E. The whole point of A+E is that sometimes its not clear if someone needs to be admitted (– I say that as a GP who has sent patients to A+E unsure if they have, for example, appendicitis or not.) Hospital based expertise is needed to make those decisions. If that expertise were not there then those patients would go elsewhere for assessment, greatly increasing the flow of patients to other A+Es beyond that which was imagined by the TSA. Furthermore because the Lewisham UCC was staffed with ED doctors too for 24 hours, and had the backup of collocated acute hospital service, it could confidently accept and manage patients with a greater degree of severity of illness than had it been a standalone UCC.

The TSA also included the notion there would be a 30% reduction in A+E attendances anyway, based on unspecified, untested and uncosted changes to "care in the community."

The TSA envisaged that the remaining 23% who did need an A+E could be transferred to other A+Es. Their aim was that the majority of those would go to Queen Elizabeth A+E. They did no modeling of the impact of this extra number of patients attending either QE or other A+Es, no modeling of patient flow and where patients were likely to go and no modeling of impact on neighbouring hospitals if their estimate of only 23% was wrong and it was actually higher. The reason the previous Picture of Health proposal to downgrade Lewisham had failed was because patient flow modeling showed most people in Lewisham

would choose to go and ambulances would take people to Guys and St Thomas's or Kings if they were very sick, and not to Queen Elizabeth in Woolwich. The way the TSA dealt with that problem was not to repeat those patient flow estimates.

Consultation with neighbouring ED colleagues suggested that they did not have the capacity to absorb these numbers. Subsequent events show that would have been a disaster as Queen Elizabeth Woolwich A+E (now part of the new Lewisham and Greenwich NHS Trust) recently failed its CQC inspection and was found "not fit for purpose" because it could not handle even the number of patients it was seeing, and did not have enough beds to admit acutely ill patients too. How much worse it would have been if Lewisham A+E with its 120,000 attendances a year had closed. Even if only the 23% the TSA envisaged had travelled to QE that would have proved disastrous.

The estimates of what would happen to the most seriously ill patients are perhaps the most important as the risks for such patients are higher. One would have thought therefore the TSA would have been at pains to get this right. But here too there were big inaccuracies. Here is what the ED doctors said:

- The TSA report claims that UHL ED receives on average 2 'Blue-light' ambulance attendances per day. This figure is not derived from any data that Lewisham ED provided.
- Lewisham ED received on average 4-5 'Blue-light' ambulance attendances/day. These verifiable numbers were derived from their departmental software which automatically logs all ED attendances.
- The use of 'Blue-light' ambulance attendances as an indicator is flawed, as it does not address the considerable number of patients admitted through other areas of the ED who subsequently deteriorate to such an extent that they then require transfer to our Resuscitation room.
- Analysis of Lewisham Resuscitation room records reveals a daily average (2011-12) of 10-11 patients being admitted to the Resuscitation room for intensive/critical level care. This was a far truer indication of the number of such patients who would need to be transferred to neighbouring EDs by 'blue light'.

2. Care in the community

The TSA plans assumed that 30% of the volume of work currently done in the ED would be transferred to the Community. This claim was central to all TSA proposals yet there was no evidence to support it.
This has not been achieved anywhere in the UK before. There was no robust evidence to support this claim (certainly it is not contained in the report or its appendices).
Such a change would require significant infrastructure and personnel investment.
There was no indication as to the facilities that would have to be put in place
There was no detailed financial costing of what is needed to achieve this
The language of the TSA report in relation to community care was peppered with words like "aspiration" and "vision" – nothing real or concrete.

3. The other-worldly travel time estimates

The sound bite used by Kershaw and his TSA Office and the Department of Health for Jeremy Hunt suggested that journey times to A&E for southeast London people would only be increased on average by 2-3 minutes. They were talking about the ***average impact on 1.64 million residents of the 6 boroughs of SE London, yet the closure of Lewisham Hospital mainly affects the 275,000 residents of Lewisham.*** Using the TSA's own data, never quoted in public statements, the impact on Lewisham people was 5-fold greater or even worse. And in the case of critically ill patients in blue light ambulance transits, at least 1 in 20 would have been in danger of breaching the standard for such emergencies to access A&E within 30 minutes.

Inadequate basis for estimating travel journeys
In the Draft Report of the TSA, an astonishing admission was offered on the source of the TSA's travel data. The TSA used its commissioned Deloitte's analysis of data derived from Google maps travel time analysis (p25, Health and Equality Impact Assessment Scoping Report, Appendix H). Footnote 28 helpfully advises how typical Deloitte's quoted times might be with the following cautionary note: *'Private transport travel times are calculated on the basis of average speeds and travel times during periods of no traffic. Travel times may be higher during periods of busy traffic.'* If this were not so outrageous it would be funny. Less funny if you are setting off at any normal time of day ***when there is traffic***, let alone in rush hour traffic between 7.30-9.30am or 4.30-6.30pm for an appointment, or a visit to A&E, or a visit to a relative in the hospital.

Save Lewisham Hospital Campaign tested public transport journeys from Lewisham to Queen Elizabeth Hospital in Woolwich. The journeys were filmed and put on the campaign website.
Campaigners' two test journeys by public transport each took well over 90 minutes! – one on a Sunday morning (1 hour 50 mins) and one on a Wednesday morning at 9am (1 hour 48 mins). A third journey by taxi took trust doctors 40 minutes to travel to a meeting at Queen Elizabeth Hospital on a Friday morning at 8.30am

4. The "100 lives a year saved" claim

TSA consultation document stated their plans would "save 100 lives a year" I south east London. This was based on a back of an envelope extrapolation from national estimates of differences in hospital mortality between weekdays and nights and weekends. The idea that you could simplistically extrapolate to a local situation from research that was quite circumspect in its conclusions was roundly criticised in a letter from Lewisham consultant Dr John O'Donohue to Sir Bruce Keogh which I attach as an appendix to this.

5. The "everything is better in specialist units and we don't need DGH's claim"

This notion, promoted by the TSA to justify closing acute medical and surgical services in Lewisham, was taken apart in Dr O'Donohue's letter. In short, one cannot extrapolate from the 3-5% of emergencies which are stroke, heart attack and major trauma and are better treated in specialised centres, to the >95% of common emergencies for which there is no evidence that they are better treated in specialist centres and moreover evidence that, especially for the most time-critical conditions such as meningitis and acute asthma, it is better to treat patients where they can get the right care most quickly – in their local DGH.

6. The proposals for either no maternity or a "free standing obstetric led unit".

Lewisham Public Health provided a detailed critique of the plans focusing on the impact on women and children of losing acute paediatrics and maternity. They said:

> The growth of the population within Lewisham continues to rise. Kings and Guy's and St Thomas's do not have the capacity to manage extra 4-5,000 births per year. Furthermore between 10-20% of Lewisham pregnant mothers at any one time are receiving additional support from both maternity and health visiting services because of their complex health needs and/or vulnerability. With the closure of maternity services the lack of a robust pathway and timely communication from other non local providers of maternity services will place the unborn child and mother at increased risk of poorer health outcomes.

What is striking about the public health paper is the detailed evidence they used right down to ward based information on birth rates, for example. This rigorous and evidence based approach contrasted with the woolly arguments of the TSA report– it seemed to have no connection at all with not only the reality of Lewisham but also the already rich source of data on the lives and health needs of the population. For proposals that would have such a profound impact on health services one would expect the TSA to have been at least as rigorous and evidence based and actually used public health knowledge, skills and expertise.

> In the end the TSA changed the maternity proposals after the consultation period was over to propose something that was not even mentioned in the consultation – a "standalone midwife led unit". Lewisham consultant obstetricians did not believe that was appropriate because of the high number of higher risk births in Lewisham but there was no opportunity for them to put this view forward as the proposal was not consulted on at all.

7. The lack of any consultation on paediatrics

The TSA recommendations make no reference to how proposed changes will affect the provision of children's services in Lewisham, indeed the recommendations make no comment on how changes may affect children at all. This was an astonishing omission considering that 20% of the population were children and both Lewisham and Greenwich are two of the most deprived boroughs in the country, with known impact on child health from deprivation.

8. Lack of consultation on mental health

There was no mention of mental health impact in the consultation even though the A+E is a place for mental health emergencies to receive urgent care and assessment through on call Psychiatric Liaison Nurses and Psychiatrists. There was no discussion of the fate of the inpatient psychiatric unit run by SLAM on the Lewisham Hospital site. The site was in the area indicated for self off in the plans for the hospital site hidden in an appendix of the TSA report.

9. Lack of health equalities impact assessment

- The TSA did not perform any health & equalities impact assessment prior to the end of the consultation period
- Appendix H *scopes what should be done but has not started* the assessment
- TSA proposals were therefore developed without knowing the potential impact
- Matthew Kershaw confirmed that when the HEIA assessment was to be completed it would be after the closure of the consultation period.
- The Secretary of State for Health received the HEIA but the public and Lewisham Healthcare were not able to respond
- This was fundamentally flawed and unjust and the failing was in the context of Lewisham and Greenwich being amongst the most deprived local authority areas in the country whilst Bexley and Bromley are amongst the more affluent (notwithstanding small individual pockets of deprivation within Bexley)
- TSA report refers to benefits of super-centres for stroke, heart attack, vascular and major trauma emergency as an argument supporting the loss of Lewisham's A&E en route to better care; ignoring the vast majority of urgent medical situations of the local population, many of which are linked to deprivation and the specific needs of a multi-ethnic population such as Lewisham, a few examples being:
  - Diabetic crises
  - Bleeding in pregnancy
  - Sick children
  - Sickle Cell crises; etc.
- No *serious* assessment of impact on access to A&E healthcare for Lewisham residents has been done: estimates are based on travel at times when there is 'no traffic' (Table 4) **p25**
- Barriers to access put before a vulnerable population will harm health
  No health equalities assessment = no credible proposals

10. Lack of any consideration of impact on training

> The TSA report totally failed to mention teaching and training. In Lewisham the proposed downgrade would have had an impact on specialist medical, surgical, GP, nurse (including specialist nurse training in colorectal cancer, upper GI cancer, endoscopy and enhanced recovery), physiotherapist and medical student training. Contributors noted that this commitment to training was part of the ethos and helped to raise the standards of the care they delivered to the residents of Lewisham,

It was noted that the Deaneries and Colleges would be unlikely to sanction the hospital for training if there were no acute services on site. The loss of trainees would lead to severe challenges in providing physician cover for any proposed UCC, thus increasing our dependence on locum doctor cover.

11. Implausibility of the elective centre

> The TSA proposal for an elective surgery centre in the Lewisham site was so full of holes that it is clear it would never have got off the ground.
>
> Here are some of the comments made by Lewisham surgeons on why the plan was not feasible:
>
> The proposed Lewisham Elective Surgical Site centre (which should perhaps be called "LESS") with up to 44,000 cases per annum by 2015/16 assumed a referral pattern which has little basis in reality. As surrounding hospitals are to retain their day surgical centres, they are likely to keep their minor and intermediate cases, which will stay "local". Neither will complex major cases be referred, as these would require ITU care, which you plan not to have at the LESS. This leaves a rather uncertain number of "simple" major cases to be done at LESS – presumably only if this can be achieved at less cost. Even "simple" major cases will, on occasion, need ITU care. If there is no ITU on site safe clinicians will modify their case selection to allow only the simpler major cases to be done at LESS, narrowing the selection profile further. Since there is no guarantee that future commissioners will wish to refer cases to LESS, the actual numbers of suitable referral cases would appear to be very limited and we cannot see how this would be viable in the long term without the retention of critical care facilities.

Dr Louise Irvine, Chair of Save Lewisham Hospital Campaign and Lewisham GP
25.03.15

01 February 2013

Professor Sir Bruce Keogh
NHS Medical Director

Dear Professor Sir Bruce Keogh,

We noted with great interest your letter to the Secretary of State for Health dated 30th January 2013[i] following his request for an independent clinical view on the recommendations by the Trust Special Administrator (TSA) for South London Healthcare NHS Trust (SLHT). The Secretary of State for Health's decisions were influenced by your advice, including the amendments made to the TSA's recommendations regarding Lewisham Healthcare NHS Trust.

We write with particular reference to the Secretary of State's decision to recommend the downgrading of University Hospital Lewisham's (UHL) emergency admissions and maternity services. We consider it a matter of public interest that you make available the evidence on which you have based your advice to the Secretary of State. This advice may ultimately have proved pivotal, since it has underpinned the assertions he made during the announcement to parliament on 31 January and has therefore provided clinical justification for the changes now proposed at UHL.

1. We would be grateful if you would supply us with the clinical evidence behind the Secretary of State for Health's claim[ii]:

   "Already, her constituents who have a stroke or a heart attack do not go to Lewisham hospital. They go to Tommy's or Guy's or other places where those specialist services can be delivered, and they get better treatment. We are expanding that principle through what I am announcing today, and it will save around 100 lives a year. That is something that she should welcome."

   In your letter to the Secretary of State, there is no mention of, or clinical justification for, the assertion that extending 'that principle' would save around 100 lives a year.

   We have investigated the origin of this assertion. A similar assertion has been made by NHS London: *Adult emergency services: Acute medicine and emergency general surgery; Case for change.*[iii] In pages 16-17, the main source for this assertion is the analysis performed by Aylin et al of the Dr Foster Unit at your own institution[iv] of 4.3m emergency admissions from 2005-6. Reference is also made to smaller studies which present similar results [v vi vii].

The interpretation of the Aylin study by NHS London ([viii]page 17) is as follows:

In a national study Aylin et al found that this effect is of the order of 10% nationally for in hospital mortality, and may be even greater if the period extended to 30 days post admission.

London data is [sic] in line with these findings. This suggests that across London there will be a minimum of 500 deaths each year which may be avoidable if services functioned more effectively.

From the Aylin study, the excess mortality for England is estimated as 3369 deaths. We can see how, proportional to population share, a London figure of 500 can be derived from this by NHS London as above, and a figure of 100 could be derived for SE London for use by the Secretary of State for Health.

But if we examine the Aylin study itself from which this figure was derived, there are fundamental flaws with this deduction.

<u>The calculation of excess mortality makes an unwarranted assumption:</u>

On the assumption that patients admitted at the weekend have the same risk of death as those admitted on weekdays, we estimate a possible excess of 3369 deaths (95% CI 2.921 to 3.820) occurring at the weekend for 2005/2006, equivalent to a 7% higher risk of death.

This is indeed a heroic assumption: that patients admitted as an emergency to hospital have the same risk of death (prior to admission) as patients admitted during the week. In the discussion, the authors themselves acknowledge the limitations of this assumption:

There could have been differences in case mix between patients admitted during the week and at weekends. We attempted to take some account of case mix in our model, but there may be still some residual confounding, which could lead to either an overestimation or underestimation of risk. There were indeed fewer patients admitted on average at the weekend, and this might point to a different case mix for which we have not adequately adjusted.

A major weakness of the study is the lack of calculation of severity score of the presenting illness. This cannot be resolved without the source data. A proper analysis would also require the severity score at time of admission and the duration from point of admission to death. The fact that the daily emergency admission rate at the weekend is only 75% of that during the week may well indicate that patients who present at the weekend are a sicker subset of those who present through the working week, with heir more severe illness explaining their higher mortality. That the weekday-admitted and weekend-admitted groups were matched for age, sex, co-morbidity and deprivation in no way proves that the severity of the presenting illness leading to death was equivalent. A more recent study[ix] has found similar differences in mortality in patients admitted at the weekend, in particular Sunday, but has cautioned against the interpretation that this is as a result of differences in quality of care.

A second weakness is the assumption that higher mortality in patients admitted at the weekend results from a decreased level of staffing at the weekend. There are other explanations, including a reduced level of specialist intervention and access to diagnostic services at weekends. It is noteworthy that Lewisham Hospital has had a robust system of twice-daily consultant ward-rounds and access to out-of-hours diagnostics for 8 years.

The conclusion made by the Secretary of State is therefore not founded on robust clinical evidence. It is troubling that such an unsafe conclusion could be used to make an assertion that has obviously influenced his decision, not just in the case of Lewisham Hospital but in general, that larger units will achieve better clinical outcomes.

2. We would also be grateful for your urgent clarification of the evidence for the following assertions made by Mr Hunt in parliament[x]:

   To meet the London-wide clinical quality standards, which are not being met in south-east London at present, it is necessary to centralise the provision of more complex services in the same way that we have already successfully done for heart attacks and strokes. That principle applies as much to complex births and complex pregnancies as it does to strokes and heart attacks, and it will now apply for the people of Lewisham to conditions including pneumonia, meningitis and if someone breaks a hip. People will get better clinical care as a result of these changes.

   Our maternity care is well-regarded: of women booked into antenatal care at Lewisham, there have been no maternal mortalities in the past 7 years. This is despite the fact that high-risk pregnancies form the majority of our maternity workload[xi]. A free-standing midwifery-led birthing unit at Lewisham could only be expected to accommodate low-risk women who had already had at least one baby (RCOG, 2011), amounting to only 12% of the present total, rather than the "up to 60%" claimed by Mr Hunt.

   You may in fact be unaware, or have not informed the Secretary of State, that UHL is in fact one of the highest performing Trusts nationally for the management of hip fractures.

   Guidance on the management of meningitis emphasise the speed of administration of definitive treatment and not the size of the hospital it is treated in. Furthermore, a recent UK study of over 19,000 patients with meningococcal disease shows that mortality is the same (4.9%) whether the patient is admitted during the week or at the weekend[xii]. Neurology guidance recommends that that the patient with suspected bacterial meningitis should be transferred immediately to the nearest secondary care hospital[xiii]. There is therefore no basis in clinical evidence for the assertion made by the Secretary of State.

   The overall standardised hospital mortality index for UHL is 0.91 (NHS Choices), which compares favourably with hospitals in the South London Healthcare Trust. Lewisham ICU is one of the better performing ICUs in the country[xiv]

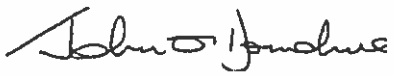
We are aware of the need for financial prudency and the drive towards the proposed clinical standards. Our alternative proposal put to the TSA was that the future merged Lewisham/ Greenwich Trust would achieve these clinical standards and within budget, but retain its discretion to allocate emergency and elective services across the Lewisham and Woolwich sites as commissioners require.

We are sure that you, a fellow medical professional, would agree that the evidence-base upon which we practice should be sound in order to deliver high-quality care to our patients. This duty extends to those members of the profession, like you, who have put themselves forward to provide medical advice on matters of public policy. This is especially true where that evidence is being used to inform a decision on reconfiguration and centralisation of acute services: if the clinical evidence base is wrong, or the deduction from the evidence is flawed, patients may actually be harmed. We believe that there is a significant risk of this resulting in Lewisham, if high-quality local emergency services are withdrawn in the mistaken belief that they will be provided to a higher standard elsewhere.

Your advice to the Secretary of State may also have a profound impact nationally if these specious grounds for centralisation of most emergency admissions are accepted, and as a result other high-quality DGHs are sacrificed as a result.

We believe that the clinical evidence underlying last week's decision is deeply flawed, and therefore call on you to reconsider urgently your advice to the Secretary of State.

Yours sincerely,



Dr John O'Donohue, Consultant Physician, Lewisham Healthcare NHS Trust

Dr John Miell, Consultant Physician and Director of Service for Specialist Medicine, Lewisham Healthcare NHS Trust

Dr Tony O'Sullivan, Consultant Paediatrician and Director of Service for Children

Dr Elizabeth Aitken, Consultant Physician and Director of Service, Acute and Emergency Medicine, Lewisham Healthcare NHS Trust

Mr Dan Zamblera, Consultant Obstetrician and Director of Service, Women and Sexual Health, Lewisham Healthcare NHS Trust

Mr Nabil Salama, Consultant Surgeon and Director of Service, Surgery and Anaesthesia, Lewisham Healthcare NHS Trust

Dr Chidi Ejimofo, Consultant, Emergency Dept, Lewisham Healthcare NHS Trust

Miss Ruth Cochrane, Consultant Obstetrician, Lewisham Healthcare NHS Trust

Dr Asra Siddiqui, Consultant Neurologist, Lewisham Healthcare NHS Trust

Dr Richard Breeze, Consultant Intensivist and Director of ITU, Lewisham Healthcare NHS Trust

Dr Louise Irvine, General Practitioner, Lewisham PCT

References

[i] https://www.wp.dh.gov.uk/mediacentre/files/2013/01/SLHT.pdf

[ii] Hansard-31 Jan 2013: Column 1080, the Right Hon Jeremy Hunt, in reply to Dame Joan Ruddock

[iii] http://www.londonhp.nhs.uk/wp-content/uploads/2011/09/AES-Case-for-change_September-2011.pdf

[iv] Aylin P, Yunus A, Bottle A, Majeed A, Bell D. Weekend mortality for emergency admissions. A large, multicentre study. Quality and Safety in Health Care 2010; 19:213-217

[v] Bell, M. D., Redelmeier, D. A. (2001). Mortality among patients admitted to hospitals on weekends compared with weekdays The New England Journal of Medicine 345: 9

[vi] Barba, R., Losa, J. E., Velasco, M., Guijarro, C., Garcia de Casasola, G. & Zapatero, A. (2006). Mortality among adult patients admitted to the hospital on weekends The European Journal of Internal Medicine 17: 322-324

[vii] Riciardi, P. (2011) Mortality rate after non-elective hospital admission. Arch. Surg. 2011; 146(5): 545-551

[viii] http://www.londonhp.nhs.uk/wp-content/uploads/2011/09/AES-Case-for-change_September-2011.pdf

[ix] Freemantle N, Richardson M, Wood J, et al. Weekend hospitalization and additional risk of death: An analysis of inpatient data. Journal of the Royal Society of Medicine. Published online on February 2 2012

[x] Hansard, 31 Jan 2013 : Column 1081

[xi] In 2012, there were 4,129 Lewisham deliveries: 898 women delivered in our Birth Centre, of whom 509 were multiparous women.

[xii] Mortality from meningococcal disease by day of the week: English national linked database study J Public Health (Oxf) 2013;0:2013 fdt004v1-fdt004 RCOG (2011) http://www.rcog.org.uk/what-we-do/campaigning-and-opinions/statement/rcog-statement-results-npeu-birthplace-study

[xiii] EFNS guideline on the management of community-acquired bacterial meningitis: report of an EFNS Task Force on acute bacterial meningitis in older children and adults. European Journal of Neurology 2008, 15: 649–659 doi:10.1111/j.1468-1331.2008.02193.x

[xiv] www.ICNARC.org

Written submissions of Professor Allyson Pollock (Professor of public health research and policy, QMUL and Director of Global Public Health Unit, QMUL)

1. The implications and impact of the Health and Social Care Act 2002 have so far received too little attention in the context of the concerns about North West London. It is important to see these changes in that broader context.

2. The Act abolished the duty on the Secretary of State to provide listed health services throughout England (ss. 1 and 3, National Health Service Act 2006), leaving only the much weaker duty to "promote" comprehensive services as the principle purpose. The abolition of this duty means that there is no longer a national health service throughout England, although NHS funding still remains.

3. Market contracting, and acute and community service closures associated with privatisation and the private finance initiative (PFI) have been ongoing since the early 1990s and, most notably since 2000, market contracting for clinical services. However the duty to provide acted as a check on the rate of privatisation, commercialisation and closure of NHS services, because the risks, legal responsibility and accountability remained with the Secretary of State. The duty to provide was the anchor for a national health service.

4. The 2012 HSC Act allows for the denationalisation and privatisation of health services in England. It also allows the withdrawal of NHS care and services from people throughout England, paving the way for mixed funding and user charges in much the same way as the National Health Service and Community Care Act 1990 did for long-term care.

5. Unlike primary care trusts, which had a delegated duty to provide listed services to residents in their area, clinical commissioning groups (CCGs) are contracting bodies: they have a duty only to arrange and to meet the reasonable requirements of their members in accordance with the duty on the Secretary of State to promote a comprehensive service.

6. The duty to arrange puts the contract centre stage: the contract is now the basis of all transactions. Previously, primary care trusts could and did provide services directly and allocate resources to NHS trusts outside of a contract. Since 1990, when the internal market introduced the mechanism of contracting, contracting ran alongside service planning - needs assessment and service planning was weakened as commercial contracting took the place of what were service-level agreements between commissioners and providers. Now, planning has been abolished as strategic health authorities and PCTs responsible for planning and meeting needs have been abolished, and public health and what remains of planning and information functions have been carved out to local authorities or to Commissioning Support Units. Increasingly advice on contracting and service change has been outsourced to large firms of management consultants, such as McKinsey and PWC. It is neither led by clinicians nor patients nor the public.

7. In the commercial world, the contract is the means by which risk is allocated between parties but providers must be able to select out the risks or limit their risks. No private contractor would accept a duty to provide regardless of the risks,

as parliamentary enquiries into PFI contracts and Independent Sector Treatment Centre (ISTC) contracts reveal.

8. Commercial contracts require risks to be identified and allocated through a contract; commercial providers need to be able to decide what risks they will take, which risks they will turn away and how they will price risks. In health care, high-risk groups are typically older people, the poor, the chronically ill and the mentally sick (try turning up at your local BUPA hospital when you have not paid your annual membership fee!) The duty of the Secretary of State to provide listed services carried through to primary care trusts, NHS hospitals and community health trusts. Increasingly patient choice, means that with the introduction of market contracts, members of CCGs can only go to where their CCGs have contracts for their routine care.

9. In the absence of a national duty to provide listed services, CCGs, PCTs and commercial providers under contract to the CCG have greater freedom to manage their financial risks by withdrawing from care, closing NHS services and reducing local entitlements and access to NHS funded care, paving the way for the denial of NHS care and the charging for services.

10. Using the contracting mechanism, CCGs are seeking to reduce their liabilities for the fixed costs of acute hospitals and the staff associated with them, by cutting funding and diverting it to ephemeral community services. Community services such as these are far more difficult to enumerate and to quantify and as they have far less visibility and are much easier to cut, they are very attractive to companies such as Virgin. CCGs and health providers are now exploring a variety of ways through the mechanism of the commercial contract to offset their liabilities and financial risks. CCGS are now hiring management consultants to bring about the service change options. Needs assessment and evidence for service changes play no part in these as the People's Health Assembly in Lewisham and plans for North West London reveal.

11. New models of care are once again being sold to the public as the motivation for closing hospitals and major service reconfigurations. But the reality is that CCGs faced with major budget cuts are looking for ways to reduce financial liabilities of the fixed costs of capital in acute hospitals and the staff associated with them. Acute hospitals are a target, just as long-stay NHS hospitals four decades ago were the target of community care and care in the community policies. Instead of modernizing the decaying fabric of Victorian buildings successive governments decanted them and diverted funds to for profit companies and investors in nursing home and residential care at enormous cost which we are paying for today, The government has lost control of this sector. 'Community care' as a new organisational form was the key justification for shifting funding to a means testing system and contracting out beds to the private sector. In reality, 'deinstitutionalisation' within the NHS was accompanied by 'reinstitutionalistaion' in private-for-profit homes. The same occurred with PFI: care closer to home, centralisation and the closure of hospitals, and lack of staff were used as key main arguments for closing hospitals and services to disguise the high costs of PFI and market contracting. These are costs that the public continues to pay. But as with care in the community, PFI driven service closures were also

sold to the public as bringing care closer to home and the same option appraisals were being presented as are being presented today in NW London.

12. Today, once again we see how new models of care and care in the community is the new mantra for reducing access to NHS services. This is the argument being used to close emergency departments and hospitals.

13. The process has begun. NHS England has reduced the amount it pays for A&E care to 30% of the standard tariff price for levels of activity over 2008-9. The Health Select Committee noted: "The current arrangements for remunerating A&E departments with only 30% of the tariff for activity over 2008–09 levels is no longer viable. The baseline is five years old and does not account for, or reflect, the pressures that hospitals face."

14. The reduction in tariff is supposed to act as an incentive to hospitals to turn people away. This accounts for the signs in every Emergency department urging patients not to attend unless it is an emergency. The policy is not working, as patients unable to access their GP surgeries and OOH services are forced to turn to emergency departments. But, CCGs and hospital Trusts starved of cash, are looking for ways of closing A&E departments through trust mergers and service closures. Trust mergers such as those set out in the Dalton Review, and NHS England's Five-year-Forward View, are strongly endorsed by the Government as they enable swifter service closure and erode public accountability.

15. The effect of A&E closures will be to decrease public access to services and increase travel time. Also, it will increase waits so that people increasingly will expect not to be able to receive publicly funded care: very much like the US situation where the public hospitals are used by the poor and uninsured. But where will private patients go? The acute private sector is still small (the data are difficult to obtain, but in the region of fewer than 10,000 beds and numbers are falling, most hospitals don't have intensive care beds); the NHS had around 181,000 beds (all specialties excluding day only beds) in 2005 and is now down to 134,600 in Quarter 3 of 2015/16
http://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/

16. The private sector is unwilling to invest in capital without a major government subsidy: the five billion pound ISTC programme is a good example of this, funds flowed to the private sector and the Government underwrote all the risks at huge cost and with no evidence of value for money.

17. The Act allows the privatization of remaining NHS trusts, thereby freeing up the capacity it currently has in NHS hospitals for private sector use. The Act achieves this by requiring that all NHS trusts become Foundation Trusts (FTs). Compared with 2010, there are only 100 NHS trusts; the government intends that there will be none and had intended that all NHS Trusts would be FTs by April 2014, failing which they would be under the guidance of the Trust Development Authority The significance of the switch from Trusts to Foundation Trusts is that NHS FTs are no longer fully NHS: the abolition of the private patient income cap means that now they will only be 51% public and 49% private: one half of the beds, the staff and the services currently being used by NHS patients can be diverted to non-

NHS activities. FTs have no legal duty to provide and have new legal powers to decrease entitlements to NHS-funded care and to turn people away.

18. But the difficulty for CCGs and FTs is that NHS patients are still using the services and the beds: how can they turn them away? How can CCGs reasonably close hospitals when they have to appear to show they are reasonably meeting the needs of their members?

19. The answer lies once again in the new models of care and the contracting mechanism. A plethora of new organizational forms is developing. These are described as integration, but in reality, the changes remove services from local people as contracting displaces service planning.

20. These new organizational forms are modeled on US Health Maintenance Organisations (HMOs), ironically termed Accountable Care Organisations, which are unique for the different ways in which they devolve risk to patients through user charges, impose harsh eligibility criteria and are not accountable to local people or patients although they are in receipt of government funds. In England, NHS England is already adopting hybrid HMOs as the way forward and this is clearly set out set out in the Five Year Forward View. These include hospital chains or chains of hospital and community services where NHS Trusts and FTs merge. These chains are no longer anchored in their local area nor are they dependent on funding from one area instead they compete for patients across areas. The point is there is no local accountability and no real way that local needs can inform provider decisions except through a contract. Their incentive is to look for the profitable sources of income and to decrease their fixed costs hence the closures of local A&E departments, and decisions to enter into joint ventures with the private sector. Hence cancer services in Mid Staffordshire are being unbundled and put into the marketplace; general practices are also merging and federating so that the practice becomes part of a company and is no longer the main decision maker.

21. The Manchester DEVO experiment, under which 10 local authorities and 12 CCGs are to co-commission care, raises major issues about funding and accountability. In the absence of a duty to provide listed services, how will needs be assessed and planned and who will decide entitlement and eligibility for care?

22. It is worth noting that overall social services budgets for community care have fallen dramatically as have the number of people in receipt of home care, day care, meals on wheels and all other kinds of support. Reductions in funding and budgets for social services and long-term care and reductions in local authority provision add to the strain on NHS services. The volume of services provided is shrinking and are not keeping pace with need.
The amount spent on adult social care services has fallen nationally by £1.4 billion (8%) from 2010/11 to 2012/13. The number of adults receiving state-funded care fell from 1.8 million in 2008-09 to 1.3 million in 2012-13.
According to Age UK, in the three years between 2010/11 and 2013/14:
    - Numbers of older people receiving home care have fallen by 31.7%
    - (from 542,965 to 370,630) .

- Day care places have dropped by 66.9% from 178,700 to 59,125.
- Spending on home care has fallen by 19.4%from £2,250,168,237 to £1,814,518,000.
- Spending on day care has fallen even more dramatically by 30% from £378,532,974 to £264,914,000.

23. CCGs are repackaging and marketing the old claim of shifting care from the hospital to the community, just as PCTs did for PFI, and area health authorities did for community care. Each time, this shift to community care involves commercial contracts and commercial providers in order to shift the costs and risks to patients and carers. In the case of PFI and hospital closures, much needed community services did not ever materialise. In the case of long-term NHS care, community care meant means tested social care, reduced entitlement and eligibility, and the transfer of ownership to large multinational companies. The private for profit sector owns and operates and controls more than 400,000 beds for care of elderly and for mental health (2012-13) compared with fewer than 150,000 NHS beds in England in 2013-14. The NHS at inception had more than 450,000 beds, most of these are now under the control of the private for profit sector and charged for.

24. Under the rubric of care in the community CCGs intend to shift large amounts of money out of the acute hospital sector to unknown providers in the private sector. It will do this even though England has fewer public beds per capita than any country in Europe and bed occupancy is at dangerous levels on many days of the year. Flows of money out of the services will once again destabilize hospitals and services forcing their merger, closure and sale. FTs in more affluent areas will adapt their business model and turn their attention to private patient income, as well as to new business, entering into PPPs with the insurance industry and private sector in order to generate half their income from private patients.

25. All the evidence from previous experiments shows that shifting care in these ways will accelerate the loss of entitlement and basic package of care and privatise the risks and costs to individuals. The NHS will remain free at the point of delivery; but, what that care will comprise is unknown. The Government is importing American solutions and with it a major new sets of problems, not least of which are the exorbitant costs of the market, denial of care for millions and the overtreatment of those that can afford to pay.

Dated 24 March 2015.

I confirm that this statement is true to the best of my knowledge and understanding.

NHS

North West London

Appendix A

Month 10 Budget Update

Consultancy Contracts Let

SaHF & NWL Strategy and Transformation Programmes

February 2014

S&T consultancy contracts let since 1st April 2014 (1/3)

Contract let	Contract	Value	Provider	Decision-making panel
April 2014	**ST002-Patient Travel Patterns Data Analysis for 9 Hospital Sites in North West London**	£58,500	Sky High Technology	GP & Deputy Chair Ealing CCG, Deputy Director Strategy & Transformation, (S&T), Travel Plan Adviser, PMO Strategy & Transformation
April 2014	**F7538-A&E Closures at Central Middlesex and Hammersmith Hospitals**	£301,233	M&C Saatchi Group	SaHF Communications Lead, Head of Public Affairs Imperial College, Head of Communications NWLH NHS Trust, Media Manager NWLH NHS Trust, Matron Specialist Nurses NWLH NHS Trust
May 2014	**F6966-Continued Support to approval of OOH PIDs, OBCs & FBCs**	£353,208	PA Consulting	Extension of existing contract (Single Tender Waiver)
May 2014	**Financial and Activity Support to SaHF**	£297,000	Baker Tilly	Single Tender Waiver Agreement
May 2014	**F7594-Portfolio & PMO Support for Strategy & Transformation Directorate**	£2,827,008	PA Consulting	Chief Officer CWHEE, Chief Financial Officer CWHEE, Director Strategy & Transformation, Deputy Director Strategy & Transformation
June 2014	**F6771-Imperial OBC Redevelopment**	£267,273	PwC	Extension of existing contract (Single Tender Waiver)
June 2014	**F7505-Hospital BC Assurance Support & IMBC**	£1,235,000	Consortium led by McKinsey	Chief Financial Officer BHH, Deputy Director Strategy & Transformation, Portfolio Director NWL TDA, Deputy Regional Director NHSE, Head of Financial Strategy NHSE
June 2014	**F7506-Single OBC and Individual Specs for CMH**	£1,058,000	PwC	Chief Officer BHH, Deputy Director S&T, Director of Strategy Imperial College NHS Trust, Director NWLH Trust, Lay Member Brent CCG, Head of Estates CNWL
June 2014	**F6972-Communications Support Extra Resource**	£32,640	Consolidated PR	Single Tender Waiver Agreement

S&T consultancy contracts let since 1st April 2014 (2/3)

Contract let	Contract	Value	Provider	Decision-making panel
June 2014	**7-Day Service Hillingdon Hospital - 50% S&T support (Tendai Chikasa)**	£65,500	Hillingdon Hospital	Contract signed by Deputy Director, Strategy & Transformation Directorate
June 2014	**7-Day Service Ealing Hospital - 50% S&T support (Jennifer Roye)**	£40,809	Ealing Hospital	Contract signed by Deputy Director, Strategy & Transformation Directorate
July 2014	**F090514EPGR – Whole Systems Integration Programme**	£4,400,000	McKinsey & Company	Non-Executive Director Outer Sub Cluster NHS NWL (Chair), Chief Officer CWHHE, Director Strategy and Transformation NHS Collaboration of 8 CCGs, Chair, NWL Integrated Pilots Programme Board, Lay Member CL CCG, Director of Business & Strategy WLMH NHS Trust, Interim Director Strategic Planning CNWL, Assistant Directors Strategy & Transformation NHS NWL Collaboration of 8 CCGs, informatics Lead/Whole Systems NWL Strategy & Transformation Team, Chair Ealing CCG, Chair Hounslow CCG
Aug 2014	**F6966-Transitional support to Business Case Team**	£186,120	PA Consulting	Single Tender Waiver
Aug 2014	**Extension of high priority programmes for NHS England**	£350,000	Qi Consulting	Single Tender Waiver
Aug 2014	**SaHF OBC Assurance Process and ImBC Production** OOH Hubs for ImBC (not part of original spec) ImBC Development	£329,010 £182,950 £146,060	Consortium led by McKinsey - PA Consulting	Single Tender Waiver – Signed by Chief Officer CWHHE & Central London CCG Chair
Sept 2014	**Consultancy for Video Conferencing**	£12,000	Consard Limited	Deputy Director, Strategy & Transformation approved lowest quotation
Oct 2014	**Contract Extension to Comms Support**	£146,241	Consolidated PR/LCA	Single Tender Waiver

S&T consultancy contracts let since 1st April 2014 (3/3)

Contract let	Contract	Value	Provider	Decision-making panel
Oct 2014	**SaHF OBC Assurance Process and ImBC Production** Oct – 7th Nov	£152,650	Consortium led by McKinsey - McKinsey	Single Tender Waiver – Signed by Chief Officer CWHHE & Central London CCG Chair
Nov 2014	**Development of OBC and Single Specification for CMH**	£202,788	PwC	Single Tender Waiver – Signed by Chief Officer CWHHE & Central London CCG Chair
Nov 2014	**SaHF OBC Assurance Process and ImBC Production** 10th Nov – 28th Nov	£99,000	Consortium led by McKinsey - McKinsey	Single Tender Waiver – signed by Chief Officer CWHHE & Chief Financial Officer CWHHE
Nov 2014	**SaHF OBC Assurance Process and ImBC Production**	£22,000	Consortium led by McKinsey - Grant Thornton	Single Tender Waiver – Signed by Chief Officer CWHHE & Central London CCG Chair
Dec 2014	**NWL Whole Systems Integration Programme – PC & OD**	£1,000,000	McKinsey	Single Tender Waiver – Signed by Chief Officer CWHHE & Central London CCG Chair

Smith Peter

From: nick martin [redacted]
Sent: 14 March 2015 14:02
To: Smith Peter
Cc: [redacted]
Subject: Healthcare hearings (chaired by Michael Mansfield QC)

Dear Mr Smith

These hearings are fundamentally misguided.

London has plenty of hospitals within a few miles of residents. What is needed here is best quality of healthcare; not maximum proximity of care.

It also misses the fact that the key need is to transfer services OUT of Hospitals and into the communities.

What we need is not "Save our Hospitals" but "Preserve the Best healthcare" .

These messages are different.

Best wishes

Doc Martin
H and F resident

Sent from my BlackBerry 10 smartphone.

Smith Peter

From: [redacted]
Sent: 25 March 2015 10:25
To: Smith Peter
Subject: Ealing and Hammersmith Hospitals Hearings

Dear Mr Smith - thank you for giving me your email address last Saturday at Ealing Town Hall at the hearing under Michael Mansfield.
I have worked as a medical secretary in the private sector for 30 years and private insurance/medicine is NOT the answer. My boss works in his NHS at St Mary's Hospital and as they have moved the cardiac department out to the Hammersmith Hospital he now works there every Wednesday doing procedures - he's a cardiologist.
Firstly, if someone has a heart attack in the Ealing area - will they now be brought to the A & E Department at St Mary's Hospital only to have to be re-transferred out to the Hammersmith if they need a procedure as they have moved that Department to the Hammersmith? - This seems ridiculous if they do.
Secondly, insurance companies are covering less and less these days and making it harder for people to be covered and the premiums are increasing so we have more and more (what I would call!) reasonably well-off people saying they can't afford the premiums and can they be put on the NHS list at St Mary's to be seen. Already insurance companies will not cover pacemaker checks (they need their batteries to be checked once a year). They will cover to have a pacemaker put in but not the checks which are essential, which is also ridiculous of them.
Thirdly, there is NO A @ E facility in the private sector - all our patients are told that in the case of an emergency they MUST call the emergency services and our patients who have benefitted from A & E have only positive things to say about the NHS.
So I am opposed to privatisation of the NHS and vehemently opposed to the reduction in services. As a country we CAN afford it - it is purely a case of where your priorities lie.
Hope this is a helpful point of view. [redacted]

Written submissions of Julian Redhead, Chair of the London Board of the Royal College of Emergency Medicine:

1. I am Chair of the London Board of the Royal College of Emergency Medicine.

2. Healthcare in communities need to adapt and change. Patients are living longer and are more likely to suffer with multiple comorbidities and chronic conditions. However patients will continue to have acute exacerbations of these conditions and present with new conditions requiring the expertise of the Emergency Department. However we recognise that prevention of these conditions, or exacerbations, by improving care in the community is preferential.

   Emergency departments reflect the effective and efficient care provided across the whole patient pathway, from community based care to hospital care and back to community care.

   The care provided in an Emergency department also reflects the effectiveness of the other services provided within a hospital, or across a network. Centralisation of trauma, stroke and cardiac care have improved outcomes and experience for patients involved. Where effective care cannot be provided, due to lack of, or experience of doctors or other staff in back up services, such as acute surgery, then further centralisation will be required to ensure safe patient care.

   Where centralisation occurs, accurate modelling needs to occur to allow services and infrastructure to grow or adapt to meet the increased demand and acuity of patients.

   The Royal College of Emergency Medicine has asked for changes to the tariff system in place for emergency care to allow this growth and adaption and allow for appropriate senior staffing of the departments - many departments struggle to recruit senior staff, mainly due to the nature of the emergency work and the effects on work – life balance.

   Hospitals and communities need to work together to develop pathways of care which allow patients to be cared for 'closer to home' and prevent overcrowding in the Emergency department due to 'exit block'. This includes the provision of Urgent Care Centres co-located with Emergency departments, to allow care of patients with conditions more appropriately treated within primary care. These centres need appropriate staffing 24 hours a day, to allow the Emergency Department staff to concentrate their expertise and resources on those patients requiring this level of care.

   Shaping a healthier future lays out an ambitious program of change. The College believe that effective modelling of patients must be undertaken to ensure that services are resourced to adequately care for the numbers and acuity of patient's presenting. Changes in the provision of social and primary care need to be effective before large scale changes are made to the emergency care landscape. This modelling must be realistic and as far as possible evidence based.

   The changes should be based on improving the care provided to patients.

Dated 20 March 2015.

I confirm that this statement is true to the best of my knowledge and understanding.

Submission to the Michael Mansfield Council NHS Inquiry from Angie Bray MP

Shaping a Healthier Future is a programme designed by clinicians working in NHS North West London, rather than the Government, to move towards a more integrated healthcare with more advanced technology and treatments and also to face some of the challenges faced with an ageing population. As an MP it is not my job to always support healthcare decisions made by local doctors but I absolutely support that they are the right people to make them.

NHS North West London ran a consultation in 2012 on the potential closure of up to 4 A&Es in the area. I joined the local campaign against the closure of all 4, arguing as others did that residents in Ealing Central and Acton were disproportionately affected. I lobbied a number of Ministers including the Prime Minister on the issue. Crucially Health Secretary, Jeremy Hunt referred the Shaping a Healthier Future to an independent review panel.

In October 2013, Jeremy Hunt MP announced the findings of the Independent Review Panel which he accepted with one vital proviso – that the A&Es at Charing Cross and Ealing remain open. It was also confirmed by Health Minister that they should meet in full the requirements laid out in the forthcoming report by NHS Medical Director Sir Bruce Keogh. Apart from that the Independent Reconfiguration Panel concluded that the SaHF programme "provides the way forward for the future and that the proposals for change will enable the provision of safe, sustainable and accessible services." It is not accurate to say that investment in capacity of out-of-hospital and community services is designed to offset reductions in acute provision. Rather both are part of a shift towards preventative and at home care which are preferable for the patients.

The two smaller A&Es at Hammersmith and Central Middlesex were closed in the Autumn of last year. Figures for both had been low with Central Middlesex treating on average around 36 people a day according to local NHS figures. 24/7 Urgent Care Centres are open at both sites. I would suggest that more could be done to promote the usage of Urgent Care Centres as I have spoken to residents who have found the service there to be of a high standard and with short waits.

I was disappointed that due to poor management the NHS failed to open the new Northwick Park A&E to before the closures of the A&Es at Hammersmith and Central Middlesex not least because of the reassurance that may have been offered to residents. Also, further to some concerns raised by constituents I have spoken to TfL who have said they will keep the public transport access to hospitals under review.

I agree that there was a serious slippage in meeting A&E waiting time targets over the Christmas period and high volumes of attendees added to the usual Winter strain which was seen across the country. Over this time I had regular meetings with the Health Secretary and local NHS representatives to keep informed of the situation. It was clear that the problems could not be explained by patients from Hammersmith and Central Middlesex alone. Discussions with the NHS confirmed this was the case. The closure for refurbishment of a ward at Ealing Hospital had a knock on effect on so called 'bed-blocking'. It was notable how quickly the figures improved once some problems of implementation were ironed out.

I also appreciate that there are rumours circulating that Ealing and Charing Cross Hospitals are to be demolished and that if that is not the case the A&Es will not remain as A&Es. This is absolutely

refuted by the local NHS who confirm that the A&Es will stay serving the community for the long term. Indeed they will have brand new facilities when parts of the hospitals are rebuilt in a few years' time. They will have beds to admit to as well as A&E trained staff, consultant oversight and a wide range of up-to-date technical equipment. A great deal has been made of how many ambulances attend each site but it was in fact part of the previous Government's reforms that if you are unfortunate enough to find yourself in an ambulance with stroke, heart or trauma conditions you will be taken straight to the nearest specialist centre. Ealing Hospital did not have specialist status. These were successful reforms, perhaps from a time when the opposition had a more progressive stance on the NHS than currently.

It has not been my experience that residents in my constituency have seen first hand the crisis as it has been reported. I actually receive very few letters and emails on the NHS and the overwhelming majority of those are either part of an organised 38Degrees campaign or in response to a Labour Party leaflet. I believe that educating people as to how to use their health service is crucial and there is more to be done to encourage those seeking treatment to attend the appropriate facility to meet their needs. The King's Fund reports that nearly 40% of patients who attend an A&E are discharged without requiring treatment. There are genuine challenges faced by the NHS in the long term and it is a shame that the political consensus that seemed to have been achieved has now been broken. Both main parties had agreed the NHS Five Year Forward View, published in October of last year, which talks about new models of care, more preventative and community based treatment and a more integrated patient journey. Shaping a Healthier Future seems very much an attempt to be in line with that ambition.

Angie Bray MP, Ealing Central and Acton

Stronger Together

London North West Healthcare NHS
NHS Trust

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Northwick Park Hospital
Watford Road
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HA1 3UJ

Tel. 020 8869 2717

www.lnwh.nhs.uk

10th February 2015

Mr Michael Mansfield QC
Chair, North West London Healthcare Commission

c/o Peter Smith, Clerk to the Commission
Hammersmith & Fulham Council
Room 39
Hammersmith Town Hall
London W6 9JU
by email to peter.smith@lbhf.gov.uk.

Dear Mr Mansfield

RE: **Independent Healthcare Commission for North West London**

The Legacy North West London Hospitals NHS Trust was responsible for implementing the closure of Central Middlesex Hospital (CMH) emergency pathway as the first phase of the Shaping a Healthier future programme for North West London Health services.

Whilst the programme was very supportive in terms of managing the public consultation for this to occur, the Trust's own strategy would have been to make this change anyway for the following reasons:

- The attendances at the A&E department at CMH had dropped to on average 30 per day which is significantly below the level which would maintain both clinical and financial viability for the service.
- The required level of staffing to maintain this service was over and above that required for the actual activity. This is similar to the Acute medical take at CMH where admissions had fallen to 13 per day on average; this would therefore make the unit unattractive for acute medical trainees and consultants alike. Maintaining staffing for this was an increasing challenge.
- Tina Benson Director of Operations, Nigel Stephens Clinical Director for Emergency Medicine and Charles Cayley Medical Director spent careful and considered time with the staff who wanted certainty for the future as well as advising us that the ability to maintain the service through the winter of 2014/15 may not be possible.
- Maintaining the unit was carrying a significant risk of an emergency closure due to lack of staffing as had previously occurred with the overnight closure. This was not a good way for the Trust to manage change for the public.

The legacy Trust Board was therefore supportive of closing CMH emergency pathway on 10th September 2014. I have attached the final board paper which was the Trust's last

assurance paper on the change. We have many documents on the change which we would be happy to provide should you find it useful.

Yours sincerely

Simon Crawford
Acting Chief Executive

Enc. Legacy NWLH Trust Board papers:

1. July Trust Board Cover Sheet
2. Closure of CMH A&E Critical Path update for Trust Board
3. Communications Update
4. Standards for CMH A&E Closure
5. NHS England A&E Closure Programme Assurance report

NHS England

A&E Closure Assurance Programme:

Interim Assessment (EPRR) – The North West London Hospitals NHS Trust

This interim assessment forms part of the on-going joint assurance process that NHS England (London) and the National Trust Development Authority (NTDA) have put in place with regard to the respective functions and responsibilities of each organisation.

This advisory note supports NHS England's statutory duty to ensure that all providers of NHS funded care are prepared to respond to and recover from emergencies. The Emergency Preparedness Resilience and Response (EPRR) assurance does not consider the clinical rationale or final decision to close, only the preparedness of the Trust at this stage of the process.

This assessment and its accompanying recommendations are based on the evidence which was provided by the Trust between 30th June and 10th July, and is intended to inform the on-going preparations. In making this assessment, the progress made to date is acknowledged as work in progress.

Further assurance on the state of readiness for closure as the planning progresses including on how these recommendations have been taken forward, will be sought over the period between this assessment and the date of closure, September 10th. Post closure assurance will be sought through the annual EPRR Safe Systems Assurance process which assesses the Trust's overall levels of emergency preparedness against the National EPRR Core Standards.

The EPRR assurance domain of the joint assurance process reviewed four areas;

1. Business Continuity
2. Major Incident Response
3. Surge Management
4. Command & Control

The Trust supplied revised copies of the Emergency and Business Continuity Plans and this evidence was further supported by direct positive discussions between the EPRR Lead Manager for the North West London area from NHS England (London) and the Trust Emergency Planning Manager.

Although some areas of development were noted (table 1) sufficient assurance has been obtained at this point in the programme to confirm that the Trust is on course to deliver the necessary revisions to their incident response procedures.

P.P. [signature] (PETER BOORMAN, DEPUTY HEAD OF EPRR)

Nicki Smith
Regional Head of EPRR
NHS England (London)

Assurance Criteria
1. Business Continuity 2. Surge Management 3. Major Incident Response 4. Command and Control
Assurance Sub Criteria
1. All Business Continuity Plans reflect changes in configuration of service delivery units 2. All internal surge management plans to reflect changes in configuration of services including procedures for escalation across sites 3. Major Incident Plans to reflect changes in capability 4. Trust wide Command and Control Procedures to reflect changes in service provision
Overall Assessment of Preparedness
AMBER – Partially met/More information required/Work is in progress
Recommendations
North West London Hospital Trust needs to develop a clear delivery plan for the training, testing and exercising to validate the changes to their revised Emergency Response and Business Continuity Plans.

Table 1

The North West London Hospitals NHS	Agenda Item	14
Trust Board	Paper	14/07/12
Meeting on: 30th July 2014	Board Assurance Framework Reference	5.1 and 5.2

Subject: Central Middlesex Closure of Emergency Services

Director Responsible:	**Author:**
Tina Benson Director of Operations	Tina Benson Director of Operations

Summary:
The Secretary of State for Health gave his response to the Independent Review Panel's report on *Shaping a healthier future* in October 2013. The outcomes for the Trust are that Central Middlesex Hospital, CMH, will be developed in line with the local and elective hospital models of care which include an Urgent Care Centre operating 24/7, and Northwick Park Hospital will become a one of five major acute hospitals in north west London

Following on from the last meeting on 26th June 2014 where the board approved the move to closure at 7pm on 10th September 2014 work has continued through the weekly team meetings. This has led to a proposed model pathway for patients in sickle cell crisis which is being proposed to the patient group later today and a clear position on critical care beds at CMH.

The closures of both Hammersmith Emergency Unit and CMH A&E have been through a rigorous assurance process with the local CCG's, (22nd and 23rd July 2014) and NHS England and the National Trust development Agency, (8th July2014); at the time of writing the outcomes of these processes are unknown.

An attached document does give assurance that the work will be complete in terms of Emergency Preparedness Resilience and Response and this was tested in a large North West London wide table top exercise on 22nd July 2014.

The Trust will plan to meet internal standards to maximise available capacity at both sites prior to the closure and will utilise a command and control methodology to achieve this from 1st September 2014 until 3rd October 2014, which will then be reviewed against plan.

In addition the public communications started 28th July 2014 and as this is so critical to the success of the project and communication update is attached.

The activities on the critical pathway are on track to deliver by 10th September 2014.

Financial Implications:
Reduction of income and increased efficiency at NPH site.

Risk Issues (including legal implications, reference to Assurance Framework and Risk Register): BAF 5.1 and 5.2 require the Trust to perform to the level of National targets which will need to be maintained through the closure. Due to a reduction of activity at CMH this will impact the achievability of the ED target especially type 1 performance.
Communication & Consultation Issues (including PPI): Full communication with stakeholders is ongoing and the public communication campaign started on 28th July2014.
Workforce Issues (including training and education implications): Staff consultation has started and completes on 4th August 2014.
How this Policy/Proposal Recognises Equality Legislation: This is covered in the Equality Impact assessment which can be found in Appendix 10 of 26th June 2014 board papers.
Has an Equality Impact Assessment been carried out on this issue or proposal? Yes see Appendix 10 of 26th June 2014 board papers.
What impact will this have on the wider health economy, patients and the public? The impact assessment is well described in the SaHF business case including enhanced safety and quality, the largest negative impact for patients and public is travel times and transport.
What is required of the Trust Board? The Trust Board is asked to: • Note the readiness to deliver a safe closure on 10th September 2014.

Closure of Emergency Services at Central Middlesex Hospital

Critical Path Update

Clinical Pathways & Policies

Items completed:

- Site cover for CMH 24/7-emergency response team, site operations, hospital at night team agreed post closure and posts have been appointed into and start dates ahead of closure
- NWLHT major incident/emergency planning policies revised to reflect CMH closure
- Admission pathway from CMH outpatient department to Northwick Park & St Marks (NPSM site in case of unwell patient agreed
- Elderly Care Pathway agreed.

To be done:

- Major Incident testing 22 July 2014
- Finalisation of pathways for CMH ITU and Sickle Cell Patient in respect of staffing, clinical service standards and optimum patient experience.

UCC Pathways and Contracts

- Clinical delivery group with representatives from NWLHT, Brent CCG, Care UK, CNWL & LAS formed and output pathways revised for UCC.
- Joint operations Group (representatives from NWLHT, Brent CCG, Care UK, CNWL & LAS) established to co-ordinate and oversee the implementation and delivery of a safe and robust stand -alone UCC at CMH.
- Brent CCG managing the contract negotiations with Care UK re "stand alone" UCC provision

To be done:

- A revised UCC contract as well as new operating specifications for UCC at CMH to be in place by end July 2014.
- Pathways agreed and signed off by Brent CCG, Care UK, LAS, NWLHT, CNWL.

17.07.14

Infrastructure

Capacity at NPSM site

- 10-33 beds derived from SaHF and local modelling (including refreshed travel survey) 20 beds increase at NPH site – August 2014
- System wide contingency required (Barnet and Chase learning showed 3-6 week spike)
- Overall plan gives a net benefit of 20 beds from the current position
- Focussed work streams to review underlying bed deficit at NPH jointly with Brent and Harrow CCG.

CMH site & Services

- Detailed plan re site and review of support services post transition on track.

Workforce transition

Items completed:

- Formal Consultation process commenced 3rd July 2014 (Consultation period 3.07.14-3.08.14)
- Consultant job planning in progress.
- Joint on call consultant rota.
- Trainee rotas with HENWL approval.

JUNE/JULY 2014 COMMUNICATIONS AND ENGAGEMENT UPDATE FOR THE TRUST BOARD

The Shaping a Healthier Future (SaHF) communications work stream continues to lead on communications and engagement around the changing A&E services at Central Middlesex and Hammersmith hospitals. The full communications plan was published at last month's Trust Board meeting and all key milestones are being met.

1) Information campaign

Recent focus has been on fine-tuning and testing messaging for the public information campaign. The campaign is aimed at informing local people about the changes to A&E and signposting them towards the right treatment settings under the new arrangements. Scheduled to go live at the end of July, the campaign comprises:

- widespread media and public transport advertising
- a leaflet mail-out to 285,000 properties in core areas served by the A&Es
- launch of a new website including the spread of healthcare facilities available and 'choose well' messaging
- onsite advertising at the Trusts' 2 key sites
- information mail-outs to nurseries, schools, further education organisations, local voluntary and community organisations, police stations, faith settings, taxi companies, hotels and local businesses
- publicity through primary care settings, on GP practice screens, texts and pharmacy bags
- advertising through councils, including the outside of minibuses and in resident magazines.

Testing the messaging

User testing comprised a number of industry-standard focus groups including diverse public membership from the boroughs affected. The process was managed by an independent organisation. Internal testing also took place with clinicians, project team members and executives, and lay representatives.

2) Specific communications by the Trust

Stakeholder liaison

Dialogue with the Trust's key stakeholders continues with recent activity including the Director of Operation's attendance at the Ealing OSC on 25 June. A public engagement event about the future for Central Middlesex Hospital more generally is being coordinated by Brent CCG on 17 July.

The Trust also hosted a visit by Ian Niven and colleagues from Brent Healthwatch and Mencap on Friday 4 July; which involved a tour of both Central Middlesex and Northwick Park hospitals' A&Es.

Communications with GPs is being coordinated by CCG communication leads on the SaHF work stream. The Trust continues to support their work by publicising changes and specific operational information via newsletters and other existing forums.

The communications team has been liaising with Brent Council's communication department to inform local residents about the changes. A story was submitted for the summer edition of *The Brent Magazine* (c. 99,000 households in the borough) and council mini bus advertising has been booked. Information will also be circulated to councillors via a twice-monthly e-bulletin.

Internal communications

Updates about the project continue to be shared through the regular communications channels. The communications team also worked alongside HR and JNCC in the run up to the launch of staff consultation for those involved in the changing services. This was aimed at sharing the rationale for change, new models of care for discussion, the consultation process, meeting/discussion and job opportunities. A number of teams have responded to the offer of meetings with the Director of Operations for face-to-face updates on how the changes are taking shape.

Dedicated staff open forums continued throughout June and more are scheduled for 22 July and 19 August. These are in addition to the general chief executive events held every two months across all sites.

Specific briefings will also be held to introduce public information campaign materials to staff, so that they are briefed in advance to share information with patients. This will be supported by posters, pop-up stands, banner ads and leaflets being made available throughout the hospitals.

Patient communications

Face-to-face meetings with the Director of Operations and relevant clinicians are being arranged with patient groups that may be affected by the A&E closure or who meet regularly on the CMH site. So far meetings with cardiac patient groups, the rheumatology patient user group and sickle cell patients group are scheduled.

Wider community engagement, particularly with hard to reach groups, is being managed through the SaHF-led equalities work stream. They are also advising on information accessibility, alternative formats and languages for campaign materials to suit the two trusts' diverse communities.

Media relations

There continues to be media interest in the A&E changes, particularly around Imperial College Healthcare NHS Trust's plans. The Trust is in contact with local media and arranging briefings for key reporters. This will include encouraging editorial support to help inform the public and complement the advertising that is booked for the main titles.

Regular progress report and evaluation

Communications work-stream progress will continue to be reported regularly to the project board and team. A risk register is being maintained by the SaHF group to ensure that communications plans are kept on track and issues reported in a timely way.

In terms of evaluation, a first round is scheduled for mid-August to ensure the campaign is reaching the key audiences as intended.

15th July 2014
Tina Benson
Director of Operations

Week commencing 1.09.14

Standards expected for Closure of CMH ED

The following standards/expectations will be put in place from the 1st September to provide the best possible scenario for the Trust prior to the closure of the Emergency department at CMH at 7pm on the 10th September 2014

Key Deliverable by Monday 8th September:

- ✓ **NPH 40 beds -20 empty beds, 20 beds commissioned on Carroll Ward**
- ✓ **CMH 10 empty beds**
- ✓ **To have less than 6 delayed discharges across the site**

Beds - the aim is to have the following beds on Monday.8th September

- NPH 40 beds – 20 empty bed & opening 20 beds opening on Carroll
- CMH 10 empty beds on Roundwood to accommodate the closure of ACDU

Management – "Silver Control" in operation to ensure senior support on both sites -3.09.14-30.09.14

- On call managers & executive rota planned
- All senior managers to provide details of their availability over this period
- DGM/Senior nurse/Continuing care/Social Service rep in situ in site office for "silver control"
- Back to the floor from Wednesday 3rd -5th September. All non-urgent meetings to be cancelled, Managers to support the wards with discharge process
- CDs on site to ensure all patients receive a senior review Week 3rd -5th September

Discharge and Management plans- all patients to have management and discharge plans

- Review of all medical/surgical teams commitments for week commencing 8th September so all patients are seen by a consultant with clear management plans in the patient notes.
- Consultants available for ward rounds week 8th-12th September
- Review of all divisions OPD commitments Wednesday 3rd -Friday 5th September to ensure patients have a full review.
- Discharge lounge to extend opening hours from Wednesday 3 - Friday 5th September and open weekend 6th/7th September

Ward/Board Rounds –

- All inpatients to be seen by a Consultant or Senior decision maker and TTA's to be written up for patient able to be discharged over weekend 6th/7th September
- Discharge bundles to be completed by 4pm for the AAU handover meeting Friday 5th September.

Staffing- All ward rotas completed

- All rotas to be checked and all vacancies to be filled-any gaps to be escalated and action taken

Tests & investigations –Cardiology, Radiology & Endoscopy- All tests and investigations requested week commencing 1st September to be cleared by Monday 8th September

- Additional lists to be arranged for CT,USS, Cardiology Tests, Endoscopy weekend 6th/7th September
- no backlog of investigations -Service managers to support wards in gathering and expediting all tests

CEPOD –no patients waiting longer than 12 hours for emergency surgery week commencing 8th September

- Additional CEPOD lists if waiting list exceeds 5 patients.

Social Services - No patients to be waiting for social services package by Monday 8th September

Infection Control-
- Names of staff on call weekend 6th/7th September

Linen supplies-
- Extra supplies of linen on site and location

Occupational Therapy - To have no delays with home visits,
- All home visits requested week commencing 1st September to be completed Monday 8th September.

Paeds contingency
- Bed capacity contingency, escalation beds and staffing to be confirmed

NHS Harrow & NHS Brent CCGs- To have no patients waiting for intermediate care / rehabilitation beds by Monday 8th September –
- Daily teleconference with input from Willesden, Denham, Mount Vernon. Names of reps from CCG taking part on each day
- Plans for transfer of patients to Willesden, Denham and Mount Vernon over the weekend 6th/7th September to be shared with trust.

STARRS / HART – To have all arrangements in place for planned discharges over the weekend 6th/7th September
- Extra rounds of the wards to assess those patients that could be discharged with support

End Of Life Care – All patients to be transferred if possible to Hospice or home care prior to 8th September
- To have those patients requiring end of life care placed in the most appropriate bed
- List of all patients on the pathway to be brought down to site office by 4pm Friday 5th September

Transport – To have no delays due to transport or ward delay issues.
- Additional support to be in place to support the predicted number of discharges between 5th-8th September
- Allocation of senior staff to support wards – Transport rota to be agreed by Thursday 4th September

Maternity To ensure that all patients have prompt investigations
- Contingency plans for staffing level, surge of activity
- Matron on call rota to be confirmed
- Patients to have prompt investigations

Pharmacy - To have no patients waiting for TTAs

- Extend opening hours of pharmacy at weekend.

Monday 8th September 2014

Standards expected for Closure of CMH ED

Key Deliverable

- ✓ **NPH- 40 beds -20 empty beds & Carroll ward opens with 20 beds**
- ✓ **CMH –10 empty beds- ACDU closed in CMH ED and patients transferred to Roundwood under care of ED consultant**
- ✓ **To have less than 6 delayed discharges across the sites**
- ✓ **Transfer 3-4 patients daily to Gladstone suite**
- ✓ **Daily KPI closure scorecard**

Beds - the aim is to have the following beds on Monday.8th September

- NPH 40 beds – 20 empty bed & opening 20 beds opening on Carroll
- CMH 10 empty beds on Roundwood to accommodate the closure of ACDU

Management – Silver Control in operation to ensure senior support on both sites

- On call managers & executive rota planned
- All senior managers to provide details of their availability over this period
- DGM/Senior nurse/Continuing care/Social Service rep in situ in site office for "silver control"
- Back to the floor from 8th-12th September. All non-urgent meetings to be cancelled, Managers to support the wards with discharge process
- CDs on site to ensure all patients receive a senior review Week 8th-12th September

Discharge and Management plans- all patients to have management and discharge plans

- Review of all medical/surgical team's commitments for week commencing 8th September so all patients are seen by a consultant with clear management plans in the patient notes.
- Consultants available for ward rounds week 8th-12th September
- Review of all divisions OPD commitments week 8-12th September to ensure patients have a full review.
- Discharge lounge to extend opening hours from 8-12th September & weekend 13th/14th September

Ward/Board Rounds –

- All inpatients to be seen by a Consultant or Senior decision

Staffing- All ward rotas completed

- All rotas to be checked and all vacancies to be filled-any gaps to be escalated and action taken

Tests & investigations –Cardiology, Radiology & Endoscopy- All tests and investigations requested week commencing 8th September to be cleared by Monday 15th September

- no backlog of investigations-Service managers to support wards in gathering and expediting all tests

CEPOD –no patients waiting longer than 12 hours for emergency surgery week commencing 8th September

- Additional CEPOD lists if waiting list exceeds 5 patients.

Social Services - No patients to be waiting for social services package by Monday 15th September

Linen supplies-

- Extra supplies of linen on site and location

Occupational Therapy - To have no delays with home visits,

- All home visits requested week commencing 8th September to be completed Monday 15th September.

Paeds contingency

- Bed capacity contingency, escalation beds and staffing to be confirmed

NHS Harrow & NHS Brent CCGs- To have no patients waiting for intermediate care / rehabilitation beds by Monday 15th September –

- Daily teleconference with input from Willesden, Denham, Mount Vernon. Names of reps from CCG taking part on each day
- Plans for transfer of patients to Willesden, Denham and Mount Vernon over the weekend 13th/14th September to be shared with trust.

STARRS / HART – To have all arrangements in place for planned discharges over the weekend 13th/14th September

- Extra rounds of the wards to assess those patients that could be discharged with support

End Of Life Care – All patients to be transferred if possible to Hospice or home care prior to 15th September

- To have those patients requiring end of life care placed in the most appropriate bed

Transport – To have no delays due to transport or ward delay issues.

- Additional support to be in place to support the predicted number of discharges between 8th-12th September
- Allocation of senior staff to support wards

Maternity To ensure that all patients have prompt investigations

- Contingency plans for staffing level, surge of activity
- Matron on call rota to be confirmed
- Patients to have prompt investigations

Pharmacy - To have no patients waiting for TTAs

Tuesday 9th September 2014

Standards expected for Closure of CMH ED

Key Deliverable

- ✓ **No GP Divert to CMH**
- ✓ **To have less than 6 delayed discharges across the sites**
- ✓ **Daily KPI closure scorecard**
- ✓ **Transfer 3-4 patients daily to Gladstone suite**

Beds - the aim is to have the 10 empty beds on 9.09.14

Management – Silver Control in operation to ensure senior support on both sites

Discharge and Management plans- all patients to have management and discharge plans

Ward/Board Rounds –

- All inpatients to be seen by a Consultant or Senior decision maker.

Staffing- All ward rotas completed

- All rotas to be checked and all vacancies to be filled-any gaps to be escalated and action taken

Tests & investigations –Cardiology, Radiology & Endoscopy- All tests and investigations requested week commencing 8th September to be cleared by Monday 15th September

- No backlog to tests-Service managers to support wards in gathering and expediting all tests

CEPOD –no patients waiting longer than 12 hours for emergency surgery week commencing 8th September

- Additional CEPOD lists if waiting list exceeds 5 patients.

Social Services - No patients to be waiting for social services package by Monday 15th September

Linen supplies-

- Extra supplies of linen on site and location

Occupational Therapy - To have no delays with home visits,

- All home visits requested week commencing 8th September to be completed Monday 15th September.

Paeds contingency

- Bed capacity contingency, escalation beds and staffing to be confirmed

NHS Harrow & NHS Brent CCGs- To have no patients waiting for intermediate care / rehabilitation beds by Monday 15th September –

- Daily teleconference with input from Willesden, Denham, Mount Vernon. Names of reps from CCG taking part on each day

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End Of Life Care – All patients to be transferred if possible to Hospice or home care prior to 15th September

- To have those patients requiring end of life care placed in the most appropriate bed

Transport – To have no delays due to transport or ward delay issues.

- Additional support to be in place to support the predicted number of discharges between 8th-12th September
- Allocation of senior staff to support wards

Maternity To ensure that all patients have prompt investigations

- Contingency plans for staffing level, surge of activity
- Matron on call rota to be confirmed
- Patients to have prompt investigations

Pharmacy - To have no patients waiting for TTAs

Wednesday 10th September 2014

Standards expected for Closure of CMH ED

Key Deliverable

- ✓ **Remaining ACDU patients on Roundwood transferred to care of medics**
- ✓ **24/7 site practitioner cover at CMH reinstated.**
- ✓ **Transfer 3-4 patients daily to Gladstone suite**
- ✓ **To have less than 6 delayed discharges across the sites**
- ✓ **Emergency Department CMH closed at 7pm**
- ✓ **Silver control confirms closure with UCC at CMH & NPH**
- ✓ **Daily KPI closure dashboard**
- ✓ **Internal signage in place**
- ✓ **External signage in place**

Beds - the aim is to have the 10 empty beds on 10.09.14

Management – Silver Control in operation to ensure senior support on both sites

Discharge and Management plans- all patient to have management and discharge plans

Ward/Board Rounds –

- All inpatients to be seen by a Consultant or Senior decision maker

Staffing- All ward rotas completed

- All rotas to be checked and all vacancies to be filled-any gaps to be escalated and action taken

Tests & investigations –Cardiology, Radiology & Endoscopy- All tests and investigations requested week commencing 8th September to be cleared by Monday 15th September

- No backlog to tests-Service managers to support wards in gathering and expediting all tests

CEPOD –no patients waiting longer than 12 hours for emergency surgery week commencing 8th September

- Additional CEPOD lists if waiting list exceeds 5 patients.

Social Services - No patients to be waiting for social services package by Monday 15th September

Linen supplies-

- Extra supplies of linen on site and location

Occupational Therapy - To have no delays with home visits,

- All home visits requested week commencing 8th September to be completed Monday 15th September.

Paeds contingency

- Bed capacity contingency, escalation beds and staffing to be confirmed

NHS Harrow & NHS Brent CCGs- To have no patients waiting for intermediate care / rehabilitation beds by Monday 15th September –

- Daily teleconference with input from Willesden, Denham, Mount Vernon. Names of reps from CCG taking part on each day

- Plans for transfer of patients to Willesden, Denham and Mount Vernon over the weekend 13th/14th September to be shared with trust.

STARRS / HART – To have all arrangements in place for planned discharges over the weekend 13th/14th September

- Extra rounds of the wards to assess those patients that could be discharged with support

End Of Life Care – All patients to be transferred if possible to Hospice or home care prior to 15th September

- To have those patients requiring end of life care placed in the most appropriate bed

Transport – To have no delays due to transport or ward delay issues.

- Additional support to be in place to support the predicted number of discharges between 8th-12th September
- Allocation of senior staff to support wards

Maternity To ensure that all patients have prompt investigations

- Contingency plans for staffing level, surge of activity
- Matron on call rota to be confirmed
- Patients to have prompt investigations

Pharmacy - To have no patients waiting for TTAs

Thursday 11th September 2014

Standards expected for Closure of CMH ED

Key Deliverable

- ✓ **ED staff transferred to NPH in line with consultation outcome**
- ✓ **Roundwood ward closed to admissions. Beds to close as patients are discharged**
- ✓ **CCU –bed closure as patients are discharged**
- ✓ **To have less than 6 delayed discharges across the sites**
- ✓ **Transfer 3-4 patients daily to Gladstone suite**
- ✓ **Daily KPI closure scorecard**

Beds - the aim is to have the 10 empty beds 11.09.14

Management – Silver Control in operation to ensure senior support on both sites

Discharge and Management plans- all patients to have management and discharge plans

Ward/Board Rounds –

- All inpatients to be seen by a Consultant or Senior decision

Staffing- All ward rotas completed

- All rotas to be checked and all vacancies to be filled-any gaps to be escalated and action taken

Tests & investigations –Cardiology, Radiology & Endoscopy - All tests and investigations requested week commencing 8th September to be cleared by Monday 15th September

- No backlog to tests-Service managers to support wards in gathering and expediting all tests

CEPOD –no patients waiting longer than 12 hours for emergency surgery week commencing 8th September

- Additional CEPOD lists if waiting list exceeds 5 patients.

Social Services - No patients to be waiting for social services package by Monday 15th September

Linen supplies-

- Extra supplies of linen on site and location

Occupational Therapy - To have no delays with home visits,

- All home visits requested week commencing 8th September to be completed Monday 15th September.

Paeds contingency

- Bed capacity contingency, escalation beds and staffing to be confirmed

NHS Harrow & NHS Brent CCGs- To have no patients waiting for intermediate care / rehabilitation beds by Monday 15th September –

- Daily teleconference with input from Willesden, Denham, Mount Vernon. Names of reps from CCG taking part on each day
- Plans for transfer of patients to Willesden, Denham and Mount Vernon over the weekend 13th/14th September to be shared with trust.

STARRS / HART – To have all arrangements in place for planned discharges over the weekend 13th/14th September

- Extra rounds of the wards to assess those patients that could be discharged with support

End Of Life Care – All patients to be transferred if possible to Hospice or home care prior to 15th September

- To have those patients requiring end of life care placed in the most appropriate bed

Transport – To have no delays due to transport or ward delay issues.

- Additional support to be in place to support the predicted number of discharges between 8th-12th September
- Allocation of senior staff to support wards

Maternity To ensure that all patients have prompt investigations

- Contingency plans for staffing level, surge of activity
- Matron on call rota to be confirmed
- Patients to have prompt investigations

Pharmacy - To have no patients waiting for TTAs

Friday 12th September 2014

Standards expected for Closure of CMH ED

Key Deliverable

- ✓ **Decant & reduce capacity on Roundwood on patient discharge**
- ✓ **CCU- bed closures as patients are discharged**
- ✓ **To have less than 6 delayed discharges across the sites**
- ✓ **Transfer 3-4 patients daily to Gladstone suite**
- ✓ **Daily KPI closure scorecard**

Beds - the aim is to have the 100 discharges 12.09.14

Management – Silver Control in operation to ensure senior support on both sites

Discharge and Management plans- all patients to have management and discharge plans

Ward/Board Rounds –

- All inpatients to be seen by a Consultant or Senior decision maker and TTA's to be written up for patient able to be discharged over weekend 13th/14th September
- Discharge bundles to be completed by 4pm for the AAU handover meeting Friday 12th September.

Staffing- All ward rotas completed

- All rotas to be checked and all vacancies to be filled-any gaps to be escalated and action taken

Tests & investigations –Cardiology, Radiology & Endoscopy- All tests and investigations requested week commencing 8th September to be cleared by Monday 15th September

- Additional lists to be arranged for CT,USS, Cardiology Tests, Endoscopy weekend 13th/14th September
- No back log for tests-Service managers to support wards in gathering and expediting all tests

CEPOD –no patients waiting longer than 12 hours for emergency surgery week commencing 8th September

- Additional CEPOD lists if waiting list exceeds 5 patients.

Social Services - No patients to be waiting for social services package by Monday 15th September

Infection Control-

- Names of staff on call weekend 13th/14th September

Linen supplies-

- Extra supplies of linen on site and location

Occupational Therapy - To have no delays with home visits,

- All home visits requested week commencing 8th September to be completed Monday 15th September.

Paeds contingency

- Bed capacity contingency, escalation beds and staffing to be confirmed

NHS Harrow & NHS Brent CCGs- To have no patients waiting for intermediate care / rehabilitation beds by Monday 15th September –

- Daily teleconference with input from Willesden, Denham, Mount Vernon. Names of reps from CCG taking part on each day
- Plans for transfer of patients to Willesden, Denham and Mount Vernon over the weekend 13th/14th September to be shared with trust.

STARRS / HART – To have all arrangements in place for planned discharges over the weekend 13th/14th September

- Extra rounds of the wards to assess those patients that could be discharged with support

End Of Life Care – All patients to be transferred if possible to Hospice or home care prior to 15th September

- To have those patients requiring end of life care placed in the most appropriate bed
- List of all patients on the pathway to be brought down to site office by 4pm Friday 12th September

Transport – To have no delays due to transport or ward delay issues.

- Additional support to be in place to support the predicted number of discharges between 8th-12th September
- Allocation of senior staff to support wards.

Maternity To ensure that all patients have prompt investigations

- Contingency plans for staffing level, surge of activity
- Matron on call rota to be confirmed
- Patients to have prompt investigations

Pharmacy - To have no patients waiting for TTAs

Saturday 13th September 2014

Standards expected for Closure of CMH ED

Key Deliverable

- ✓ **Decant & reduce capacity on Roundwood on patient discharge**
- ✓ **CCU- bed closures as patients are discharged**
- ✓ **Transfer 3-4 patients daily to Gladstone suite**
- ✓ **To have no more than 6 delayed discharges across the sites**
- ✓ **Daily KPI closure scorecard**

Beds - the aim is to have the 50 discharges on 13.09.14

Management – Silver Control in operation to ensure senior support on both sites

Discharge and Management plans- all patients to have management and discharge plans

- Discharge lounge open 13th/14th September

Ward/Board Rounds –

- All inpatients to be seen by a Consultant or Senior decision maker and TTA's to be written up for patient able to be discharged over weekend 13th/14th September
- Discharge bundles to be completed by 4pm for the AAU handover meeting Friday 12th September.

Staffing- All ward rotas completed

- All rotas to be checked and all vacancies to be filled-any gaps to be escalated and action taken

Tests & investigations –Cardiology, Radiology & - All tests and investigations requested week commencing 8th September to be cleared by Monday 15th September

- Additional lists to be arranged for CT,USS, Cardiology Tests, Endoscopy weekend 13th/14th September
- No back log for tests-Service managers to support wards in gathering and expediting all tests

CEPOD –no patients waiting longer than 12 hours for emergency surgery week commencing 8th September

- Additional CEPOD lists if waiting list exceeds 5 patients.

Social Services - No patients to be waiting for social services package by Monday 15th September

Infection Control-

- Names of staff on call weekend 13th/14th September

Linen supplies-

- Extra supplies of linen on site and location

Occupational Therapy - To have no delays with home visits,

- All home visits requested week commencing 8th September to be completed Monday 15th September.

Paeds contingency

- Bed capacity contingency, escalation beds and staffing to be confirmed

NHS Harrow & NHS Brent CCGs- To have no patients waiting for intermediate care / rehabilitation beds by Monday 15th September –

- Daily teleconference with input from Willesden, Denham, Mount Vernon. Names of reps from CCG taking part on each day
- Plans for transfer of patients to Willesden, Denham and Mount Vernon over the weekend 13th/14th September to be shared with trust.

STARRS / HART – To have all arrangements in place for planned discharges over the weekend 13th/14th September

- Extra rounds of the wards to assess those patients that could be discharged with support

End Of Life Care – All patients to be transferred if possible to Hospice or home care prior to 15th September

- To have those patients requiring end of life care placed in the most appropriate bed
- List of all patients on the pathway to be brought down to site office by 4pm Friday 12th September

Transport – To have no delays due to transport or ward delay issues.

- Additional support to be in place to support the predicted number of discharges between 8th-12th September
- Allocation of senior staff to support wards.

Maternity To ensure that all patients have prompt investigations

- Contingency plans for staffing level, surge of activity
- Matron on call rota to be confirmed
- Patients to have prompt investigations

Pharmacy - To have no patients waiting for TTAs

- Extended Opening hours of pharmacy weekend, 13th/14th September

Sunday 14th September 2014

Standards expected for Closure of CMH ED

Key Deliverable

- ✓ **Decant & reduce capacity on Roundwood on patient discharge**
- ✓ **CCU- close beds as patients are discharged**
- ✓ **To have no more than 6 delayed discharges across the sites**
- ✓ **Transfer 3-4 patients daily to Gladstone suite**
- ✓ **Daily KPI closure scorecard**

Beds - the aim is to have the greater than 40 discharges on 14.09.14

Management – Silver Control in operation to ensure senior support on both sites

Discharge and Management plans- all patients to have management and discharge plans

- Discharge lounge open 13th/14th September

Ward/Board Rounds –

- All inpatients to be seen by a Consultant or Senior decision maker and TTA's to be written up for patient able to be discharged over weekend 13th/14th September
- Discharge bundles to be completed by 4pm for the AAU handover meeting Friday 12th September.

Staffing- All ward rotas completed

- All rotas to be checked and all vacancies to be filled-any gaps to be escalated and action taken

Tests & investigations –Cardiology, Radiology & Endoscopy- All tests and investigations requested week commencing 8th September to be cleared by Monday 15th September

- Additional lists to be arranged for CT,USS, Cardiology Tests, Endoscopy weekend 13th/14th September
- No back log for tests-Service managers to support wards in gathering and expediting all tests

CEPOD –no patients waiting longer than 12 hours for emergency surgery week commencing 8th September

- Additional CEPOD lists if waiting list exceeds 5 patients.

Social Services - No patients to be waiting for social services package by Monday 15th September

Infection Control-

- Names of staff on call weekend 13th/14th September

Linen supplies-

- Extra supplies of linen on site and location

Occupational Therapy - To have no delays with home visits,

- All home visits requested week commencing 8th September to be completed Monday 15th September.

Paeds contingency

- Bed capacity contingency, escalation beds and staffing to be confirmed

NHS Harrow & NHS Brent CCGs- To have no patients waiting for intermediate care / rehabilitation beds by Monday 15th September –

- Daily teleconference with input from Willesden, Denham, Mount Vernon. Names of reps from CCG taking part on each day
- Plans for transfer of patients to Willesden, Denham and Mount Vernon over the weekend 13th/14th September to be shared with trust.

STARRS / HART – To have all arrangements in place for planned discharges over the weekend 13th/14th September

- Extra rounds of the wards to assess those patients that could be discharged with support

End Of Life Care – All patients to be transferred if possible to Hospice or home care prior to 15th September

- To have those patients requiring end of life care placed in the most appropriate bed
- List of all patients on the pathway to be brought down to site office by 4pm Friday 12th September

Transport – To have no delays due to transport or ward delay issues.

- Additional support to be in place to support the predicted number of discharges between 8th-12th September
- Allocation of senior staff to support wards.

Maternity To ensure that all patients have prompt investigations

- Contingency plans for staffing level, surge of activity
- Matron on call rota to be confirmed
- Patients to have prompt investigations

Pharmacy - To have no patients waiting for TTAs

- Extended opening hours of pharmacy at weekend 13th/14th September

Week commencing Monday 15th September 2014

Standards expected for Closure of CMH ED

Key Deliverable

- ✓ **Transfer 3-4 patients daily to Gladstone suite**
- ✓ **Daily KPI closure scorecard**
- ✓ **To have no more than 6 delayed discharges across the sites**
- ✓ **Review & decision in respect of weekend Silver control- 17.09.14**
- ✓ **Decant & reduce capacity on Roundwood/CCU on patient discharge-review closure date 30th September – 17.09.14**

Beds - the aim is to have the 10 empty beds and no patients awaiting a bed in A&E on Monday15th September

Management – Silver Control in operation to ensure senior support on both sites -

- On call managers & executive rota planned
- All senior managers to provide details of their availability over this period
- DGM/Senior nurse/Continuing care/Social Service rep in situ in site office for "silver control"
- Back to the floor from 15-19th September. All non-urgent meetings to be cancelled, Managers to support the wards with discharge process
- CDs on site to ensure all patients receive a senior review Week 15th-19th September

Discharge and Management plans- all patients to have management and discharge plans

- Review of all medical/surgical team's commitments for week commencing 8th September so all patients are seen by a consultant with clear management plans in the patient notes.
- Consultants available for ward rounds week 15th-19th September
- Review of all divisions OPD commitments week 15th -19th September to ensure patients have a full review.
- Discharge lounge to extend opening hours from 15th-19th September and open weekend 20th/21st September

Ward/Board Rounds –

- All inpatients to be seen by a Consultant or Senior decision maker and TTA's to be written up for patient able to be discharged over weekend 20th/21st September
- Discharge bundles to be completed by 4pm for the AAU handover meeting Friday 19th September.

Staffing- All ward rotas completed

- All rotas to be checked and all vacancies to be filled-any gaps to be escalated and action taken

Tests & investigations –Cardiology, Radiology &Endoscopy - All tests and investigations requested week commencing 15th September to be cleared by Monday 22th September

- Additional lists to be arranged for CT,USS, Cardiology Tests, Endoscopy weekend 20th/21st September
- No backlog of investigations-Service managers to support wards in gathering and expediting all tests

CEPOD –no patients waiting longer than 12 hours for emergency surgery week commencing 15th September

- Additional CEPOD lists if waiting list exceeds 5 patients.

Social Services - No patients to be waiting for social services package by Monday 22nd September

Infection Control-

- Names of staff on call weekend 20th/21st September

Linen supplies-

- Extra supplies of linen on site and location

Occupational Therapy - To have no delays with home visits,

- All home visits requested week commencing 15th September to be completed Monday 22nd September.

Paeds contingency

- Bed capacity contingency, escalation beds and staffing to be confirmed

NHS Harrow & NHS Brent CCGs- To have no patients waiting for intermediate care / rehabilitation beds by Monday 22nd September –

- Daily teleconference with input from Willesden, Denham, Mount Vernon. Names of reps from CCG taking part on each day
- Plans for transfer of patients to Willesden, Denham and Mount Vernon over the weekend 20th/21st September to be shared with trust.

STARRS / HART – To have all arrangements in place for planned discharges over the weekend 20th/21st September

- Extra rounds of the wards to assess those patients that could be discharged with support

End Of Life Care – All patients to be transferred if possible to Hospice or home care prior to 22nd September

- To have those patients requiring end of life care placed in the most appropriate bed
- List of all patients on the pathway to be brought down to site office by 4pm Friday 19th September

Transport – To have no delays due to transport or ward delay issues.

- Additional support to be in place to support the predicted number of discharges between 15th-19th September

- Allocation of senior staff to support wards

Maternity To ensure that all patients have prompt investigations

- Contingency plans for staffing level, surge of activity
- Matron on call rota to be confirmed
- Patients to have prompt investigations

Pharmacy - To have no patients waiting for TTAs

- Extended opening hours of pharmacy at weekend 20th/21st September

Week commencing Monday 22nd September 2014

Key Deliverable

- ✓ **Transfer 3-4 patients daily to Gladstone suite**
- ✓ **Daily KPI closure scorecard**
- ✓ **To have no more than 6 delayed discharges across the sites**
- ✓ **Review & decision in respect of weekend Silver control- 24.09.14**
- ✓ **Decant & reduce capacity on Roundwood/CCU on patient discharge-review closure date 30th September – 24.09.14**

Silver Control standards in place as week commencing 15th September 2014

Week commencing Monday 29nd September 2014

Key Deliverable

- ✓ **Transfer 3-4 patients daily to Gladstone suite**
- ✓ **Daily KPI closure scorecard**
- ✓ **To have no more than 6 delayed discharges across the sites**
- ✓ **Any remaining patients on Roundwood /CCU to be transferred on 30th September 2014**
- ✓ **Silver control stopped 30th September**
- ✓ **Roundwood & CCU areas closed and secured 30.09.14**
- ✓ **Staff transferred to agreed area in line with consultation outcome.**