# IRP

**Independent Reconfiguration Panel**

***ADVICE ON* SHAPING A HEALTHIER FUTURE *PROPOSALS FOR CHANGES TO NHS SERVICES IN NORTH WEST LONDON***

Submitted to the Secretary of State for Health

13 SEPTEMBER 2013

## Independent Reconfiguration Panel

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# SUMMARY AND RECOMMENDATIONS

**The current problems and future challenges faced by the NHS in north west London require large-scale change in the way services are designed and delivered. Overall, the Panel believes that the *Shaping a Healthier Future* 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 in the interests of local people to delay the progress of the programme. Well recognised improvements to out of hospital services need to be implemented in parallel with changes to hospital services that will also bring benefits for patients.**

**The changes to A&E at Central Middlesex and Hammersmith hospitals should be implemented as soon as practicable. Further work is required before a final decision is made about the range of services to be provided from the Ealing and Charing Cross hospital sites. Clinical service collaboration across hospitals will be vital for the A&E services at Ealing and Charing Cross hospitals to continue to function safely until the point where the alternative is demonstrably ready and implemented.**

- **Commissioners and providers of acute hospital services across north west London must ensure that changes required to secure safety and quality for patients are made without delay.**

- **Subject to the recommendations below, the *Shaping a Healthier Future* programme should continue and be implemented.**

- **Out of hospital service development plans should be built up from the individual practice and locality level to ensure services address differences in the needs of a diverse population and the associated health inequalities.**

# SUMMARY AND RECOMMENDATIONS

- **As an integral element of *Shaping a Healthier Future*, the NHS should build on existing initiatives and engage local authorities as partners in the commissioning of more integrated care, particularly for vulnerable and frail older people.**

- **The NHS should review its workforce programme and ensure that it has the means in place to deliver what is required.**

- **Current plans to put all urgent care centres on a common specification by the end of March 2015 must be implemented. A common approach for accessing GP services in normal hours and out of hours is needed to create, with the appropriate use of 111 and the emergency ambulance service, a consistent urgent and emergency care service to the public across north west London.**

- **The proposal for the five major hospitals to provide A&E and associated services in north west London should be implemented. It is more sustainable than the alternatives and will deliver benefits including a reduction in avoidable morbidity and mortality.**

- **Maternity and paediatric inpatient services should be concentrated on the sites identified by *Shaping a Healthier Future*.**

- **The Panel agrees that the proposal to create a dedicated elective care centre at Central Middlesex Hospital will deliver quality benefits for patients and efficiency benefits for the NHS. The possibility of a further dedicated elective centre on the Charing Cross site should be considered by commissioners in the context of what has already been agreed for Central Middlesex and the overall need for elective care.**

- **As part of a staged approach for implementing *Shaping a Healthier Future*, the proposals for A&E services at Hammersmith and Central Middlesex hospitals should proceed as soon as practicable.**

- **The future of the proposed local hospitals at Ealing and Charing Cross, and the final decision about what might best be provided from each location as part of *Shaping a Healthier Future*, must be the subject of a specific programme of work led by local commissioners and engaging the public, service users, staff and the relevant local authority. This work should address the need for inpatient services for the vulnerable and frail elderly and its outcome will determine whether there is a need for further consultation.**

- **The NHS must use the next period to achieve a shift in approach from communicating what they are doing to involving and engaging people in the challenge of improving services through co-design, evaluation and change.**

- **The NHS's implementation programme must demonstrate that, before each substantial change, the capacity required will be available and safe transition will be assured.**

- **The A&E departments at Ealing and Charing Cross hospitals must be sustained until further work to inform a final decision on the future of these two local hospitals has been completed and the alternative services that will provide a safe, high quality urgent emergency care system for local residents are in place.**

- **The NHS should assure itself that the implementation programme has the depth and breadth of leadership combined with the resources and skills to sustain the high level of commitment and progress that will be required over the expected period of five years.**

# OUR REMIT

## *What was asked of us*

1.1 The Independent Reconfiguration Panel's (IRP) general terms of reference are included in Appendix One.

1.2 On 19 March 2013, Cllr Abdullah Gulaid, Chair of Ealing Health and Adult Social Services Standing Scrutiny Panel (HASSSSP) wrote to the Secretary of State for Health, Jeremy Hunt, to refer for his consideration the *Shaping a Healthier Future* proposals for changes to NHS services in north west London (Appendix Two).

1.3 The Secretary of State wrote to Lord Ribeiro, IRP Chairman, on 23 May 2013 requesting that the IRP undertake a review of the proposals (Appendix Three). Lord Ribeiro responded on 30 May 2013 accepting the commission and setting out proposed terms of reference. The Secretary of State agreed the terms of reference on 13 June 2013 (Appendix Four) as below:

*With regard to the Panel's general terms of reference, as agreed between DH and the IRP, the Panel is to advise by 13 September 2013:*

a. *Whether it is of the opinion that the* Shaping a Healthier Future *proposals for change will enable safe, sustainable and accessible services for north west London and if not, why not;*
b. *On any other observations the panel may wish to make in relation to the changes; and*
c. *On how to proceed in the best interests of local people in light of a. and b. above and taking into account the issues raised by the Ealing Council Health and Adult Social Services Standing Scrutiny Panel in its referral letter of 19 March 2013*

# OUR PROCESS

## *How we approached the task*

2.1 The NHS North West London collaboration of clinical commissioning groups (CCG) were asked to provide the Panel with relevant documentation and to assist in arranging site visits, meetings and interviews with interested parties.

2.2 The Ealing HASSSSP were also invited to submit documentation and suggest other parties to be included in meetings and interviews.

2.3 IRP press releases, advising that the Panel were undertaking a review, were issued on 18 June 2013 and 9 July 2013 (Appendix Five). The Panel Chairman, Lord Ribeiro, wrote an open letter to editors of local newspapers on 18 June 2013 informing them of our involvement (Appendix Six). The letter invited people who felt that they had new evidence to offer or who felt that their views had not been heard adequately during the formal consultation process to contact the Panel.

2.4 A sub-group of the full IRP carried out the review. It consisted of Lord Ribeiro and seven Panel members, Shera Chok, Rosemary Granger, Jane Hawdon, Nicky Hayes, John Parkes, Linn Phipps, and Gina Tiller. Sub-group members visited all the acute hospital sites covered by the proposals as well as examples of primary care and community services. The sub-group also undertook an orientation tour of Ealing borough provided by the local authority. In total, 15 days of familiarisation and oral evidence taking were undertaken. Members were accompanied on visits and at evidence sessions by the IRP Secretariat. Details of the people seen during these sessions are included in Appendix Seven.

2.5 Meetings were held with local MPs – Andy Slaughter (MP for Hammersmith) on 10 July 2013, Karen Buck (Westminster North), Seema Malhotra (Feltham and Heston), Virendra Sharma (Ealing Southall), and Andy Slaughter on 17 July 2013[1], and Greg Hands (Chelsea and Fulham) on 18 July 2013.

[1] Barry Gardiner (Brent North) was also represented.

2.6 A number of other visits and meetings were held. The Panel met representatives of Imperial College London and observed at a public meeting organised by the Save our Hospitals campaign. Staff drop-in sessions were held at Ealing, Charing Cross and Central Middlesex hospitals.

2.7 A list of all the written evidence received – from NHS North West London, the *Shaping a Healthier Future* programme team, CCGs, NHS trusts, the Ealing HASSSSP, local authorities, campaigners and local interest groups, MPs and all other interested parties is contained in Appendix Eight. The Panel considers that the documentation received, together with the information obtained in meetings, provides a fair representation of the views from all perspectives.

2.8 Throughout our consideration of these proposals, our aim has been to consider the needs of patients, public and staff taking into account the issues of safety, sustainability and accessibility as set out in our terms of reference.

2.9 The Panel wishes to record its thanks to all those who contributed to this process. We also wish to thank all those who gave up their valuable time to present evidence to the Panel and to everyone who contacted us offering views.

2.10 The advice contained in this report represents the unanimous views of the Chairman and members of the IRP[2].

[2] Panel members Shane Duffy and Tessa Green declared an interest in the proposals and took no part in the Panel's review.

# THE CONTEXT

## *A brief overview*

3.1 Work began in 2009 to improve out-of-hospital care and heart attack, stroke and trauma services in London. A five-year commissioning strategic plan was published that detailed the case for change. A number of changes to services in north west London followed from this programme including, in 2009, the establishment of hyper-acute stroke services at Northwick Park and Charing Cross hospitals and, in 2011, the establishment of a major trauma centre at St Mary's Hospital and the consolidation of complex vascular surgery at Northwick Park and St Mary's hospitals.

3.2 Between 2009 and 2011, a series of clinical working groups were established in north west London to develop suitable models for clinical services which culminated in some of the key elements of the 2011 Commissioning Strategy Plan, including:

- The definition of a case for change for north west London
- The definition of a detailed strategy to localise care close to patients' homes, to centralise specialist care and to integrate care for people with long-term conditions and the elderly
- Clinical quality standards for north west London
- Proposals for the establishment of a service change programme

3.3 As a result, the *Shaping a Healthier Future* programme was established in November 2011 to develop proposals for service change across north west London encompassing acute services and out of hospital care. The programme was launched publicly in January 2012 and a case for change published.

3.4 National Clinical Advisory Team (NCAT) reviews of emergency services and maternity and paediatric services in north west London were published in April 2012. A Health Gateway Review team visited NHS North West London between 24-27 April 2012. The team noted the programme's structure, governance, board membership, clinical engagement, proactive approach to workstreams, and comprehensive programme management. Their subsequent *Delivery Confidence Assessment* rated the *Shaping a Healthier Future* programme as amber/green indicating that *"successful delivery appears*

*likely. However, attention will be needed to ensure risks do not materialise into major issues threatening delivery".*

3.5 At a North West London Cluster Board meeting in May 2012, it was resolved to form a Joint Committee of Primary Care Trusts (JCPCT) comprising the eight north west London PCTs (NHS Brent, NHS Ealing, NHS Hammersmith & Fulham, NHS Harrow, NHS Hillingdon, NHS Hounslow, NHS Kensington & Chelsea and NHS Westminster) and three neighbouring PCTs (NHS Camden, NHS Wandsworth and NHS Richmond). The JCPCT was formally constituted in June 2012 (having met previously in shadow form) to make decisions regarding proposed significant service changes and, on 25 June 2012, approved the launch of a formal public consultation.

3.6 A proposed programme of change was set out in a pre-consultation business case published on 20 June 2012. On 28 June 2012, the NHS London Board provided quality assurance for the programme and endorsed the plans for consultation. Public consultation began on 2 July 2012 and ran for 14 weeks.

3.7 The consultation sought views on proposals to improve care both in hospitals and in the community. The consultation document raised 34 key questions on the proposals, ranging from the reasons behind the desire to change the way healthcare is delivered in north west London through to specific proposals for individual sites. Key areas included:

- *The vision for healthcare in north west London*
- *The vision for providing world class healthcare outside of hospitals*
- *Making hospitals centres of excellence*
- *Where care will be provided under the proposals*
- *Plans for delivering care outside of hospitals*
- *Proposals for local hospitals in north west London*
- *Proposals for elective hospitals*
- *Proposals for major hospitals and the three options for major hospitals*
- *Proposals for changes to some specialist services (ophthalmology and hyper-acute strokes)*
- *Making the proposals work for patients*

3.8 A North West London Joint Health Overview and Scrutiny Committee (JHOSC) was convened to scrutinise the proposals.

3.9 The London Borough of Ealing (Ealing Council) commissioned an independent review of the proposals from Tim Rideout Ltd to assess their implications and robustness from the Borough's perspective and to inform its formal response to the consultation. Ealing HASSSSP submitted comments to the JHOSC following its meeting on 26 July 2012, which had considered the proposals and heard views from residents and local clinicians.

3.10 The consultation closed on 8 October 2012. Over 17,000 responses were received from a range of stakeholders as well as some 80,000 signatures to petitions. Ipsos MORI was commissioned to produce an independent report analysing responses received.

3.11 Ealing Council responded to the consultation, informed by the independent review it had commissioned and which had been submitted to the council in September 2012. While accepting that to *"do nothing"* was not an option, the council was *"not convinced that the specific proposals presented by NHS North West London are supportable in their current form"*.

3.12 The Chairman's preface to the JHOSC response to the consultation commented that *"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…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…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"*.

3.13 A public stakeholder event was held on 28 November 2012 to report on the findings of the consultation and to discuss emerging recommendations. Also in November 2012, NCAT conducted a follow-up visit to north west London focusing on the NHS responses to consultation on the acute models of care and urgent care centres.

3.14 The JCPCT held a public meeting on 6 December 2012 to consider the findings of the consultation.

3.15 A further visit to north west London by NCAT to review in detail the CCG's out of hospital strategies in early February 2013 confirmed their support for the proposals outlined by the *Shaping a Healthier Future* programme.

3.16 The JCPCT held a final decision-making meeting on 19 February 2013. All the relevant CCGs[3] were represented on the committee. The Committee considered 11 recommendations as described in the *Shaping a Healthier Future* decision-making business case (DMBC) along with two further recommendations regarding additional proposals for Ealing and Charing Cross hospitals that had emerged as a response to feedback received during consultation. That feedback had suggested that there was the potential to deliver an enhanced service that went beyond the outpatient and urgent care needs suggested by the DMBC recommendation. The 11 recommendations contained in the DMBC along with the two further recommendations were agreed by the JCPCT.

3.17 Following a meeting of the Ealing HASSSSP on 4 March 2013, the HASSSSP referred the proposals to the Secretary of State for Health. The referral letter indicates that the HASSSSP *"is firmly of the view that the proposal is not in the interests of the health service in Ealing. The proposal fails to satisfy the four tests [that you have] set for reconfiguration proposals to meet in [your] document Revision to the operating Framework for the NHS in England 2010/2011. The Panel does not believe that there has been adequate consultation or engagement with the public, clinicians or Ealing Council ("the Council"). The Panel therefore refers the matter to you under Regulation 4 of the*

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[3] Changes to the structure of the NHS came into effect on 1 April 2013 – notably the abolition of primary care trusts with responsibility for commissioning of local health services transferred to clinical commissioning groups (CCG), NHS England, Public Health England and local authorities

*Local Authority (Overview and Scrutiny Committees Health Scrutiny) Functions Regulations 2002".*

3.18 On 17 May 2013, Ealing Council lodged an application for a judicial review of the JCPCT's decision. The application was denied on 9 August 2013. Subsequently, Ealing Council was granted an oral hearing which is due to be heard on 9 October 2013.

# INFORMATION

## *What we found*

4.1 A vast amount of written and oral evidence was submitted to the Panel. We are grateful to all those who took the time to offer their views and information. The evidence put to us is summarised below – firstly general background information followed by an outline of the proposals agreed by the JCPCT, the reasons for referral by Ealing HASSSSP, issues raised by others and finally other evidence gathered.

4.1.1 The tables and maps have been taken from documentation provided to the IRP by the NHS.

### 4.2 Geography of north west London

4.2.1 The *Shaping a Healthier Future* proposals cover an area of north west London with a population of circa two million people. The area includes eight London boroughs: Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington & Chelsea, and Westminster. CCGs are closely aligned to the boundaries of local authorities although not always co-terminous.

4.2.2 Within this area there are nine acute and specialist trusts:

- Chelsea and Westminster Hospital NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- The Hillingdon Hospitals NHS Foundation Trust
- The North West London Hospitals NHS Trust
- West Middlesex University Hospital NHS Trust
- Ealing Hospital NHS Trust (incorporates Ealing Integrated Care Organisation)
- The Royal Marsden NHS Foundation Trust
- The Royal Brompton and Harefield NHS Foundation Trust
- The Royal National Orthopaedic Hospital NHS Trust

4.2.3 The location of the hospitals within these trusts and hospitals in the surrounding area is shown in the map below.

**Map 1:** Hospital sites in north west London and surrounding areas

Source: NWL DMBC Vol 1

4.2.4 There are two community health trusts within the area:

- Central London Community Healthcare NHS Trust, covering Hammersmith & Fulham, Kensington & Chelsea and Westminster
- Hounslow and Richmond Community Healthcare NHS Trust covering Hounslow although the Trust is situated outside of north west London in Teddington

Ealing Integrated Care Organisation, part of Ealing Hospital NHS Trust, is the community health provider covering Brent, Ealing and Harrow. Central and North West London NHS Foundation Trust incorporates Hillingdon community services provider.

4.2.5 There are two mental health trusts within the area:

- Central and North West London NHS Foundation Trust, covering Brent, Kensington & Chelsea, Harrow, Hillingdon and Westminster
- West London Mental Health NHS Trust, covering Ealing, Hammersmith and Fulham and Hounslow

4.2.6 The eight CCGs covering the area manage their operations in two groups of four to provide a balance between economies of scale and ensuring a local focus.

- BEHH Federation of CCGs (outer north west London), covering the CCGs of Brent, Ealing, Harrow and Hillingdon
- CWHH Collaborative of CCGs (inner north west London), covering the CCGs of Central London, West London, Hammersmith & Fulham and Hounslow

4.2.7 The eight CCGs together form NHS North West London Collaboration of Clinical Commissioning Groups.

4.2.8 Some residents of neighbouring boroughs and CCGs also access the services provided by north west London Trusts.

4.2.9 *Organisation changes*

The North West London Hospitals NHS Trust and Ealing Hospital NHS Trust are progressing plans for a merger.

4.2.10 West Middlesex University Hospital NHS Trust announced in September 2012 the intention to commence a competitive process to identify a partner with whom to achieve Foundation Trust status. A Strategic Options Assessment was completed in April 2013 with the selection of Chelsea and Westminster NHS Foundation Trust. The two Trusts are now working to explore business case development for potential acquisition in 2014.

4.2.11 Ealing CCG has developed a case to transfer from the BEHH Federation of CCGs to the CWHH Collaborative of CCGs. Any change in the composition of the two CCG groups would need to be approved by NHS England.

## 4.3 Scope of *Shaping a Healthier Future* proposals

4.3.1 The *Shaping a Healthier Future* programme, established in November 2011, encompasses acute services in nine hospitals: Central Middlesex, Charing Cross, Chelsea & Westminster, Ealing, Hammersmith (including Queen Charlotte's and Chelsea), Hillingdon, Northwick Park, St Mary's and West Middlesex and out of hospital care in north west London. Other planned activity to improve services, as part of the Commissioning Strategic Plan 2011, for example integrated care systems, is outside the direct scope of the programme.

4.3.2 Hospitals in north west London providing elective and specialist services not involved in the *Shaping a Healthier Future* programme are: Mount Vernon, Royal Marsden, Royal Brompton, Harefield and the Royal National Orthopaedic Hospital. The Western Eye Hospital is a specialist ophthalmology hospital where no changes are proposed to the services as part of *Shaping a Healthier Future* though a move from its current building to St Mary's Hospital has been proposed.

## 4.4. Current service provision and activity

4.4.1 *Acute services*

The nine hospitals within the scope of *Shaping a Healthier Future* provide a range of local acute services including A&E, emergency admission, obstetrics and planned care and a number of specialist services.

4.4.2 Charing Cross, Hammersmith (including Queen Charlotte's and Chelsea) and St Mary's hospitals are part of Imperial College Healthcare NHS Trust. The Hillingdon Hospital is part of the Hillingdon Hospitals NHS Foundation Trust. Central Middlesex and Northwick Park Hospitals are part of The North West London Hospitals NHS Trust. Chelsea and Westminster, West Middlesex University and Ealing Hospitals are all separate trusts. The Western Eye Hospital is part of Imperial College Healthcare NHS Trust.

4.4.3 St Mary's Hospital is the major trauma centre for the area. North west London patients thought to be suffering from a stroke are initially taken to a hyper-acute stroke unit at Northwick Park Hospital or Charing Cross Hospital. North west London has two of the eight London heart attack centres - located at Hammersmith Hospital and Harefield Hospital - providing 24 hour emergency care and treatment for anyone suspected of having a heart attack in the west London area. St Mary's Hospital and Northwick Park Hospital provide a 24-hour regional service for vascular emergencies. St Mary's Hospital also provides a 24-hour national service for complex aortic vascular disease.

4.4.4 Specialist cancer services in north west London are primarily provided at Imperial (Charing Cross and Hammersmith hospitals), Royal Marsden Hospital and Mount Vernon Cancer Centre.

4.4.5 The specialist neuroscience centre for north west London is part of Imperial College Healthcare NHS Trust with neurosurgery at Charing Cross Hospital and neurosurgical trauma at St Mary's Hospital.

4.4.6 The table below sets out the current services provided at each of the hospital sites.

**Table 1: Current services provided at hospital sites in north west London**

| Core services | Acute Hospital[1] | | | | | | | | | | | | | Elective[1] | | | Specialist[8] | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Urgent care centre | Outpatient and diagnostics | 24/7 A&E | Emergency Surgery | ICU Level 3 | Psychiatric liaison | Complex Elective Surgery | Major Trauma | Emergency medicine | Inpatient Paediatrics | Obstetrics & Maternity Unit | HASU | Heart Attack | Elective Surgery | Elective Medicine | ITU/HDU | Cardiothoracic | Neurosurgery | Vascular | Cancer Care[7] |
| Central Middlesex | ♦ | ♦ | ♦[6] | | ♦ | ♦ | | | ♦ | | | | | ♦ | ♦ | ♦ | | | | |
| Charing Cross | ♦ | ♦ | ♦ | ♦ | ♦ | ♦ | ♦ | | ♦ | | | ♦ | | ♦ | ♦ | ♦ | | ♦ | | ♦ |
| Chelsea & Westminster | ♦ | ♦ | ♦ | ♦ | ♦ | ♦ | ♦ | | ♦ | ♦ | ♦ | | | ♦ | ♦ | ♦ | | | | ♦ |
| Ealing | ♦ | ♦ | ♦ | ♦ | ♦ | ♦ | ♦ | | ♦ | ♦ | ♦ | | | ♦ | ♦ | ♦ | | | | |
| Hammersmith (incl. QCCH) | ♦ | ♦ | ♦ | ♦ | ♦ | ♦ | ♦ | | ♦ | ♦ | ♦ | | ♦ | ♦ | ♦ | ♦ | ♦ | | | ♦ |
| Hillingdon | ♦ | ♦ | ♦ | ♦ | ♦ | ♦ | ♦ | | ♦ | ♦ | ♦ | | | ♦ | ♦ | ♦ | | | | |
| Northwick Park | ♦ | ♦ | ♦ | ♦ | ♦ | ♦ | ♦ | | ♦ | ♦ | ♦ | ♦ | | ♦ | ♦ | ♦ | | | ♦ | ♦ |
| St Mary's | ♦ | ♦ | ♦ | ♦ | ♦ | ♦ | ♦ | ♦ | ♦ | ♦ | ♦ | | | ♦ | ♦ | ♦ | | ♦ | ♦ | ♦ |
| West Middlesex | ♦ | ♦ | ♦ | ♦ | ♦ | ♦ | ♦ | | ♦ | ♦ | ♦ | | | ♦ | ♦ | ♦ | | | | |
| Western Eye[5] | | ♦ | ♦ | | | | | | | | | | | ♦ | | | | | | |
| Mount Vernon | | ♦ | | | | | | | | | | | | ♦ | ♦ | | | | | ♦ |
| Royal Marsden[2] | | ♦ | | | ♦ | | ♦ | | | | | | | ♦ | ♦ | ♦ | | | | ♦ |
| Royal Brompton[3] | | ♦ | | | ♦ | | ♦ | | | ♦ | | | | ♦ | ♦ | ♦ | ♦ | | | ♦ |
| RNOH[4] | | ♦ | | | ♦ | | | | | ♦ | | | | ♦ | | ♦ | | ♦ | | ♦ |
| Harefield | | ♦ | | | ♦ | | ♦ | | | | | | ♦ | ♦ | | ♦ | ♦ | | | |

Source: NWL IRP Template

4.4.7 2012/13 activity levels and bed numbers for the nine acute hospitals that are the subject of *Shaping a Healthier Future* proposals are shown in the table below.

**Table 2: 2012-13 North West London hospitals activity and beds by site**

| | | HOSPITAL | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Ealing | Charing Cross | Central Middlesex | Chelsea & Westminster | Northwick Park & St Mark's | West Middlesex | Hillingdon | Hammersmith | St Mary's |
| ACTIVITY | **Elective**[1] | 14,650 | 37,092 | 14,779 | 28,409 | 25,388 | 12,187 | 15,008 | 15,194 | 23,054 |
| | **Non-elective**[1] | 15,305 | 16,180 | 11,563 | 26,550 | 41,249 | 16,819 | 21,308 | 9,704 | 16,202 |
| | **Maternity (Births)** | 3,141 | - | - | 5,561 | 5,042 | 4,728 | 4,239 | 4,938 | 3,851 |
| | **Paediatrics**[1] | 3,052 | 7 | 1,205 | 15,193 | 11,405 | 3,571 | 2,447 | 266 | 6,965 |
| | **Critical care**[1] | 3,151 | 1,576 | 1,541 | 4,055 | 8,628 | 4,502 | 3,003 | 7,795 | 4,270 |
| | **Outpatients**[2] | 158,396 | 162,885 | 125,112 | 403,819 | 219,397 | 235,821 | 299,410 | 123,099 | 276,266 |
| | **A&E (major & sta.)**[2] | 26,246 | 25,439 | 11,957 | 28,927 | 57,209 | 39,399 | 52,206 | 15,591 | 41,621 |
| | **A&E (minor)**[2] | 19,832 | 8,113 | 2,784 | 14,006 | 37,039 | 20,756 | 32,986 | 5,657 | 73,553 |
| | **UCC**[2] | 71,540 | 49,612 | 53,602 | 70,328 | 74,964 | 80,430 | 29,033 | 32,016 | 27,424 |
| | **Specialist**[1,2] | - | 63,844 | - | 95,129 | 37,388 | - | - | 358,440 | 71,591 |
| BEDS | **Adult** | 239 | 436 | 182 | 325 | 627 | 327 | 412 | 316 | 321 |
| | **Critical care** | 15 | 7 | 9 | 13 | 19 | 13 | 9 | 13 | 16 |
| | **Maternity** | 42 | - | - | 80 | 69 | 56 | 46 | 44 | 41 |
| | **Paediatrics** | 16 | - | 6 | 80 | 24 | 24 | 41 | - | 40 |
| | **TOTAL** | **312** | **443** | **197** | **498** | **739** | **420** | **508** | **373** | **418** |

Source: NWL
Notes: For activity: 1 is measuring Spells 2 is measuring Attendances
Excludes neonates, general maternity and activity labelled as other. Specialist activity includes renal dialysis

4.4.8 *Urgent care centres*

All nine acute hospitals within the scope of *Shaping a Healthier Future* currently have urgent care centres (UCC). However, they are run by a variety of organisations. Some are operated in-house by the acute trust and others by private providers. There is no consistent operating model across north west London.

4.4.9 *Medical and nursing education*

Imperial College Healthcare NHS Trust works in partnership with Imperial College London to deliver undergraduate medical education as well as with other academic centres such as King's College London Florence Nightingale School of Midwifery, Bucks New University and Thames Valley University for undergraduate nursing education. Campus locations for Imperial College include the following hospitals: Hammersmith, Charing Cross, St Mary's, Chelsea and Westminster, Central Middlesex,

Northwick Park & St Marks, and Royal Brompton. Postgraduate medical education is also provided in a wide range of hospital, community and primary care settings.

4.4.10 *Out of hospital service provision in north west London*

The majority of the care of patients in the NHS takes place outside of hospitals. Within north west London there are estimated to be over 11 million attendances at GP surgeries annually along with almost three million other community attendances.[4] Out of hospital service settings include: GP practices and health centres, community health services, dental practices, pharmacies, opticians, walk-in centres, mental and community health services and patient's homes.

4.4.11 There are 407 GP practices in north west London. The table below shows the number of GP practices by list size. Across the NHS NWL Collaboration of CCGs, 103 of 407 (25.3 per cent) of GP practices have a list size of less than 3,000 with the highest number of practices in West London CCG - 23 out of 55 practices (41.8 per cent).

**Table 3: North west London GP practices by list size**

| CCG | No of GP Practices < 3,000 | % of total | No. of GP Practices 3,000 – 7,500 | % of total | No. of GP Practices > 7,500 | % of total | Total GP Practices |
|---|---|---|---|---|---|---|---|
| **Brent** | 20 | 29.9 | 38 | 56.7 | 9 | 13.4 | 67 |
| **Ealing** | 20 | 25.3 | 46 | 58.2 | 13 | 16.5 | 79 |
| **Hammersmith & Fulham** | 4 | 12.9 | 16 | 51.6 | 11 | 35.5 | 31 |
| **Harrow** | 6 | 16.7 | 20 | 55.6 | 10 | 27.8 | 36 |
| **Hillingdon** | 8 | 16.7 | 30 | 62.5 | 10 | 20.8 | 48 |
| **Hounslow** | 10 | 18.5 | 35 | 64.8 | 9 | 16.7 | 54 |
| **Central** | 9 | 24.3 | 22 | 59.5 | 6 | 16.2 | 37 |
| **West London** | 23 | 41.8 | 27 | 49.1 | 5 | 9.1 | 55 |
| **Total** | **103** | | **232** | | **72** | | **407** |

Source: NHS England, Primary Care NW London, GP Capitation data as at 1/7/13 utilising all GP list size (normalised weighted list size)

[4] Source: DMBC Vol 1. Reference costs 2009/10 - District Nursing, Health Visitor (HV) Post natal visits, specialist palliative care, GP practice list size (Quality and Outcomes Framework 2010/11). National average GP visits per person (Qresearch 2009), Reference costs 2009/10, other community activity (including HV activity other than post-natal visit)

## 4.5 Demography[5]

### 4.5.1 *Population Profile*

The area covered by NHS NWL Collaboration of CCGs is densely populated. There is a wide variation in household income. Inner north west London has a higher population density than outer north west London.

4.5.2 Taken together, the London boroughs covered by NHS NWL Collaboration of CGGs have a population of circa 1.9 million. However, population estimates vary depending on the source of the information. The number of patients registered with GPs in the eight CCGs is higher at 2.16 million[6] and is shown in the table below. Some sections of the population are highly transient and there are sections of the community who are not counted in official statistics nor registered on GP patient lists.

**Table 4: North west London CCG population**

| CCG | ONS Clinical Commissioning Groups population estimates (April 2011) | Attribution Data Set 2012 registered population |
|---|---|---|
| **Brent** | 312,245 | 340,129 |
| **Ealing** | 339,314 | 399,037 |
| **Hammersmith & Fulham** | 254,927 | 281,242 |
| **Harrow** | 182,445 | 200,012 |
| **Hillingdon** | 240,499 | 238,213 |
| **Hounslow** | 275,499 | 283,647 |
| **Central London** | 157,640 | 194,600 |
| **West London** | 220,193 | 225,385 |
| **Total** | **1,982,762** | **2,162,260** |

Source: NHS England, Primary Care NW London, GP Capitation data as at 1/7/13 utilising all GP counts

4.5.3 The table below contains the population predictions for north west London by borough for 2021 and 2031. By 2031, the population of north west London is predicted to rise by seven per cent (from 2011).

[5] Unless otherwise indicated the population profile information has been sourced from PCT 2011-12 Annual Reports, 2012/2011 JNSA refresh, NWL IRP Template (GLA population projections) and *Shaping a Healthier Future* DMBC.

[6] NWL data source

**Table 5: Borough population projections for north west London**

| Borough | Estimated 2011 population (000s) | Estimated 2021 population (000s) | Estimated 2031 population (000s) |
|---|---|---|---|
| **Brent** | 283.0 | 303.5 | 305.2 |
| **Ealing** | 322.0 | 346.7 | 349.7 |
| **Hammersmith & Fulham** | 183.2 | 197.7 | 204.6 |
| **Harrow** | 223.8 | 229.9 | 233.8 |
| **Hillingdon** | 265.9 | 279.5 | 285.0 |
| **Hounslow** | 239.7 | 246.7 | 249.8 |
| **Kensington & Chelsea** | 172.2 | 183.3 | 184.7 |
| **Westminster** | 221.1 | 236.5 | 241.3 |
| **Total** | **1,911.1** | **2,023.7** | **2,054.1** |

Source: GLA population projections 2010 round

4.5.4 The Joint Strategic Needs Assessments (JSNA) covering north west London all identify cardiovascular disease, cancer and respiratory disease as the most common causes of death but as a result of earlier diagnosis and improved treatments fewer people are dying prematurely from these diseases. Since 2001, the number of people dying aged under 65 from cancer, heart disease and stroke has dropped by 15, 38 and 36 per cent respectively[7]. These improvements mean that people are living longer and, therefore, the population as a whole is getting older. Over the last ten years, life expectancy in north west London has increased by about three years to 80 years for men and 84.5 years for women.

4.5.5 *Ethnicity*

Each of the eight London boroughs covered by the NHS NWL Collaboration of CCGs has a significant ethnic community with different communities in different areas.

4.5.6 Sections of the Ealing community have links to east Africa (notably in Greenford), Poland (Central Ealing) and northern India (Southall). Newer migrant groups include Somalis, Sri Lankans and from the Balkan republics. Ealing is the third most ethnically diverse borough in London after Newham and Brent. GLA projections for Ealing show that 41 per cent are from black and minority ethnic (BME) groups. The largest BME group in Ealing is Asian (26 per cent).

7 NHS Information Centre

4.5.7 Brent is one of the most densely populated outer London boroughs with 58 per cent of the residents belonging to black and minority ethnic communities compared to a London average of 33 per cent. The population is relatively young with 48 per cent of residents being under 35 years of age and almost a quarter are under 19 years old. Brent's population is highly dynamic, with many transient communities and high numbers of people moving in and out of the borough every year. In Hillingdon, ethnic communities make up approximately 32 per cent of the residents with the largest ethnic minority community being Asian (20 per cent).

4.5.8 Harrow is a diverse borough with the JNSA 2012 refresh reporting more than half of its population is from black and ethnic communities with the Indian ethnic group making up over a quarter of the total population. In Hounslow, 43 per cent of residents identify themselves as being Black, Asian or minority ethnic origin. In 2011, migration mainly from India, Nepal, Poland and Pakistan accounted for 3.4 per cent of the population with smaller numbers from other countries including Somalia, Iraq, Iran, Afghanistan and Sri Lanka.

4.5.9 The three central London boroughs of Kensington and Chelsea, Westminster and Hammersmith & Fulham share a number of demographic characteristics. The age profile for all three is typical of inner city areas with a very high proportion of young working age adults and a smaller proportion of older people and children. Kensington and Chelsea has a smaller proportion of residents from 'White British', 'Black' and 'Asian' ethnic groups compared to London but has far more residents from 'White other' category – the highest in the country. This category includes those from Europe, Ireland, the Americas and Australia. Westminster has a smaller proportion of residents from 'White British', 'Black' and 'Asian' ethnic groups in comparison to London. There are more from the 'Others/mixed' category and two and a half times more from 'White other' category. Hammersmith and Fulham has a similar proportion of residents from 'White British', 'Black' and others/mixed' ethnic groups in comparison to London. There are far more from the 'White other category' and far fewer from the 'Asian' category.

4.5.10 *Deprivation*

The English Indices of Deprivation 2010 are the Government's official measure of multiple deprivation at the local authority level. The table below shows the rank of each local authority covering the north west London area. (1 being the most deprived authority in the Country and 326 the least deprived).

**Table 6: Index of Multiple Deprivation by Local Authority Rank out of 326 English Local Authorities**

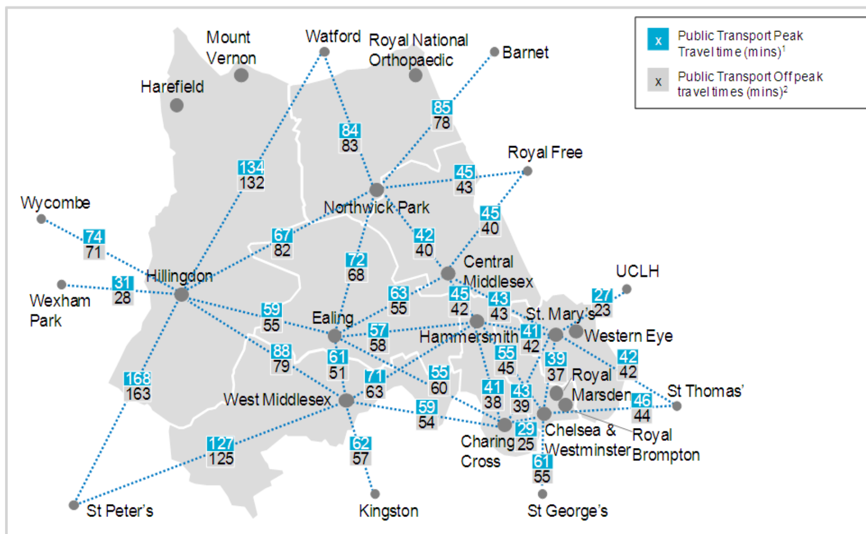
| Local Authority | Rank |
|---|---|
| **Brent** | 24 |
| **City of Westminster** | 75 |
| **Ealing** | 61 |
| **Hammersmith and Fulham** | 31 |
| **Harrow** | 184 |
| **Hillingdon** | 130 |
| **Hounslow** | 92 |
| **Kensington and Chelsea** | 98 |

Source: English indices of deprivation 2010 local authority summaries

## 4.6 Access and transport

4.6.1 North west London is a geographically compact area. The area is well served by the underground, overland train service and buses. In general, road and national rail routes radiate out from central London and therefore north-south journeys by public transport are more difficult. The map below illustrates the public transport times for travel between hospitals and shows that travel times in inner north west London are relatively short compared to outer north west London.

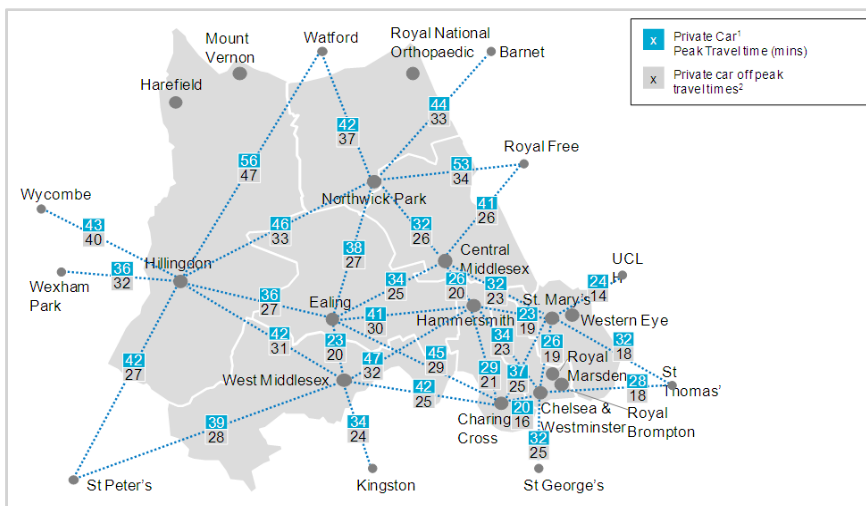
### Map 2: Public transport travel times between hospitals in north west London[8]




Source: TfL HSTAT database

4.6.2 The distance between hospital sites is such that journey time for private car travel is relatively short. As with any major city, road congestion can be severe on some major roads at certain times of the day or week.

### Map 3*:* Private car travel times between hospitals in north west London[9]




Source: TfL HSTAT database

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8 Notes for maps 2 &3
1 Peak time = Morning peak = 7 AM-10 AM
2 Off peak time = Daytime = 10 AM-4 PM
3 Travel time within NWL are the maximum travel time in either direction between hospital sites. For travel time to hospitals outside NWL, the time from within NWL to out of NWL is shown
9 As previous footnote.

## 4.7 Estate

### 4.7.1 *Acute care*

The current condition of the estate across north west London is variable. The table below sets out the quality of acute estate affected by *Shaping a Healthier Future* proposals as reported through the NHS ERIC return 2010/11. The estate quality rating is a qualitative assessment.

**Table 7: Quality of acute estate covered by the *Shaping a Healthier Future* proposals**

| Acute hospital site | Not functionally suitable space (000m$^2$)[1] | % Estate dating post 1964 | % Estate dating post 1984 | Estate Quality[2] |
|---|---|---|---|---|
| **Chelsea & Westminster** | 0 | 100 | 100 | HIGH |
| **Ealing** | 0 | 100 | 10 | LOW |
| **Hammersmith** | 6 | 59 | 50 | MEDIUM |
| **Charing Cross** | 4 | 100 | 6 | MEDIUM |
| **St Mary's** | 35 | 44 | 0 | LOW |
| **West Middlesex** | 0 | 100 | 72 | HIGH |
| **Hillingdon** | 8 | 83 | 17 | MEDIUM |
| **Northwick Park** | 24 | 100 | 3 | LOW |
| **Central Middlesex** | 1 | 99 | 99 | HIGH |
| **TOTAL** | **78** | **73** | **25** | |

Source NWL IRP template and ERIC return 2010/11 (http//www.hefs.ic.nhs.uk/DataFiles.asp)

4.7.2 St Mary's Hospital has the largest amount of estate categorized as 'not functionally suitable NHS Space' with Northwick Park Hospital the only other hospital to have more than 10,000m$^2$ of 'not functionally suitable NHS space'. The three acute hospitals given a 'low' estate quality assessment are:

- St Mary's Hospital, where more than fifty per cent of the build is over 50 years old. There is no significant estate build under 20 years old
- Northwick Park Hospital, where most of the estate is between 49 and 29 years old
- Ealing Hospital, which has 90 per cent of its built estate between 49 and 29 years old

Hammersmith Hospital, whilst having nearly 40 per cent of its built estate over 50 years old, also has 50 per cent of its built estate less than 20 years old and only a small amount of not functionally suitable NHS space (6,000m$^2$).

4.7.3 There are a number of significant trust estate developments (above £700k) which are outside the scope to the *Shaping a Healthier Future* proposals and are currently either in the advanced stages of planning or building work has already begun. These are:

- Hillingdon Hospital
  - A&E Redevelopment (£13.3m)
  - Endoscopy Upgrade (£920k)
  - Maternity Delivery Room Refurbishment (£1,040k)
  - Improvement to Dementia Environment (£840k)
- Northwick Park Hospital
  - Emergency Department redevelopment (£24m)
  - Theatres redevelopment (£14m)
- St Mary's Hospital
  - New Endoscopy Unit (£6m)
  - New endoscope decontamination unit (£900k)
- Hammersmith Hospital
  - New imaging suite
- Charing Cross Hospital
  - Linear accelerator replacement (£4.2m)
- Imperial College Healthcare Trust (Trust wide programmes)
  - ICT infrastructure Renewal (£6m)
  - Medical equipment replacements (£5m)
  - Backlog maintenance (£3.2m)
- Chelsea and Westminster Hospital
  - Paediatrics wards, burns unit and Outpatients3 refurbishment (£7.6m)
  - Medical Day Units and discharge lounge refurbishment (£2m)
  - Adult burns unit refurbishment (£2.5m)
  - Dean Street Express clinic (GU/HIV) enhancement (£1m)
  - Laboratory refurbishment (£1.5m)
- Ealing Hospital
  - Improvement to Dementia environment (£702k)
- West Middlesex Hospital – there are currently no significant investments planned outside of *Shaping a Healthier Future*

4.7.4 *Private finance initiative (PFI)*

There are two hospitals with a PFI build in north west London:

- Central Middlesex became a PFI hospital in 2007 which included some new build and some transfer of 1997 built estate
- A substantial part of West Middlesex Hospital was built through the PFI in 2003

4.7.5 *Primary care*

The primary care estate is of variable quality and not all premises meet the Disability Discrimination Act standard for accessibility. In 2012, a voluntary survey was undertaken of GP premises open to all CCGs except Brent who undertook a similar survey but comparable results are not available. A total of 147 premises were surveyed, all were self-selected. The results were then used to estimate the cost of upgrading buildings and if this was considered not practicable then the cost of replacing lower quality premises was estimated. This extrapolation from sample practices to total number of practices was based on list size. The table below summarises the results of the survey.

**Table 8: Quality of primary care estate in north west London**

| | Sample summary | | | Surveyed premises | | | Extrapolated premises | | |
|---|---|---|---|---|---|---|---|---|---|
| | Total Number of premises | Number of premises surveyed | % of list served by premises surveyed | Rated condition B or above | Rated below condition B (not Dx)[1] | Rated DX on DDA compliance | Rated condition B or above | Rated below condition B (not Dx)[1] | Rated DX on DDA compliance |
| Harrow | 35 | 20 | 44% | 5 | 5 | 10 | 9 | 9 | 17 |
| Hillingdon | 48 | 25 | 51% | 7 | 9 | 9 | 13 | 18 | 17 |
| Brent[2] | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| Ealing | 82 | 44 | 64% | 18 | 11 | 15 | 33 | 21 | 28 |
| Hounslow | 55 | 22 | 38% | 12 | 9 | 1 | 29 | 23 | 3 |
| Hammersmith and Fulham | 32 | 11 | 43% | 8 | 1 | 2 | 23 | 3 | 6 |
| West London | 55 | 13 | 31% | 2 | 5 | 6 | 8 | 22 | 25 |
| Central London | 36 | 12 | 38% | 6 | 3 | 3 | 18 | 9 | 9 |

Source: DMBC Vol 1.

## 4.8 Financial profile

4.8.1 The base case forecasts (pre-reconfiguration) are set out for each of the nine acute hospitals in the table below together with 17/18 forecast and downside forecast for 17/18. The differences in how site income & expenditure develops over the forecast

period are due to the differential impact of Quality, Innovation, Productivity and Prevention and trust cost improvement programmes.

**Table 9: Income & Expenditure (I&E) base case pre-reconfiguration, 17/18 forecast and downside forecast 17/18**[10]

Surplus (>1%) | Borderline (within £1m of 1% surplus) | More than £1m below 1% surplus

£m

Financial forecasts for NWL acute sites, pre-reconfiguration scenario, 12/13, 17/18 and 17/18 downside

| | 12/13 | | | 17/18 Base case | | | 17/18 downside[1] | | |
|---|---|---|---|---|---|---|---|---|---|
| Site[2] | Income | Costs | Surplus | Income | Costs | £m | Income | Costs | Surplus |
| St Mary's | 342 | 341 | 1 | 326 | 320 | 6 | 326 | 335 | -9 |
| Hammersmith | 330 | 336 | -6 | 327 | 325 | 2 | 327 | 340 | -13 |
| Charing Cross | 257 | 246 | 11 | 245 | 231 | 14 | 245 | 241 | 4 |
| Chelsea & Westminster | 343 | 331 | 13 | 332 | 323 | 8 | 332 | 337 | -5 |
| West Middlesex | 142 | 148 | -6 | 122 | 130 | -8 | 122 | 136 | -14 |
| Ealing | 125 | 125 | 0 | 110 | 111 | -1 | 110 | 117 | -6 |
| Central Middlesex | 76 | 89 | -14 | 65 | 76 | -10 | 65 | 80 | -14 |
| Northwick Park & St. Mark's | 286 | 297 | -11 | 247 | 255 | -8 | 247 | 268 | -21 |
| Hillingdon | 160 | 161 | 0 | 135 | 140 | -4 | 135 | 147 | -11 |
| Total | 2,061 | 2,074 | -13 | 1,910 | 1,910 | 0 | 1,910 | 1,999 | -89 |

The differences in how site I&E develops over the forecast period are due to the differential impact of acute QIPP and Trust CIPs

Potential I&E upsides include:

- Higher than expected demand growth (with Trust incomes allowed to grow), or under-delivery of QIPP (with Trusts reimbursed for additional activity)
- Potential for Trusts to bid for investment in out of hospital services

Source: NWL IRP template

4.8.2 The 2012/13 year end position of the eight PCTs is shown below.

**Table 10: 2012/2013 PCT financial position year end**

| PCT | Surplus (Deficit) against Revenue Resource Limit (£'000) |
|---|---:|
| **Brent PCT** | 25,795 |
| **Ealing PCT** | 2,500 |
| **Hammersmith & Fulham PCT** | 6,884 |
| **Harrow PCT** | 3,252 |
| **Hillingdon PCT** | 1,979 |
| **Hounslow PCT** | 1,988 |
| **Kensington & Chelsea PCT** | 16,144 |
| **Westminster** | 21,101 |

Source: North West London Data

## 4.9 Care Quality Commission annual assessment

4.9.1 The Care Quality Commission (CQC) currently inspects most hospitals, care homes and domiciliary care services at least once a year, and inspect dental services at least once

[10] Downside includes base case assumptions, with additional 1%pt cost inflation until 14/15 and Trust achieve only 90% of planned efficiency savings prior to mitigation. Only includes acute business for the specific site – i.e. excludes community services and services at sites not specifically listed (e.g. Mount Vernon)

every two years. Services that are not meeting national standards or those considered to be providing poor care that might be putting people at risk are inspected more frequently.

4.9.2 The CQC has inspected each of the hospitals in north west London included in *Shaping a Healthier Future* against the National Standards. All the hospitals have achieved CQC national service standards. NHS NWL Collaboration of CCGs has stated there have been no other CQC reports in the last two years.

4.10 **The proposals**

4.10.1 The *Shaping a Healthier Future* programme was established in November 2011 and built on the significant work carried out in north west London since 2009. The aim of the programme is to ensure that the right care is delivered in the right places and is based on four core principles which reflect the Government's four key tests for reconfigurations:

- Clinically-led and supported by GP commissioners
- Informed by engagement with the public, patients and local authorities
- Incorporate a robust and transparent process underpinned by a sound clinical evidence base
- Consistent with current and prospective patient choice

4.10.2 The JCPCT (until end March 2013) was the decision-making body for the programme and was a joint committee formed by 11 PCTs, eight North West London PCTs: NHS Brent, NHS Ealing, NHS Hammersmith & Fulham, NHS Harrow, NHS Hillingdon, NHS Hounslow, NHS Kensington & Chelsea and NHS Westminster, together with NHS Camden, NHS Wandsworth and NHS Richmond. With the abolition of PCTs, NHS North West London Collaboration of CCGs will lead *Shaping a Healthier Future*.

4.10.3 The c*ase for change*

The *Shaping a Healthier Future* documentation outlines the challenges facing north west London which have then been used to develop the case for change. In summary the reasons put forward for change are:

- The population of north west London is growing. The forecast is for it to grow to circa 2.15 million by 2018. Therefore, there will be greater pressure on health services
- North west London has an ageing population. Life expectancy has increased by about three years over the last ten years. It is now 80 years for men and 84.5 years for women. There is a difference of 17 years between the most and least deprived[11]
- An ageing population impacts on the use of NHS services because older people are more likely to develop long term conditions such as diabetes, heart disease and breathing difficulties.
- In north west London around 300,000, nearly one in six of people of all ages, have one of the following long term conditions: diabetes, asthma, coronary heart disease, chronic obstructive pulmonary disease (COPD) and congestive heart failure[12]
- Significant variations in mortality at the weekend compared to weekdays. A pan-London study in 2011 established for emergency admissions the difference is a ten per cent higher mortality rate at the weekend compared to the weekday
- Quality variation. For example number of readmissions after various procedures varies considerably from one hospital to another
- Clinical evidence[13] that for specialist emergency care services, early involvement of senior medical personnel in the assessment and subsequent management of acutely ill patients improves outcomes
- Royal College recommendations on increased consultant presence particularly to cover emergency services and maternity services
- The need for centralising or consolidation of some clinical specialist services in north west London for clinical benefit. This would build on the success of major trauma centres, HSAU and acute heart attack centres

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[11] DMBC Vol 1

[12] Source: QOF, proportion of GP registered population in NW London who are on the CHD,COPD,CHF and diabetes and asthma registers

[13] National Confidential Enquiry into Patient Outcome and Death (2007); Emergency admissions: A step in the right direction, NCEPOD; Royal College of Surgeons (2011), Emergency Surgery, Acute Medical Care (2007) Royal College of Physicians; Report of the acute medicine task force, Royal College of Physicians.

- For certain surgical and medical services fewer centres are needed to ensure the medical and surgical teams are treating enough patients to maintain and develop their specialist skills
- Clinical expertise is becoming more difficult to maintain in some A&E centres or to the College of Emergency Medicine recommended level
- Difficulty in accessing GP care with too many people ending up in A&E
- Too few services for people with long term conditions leading to more complications and unnecessary hospital admissions
- The need to invest in GPs services and other local primary and community care to reduce variation in quality of care and ensure consistent services of a higher standard
- Inefficient poor quality NHS and primary care estate and the need to make best use of good estate
- The likelihood that the amount of money available to the NHS in real terms will only increase very slightly in the years up to 2015 which will mean that savings will be required to deliver new technologies and better treatments for a changing population in north west London
- Without change it is predicted that most of the hospitals in north west London will be under severe financial pressure

4.10.4 To meet these clinical and financial challenges, the *Shaping a Healthier Future* vision proposed that local practitioners should support people to stay healthy and ensure that if they get ill, the best community and hospital services are available to them. This means:

- Supporting patients in taking better care of themselves
- Increasing patients' understanding of where, when and how they can be treated
- Giving patients the tools and support they need to manage their own medical conditions
- Easing access to primary care providers, such as GPs, 24 hours a day, seven days a week through more convenient opening hours and improved communications (be this by phone, email or in person) – when urgent access is key
- Providing fast and well co-ordinated access to specialists, community and social care providers (access managed by GPs)
- Having properly maintained and up-to-date hospital facilities with highly trained

specialists available at all times

4.10.5 To deliver this, the *Shaping a Healthier Future* programme is based on three principles:

- **Localised where possible**
  Delivering as much care as possible, as soon as possible, in convenient places which are easy to access – for example, closer to home.
- **Centralised where necessary**
  Bringing more services together on a number of specific sites, so that more expertise is available more of the time
- **In all settings, care should be integrated across health, social care and local authority providers to improve seamless patient care**
  Ensuring that all parts of the NHS and social services work more closely together.

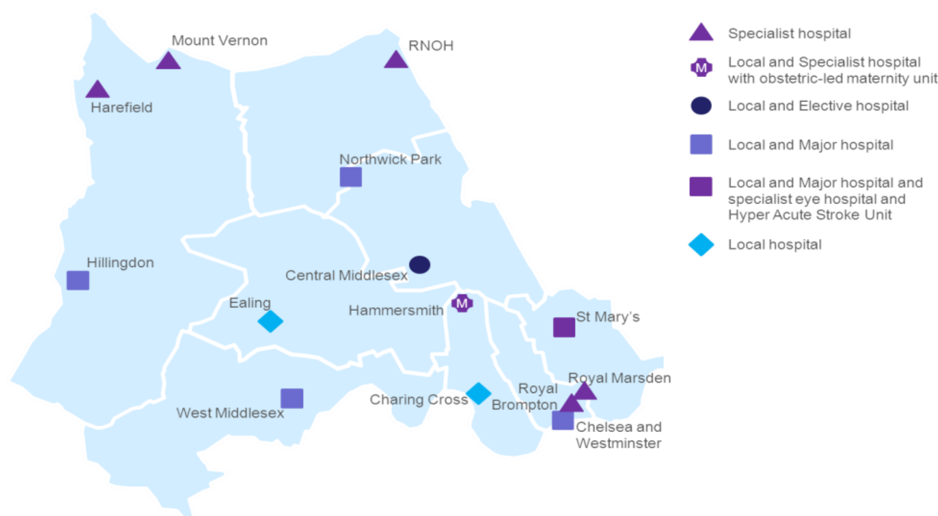
4.10.6 In February 2013, the JCPCT agreed the following resolutions which taken together form the *Shaping a Healthier Future* proposals:

1. To adopt the North West London acute and out of hospital standards, the North West London service models and clinical specialty interdependencies for major, local, elective and specialist hospitals
2. To adopt the model of acute care based on five major hospitals delivering the London hospital standards and range of services
3. That the five major hospitals should be: Northwick Park Hospital, Hillingdon Hospital, West Middlesex Hospital, Chelsea and Westminster Hospital and St Mary's Hospital
4. That Central Middlesex Hospital should be developed in line with the local and elective hospital models of care including an Urgent Care Centre operating 24 hours a day, seven days a week
5. That Hammersmith Hospital should be developed in line with the local and specialist hospital models of care including an Urgent Care Centre operating 24 hours a day, seven days a week
6. That Ealing Hospital be developed in line with the local hospital model of care including an Urgent Care Centre operating 24 hours a day, seven days a week
7. That Charing Cross Hospital be developed in line with the local hospital model of care including an Urgent Care Centre operating 24 hours a day, seven days a week

8. The Hyper Acute Stroke Unit (HASU) currently provided at Charing Cross Hospital be moved to St Mary's Hospital
9. The Western Eye Hospital be moved from its current site at 153 to 173 Marylebone Road to St Mary's Hospital
10. Implementation of resolutions one to seven should be coordinated with the implementation of the CCG out of hospital strategies
11. The NHS Commissioning Board and NW London CCGs should adopt the proposed implementation plan and governance model
12. The further proposals that Ealing CCG has developed for the Ealing Hospital in response to feedback from consultation were commended. The JCPCT recommends that Ealing CCG and all other relevant commissioners should work with local stakeholders, including Ealing Council and Healthwatch, to develop an Outline Business Case (OBC) for an enhanced range of services on the Ealing Hospital site consistent with decisions made by this JCPCT. This OBC is to be approved by the *Shaping a Healthier Future* Implementation Board before final submission
13. The further proposals that Hammersmith and Fulham CCG has developed for the Charing Cross Hospital in response to feedback from consultation were commended. The JCPCT recommends that Hammersmith and Fulham CCG and all other relevant commissioners should work with local stakeholders, including Hammersmith and Fulham Council and Healthwatch, to develop an Outline Business Case (OBC) for an enhanced range of services on the Charing Cross Hospital site consistent with decisions made by this JCPCT. This OBC is to be approved by the *Shaping a Healthier Future* Implementation Board before final submission.

4.10.7 The *Shaping a Healthier Future* proposals lead to a new hospital configuration for north west London. This is shown in the map below.

Map 4: *Shaping a Healthier Future* proposed hospital configuration




Source: DMBC Vol 1.

4.10.8 There are eight settings of care to deliver the vision - four relating to in-hospital, and four to out of hospital care.

4.10.9 The proposed in-hospital model of care is based on four types of hospital:

- **Local hospital** comprising 24/7 urgent care centre, outpatients and diagnostics, and at some hospitals additional services such as outpatient and rehabilitation and specialist clinics. Hammersmith Hospital will also be a specialist hospital with an obstetric-led maternity unit (Queens Charlotte's and Chelsea), a heart attack centre, level 3 intensive care, and specialist services to include emergency surgery, emergency medicine, elective medicine, and elective surgery
- **Major hospital** comprising all the services available at a local hospital and 24/7 A & E, emergency surgery, emergency medicine, elective medicine, elective surgery, level 3 intensive care, psychiatric liaison, inpatient paediatrics, obstetrics and maternity unit including an alongside midwifery led unit. Some of the designated major hospitals will have some specialist services such as major trauma (St Mary's) hyper-acute stroke unit (HASU) (St Mary's and Northwick Park) and specialist cancer services (St Mary's)
- **Elective hospital** comprising elective surgery and/or medicine and a high dependency service and local hospital services

- **Specialist hospitals** are not involved in *Shaping a Healthier Future* although form part of the hospital model of care for north west London. The five specialist hospitals are Harefield, Mount Vernon, Royal Brompton, Royal Marsden and RNOH.

4.10.10 The Panel was told that work was on going to develop the proposals for the enhanced range of services on the Ealing Hospital site and the Charing Cross Hospital site. These proposals, in the form of an Outline Business Case, will need to be approved by the *Shaping a Healthier Future* Implementation Board before being submitted for capital approval.

4.10.11 The proposed model of care for out-of-hospital care is based on four settings;

- **Home** comprising GP, community nursing, community therapy and social care services delivered in patients' homes, patient navigation using 111, patient triage and response within 4 hours, short term intensive support, integrated health and social care teams and enhanced self-management
- **GP practice** comprising GP consultations and long term condition (LTC) management, health promotion and delivery of preventative services such as immunisations and screenings. Some sites will also have: extended access to GP consultations, simple diagnostics and treatments, specialist GP services, children's health services, enhanced LTC management, care coordination and care planning, GP consultations triage and response within 4 hours
- **Care network** delivering GP consultations triage and response within 4 hours, enhanced LTC management, care coordination and care planning, multi-disciplinary group case conferences, access to diagnostics, access to treatments, therapy services, specialist GP services, children's health services (these may be co-located with Children's Centres). Some sites will also have health and social care coordination
- **Health centre** comprising access to GP services and consultations, specialist GP services, therapy and enhanced rehabilitation services, enhanced diagnostics services, specialist GP MDT services. Some sites will have GP consultations triage and response within 4 hours, specialist clinics and complex diagnostics (for example, imaging pathology)

4.10.12 Taken together, *Shaping a Healthier Future* new models of care aim to invest more into primary care and other local healthcare to ensure quality and consistency, and provide more proactive services in the community and close to patients' homes supported by appropriate in-hospital care.

**4.11 Issues raised by Ealing Health and Adult Social Services Standing Scrutiny Panel**

4.11.1 In its referral letter of 19 March 2013 the Ealing HASSSSP stated that the proposals were not in the interests of the health service in Ealing and in particular they raised concerns regarding the following:

- The four reconfiguration tests have not been met so far as Ealing's health service is concerned. As the Rideout Report shows, the adverse impact on Ealing's residents is far greater than the impact on the residents of north west London as a whole, or of any other borough. This has not been properly acknowledged or catered for in the JCPCT's decision
- Wholly insufficient public and patient engagement at the stage when the proposals for consultation were being formulated. There were no specific attempts to engage with local people, and particularly the most vulnerable groups hit hardest by the proposals that emerged. Nor was there any proper attempt to engage the Council at a senior level on a sufficiently detailed basis
- Insufficient GP support for the proposals
- Insufficient clarity on the clinical evidence base. This scale of change has never before been tested in the United Kingdom, and yet no proper consideration has been given to the effect of the proposals to downgrade hospitals on resulting standards of care
- The proposals are not consistent with current and prospective patient choice. Ealing residents are being deprived of practically *all* of their current choice of local hospitals for the full range of services
- There has been a failure properly to consider the effects that the downgrading will have on specific groups within Ealing's population. Ealing also has a notably diverse community constituting a greater part of the population than elsewhere, and which experience a far higher rate of particular diseases
- Insufficient exploration of alternatives to hospital reconfiguration

- Problems with the methodology used by NHS NW London in further developing the proposals
- No final decisions should be made about hospital reconfiguration until the "Out of Hospital" strategies have been implemented and their performance properly assessed as successful
- The consultation conducted by NHS NW London in respect of the proposals was inadequate

4.12 **Issues raised by others**

4.12.1 Evidence from other parties opposed to the change broadly mirrored the concerns of Ealing HASSSSP.

4.12.2 The following sections of the report outline what the Panel heard in relation to these issues.

4.13 **The case for change**

4.13.1 The *Shaping a Healthier Future* documentation outlines the challenges facing north west London which have then been used to develop the case for change outlined in section 4.10.3.

4.13.2 The *Shaping a Healthier Future* team (SaHF team) provided an overview of the programme to the Panel which demonstrated that the proposals have been clinically-led with Clinical Implementation Groups for Emergency and Urgent Care, Maternity and Paediatrics; a Clinical Board and an Expert Clinical Panel. The Panel also heard from NHS England that the direction of travel was consistent with NHS England strategic priorities. The process has been subject to NCAT assessment, and Gateway Strategic Assessment. These reports were made available to the Panel. The Panel has also reviewed a considerable amount of documentary evidence including "backing papers" provided by the SaHF team to support the proposals and the process for selecting an option. These documents include: the PCBC, equalities reviews, programme governance papers, stakeholder engagement record, case for change, literature review of available evidence, Travel Advisory Group Report, CCG out of hospital strategies, patient choice report, workforce analysis and carers report.

4.13.3 The JHOSC broadly accepted the clinical arguments for reconfiguring A&E services although the Panel heard that this was not a unanimous view and that some members did not want to see any changes to A&E services. At the time of the consultation the JHOSC thought it not appropriate to endorse any one of the particular options put forward.

4.13.4 The referring authority, Ealing Council, recognised that the status quo is not desirable or sustainable but they told the Panel that, taken together, the proposals for Ealing, Charing Cross and Central Middlesex hospitals would have huge implications for residents of Ealing - not only for patients and residents who use Ealing Hospital, but for residents from the east of the borough who use Central Middlesex Hospital and Ealing residents who use either Hammersmith or Charing Cross hospitals. As all four of these hospitals would lose A&E services and there would be a significant change in services offered, they told the Panel that they could not accept that the proposals would improve health services for the local Ealing population.

4.13.5 Hammersmith and Fulham Council told the Panel that they accepted the case for change and recognised the clinical arguments in favour of centralising services acknowledging that patients had seen benefits through centralisation of cardiac services locally. However, they stated that they would have liked to see Charing Cross as a major acute hospital under the *Shaping a Healthier Future* proposals.

4.13.6 Four campaign groups submitted documentary evidence and in some cases met with the Panel to give oral evidence. The strength of support for the case for change varied across the campaign groups, from not agreeing with the majority of the case for change to agreeing in principle with specific elements. However, even in the latter case the campaign group strongly disagreed with the reconfiguration of hospitals proposed by *Shaping a Healthier Future* to address the case for change.

4.13.7 Drop-in staff sessions were held at Ealing, Charing Cross and Central Middlesex hospitals to facilitate staff meeting the IRP. Individual evidence sessions were also held. The Panel heard from a wide variety of staff, particularly those from Ealing Hospital, who said that they had understood the case for change and would support a direction of travel that moved services into the community but did not feel that any

detail as to how this would work in practice had been provided during the process.

4.13.8 The Panel found that many people accepted that health services in north west London need to change but took issue with the detail and scale of the change proposed especially for Ealing and Charing Cross hospitals. Even if the need for change was accepted, the Panel heard that there was little confidence that the local health care system could deliver this scale of change successfully. The Panel heard from a number of people who felt that change on this scale had never been undertaken before in any area and that there was no evidence to say that it could be successfully delivered.

4.13.9 Not everyone agreed with the need for change. The Panel heard from a number of people who wished to see maternity and A&E services remain unchanged. Some people felt that the financial challenge, both current and into the future, had driven the proposals rather than clinical quality and improved services for patients. Some felt that the option selection process was influenced by the need to solve the financial and utilisation challenges of the PFI hospitals. The view was also expressed that it would be very difficult to change services at some of those hospitals.

4.13.10 The Panel also heard concerns about the impact on medical education and training. The Panel sought clarification from Imperial College London about the impact of *Shaping a Healthier Future* on medical education. The Panel heard that Imperial College was supportive of the proposals and that, although they could result in substantial clinical service change at some hospital sites, this would not impede medical education. Imperial College drew to the attention of the IRP that should it not be possible to use their current Charing Cross Hospital medical education facility in the future then an appropriate business case would need to include the capital costs of re-providing this facility. The Panel were told that the costs associated with any re-provision of medical education facilities will be included in an appropriate business case.

4.13.11 The SaHF team told the Panel that the programme requires a significant amount of capital investment. A number of people raised with the Panel the issue of capital receipts from estate disposal.

4.13.12 Some people giving evidence to the Panel also expressed their concern that the consultation document did not make clear the scale of reduction in size of any remaining hospital on the Ealing and the Charing Cross sites. This led to some people telling the Panel that they felt the public had little idea of the scale of the changes being proposed either in terms of service or physical estate.

4.13.13 The Panel sought clarification from the NHS and local councils on any potential plans for surplus land on the Ealing and Charing Cross sites. Whilst limited discussions had taken place for some sites, this would be considered as part of the normal process that is required for any new healthcare build. The Panel did not hear that any planning application had been submitted to any local authority in connection with the programme to use current NHS land other than for healthcare.

4.13.14 Documentary and oral evidence confirmed that implementing the *Shaping a Healthier Future* proposals will not resolve all the current financial challenges around PFI builds. In particular, the Panel were told that the Central Middlesex Hospital site (part of the North West London Hospitals NHS Trust) would continue to have an annual deficit under the proposals agreed by the JCPCT. The Panel heard from key NHS stakeholders that the health system realises it needs to find appropriate solutions for its PFI builds collectively and the Panel noted that this work is ongoing. The Panel were informed the latest workshop had taken place as recently as August 2013.

4.13.15 The SaHF team clarified their work on the overall financial position of implementing the proposals and the impact on the financial position of the Central Middlesex Hospital site. The DMBC also looked at the impact on each site of implementing the *Shaping a Healthier Future* service changes. The Panel were told that implementation of *Shaping a Healthier Future* will lead to savings overall. The modelling predicts an annual surplus of £42m from 2017/18 but that the Central Middlesex site still has an annual deficit of £11m.

## 4.14 Emergency Care

4.14.1 Under the *Shaping a Healthier Future* proposals, the number of A&E services will be reduced from the current nine to five and be located in five designated major hospitals.

4.14.2 Ealing, Hammersmith, Charing Cross and Central Middlesex hospitals[14] will not have a 24/7 A&E service but instead have 24/7 urgent care centres.

4.14.3 The Panel heard from the SaHF team that by moving to five major hospitals the following quality benefits would be achieved:

- Enable larger clinical teams to operate consultant delivered care and seven day services
- Introduce a consistent range of services, reducing the existing need for patient transfers
- Provide patients with access to a full range of specialists with increased accessibility to diagnostics
- Enhance doctors specialist skills through the provision of more opportunities to deal with specialist cases
- Consultant delivered service:
  - Reduces admissions
  - Reduces complications and investigations
  - Reduces weekend mortality and morbidity

4.14.4 The SaHF team described work to determine the optimal number of major hospitals in north west London. They explained this was a balance between deliverability and good access.

4.14.5 For staffing, the key issues were:

- To meet the London standards and provide seven day services large consultant teams are needed
- This is only affordable and attainable on five sites (or fewer)
- The particular workforce challenge in A&E, paediatrics, general surgery and midwifery

4.14.6 The SaHF team advised that five major sites retained good access whilst being deliverable in terms of workforce and investment. The College of Emergency Medicine recommends 24/7 senior clinical cover in A&E departments as being the key

[14] Currently not 24/7

mechanism to ensure the highest standards of emergency care. For emergency care services, early involvement of senior medical personnel in the assessment and management of acutely ill patients improves outcomes. The Panel was told that by establishing specialist centres and networks, patients will experience better clinical outcomes. An example given was in emergency surgery where access to surgeons who are trained in laparoscopic surgery for emergency situations is important.

4.14.7 The evidence of better outcomes in specialist centres and through networks was often not accepted by people opposed to the changes - citing the lack of clinical evidence for all specialities.

4.14.8 The Panel was told by SaHF clinicians that there are currently 52 emergency surgeons across north west London, of whom 87 per cent are trained in laparoscopic surgery. The minimum number of emergency surgeons for rota cover depends on the number of hospitals. Five hospitals requires 50 WTE emergency surgeons, whereas six hospitals would require 60 WTE emergency surgeons. The SaHF team told the Panel that five major hospitals was chosen in terms of staffing due to both clinical quality and affordability.

4.14.9 The Panel visited all the nine acute trust A&E departments and urgent care centres as part of the review and was taken on a tour of Ealing borough by Council officers.

4.14.10 The Panel heard that the *Shaping a Healthier Future* proposals include a 24/7 UCC at all the local hospitals and major hospitals.

4.14.11 The Panel heard that at present there is not a clear and agreed specification for an UCC but that part of the *Shaping a Healthier Future* programme is to ensure the development of a consistent, 24/7 urgent care specification across north west London. The aim is to remove variation in the service received by patients that attend a UCC.

4.14.12 The Panel received a substantial volume of written and oral evidence from members of the public, Healthwatch and community groups, GPs and other clinicians and campaign groups expressing concern about the proposed changes to A&E services. Much of the evidence was from Ealing based groups. It also heard evidence from the JHOSC and

Ealing HASSSSP, Hammersmith and Fulham Council and received written evidence from Brent Council.

4.14.13 The most frequently voiced reasons for opposition to the proposed changes were:

- Capacity of the remaining A&E departments to cope with the extra demand as the perception is that they are already working at capacity and failing in some instances to deliver national targets
- The distance people would need to travel to get to an A&E department and the cost involved if they did not require an ambulance. Members of the public gave their own experiences of travelling to neighbouring A&E departments and the time taken. One example cited was 15 minutes from home to the A&E at Ealing Hospital as opposed to 1 hour 19 minutes from home to the A&E at Northwick Park Hospital which would become their nearest A&E under the proposals
- Difficulty with accessing a GP appointment in Ealing and therefore people tended to use A&E services when needed
- Removing A&E services from some of the most disadvantaged members of the community in north west London who are unlikely to either travel or be able to afford to travel to another A&E service.
- Being required to travel further to A&E may result in people "dying in the back of ambulances"
- The reduction in choice
- Rather than being an improvement in quality of services it was a retrograde step
- Parents with a sick child may go directly to A&E rather than an UCC thus potentially increasing journey time as well as cost

4.14.14 A number of people raised the issue of the highly diverse local Ealing population, and the particular challenges for people who speak languages other than English, to navigate the system. Cultural barriers were also cited. The Panel heard that certain groups were not registered with GPs and did not utilise general practice but instead attended A&E. Removing A&E services from Ealing Hospital would result in this section of the community having reduced access to healthcare.

4.14.15 Clinicians from Ealing Hospital highlighted the high incidence of diabetes, coronary heart disease and tuberculosis in the local population. Tuberculosis patients are often first identified through A&E. The Panel was told that the Ealing A&E department and other clinicians in the hospital had developed expertise to support this type of attendee. Removing A&E services from Ealing Hospital would remove this service for a particularly vulnerable group of people.

4.14.16 The Panel heard evidence from Ealing clinicians that a proportion of people who go to A&E also have mental health needs and there were concerns that the proposals had failed to address these even though it was raised before and during the consultation.

4.14.17 A number of people raised concerns on safety grounds with the proposal to locate standalone UCCs on the sites designated as local hospitals.

4.14.18 The Panel was told that there was a great deal of confusion amongst members of the public about what an UCC was and what services it offered. There was concern that people might go to the standalone UCC only to be told that they needed to be referred to an A&E department. People who opposed the proposals were concerned that these extra ambulance journeys had not been accounted for and that the London Ambulance Service (LAS) would not be able to cope with the additional activity.

4.14.19 The Panel heard from the LAS that they had been involved in the development of the *Shaping a Healthier Future* proposals and confirmed that initial modelling work had been undertaken. The SaHF team described to the Panel the work that had been undertaken to ensure ambulance services are appropriately resourced. Both LAS and the SaHF team confirmed that this work would continue during the implementation phase of the programme.

4.14.20 The Panel requested clarification from the SaHF team on the safety and sustainability of standalone UCCs. It was confirmed that *London Health Programme* standards for UCCs were used as a basis for the service specification. They indicated that the model had been confirmed by the SaHF Emergency and Urgent Care Clinical Implementation Group (CIG) - whose membership included representatives from the College of Emergency Medicine. Clinical members of the SaHF team confirmed that standalone

UCCs will operate with a consistent service specification. This specification was shared with the Panel. The Panel was also provided with case studies from Corby, Newark, Rochdale and Sidcup to show that standalone UCCs are currently operating around the country as a safe and sustainable model.

4.14.21 The Panel heard that the JCPCT had recommended the development of enhanced services on both the Ealing Hospital and Charing Cross hospital sites. Work is currently being taken forward by Ealing CCG with local stakeholders to confirm the enhanced services and develop the local hospital model for Ealing Hospital. A similar piece of work is being undertaken by Hammersmith and Fulham CCG with local stakeholders for the Charing Cross site.

### 4.15 Maternity and paediatrics

4.15.1 The Panel heard and received documentary evidence on the *Shaping a Healthier Future* plans for maternity and paediatric services across north west London. The Maternity and Paediatric CIGs had worked together to ensure the appropriate provision across maternity, neonatology, and paediatrics. Under the proposals, there would be six consultant-led maternity units - five co-located with the proposed major hospitals and a unit at Queen Charlotte's and Chelsea Hospital. There would be five paediatric units, all incorporating emergency care, inpatients and short stay/ambulatory facilities and co-located neonatal units. These would also be co-located in the proposed major hospitals. There would be an additional standalone neonatal unit supporting Queen Charlotte's Maternity Unit. Amongst the six neonatal units, there would be two neonatal intensive care units (NICU Level 3 units). Existing specialist paediatric services, including inpatient care, is not specifically affected by *Shaping a Healthier Future*.

4.15.2 It is intended that north west London should adopt and aim to achieve the *London Health Programme* Maternity Service Clinical Quality Standards during the implementation of the *Shaping a Healthier Future* programme. Alongside the provision of hospital based services, sector wide collaboration is intended to increase staff and develop a homebirth service in north west London in line with national evidence.

4.15.3 The Panel is aware that the four Royal Colleges of Obstetricians and Gynaecologists, Midwives, Anaesthetists and Paediatrics and Child Health recommend that maternity

units with over 5,000 births per year should aim for round-the-clock (168 hours) senior doctor presence to reduce mortality.

4.15.4 The Panel visited the current maternity units included in the *Shaping a Healthier Future* proposals. They noted that none of the units currently provided 168 hour consultant cover with some significantly below this figure. However, it was noted that not all the units currently had over 5,000 births. The SaHF team provided birth numbers for 2012–13 which showed around 3,000 births at Ealing Hospital. This is the smallest maternity unit in north west London area.

4.15.5 The SaHF team confirmed to the Panel that, under the *Shaping a Healthier Future* maternity standards, obstetric units will be required to be staffed to provide 168 hours (24/7) of obstetric consultant presence on the labour ward.

4.15.6 Few people who gave oral evidence to the Panel commented on the specific proposals for paediatric and maternity services. Of those that did (Unite, Ealing Healthwatch, campaign members and an active local community group) the main concerns were around the ability of the remaining obstetric-led maternity units to cope with the additional births, the deliverability and safety of the plans for increasing the number of home births, travel costs and the difficulties of travelling to a more distant obstetric-led maternity unit.

4.15.7 Community group members raised the issue of whether it had been clear in the documentation that under the proposals Ealing Hospital Maternity Unit would close. They told the Panel that from their experience of talking to local mums this had not been clear and in their view it would have been better if this proposal had been the subject of a separate consultation.

4.15.8 The Panel also received a presentation and documentary evidence from Ealing Hospital Paediatric Multidisciplinary Team highlighting the paediatric population served by Ealing Hospital, the inequality in health and health access amongst this population and an example of a local hospital based project developed to begin to address a specific local need.

4.15.9 During the maternity unit visits, Panel members raised the issue of capacity with each unit. The Panel heard details of plans that were currently being developed to ensure sufficient capacity in the system to absorb the births from the proposed closure of Ealing Hospital Maternity Unit.

## 4.16 Planned elective care

4.16.1 In relation to planned elective care the *Shaping a Healthier Future* proposal is to designate Central Middlesex Hospital as an elective hospital.

4.16.2 Evidence has shown that there are a number of benefits of separating planned elective care from emergency care which the SaHF team told the Panel that they would expect to achieve after designating Central Middlesex as an elective hospital. These benefits include: decrease in elective patients with hospital acquired infections such as MRSA and C-difficile, reduction in waiting times for scheduled operations and procedures, reduction in cancellations of planned operations for non-clinical reasons, reduction in average length of stay for elective patients, decrease in morbidity rates in elective patients, improved patient satisfaction and a better experience for patients as Central Middlesex Hospital is a high quality PFI building.

4.16.3 The Panel heard no evidence to suggest that these outcomes could not be delivered as similar quality benefits have been realised at other elective centres. The SaHF team cited the examples of Chapel Allerton Orthopaedic Centre, Golden Jubilee Centre and South West London Elective Orthopaedic Centre.

4.16.4 In offering evidence to the Panel, few people raised the changes to planned elective care other than to propose the possibility of a second elective centre at Charing Cross Hospital. The Panel understands that this possibility is the subject of further discussion between Imperial College Healthcare NHS Trust and the NHS NWL Collaboration of CCGs. The Trust has confirmed that they are committed to *Shaping a Healthier Future* and the plan it proposes for elective care but they will continue to explore the options for the Charing Cross site.

4.17 **Out of hospital strategies**

4.17.1 The Panel received a presentation from the SaHF team on the development of out of hospital care across north west London. The Panel were told that out of hospital care will be delivered from four settings with the local hospital delivering both out of hospital care and more specialist in-hospital care. The SaHF team told the Panel that under *Shaping a Healthier Future* an additional £190 million will be spent across the area on out of hospital services, primarily through the reinvestment of funding released from secondary care. *Shaping a Healthier Future* out of hospital initiatives can be categorised under five headings:

- Easy access
  - Improving access to primary care
  - 111 Non-emergency number
- Rapid response
  - Urgent Care Centres
  - Rapid response and care at home
- Integrated care
  - Integrated care and case management
  - Mental Health Integrated Care Pilot
  - End of life care
  - Health and social care co-ordination
- Planned pathways
  - Planned care pathway redesign, for example, pre-op assessments in GP clinics, elective procedures in enhanced community clinics
  - Referral facilitation services and peer review
- Appropriate hospital time
  - Community discharge teams
  - Psychiatric liaison service
  - Hospital at Home

4.17.2 The SaHF team told the Panel that they had surveyed over 1,000 users representatives of north west London about their priorities for general practice and the top three priorities were quick access to an emergency appointment when needed, enough time in an appointment and consistently good service from their GP surgery. The SaHF team

told the Panel that communication of CCGs' out of hospital plans is a priority and is ongoing particularly focussing on patient engagement. The Panel visited the STARRS (Short Term Assessment, Reablement and Rehabilitation Service) facility at Northwick Park Hospital and received a presentation on the project. Members found the staff to be enthusiastic about the service and what it could achieve. The Panel also received information on the Integrated Care Pilot focussing on those patients most at risk of non-elective admissions and the Integrated Care Scheme (ICE) which seeks to prevent non-elective admissions through the review of patients most at risk of admission in community settings.

4.17.3 Each CCG provided written evidence to the Panel on their out of hospital strategy detailing progress to date and outline plans for 2013/2014. Further documentary evidence was received by the Panel which gave more detail for each of the CCGs. No evidence was presented to the Panel on how these initiatives would reduce hospital admissions.

4.17.4 The Panel heard many concerns that, for out of hospital strategies, the physical estate and people capacity to deliver these new initiatives was not in place. The Panel heard very real worries from people that a hospital service would be withdrawn without the appropriate out of hospital service in place. They, therefore, felt the service available to the community would be worse rather than better. These concerns were expressed by a variety of sources - local authority, clinicians, community groups and members of the public. The Panel heard support for the principle of more care being delivered closer to home as long as it was appropriate to do so and that the service was established and well resourced.

4.17.5 The Panel sought clarification from the SaHF team on the funding model for the out of hospital strategy and the amount of funding included for 'double running' of services. The Panel also heard evidence on the workforce required to deliver the out of hospital strategy. The SaHF team confirmed that the *Shaping a Healthier Future* finance model included some funding to enable an existing service to be maintained while the alternative out of hospital service is developed. However, they indicated that this funding was limited. Workforce numbers were presented to the Panel that indicated an extra 765 – 890 staff would be required to deliver the out of hospital strategy at a cost of

around £80/90 million. It was confirmed that these would be a combination of new and existing staff, involving a change of role for some. No evidence was heard that this had been discussed with staff.

4.17.6 The Panel heard a number of personal stories from members of the public which confirmed the variable nature of primary care services. Some were of excellent care and easy access, others less so describing the difficulty of accessing GP services both during normal working hours and out of hours. The services offered by practices also differed and were dependent on where an individual lived. The challenges to general practice of language and culture were highlighted to the Panel.

4.17.7 A number of people raised the high number of single-handed and small practices in north west London and, in particular, in Ealing. The Panel heard concerns that these practices may not have the capacity to develop, plan and deliver the additional services proposed or the physical estate that would be needed. The Panel visited a small practice in Ealing which illustrated the challenges to delivering an out of hospital strategy 'on the ground'. It highlighted, as an example, the physical constraints of some facilities in north west London and the capacity, however willing, of single-handed GPs to deliver the vision.

4.17.8 The SaHF team told the Panel that they were aware of the challenge arising from the number of single-handed practices and described the infrastructure for delivering out of hospital care. It uses three elements of the model: local hospitals, hubs and health centres and networks of care.

- Local hospitals will offer a range of out of hospital services to their locality, including outpatient appointments, associated diagnostics and urgent care
- Hubs/health centres will provide a setting for a further range of services across all CCGs, including outpatient appointments, diagnostics, social care and therapies
- Networks of care, formed of GP practices, will offer opportunities for joint working between GPs and enhance the capacity of primary care to deliver of out hospital services

4.17.9 The plans for each CCG include three to six hubs, some of which are current facilities while others require rebuilds, refurbishments or are new builds.

4.17.10 The Panel visited a potential hub – Heart of Hounslow Centre for Health and were taken to the White City Health Centre currently being built and due for completion in spring 2014. The Panel understands that costs for all other new build or upgrading of estate will be included in *Shaping a Healthier Future* financial projections.

4.17.11 The Panel heard from NHS England and the Trust Development Authority (TDA) that the direction of *Shaping a Healthier Future* was supported and that they were aware of the financial projections for the programme.

4.18 **Transport and access**

4.18.1 Members of the public shared with the Panel their experiences of travelling to different hospitals in north west London and said that, whilst distances between the hospitals across the area are relatively short, people are generally travelling from home to hospital rather than between hospitals. For local stakeholders, being able to get to a hospital appointment or a local A & E service easily is a key issue. The Panel heard from people who felt that, with the new configuration, getting to a different hospital would often mean a number of different buses or modes of public transport and that although the actual distance is short the length of time it takes can be significant. The Panel also heard that it is more difficult to travel in a north-south direction than east-west by public transport and this would raise travel costs for vulnerable groups.

4.18.2 A number of people provided the Panel with information about cost the cost of taxis to travel to their new nearest A & E service under the proposals. People indicated that this would be an expensive option.

4.18.3 The Panel heard concerns that being treated further away from home will impact on the ability of family and friends to visit and this would contribute to social isolation and confusion. Ealing Local Medical Committee expressed the view that patients who would in future need to use transport could increasingly be denied access to health services.

4.18.4 Some concern was voiced that accessibility of services would be worse than it is currently - particularly in relation to A&E services at Ealing Hospital. The phrase *"having an A & E Department close by equals a safe and accessible service"* was expressed to the Panel.

4.18.5 The SaHF team submitted written evidence on the work undertaken between April 2012 and January 2013 on transport and access. They told the Panel that, as part of the programme, a Travel Advisory Group had been established to provide advice on transport issues. The Panel noted membership included council and Local Involvement Network (LINk) representatives, Transport for London and the LAS. The group has received presentations on travel analysis, equalities impact assessment and consultation responses. Trusts have also shared their current travel plans and patient transport policies. The SaHF team provided the Panel with maps on travel times between hospitals in north west London.

**4.19 Development of options, assessment and decision making**

4.19.1 The Panel received a substantial amount of written information from the SaHF team on the process used to develop the options for *Shaping a Healthier Future.* On two occasions the Panel received oral evidence on the process adopted.

4.19.2 The Panel heard that the process for developing proposals used a clinically-led seven stage process to identify a recommendation for the reconfiguration of healthcare services. This was a sequential methodology and had been developed with stakeholders during pre-consultation to ensure a systematic approach. The seven stage process is categorised as:

1. Case for Change
2. Vision development
3. Clinical standards for:
    - i. out of hospital care
    - ii. acute care - urgent and emergency care, maternity and paediatrics
4. Development of service models or models of care
5. Hurdle Criteria – seven criteria developed by clinicians to establish the right number of major hospitals in the options
6. Evaluation of options

7. Sensitivity Analysis

4.19.3 The Panel heard this process led the Clinical Board to agree at its meeting on 1 March 2012 that there should be between three and five major hospitals. Following this decision, the next step was to identify the optimal number of major hospitals. The Panel were told that the outcome of this work was that clinicians recommended that five major hospitals were needed. A medium list of eight options was then taken forward for further detailed evaluation. At the meeting of the JCPCT on 25 June 2012, the decision was taken to consult on Options A, B and C[15] but indicating that the JCPCT preferred option A as they believed that option A would give the greatest benefits for north west London.

4.19.4 The Panel heard from a number of organisations that they felt they had not been involved or engaged in the identification and initial development of the options or the process of generating the criteria which were then used to assess the options. Some people told the Panel that involvement had been at an early stage through workshop participation. The evidence the Panel received supported the view that most involvement outside of the SaHF programme team was around commenting on the output rather than using more open methodologies.

4.19.5 The Panel noted that, following consultation, all aspects of the decision making process were revisited. The Panel received evidence from the SaHF team that indicated stakeholders had been engaged throughout the programme in the development of the proposals. Written evidence provided an example with details of the groups involved in the development of the medium list of eight options. This included: acute trusts, presentations of approach at multilateral provider/CCG/cluster meetings, non-executive director briefing, Clinical Board input, Expert Clinical Panel, Programme Board, Programme Executive, and a presentation and request for comments to the Patient and Public Advisory Group (PPAG).

[15] See DMBC Vol 1

4.20 **Consultation and engagement**

4.20.1 The Panel heard evidence from the SaHF team about the scope of the pre-consultation, consultation and engagement process. The Panel acknowledged that considerable resources were invested in the consultation process. Pre-consultation involved clinicians and staff, HOSCs, MPs, GLA members, borough councillors, GPs, acute trusts, community service providers, local authorities, LINks, a Patient and Public Advisory Group and members of the public. The SaHF team explained that a variety of methods had been used to involve these groups including: 1:1 briefings, presentations to committees, website and social media, three large open forum public events, attendance at public meetings, clinical engagement meetings and focus groups with hard-to-reach groups. Following this work, the SaHF team informed the Panel that the feedback from these stakeholders was incorporated into the development of the proposals. The Panel were told that the PPAG played a key role in this process and reviewed the proposals as they developed. Members of this group also sat on key groups including the Programme Board, Clinical Board, Finance and Business Planning Group, Travel Advisory Group and Equalities Impact Review Steering Group. The PPAG also advised on the consultation plan, consultation document, consultation materials and delivery of the consultation.

4.20.2 The SaHF team told the Panel that the JHOSC agreed the consultation plan on 12 June 2012. As the consultation progressed, a significant number of activities were added to the consultation process. The SaHF team told the Panel that a high volume of responses to the consultation were received. In total 17,022 responses including 18 petitions. These petitions contained 58,453 signatories generally opposing the proposals and 18,807 signatories generally supporting the options. Over two thirds of the responses were from online response forms. 421 of the responses received were in languages other than English. The SaHF team commissioned Ipsos MORI Social Research Institute to undertake an analysis of the consultation responses received. This was produced on 28 November 2012.

4.20.3 The Panel heard that members of the PPAG had concerns before the commencement of consultation as to whether all the elements were in place for a successful launch - in particular, whether the information, literature and planning for the public events would be in place for the start of the consultation period. One PPAG representative told the

Panel that they had originally recommended to the SaHF team to delay the launch by two weeks. It was reported to the Panel that this advice was not taken and as the consultation launched the website transport tool was not working properly. There was no description for an urgent care centre in a local hospital and translated material was not available at the start of the consultation. It was reported to the Panel that this translated material was not available until August well into the consultation period. This lack of availability of translated material was a recurrent theme in evidence sessions and in written evidence submitted to the IRP. The Panel also heard people say *"it just had the feeling of all being a little bit rushed"*.

4.20.4 In response, the SaHF team re-ran some media briefings and provided more information on what an urgent care centre would look like. The SaHF team also commissioned the CITAS work as described in 4.20.12. The Panel heard from individuals who felt that the SAHF team did listen during the process and reacted to feedback when possible.

4.20.5 A recurring theme from the evidence was that the consultation document was too lengthy and complex. The Panel heard the comment "*I didn't feel consulted on what better services look like in this area"*. A number of people felt that the consultation questionnaire led to particular responses and that people were being asked to decide between one hospital or another. Some people were concerned that, given the size of the population in north west London, the number of people who responded to the consultation was very low and was, therefore, not representative. Some individuals told the Panel that without access to the internet it was very difficult to engage in the process in the initial stages or to complete the questionnaire as hard copies were not easy to access. Some members of the public reported that, at the beginning of the consultation process, they could not get a copy of the documentation from their GP surgery, public libraries or other public venues.

4.20.6 The Panel heard from a number of organisations that they had been very concerned at the limited and delayed availability of the consultation document in languages other than English.

4.20.7 The Panel also received evidence from a number of groups including the JHSOC and Ealing HASSSSP as to the wisdom of conducting a consultation over the summer

months especially in July and August 2012 because of the London Olympics and Paralympics and the holiday season.

4.20.8 The JHSOC raised the issue that "*considerable reliance"* had been placed, in the documentation, on the PPAG as one of the main mechanisms for patient involvement. The view was also expressed that it would have been preferable to see more engagement of staff and their representatives.

4.20.9 The JHOSC expressed the opinion that the consultation had not been a success because it did not generate a sufficient degree understanding, trust and confidence with citizens and staff. The extent of the changes proposed for Ealing and Charing Cross hospitals was not fully understood by the public. This view was reinforced separately and the Panel heard *"can the public really judge these proposals, do they understand?"*.

4.20.10 The Panel heard from members of the public who attended the open meetings that they felt that their questions were not answered with the Panel hearing "*we were only allowed one question each"*. Some individuals expressed the view to the Panel that the process had been one of marketing rather than consultation and engagement the Panel heard *"the consultation felt like they were selling a message rather than seeking views"*.

4.20.11 Some community groups told the Panel that the consultation had not reached out into black and minority ethnic communities sufficiently.

4.20.12 The Community Interpreting, Translation and Access Service (CITAS) told the Panel that they been approached by the SaHF team to explore how to engagement with members of communities for whom English was a second language could be supported. Their advice was that in view of the very many successful methods of bilingual outreach and community engagement, translations may be the least successful. However, these discussions took place after translations of the summary consultation document and questionnaires had already been commissioned elsewhere.

4.20.13 The Panel heard that CITAS had arranged for 20 participants who spoke key languages to attend the *Shaping a Healthier Future* training and that it was intended that these people would then deliver group workshops on the *Shaping a Healthier Future*

consultation. The initial training session took place at the end of August 2012, nearly two months into the consultation.

4.20.14 In response to the delay in making translated materials available, together with the timing of the consultation process, responses were accepted a week past the deadline and responses received in the next two weeks were also analysed by Ipsos MORI Social Research Institute.

4.20.15 Campaign members raised with the Panel the issue of how petition responses had been counted and the weighting given to a postcard campaign run on behalf of Chelsea and Westminster Hospitals NHS Foundation Trust. They indicated that a petition had only counted as one response regardless of how many signatures it contained whereas each individual postcard had counted as a separate response. They felt this had distorted the number of responses reported in relation to support for different hospitals.

4.20.16 During the review, the Panel was invited to attend as observers of a public meeting on 1 August 2013 organised by the Save Our Hospitals Hammersmith and Charing Cross. Generally, the opinions expressed at the meeting were that the local health service was stretched and needed to be expanded not cut, that future needs of the population would prove closing hospitals was a mistake and that local people had not been involved properly in *Shaping a Healthier Future*.

4.20.17 During the IRP review process, Ealing Borough Council commissioned a postcard campaign to facilitate residents of the Borough to give their view to a closed question and to provide for limited open-ended responses. A freepost postcard was delivered to every residence in the Ealing Borough Council area with the invitation *"This is your last chance to have a say…tell the Panel how this decision will affect you and your family"*. 4,168 postcards were passed to the IRP by Ealing Borough Council.

4.20.18 Although the SaHF team presented their plans for patient, public and staff communication and engagement during the implementation phase, this appeared to be a high level exercise. No evidence was presented to the Panel on the structures in place to ensure an effective local engagement process involving all sectors of the community. Although the Panel heard that a patient reference group had been established with an

interim chair for the implementation of *Shaping a Healthier Future* to ensure a transfer of knowledge and information.

4.20.19 The Panel noted that significant changes had been made to the proposals for Ealing and Charing Cross hospitals as a result of feedback from the consultation and that the JCPCT at its meeting on 19 February 2013 had agreed to two additional resolutions to develop further proposals for both hospitals with their respective CCGs and other key stakeholders including local councils and Healthwatch.

4.20.20 A number of organisations, including the campaign groups, the local council and clinicians raised with the Panel the low level of support from the Ealing GPs for the preferred option citing as evidence the results of a GP ballot. Written submissions to the IRP included the results of this ballot and the Panel received evidence from Ealing CCG.

4.20.21 The Panel heard that, as a result of the acknowledged differences in Ealing, the CCG held a ballot of all its GPs submitting the result as the CCG's response to the *Shaping a Healthier Future* consultation. The Panel noted that the GP ballot supported the case for change but did not support the preferred option. Instead, the majority of Ealing GPs who voted, supported the option to keep Ealing Hospital as a major hospital. The turnout for the vote was just over 41 per cent with 54.2 per cent of those who voted supporting Option C which maintained Ealing as a major hospital. The Panel sought clarification from Ealing CCG about their current position. The Panel was told by Ealing CCG that although the GP ballot supported Option C, as an organisation they had decided they would support the implementation of a JCPCT majority decision that was not based on Option C. The proviso to this decision was that an enhanced model for Ealing Hospital was agreed. The Panel heard that an enhanced model would put far more services on the Ealing Hospital site than was in the original decision-making business case. The Panel heard from the CCG that this is the current position with the enhanced service model being developed for the site.

## 4.21 Implementation

4.21.1 A recurring theme during evidence sessions and in written evidence received by the IRP was concerns about the deliverability of the proposals. Many people felt this meant that

the proposals should not go ahead or at least be delayed. For others, there was a need to have clear commitments to, and evidence of, the out of hospital services in place in advance of any changes to hospital services taking place.

4.21.2 A number of people raised concerns about the scale of the bed reductions proposed. Given their perception that the NHS was at times overstretched already, they did not believe the system would cope with such a decrease in available beds, undermining the credibility of the proposals for acute hospitals.

4. 21.3 The SaHF team told the Panel that the programme includes a planned bed reduction of 748 beds across north west London. This comprises a 534 bed reduction from acute efficiencies, mainly reductions in length of stay and 345 bed reductions from out of hospital strategies - giving a total reduction of 879 but with *headroom* built into the figure to give a final bed reduction of 748 beds. Beds associated with trust efficiencies were part of their cost improvement plans and achieved largely through reduction in average length of stay. The reduction in beds associated with out of hospital strategies are delivered through out of hospital avoidance schemes and QIPP[16] plans. Two types of scheme were highlighted to the Panel:

- Rapid Response: examples include STARRS, Intermediate Care Ealing and intermediate care beds
- Integrated Care: examples include Integrated Care Pilot, Whole Systems Integrated Care, Putting Patients First and Wellwatch

4.21.4 Some people were concerned that there was a lack of detail in the plans to make implementation credible. The Panel heard *"what we were presented with was a broad philosophy – the practical steps were a bit of a mystery"* The Panel reviewed the *Shaping a Healthier Future* workforce strategy and found it particularly challenging as it required staff to retrain - in some instances this could involve moving from a hospital setting to a community setting. The numbers of staff involved is circa 800.

[16] QIPP - the Quality, Innovation, Productivity, Prevention programme is a national Department of Health strategy involving all NHS staff, patients, clinicians and the voluntary sector. It aims to improve the quality and delivery of NHS care while reducing costs

4.21.5 The plans also require substantial capital funding that has not yet been fully secured but the Panel heard from both NHS England and TDA that they fully supported the approach proposed by the *Shaping a Healthier Future* proposals.

4.21.6 NHS England, senior staff including clinicians from the NHS NWL Collaboration of CCGs and senior staff from acute trusts all told the Panel of their commitment to supporting the necessary improvements and changes that would reduce the number of hospital beds in the health system required as part of *Shaping a Healthier Future*. This included the development of out of hospital services and implementation of the out of hospital strategy. The Panel heard that, across the health community, there was commitment to the shared vision and that this opportunity must not be lost.

4.21.7 The Panel heard a collective commitment to address the issues across north west London CCGs.

4.21.8 The SaHF team told the Panel that, if the proposals are implemented, there will be a strong, collective governance and assurance system, building on the assurance framework agreed by the JCPCT as part of the decision making process for approving the resolutions. The SaHF team understood the need to grow public confidence in the proposals and the need to reassure local communities that hospital services will only be changed when it is safe to do so. The SaHF team shared with the Panel their monitoring tracker which is designed to ensure safe delivery of the different elements of *Shaping a Healthier Future*. They also indicated a commitment to fully consult with and engage key stakeholders and the public in the implementation process.

# OUR ADVICE

## Adding value

5.1 **Introduction**

5.1.1 The proposals for health services in north west London, set out in *Shaping a Healthier Future,* build upon earlier work and consultations. Work began in 2009 to improve out of hospital care and heart attack, stroke and trauma services in London. A five-year commissioning strategic plan was published that detailed the case for change. A number of changes to services in north west London followed including, in 2009, the establishment of hyper-acute stroke services at Northwick Park and Charing Cross hospitals and, in 2011, the establishment of a major trauma centre at St Mary's Hospital and the consolidation of complex vascular surgery at Northwick Park and St Mary's hospitals.

5.1.2 Between 2009-11, a series of clinical working groups were established in north west London to develop suitable models for clinical services which culminated in some of the key elements of the 2011 Commissioning Strategy Plan, including:

- The definition of a case for change for north west London
- The definition of a detailed strategy to localise care close to patients' homes, to centralise specialist care and to integrate care for people with long-term conditions and the elderly
- New clinical quality standards for north west London
- Proposals for the establishment of a service change programme

5.1.3 The *Shaping a Healthier Future* programme seeks to address the challenge of how to secure a sustainable, high quality NHS for the people of north west London, and includes some changes to acute hospital services. The Panel found a broad understanding of, and support for, much of what is proposed. However, the Panel also found concerns about, in particular, the proposals for Ealing and Charing Cross hospitals, and scepticism about the real drivers for the programme and its deliverability.

5.1.4 The evidence the Panel received about the disputed proposals reflected the issues raised in the referral from the Ealing HASSSSP. This included over a thousand emails, letters and voicemail messages and more than 4,000 postcards from Ealing residents via the

local authority. No new, substantive issues emerged and much of the evidence presented had a consistent content and tone. Members of the public who use the local services often also took the opportunity to express wider concerns that their NHS was under threat from lack of funding, fragmentation and privatisation.

5.1.5 North west London's health services face significant challenges from the rapidly changing needs of the population compared to the capability to meet those needs, now and in the future. The current position is in no small part the consequence of not fully addressing issues with the health service over a long period of time. The unsustainable and undesirable status quo, and the urgency with which this must be addressed, are accepted on all sides of the debate. What needs to change and how to do that effectively, engaging all the relevant parties over a long period of large scale implementation, is difficult and the subject of differences of opinion and even dispute.

5.1.6 Taking account of the current context, the Panel has considered in detail each of the issues raised before reaching its conclusions. In doing so, the Panel's primary focus is the best interests of patients in north west London, now and in the future.

5.1.7 The Secretary of State for Health asked the IRP to advise whether it is of the opinion the proposals for change will enable the provision of safe, sustainable and accessible services under the *Shaping a Healthier Future* programme and if not, why not. He also asked for any other observations we may wish to make in relation to the changes and how to proceed in the best interests of local people.

5.1.8 **The current problems and future challenges faced by the NHS in north west London require large-scale change in the way services are designed and delivered. Overall, the Panel believes that the *Shaping a Healthier Future* programme provides the way forward for the future and that the proposals for change will enable the provision of safe, sustainable and accessible services.**

5.1.9 **It is not in the interests of local people to delay the progress of the programme. Well recognised improvements to out of hospital services need to be implemented in parallel with changes to hospital services that will also bring benefits for patients.**

5.1.10 **The changes to A&E at Central Middlesex and Hammersmith hospitals should be implemented as soon as practicable. Further work is required before a final decision is made about the range of services to be provided from the Ealing and Charing Cross hospital sites. Clinical service collaboration across hospitals will be vital for the A&E services at Ealing and Charing Cross hospitals to continue to function safely until the point where the alternative is demonstrably ready and implemented.**

## 5.2 Safety and quality of current services

5.2.1 Whilst there is general acceptance from all parties that the status quo is both unsustainable and undesirable, it was not always recognized that there are concerns about the safety and quality of existing services. For the most part, members of the public related positive experiences of using their local NHS despite the clear evidence that there are unwarranted variations in the quality of what is offered by both primary care and hospitals.

5.2.2 The Panel agree with the widely held view that the status quo is neither sustainable nor desirable. The Panel is also concerned that the current position is not stable. Some acute services, including A&E, are already at risk from increasing specialisation in surgery and shortages in supply of key clinical staff. The Panel is clear that the continuing safety and quality of some acute hospital services are a real and current risk for the NHS that should inform the priority and timing of service changes in the *Shaping a Healthier Future* implementation programme.

5.2.3 **Recommendation One**

**Commissioners and providers of acute hospital services across north west London must ensure that changes required to secure safety and quality for patients are made without delay.**

## 5.3 The proposals for change

5.3.1 The scale of the challenge facing the NHS in north west London is articulated in the case for change. The Panel received no evidence that the need for large scale change to services has diminished.

5.3.2 The Panel found an impressive coalition of clinicians and other leaders from across the NHS who are committed to working together, have created a momentum for change and, in the form of the *Shaping a Healthier Future* programme, established the vehicle for implementing the far reaching changes that are required.

5.3.3 The scope and ambition of *Shaping a Healthier Future* match the scale of the challenge. As such, it is amongst the most comprehensive set of service change proposals for a defined population that the Panel has reviewed. This apparent strength is also seen by some as a weakness, raising questions about the complexity of what is being proposed, the relative lack of implementation detail, the ability of the NHS to deliver and whether some of the key assumptions underpinning the proposals would hold true over what is anticipated to be a five year period of implementation. While these are legitimate and reasonable concerns in the circumstances, it is the Panel's view that it is better for local health services to plan changes now, implementing with known risks and assumptions under close review, rather than have unplanned failure.

5.3.4 **Recommendation Two**

**Subject to the recommendations below, the *Shaping a Healthier Future* programme should continue and be implemented.**

5.3.5 The SaHF programme combines proposals for major change for improvement in out of hospital services with reconfiguration of A&E and associated hospital services.

## 5.4 Out of hospital services

5.4.1 The development of out of hospital services is a critical and integral part of achieving the aims of *Shaping a Healthier Future*. Whilst there are examples of excellent out of hospital services already in place, there is clearly a need for a sustained period of change and investment in many areas. At the time of the consultation, there was criticism about the lack of detail about the development of out of hospital services which was seen to undermine the proposals for changes to hospital services.

5.4.2 The Panel found that the NHS has a clear vision, set of principles and outline investment plan to develop out of hospital services, including primary care, through a commissioning

partnership between local CCGs and NHS England. The Panel reviewed the current proposals for developing out of hospital care and found CGGs are leading the development of more detailed plans for 2014/15 onwards and that the means to track progress in delivering improvements has been put in place.

5.4.3 Despite the recent progress and visible commitment of NHS commissioners, there remains a lack of confidence and understanding in some quarters about the development of out of hospital services under *Shaping a Healthier Future*. Equally, the Panel found opportunities that can be exploited further as part of delivering some changes that will demonstrably meet the needs of local people better – in particular, addressing diversity and health inequality and integrating care.

5.4.4 *Addressing diversity and health inequality*

GP practices, working together in networks and supported by local hubs of shared facilities and services are at the heart of delivering the proposed out of hospital services. The Panel found some working examples and that this model is at the forefront of policy about the future of primary care. The implementation of this model of service is the opportunity to be innovative and specific about addressing the diversity and particular health needs of local populations in areas such as Southall in Ealing. The impact on public health outcomes and health inequalities should be integral to the planning and evaluation of services.

5.4.5 **Recommendation Three**

**Out of hospital service development plans should be built up from the individual practice and locality level to ensure services address differences in the needs of a diverse population and the associated health inequalities.**

5.4.6 *Integrated care*

The Panel found some good examples of service for older people that worked across health and social care and a general recognition that there is an opportunity and the necessity to collaborate more to deliver better quality and more cost effective services. As the group with greatest needs for health and social care services, meeting the needs of the vulnerable and frail elderly will be critical to the success of *Shaping a Healthier*

*Future*. However, it is unclear how current plans for out of hospital and hospital services will fit with the development of more integrated care for this group.

5.4.7 **Recommendation Four**

**As an integral element of *Shaping a Healthier Future*, the NHS should build on existing initiatives and engage local authorities as partners in the commissioning of more integrated care, particularly for vulnerable and frail older people.**

5.4.8 *Workforce*

The *Shaping a Healthier Future* programme identifies that the development of out of hospital services will require over 800 additional staff to be employed in a mix of existing and new roles. The recruitment, training and deployment of these staff alongside existing staff to deliver new models of service will be critical to success and a high risk. The Panel is concerned to ensure that the workforce development workstream continues to have the priority and resources required to deliver.

5.4.9 **Recommendation Five**

**The NHS should review its workforce programme and ensure that it has the means in place to deliver what is required.**

5.4.10 *Access to urgent and emergency care*

Access to, and the quality of, GP services, urgent and emergency care are a priority for the public. Members of the public told the Panel about their experiences of primary care. These stories reflected the documentary evidence that, whilst there are instances of excellence, there is clearly scope for improvement in both access and quality. The Panel found lack of access to GPs meant more use of urgent care centres and that there is confusion for the public about the current and future contribution of urgent care centres in terms of what service they offer and how that fits with what local GP and A&E services provide. The NHS is aware that changes are needed to achieve both a consistent model and the capacity in the right places to enable the proposed changes to hospital A&E departments.

5.4.11 **Recommendation Six**

**Current plans to put all urgent care centres on a common specification by the end of March 2015 must be implemented. A common approach for accessing GP services in normal hours and out of hours is needed to create, with the appropriate use of 111 and the emergency ambulance service, a consistent urgent and emergency care service to the public across north west London.**

5.5 **Hospital services**

The NHS's proposals for hospital services, particularly Ealing and Charing Cross, dominated the evidence received by the Panel. Many members of the public told the Panel about good experiences of the care provided by the hospitals and, with the population growing and services already overstretched at times, more services not less were needed. Some disputed the evidence that concentrating some services would lead to better outcomes and suggested that even if it did, the gains would be more than offset by the risks and costs of travelling further. Others, whilst accepting the evidence about concentrating some services, disputed the conclusion of the options appraisal that identified the five major hospitals for north west London. Finally, some accepted the proposals in principle but felt they were too risky and undeliverable in practice.

5.5.2 *Major hospitals – A&E and associated services*

The Panel reviewed the evidence that underpins the proposals to concentrate A&E and related services in major hospitals. Better care and outcomes are associated with the presence of senior and experienced clinicians able to make early decisions in the patient's pathway of care. A critical mass of clinical cases is essential to maintain and develop new skills. To address known variation in current services, NHS commissioners are proposing to implement workforce standards for the presence of senior clinicians that have been agreed by the relevant professional associations. The Panel agree that implementing these standards to create *major hospitals* will lead to better care of the acutely ill in north west London.

5.5.3 The process for identifying the proposed number of *major hospitals* for north west London (five) and their location has been driven by a combination of the population size to be served, constraints in the supply of key clinical personnel, the level of disruption to

achieve change, the availability of capital funding, accessibility for users of services and achieving the least overall cost to the NHS.

5.5.4 The Panel considered the criticisms levelled at the process including; that it did not compare options on criteria such as clinical quality; was inappropriately reductionist in the application of constraints such as the scarcity of workforce and capital; and ruled by finances, including private finance initiative commitments. The Panel concluded that the pragmatic and explicit approach used by the NHS reflected the clarity of the aim to improve quality outcomes by implementing life-saving standards through the establishment of major hospitals, the economic realities of the NHS, the urgency of making progress in the light of known risks to the sustainability of emergency services such as the ability to staff A&E and emergency surgery rotas and a desire to minimise the negative impact on access of concentrating services.

5.5.5 **Recommendation Seven**

**The proposal for the five major hospitals to provide A&E and associated services in north west London should be implemented. It is more sustainable than the alternatives and will deliver benefits including a reduction in avoidable morbidity and mortality.**

5.5.6 *Major hospitals - maternity and paediatrics*

In common with the clinical case for change and associated standards for A&E services, *Shaping a Healthier Future* proposes to implement standards for the presence of senior clinicians in obstetric units and paediatric units. These standards – 168 hours per week in obstetrics and 112 hours per week in paediatrics - are recognised by the relevant professional associations and will lead to better outcomes.

5.5.7 **Recommendation Eight**

**Maternity and paediatric inpatient services should be concentrated on the sites identified by *Shaping a Healthier Future*.**

5.5.8 *Elective care*

The proposal to establish a dedicated elective care centre at the Central Middlesex Hospital is based on clinical evidence that separating elective care from emergency care delivers better patient experience, efficiencies and improved outcomes. The Panel heard no contradictory view or evidence about the clinical case or potential benefits of the proposal.

5.5.9 Since the JCPCT decision, some parties have raised the possibility of an elective centre at Charing Cross Hospital. This is the subject of further discussion with CCGs who commission these services.

5.5.10 **Recommendation Nine**

**The Panel agrees that the proposal to create a dedicated elective care centre at Central Middlesex Hospital will deliver quality benefits for patients and efficiency benefits for the NHS. The possibility of a further dedicated elective centre on the Charing Cross site should be considered by commissioners in the context of what has already been agreed for Central Middlesex and the overall need for elective care.**

5.5.11 *Local hospitals*

Apart from major hospitals and a dedicated elective centre, the proposed pattern of hospital services is completed by *local hospitals* at Hammersmith, Central Middlesex, Ealing and Charing Cross.

5.5.12 With regard to the existing A&E at Hammersmith Hospital, the Panel found that, while residents considered it to be a valuable service, the range of conditions able to be treated is constrained by the absence on-site of relevant back-up services such as emergency surgery. Both the commissioners and the provider of this service agree that better care could be provided by concentrating A&E resources at St Mary's Hospital linked to a 24-hour urgent care centre at Hammersmith Hospital.

5.5.13 The A&E service at Central Middlesex Hospital is also limited in the range of conditions able to be treated. It is currently open for 12 hours a day. Whilst this service provides

some capacity to the A&E system in north west London, the Panel accepts that a more effective option is to concentrate A&E resources at Northwick Park Hospital linked to a 24-hour urgent care centre at Central Middlesex Hospital.

5.5.14 **Recommendation Ten**

**As part of a staged approach for implementing *Shaping a Healthier Future*, the proposals for A&E services at Hammersmith and Central Middlesex hospitals should proceed as soon as practicable.**

5.5.15 Although it is clear that the proposed local hospitals at Ealing and Charing Cross will have a key role to play, the Panel found the current position unsatisfactory. In the original proposals for consultation, local hospitals would provide a wide range of outpatient, day treatment and diagnostic services but would not admit any inpatients. Subsequent to consultation, the proposed range of services that might be provided from local hospitals was expanded, including the possibility that Ealing Hospital might admit patients currently cared for at Clayponds Hospital in Ealing.

5.5.16 The future of Clayponds Hospital in Ealing again casts the spotlight on meeting the needs of the vulnerable and frail elderly as a critical test of *Shaping a Healthier Future*. Whilst out of hospital services and more integrated care are both desirable, the future allocation of hospital beds for services such as assessment and rehabilitation remains unclear.

5.5.17 **Recommendation Eleven**

**The future of the proposed local hospitals at Ealing and Charing Cross, and the final decision about what might best be provided from each location as part of *Shaping a Healthier Future*, must be the subject of a specific programme of work led by local commissioners and engaging the public, service users, staff and the relevant local authority. This work should address the need for inpatient services for the vulnerable and frail elderly and its outcome will determine whether there is a need for further consultation.**

## 5.6 Consultation, engagement and decision making

5.6.1 The Panel recognizes the genuine and extensive effort made to engage and consult effectively within the constraints of available time and resources. With hindsight, there were opportunities to have done better that should inform further work - for example, being clear about the critical groups of service users, such as frail older people and people with dementia, and how to engage them and their representatives in service change. Although sometimes difficult to sustain through a period of organisational change, involving and engaging people are continuous activities that can be focused on particular issues or priorities as they arise. More involvement and engagement in the pre-consultation period would have changed the dynamic of the consultation, which many felt was largely selling the message and presenting a "Hobson's choice" about which hospitals to downgrade, rather than being a search for views about how to make the NHS better.

5.6.2 The Panel heard a lot of criticism about the complexity and length of the consultation document and the lack of means for particular groups to access the material and respond. On the other hand, the NHS has been criticized for a lack of detail in its proposals. Whilst there were undoubtedly some problems, the Panel heard from many people who clearly had understood what was proposed and felt able to argue their viewpoint. Equally the Panel met advocates and intermediaries who had helped make the consultation more meaningful.

5.6.3 A common theme arising from the evidence provided to the Panel was the significant gap between the public perception of what the NHS was doing to address issues and concerns and the reality. This most clearly demonstrated on the issue of accessibility to services and the impact on travelling. Many people told the Panel their concerns but were unaware of how much work was underway to address them as an integral part of the implementation programme.

5.6.4 The NHS told the Panel that it is reviewing the lessons from the process to date to inform both its approach and the resources required in future. This review should seek the feedback of key constituents, be based on the requirement for genuine involvement and identify comprehensively who to engage and how.

5.6.5 **Recommendation Twelve**

**The NHS must use the next period to achieve a shift in approach from communicating what they are doing to involving and engaging people in the challenge of improving services through co-design, evaluation and change.**

5.6.6 The Panel found that, as an integral part of its process and decision making, the NHS explicitly considered the Secretary of State's four tests and made every effort to assure itself that its proposals would meet the expectations set out in the relevant Department of Health guidance. With regard to the test that the proposals should have the support of GPs as commissioners of services, the Panel noted that in a vote of its members, Ealing CCG found that the majority agreed with the need for change and preferred the option in which Ealing Hospital was a major hospital rather than a local hospital. Nevertheless, the Ealing CCG, as a membership organisation, and part of a partnership with seven other CCGs in north west London, confirmed to the Panel that it was committed to working with the final proposals of *Shaping a Healthier Future*.

5.7 **Implementation risks**

5.7.1 Given the scale and complexity of the proposed changes and the timescale required for their implementation, the Panel share the genuine concerns expressed about the risks involved and the challenge of implementing changes safely and appropriately. The Panel has found that some acute services are already at risk of being unsustainable and that in the circumstances it is better to move forward, keeping risks and assumptions under review, than risk unplanned failure. **This conclusion is reflected in Recommendations One and Two above.**

5.7.2 Whilst the Panel is clear that it is neither safe nor practical to adopt the position that there can be no change to hospitals before everything else is in place, it is reasonable to expect that the implementation can be broken down into a logical sequence of changes and requirements for safe transition. This work should be informed by both the risks to current services across north west London and the outcome of further work on the final pattern of services at Ealing and Charing Cross hospitals.

5.7.3 A safe and effective NHS needs to have the service capacity and skills required to meet the needs of patients. *Shaping a Healthier Future* envisages a substantial reduction in total bed capacity across north west London. The majority of this (over 60 per cent) is a function of all providers achieving expected efficiency levels and is independent of the development of out of hospital services. The risk that planned bed reductions are not achievable or achieved must be kept under constant review as part of implementation and the assurance of service changes.

5.7.4 **Recommendation Thirteen**

**The NHS's implementation programme must demonstrate that, before each substantial change, the capacity required will be available and safe transition will be assured.**

5.7.5 As well as a lack of clarity about what the local hospitals at Ealing and Charing Cross will ultimately provide, the Panel found significant uncertainty about achieving a safe transition for A&E services serving local populations. Whilst it is clear that neither hospital will be a major hospital, there is a need to sustain their A&E services safely over a prolonged period (anticipated to be up to five years) while capacity in out of hospital services and at other acute hospitals is developed. This will require continued close clinical collaboration within Imperial Hospitals NHS Trust for Charing Cross and between North West London Hospitals NHS Trust and Ealing Hospital NHS Trust for Ealing.

5.7.6 Closing these services will represent a step-change in the overall capacity of the urgent and emergency care system for north west London. There remain doubts about how and when such a step-change can be safely negotiated.

5.7.7 **Recommendation Fourteen**

**The A&E departments at Ealing and Charing Cross hospitals must be sustained until further work to inform a final decision on the future of these two local hospitals has been completed and the alternative services that will provide a safe, high quality urgent emergency care system for local residents are in place.**

5.7.8 The Panel found *Shaping a Healthier Future* was founded in a strong coalition of clinical and non-clinical leaders, spanning the NHS's new commissioning organisations, provider organisations and partners such as the NHS Trust Development Authority and local authorities. This leadership has served the programme well to date and in the light of the challenges ahead every effort should be made to maintain and support the coalition required to achieve successful change.

5.7.9 **Recommendation Fifteen**

**The NHS should assure itself that the implementation programme has the depth and breadth of leadership combined with the resources and skills to sustain the high level of commitment and progress that will be required over the expected period of five years.**