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North West London Joint Health Overview and Scrutiny Committee

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

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The press and public are welcome to attend this meeting

Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members.

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Date of the next meeting: **Date Not Specified**

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DRAFT TEXT VERSION 2 (For Consideration at the JHOSC meeting on 1st October 2012)

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

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

Contents [To be included]

1 Introduction and Background

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

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

We formally adopted the following terms of reference:

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

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

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

2. EXECUTIVE SUMMARY

This Executive Summary sets out the conclusions of the scrutiny of "Shaping a Healthier Future" undertaken by the North West London Joint Health Overview and Scrutiny Committee.

Overall Case

We support the drive to improve the quality, safety and sustainability of emergency care in NW London. The need to address current variations in services and poor outcomes for patients is urgent. The case has been clearly made.

We recognise that the development of the proposals have been “clinically-led” and approved by a Board comprising the Medical Directors of the Acute Providers and Chairs of Clinical Commissioning Groups in NW London.

We accept that a clear, logical process of evaluation was used to arrive at the three options presented for consultation.

We believe that a compelling case has been made for future provision to be based on

- a comprehensive network of specialist skills and expertise covering hospital and out of hospital care
- transparent patient pathways and protocols which ensure patients gain timely access to the right services for their needs
- an appropriate combination of Accident and Emergency and Urgent Care Centres located across the sub region
- comprehensive, efficient and accessible out of hospital arrangements
  cost-effective provision and delivery of better outcomes at lower cost.

We note that most patients under each option would continue to be seen at the hospitals in which they are currently seen. But we also believe the proposed changes may have a significant impact on certain patients and communities, especially in relation to non-urgent access to services. In respect of urgent “Blue Light” ambulance transport we accept that the change in travel times is likely to be marginal.

In fulfilling our responsibilities as a Joint Health Overview and Scrutiny Committee we have examined issues objectively in respect of North West London as a whole, respecting the role of individual OSCs to address more local implications. We have considered a number of risks and concerns which have emerged from witness evidence and analysis.

We have agreed a number of specific recommendations which we believe will strengthen the proposals and increase the likelihood of positive implementation.

Main Areas of Concern

However, through the scrutiny process our work has identified a number of issues that we would like to see addressed as these proposals are developed :

- **Local Hospitals.** The impact of the emergency care change on some local hospitals may be greater than set out in the consultation. There is a danger that maternity, paediatric and mental health services will not be given the necessary degree of priority.
- **Urgent Care Centres.** Front-line healthcare professionals, who are expected to deliver the changes, do not currently have a shared view of how the proposals will work in practice. The way the proposed network of A&Es and UCCs will work together, the flows of patients across the system and the staffing needs are not clear to all our members.
- **Measurable Outcomes.** It is difficult to see what measures have been agreed to track progress on improving quality and safety across
- **Demand and Population Growth**. GP referrals to and emergency use of acute care might continue to grow beyond the assumptions in the proposals.
- **Out of Hospital Strategy**. There are concerns over the readiness and capacity of out of hospital services, the realism of timescales for change and the likelihood of cost transfer from the NHS to others. GPs may not buy-in to improve access to, responsiveness of and effectiveness of primary and community care, which could result in higher demand and cost for urgent and unscheduled care.
- **Equalities Impact and Non-urgent Transport**. There is insufficient recognition of the impact of the proposals on travel, especially for the poorest and most vulnerable communities. Plans to reduce any negative impact on access to re-located services by some local populations are not yet identified.
- **Workforce.** Insufficient skilled staff might be available in the health economy, especially during transition, meaning service quality may deteriorate, with some services failing altogether
- **Finance.** The precarious financial status of some NHS Trusts calls into question the sustainability of services and their ability to provide care at the levels envisaged. Lack of finance for major hospitals to address deficient estate and to co-locate core services, means none of the acute reconfiguration options are financially viable.
- **Risks.** Our work also identified a number of key risk areas, relating to the further development and implementation of the proposals, which would need mitigation.
- **Public Understanding**. Citizens in the most affected areas do not appear to understand the proposals fully or have confidence that they will work. This is a significant concern given the proposals depend on the public changing their behaviour and patterns of attendance.

In relation to the consultation process we believe that there has been a clear process based on communication and explanation. This has included a series of public meetings, road-shows, information and dedicated phone lines. We feel that ultimately the success of the consultation has to be judged by the degree of understanding, trust and confidence which is generated in citizens and staff. At this point we believe more needs to be done if this test is to be met in future.

Recommendations

Our recommendations therefore are:

1. More information is produced on how patients flows will change in the new system and what will happen to patients Borough by Borough. Action : NHS NW London.

2. Proposals for out of hospital care are developed further, with the direct involvement of non-NHS partners, to arrive at agreed resource models for each borough. Action : Health and Well-being Boards.

3. Milestones for how the Out of Hospital proposals will be implemented, to what standard and what measures will be used to track reductions in acute admissions.

4. Plans are produced which set out how all parts of the population will be educated in how to use the new models of provision. Action : Directors of Public Health.

5. Joint commissioning between local authorities and CCGs and between CCG should be strengthened to deliver better coordinated care. Action : Health and Well-being Boards.

6. Measurable standards and outcome measures are developed in advance of any decisions being taken in respect of "Shaping a Healthier Future". Action : NHS NW London.

7. Engagement of staff in the development of the proposals will to create greater ownership and ensure smooth implementation. Action : NHS NW London, provider organisations and Trades Unions.

8. Detailed equalities impact assessment is developed and plans for mitigation. Action : NHS NW London, Transport for London and London Ambulance Service.

9. Workforce Strategy and Transformation Group be established to provide leadership on workforce issues. Action : NHS NW London.

10. Model for all NHS public consultations which sets out standards for positive engagement with partners, staff and the public is developed. Action : NHS Commissioning Board.

11. That the JHOSC is constituted to provide continuing scrutiny of the development of proposals and the responsiveness to this report and other responses received to the consultation. Action : Local Authorities.

Our focus on risks and concerns does not mean we support delay in addressing the current problems with emergency care. Our intention is to be constructive. We welcome the reassurances from NHS NW London that they recognise many of these concerns and that they have already started to address them with their partners.

The full report explores the case for change, the risks, and the key issues that reflect the engagement with evidence and the deliberations of the Committee.

3 MAIN THEMES

3.1 Case for Change

Overall

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

We also understand there are a number of important drivers which make change a matter of urgency. In particular JHOSC notes

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

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

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

The case is made for urgent change to hospital-based emergency care with the implication being that failure to adopt a coordinated proposal (such as Option A) might require emergency action to protect quality and safety. Equally every reassurance is given throughout the proposals that no change to physical capacity and location will actually be made until out of hospital provision is in place, which may take 3 to 5 years.

Integrated Vision

We feel the case for change would be stronger, be better understood and have a greater chance of success if it could be located in a clear and agreed strategy on integrated health, care and housing for North West London. We feel the model of consultation could focus on a more up-to-date approach which values the active engagement of partners, staff and the public in co-designing solutions to complex problems facing health and social care.

Impact on Patient Experience

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

It is a strength that the proposals are presented as clinically-led. This should not however overshadow well-established customer intelligence about local services. We believe a simple, balanced and owned means of tracking forward progress which takes a rounded view of patient experience is important. The JHOSC is willing to provide this if desired.

Option Appraisal

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

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

Financial Case

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

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

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

Delivery

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

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

- flow of dependency patients in A&Es and then into hospital beds
- the case mix for A&Es and UCCs
- modelling admission rates and lengths of stay.

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

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

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

We have to conclude that there is an underlying problem with preparedness for consultation by NHS NW London on important issues. This has had knock-on effects. As the detailed work has not been completed in some areas NHS NW London have relied on providing high-level reassurances about what might possibly happen in future and process answers, which have proven unconvincing at JHOSC and public meetings. We feel that more work could have been completed before the consultation process was entered into and that this should have tested with boroughs and the public to ensure it genuinely addressed their concerns.

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

A&Es and UCCs offer an easily accessible entry point for those presenting with the full range of emergency, urgent and less urgent mental health issues. The way complex interconnections between emergency care and mental health will be handled in future have not emerged from the consultation clearly or in sufficient detail.

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

Social Care

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

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

Managing the Transition

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

3.2 Impact on Care

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

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

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

We appreciate that there is no UK agreed or validated definition of an Urgent Care Centre, nor any agreement about the cases and conditions that may be treated there, and that there are examples

of different models across the sub-region. We believe this places even more importance on the local definitions of A&E and UCC provision, which are used in this specific consultation, being clear and as importantly, having demonstrable ownership amongst those critical to front-line delivery.

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

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

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

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

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

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

NHS Trusts' Wider Plans

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

What the proposals mean for each site affected has we believe been underplayed during the process. The focus on emergency care hides deeper changes. It not proved possible for the JHOSC to get a simple, consistent or convincing picture of what local people and staff could expect to see at Charing Cross Hospital as a result of the removal of emergency services and other facilities and services related to them. We have been frustrated by the absence of information from key providers, such as Imperial College Healthcare NHS Trust, on their future development plans for sites and services. We are concerned that by treating this as a stand-alone consultation the implications for larger-scale financial and clinical plans, at a time if significant change in the NHS, have not been fully factored into the proposals.

Measurement

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

3.3 Out of Hospital Care

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

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

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

being Boards will be able to provide assurance to the Department of Health around these proposals if they have not played an active part in their design.

In the context of out of hospital care it is clear that a number of councils have concerns that there might be significant cost-shifting from NHS budgets to adult social care and housing. In the absence of locally agreed plans between key agencies and given the lack of staff buy-in at this point, we believe the projected timescale of 3 years has to be treated with caution and might be considered optimistic.

We fully support the view that building capacity amongst primary care clinicians and improving quality – especially out of hours - is critical to the success of the programme and to the maintenance of safe acute services. At present satisfaction levels with access to GP services in North West London are below national averages. This makes building capacity to the right standard, as rapidly as required to make "Shaping a Healthier Future" work, a significant challenge. We believe that acute service reform should only proceed when there has been a thorough independent verification of measurable improvements in the quality of community services, taking into account the views of patients.

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

- the extent to which small-scale integrated care pilots can be confidently extrapolated as providing the expectations of capacity placed on them by Shaping a Healthier Future.
- the ability for community services to meet the needs of highly transient populations in some areas;
- the extent to which out of hospital care can actually reduce the relentless increase in unscheduled demand – especially out of hours.

3.4 Travel, Accessibility and Equalities Impact

Travel and Transport

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

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

Emergency Ambulance Provision – "Blue Lights"

We appreciate the importance of the detailed analysis on blue-light activity and are reassured about that the likely impact of all three options on key emergency ambulance performance will not be

detrimental, provided investment is made in the London Ambulance Service – a commitment which NHS NW London has made in JHOSC sessions.

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

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

Non-urgent Transport

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

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

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

Equalities Impact

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

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

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

4.5 Risk Analysis

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

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

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

Theme	Risk
Case for Change	The money available in the system reduces and hence there is neither the capital nor the revenue available to implement the plan or that the finances no longer flow in the way envisaged.
	Issues raised by NCAT, Expert Clinical Panels and the OGC Health Gateway Review have not been effectively responded to.
	Case for change places too much confidence in the evidence of small scale pilots and their replicability and scalability as part of a major change programme.
	Local authority or CCG Commissioners are not bought into the plan or behave independently of it.
	CCGs do not commission in a way that is consistent with the proposals.
	The business cases for the individual components of the plan do not align with the proposed

	changes and assumptions set out in the plan.
Impact on Acute Care	Risk to patient quality of moving care to providers who lack the capacity or capability to respond to increased demand.
	Clinical education and the speed of implementation of research are compromised as established patterns of provision are disrupted.
	As services are transferred it will be difficult to maintain quality in those providers undergoing significant change as capacity or morale may reduce.
	Staff who have traditionally worked in hospital settings may choose not to work in the community.
Out of Hospital Care	Demand for acute services is not reduced and so resources designated for investment in community services are no longer available,
	Proposed integration through Health and Well-being Boards of a coherent model of prevention and promotion of mental and physical health and well-being is running parallel to an NHS focused change programme leading to missed opportunities for improved patient experience.
	Lack of sufficient capacity and capability across the system while new health and social care architecture is being built compromises the governance, capacity and coherence of greater integration with local government.
Travel and accessibility	Pattern of informal care is broken as carers or those self-managing long term conditions have to travel further afield to receive care.
	Staff do not wish to travel further afield.
	Lack of Equalities Impact Assessment that takes into account full range of impacts then impacts negatively on the ability of partners to assess proposals and for those proposals to change accordingly.
Analysing Risks	Lack of a risk register from NHS NW London compromises ability of partners to work towards shared or aligned mitigations.
Underlying Assumptions	Proposals tie up resource in estate that is no longer fit for purpose rather than in promoting a 21st Century vision of healthcare.
	Component parts of the leadership necessary to deliver change programme are not yet in place.
	External factors in the wider economy create higher levels of transience or deprivation than anticipated.
	Delivery of change programme is restricted by the length of time it takes to for staff to develop new skills and the cultural change programme required.
	Change is delayed by active resisted or sabotaged by staff, unions or key professional groupings.
	Risk of insufficient external challenge to stress testing and sensitivity analysis my lead to over reliance on NPV and 'group think'.
Consultation process	Lack of public engagement in an open discussion misses the opportunity to embed the unified approach to health and well-being that is set out in policy and does not build a sustainable platform for further transformational change.
	Lack of engagement with the public compromises political deliverability
	Failure to engage those response for the delivery of the proposed changes by those leading the change up to March 2013 comprises deliverability.
	The public do not appreciate the proposed models of care and hence their behaviours do not change.

We have received a response to these risks that have gone a long way to addressing these issues. However, we believe that further monitoring and mitigation of the risks to implementation as a project of this size and complexity moves forward.

4.6 Underlying Assumptions

Workforce Issues

Change on this scale needs to focus on the skills, motivation, recruitment and retention of staff. We fully accept that the network depends on having the right staff in the right place, with new working arrangements between consultants, middle grade staff, nurse specialists and GPs. It can be seen as an opportunity to create a genuine network of expertise embracing a wide range of different skills and professional backgrounds.

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

We are concerned that this underestimates the likely impact on individual staff. There does not seem to be an overall workforce plan or model from which the figures derive, nor a group responsible and accountable for gaining agreement with professional bodies that the model is sound. We would echo the assessment of the NCAT Emergency and Urgent Care Report and maternity and paediatrics report about priority areas on workforce following visits to NHS NW London earlier in 2012. In particular we would support fully its assessment that more work needs to be done on :

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

Pace of change.

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

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

Public education.

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

This suggests there is real potential for confusion amongst the public and a danger, as a result, of even reduced speed of access to the right care and treatment arising from the separation of A&E and UCC facilities. If it is difficult for the professional staff to be clear on where a patient should go how much more difficult will it be for a member of the public at a time of stress?

Serious doubts have to be raised about the reliance of the plans for change on a programme of wholesale re-education of the public about emergency care. In deprived communities there is the potential for language and other barriers to mean that care pathways might not be effectively communicated. The 111 service which is designed to enable people to make informed choices about their care will help in this regard. However, it will be a challenge to enable people to make informed choices within the timeframe available.

Population

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

Resilience

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

Emergency Planning

We received reassurances from the NHS London Emergency Preparedness team that “the North West London health system described in the proposal will have sufficient resilience built-in to handle surges in demand such as those posed by concurrent major incidents.” We also heard that “the numerical modelling that has been done to date shows that the plans will generate an excess of bed capacity in the order of 10% over what is required for the area.”

4.7 Consultation Process

Any changes to A&E provision are notoriously difficult for the public to accept and for staff to embrace. This means that the process of consultation needs to be grounded in a genuine

commitment to engage with the public, with staff and with partners from the outset - in identifying the key issues and co-designing the solutions together. This builds necessary trust and confidence and reduces public anxiety.

Public Engagement

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

Consultation Period

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

Patient Involvement

Considerable reliance in it's documentation on the Patient and Public Advisory Group (PPAG), a network of LINks Chairs, as the main path for patient involvement on the inside of the process. We question whether this is sufficient. We would have preferred to have seen more engagement of staff and their representatives about the proposed changes. This has undoubtedly lost some key potential allies and a source of valuable intelligence and support.

Remit for Consultation

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

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

Appendix 1 Members of the JHOSC

Appendix 2 List of Witnesses attending meetings

Appendix 3 List of Witness Statements received