

# North West London Joint Health Overview and Scrutiny Committee

## Agenda

Tuesday 23 January 2018

9.30am COUNCIL CHAMBER  
EALING TOWN HALL, NEW BROADWAY, EALING W5 2BY

### MEMBERSHIP

Chair - Cllr Mel Collins (LB Hounslow)  
Cllr Shaida Mehrban (LB Hounslow)  
Cllr Ketan Sheth (LB Brent)  
Cllr Barbara Pitruzzella (LB Brent)  
Cllr Daniel Crawford (LB Ealing)  
Cllr Theresa Mullins (LB Ealing)  
Cllr Rory Vaughan (LB Hammersmith & Fulham)  
Cllr Sharon Holder (LB Hammersmith & Fulham)  
Cllr Vina Mithani (LB Harrow)  
Cllr Michael Borio (LB Harrow)  
Cllr Robert Freeman (RB Kensington & Chelsea)  
Cllr Catherine Faulks (RB Kensington & Chelsea)  
Cllr John Coombs (LB Richmond)  
Cllr Liz Jaeger (LB Richmond)  
Cllr Jonathan Glanz (Westminster City Council)  
Cllr Barbara Arzymanow (Westminster City Council)

**CONTACT OFFICER:** Anna-Marie Rattray  
Scrutiny Review Officer  
Legal & Democratic Services  
Ealing Council  
Tel: 020 8825 8227  
E-mail: [RattrayA@ealing.gov.uk](mailto:RattrayA@ealing.gov.uk)

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Members of the public are welcome to attend.

# North West London Joint Health Overview and Scrutiny Committee

## 23 January 2018

1. **WELCOME AND INTRODUCTION**
2. **APOLOGIES FOR ABSENCE**  
To receive apologies for absence (if any)
3. **DECLARATIONS OF INTEREST**  
To receive declarations of disclosable pecuniary or non-pecuniary interests, arising from business to be transacted at this meeting, from:
  - (a) all Members of the Joint Committee;
  - (b) all other Members present in any part of the room or chamber.
4. **MINUTES**  
That the minutes of the meeting held on 5 December 2017 be taken as read and signed as a correct record.
5. **MATTERS ARISING**  
Follow up from 5 December 2017 meeting –
  1. Presentation of initial A&E data for Committee to discuss in preparation for the March meeting.
  2. Update on London Hospital and Western Eye Hospital covenant issues
  3. Update on response from Councillor Collins to Royal College of Nursing letter
  4. Equalities Impact Assessment has been added to the Work Programme – to be discussed at March meeting
  5. Implementation date / timelines for STP
6. **UPDATE FROM LONDON AMBULANCE SERVICE**
  - a) Response to Councillor Crawford's queries from the April meeting
  - b) Present main points from CQC report and LAS Response
  - c) Update on effectiveness 'cross-border working'
  - d) Update on ambulance 'stacking' – i.e. transfers into A&E
7. **INVESTMENT INTO CHARING CROSS HOSPITAL**  
Update on investment plans for Charing Cross Hospital and how these relate to plans for changes to A&E post-2021.
8. **DISCUSS PERFORMANCE METRICS FOR SHAPING A HEALTHIER FUTURE PROGRAMME AND STP**  
Discuss framework of performance metrics / monitoring – members to consider options for framework prior to meeting (Councillor Collins and officers to circulate initial ideas for feedback and additions)
9. **ANY OTHER MATTERS THAT THE CHAIR CONSIDERS URGENT**

**NORTH WEST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE**

Minutes of the meeting held on Tuesday, 5 December 2017.

**PRESENT:** Councillor Mel Collins (Chairman), Councillor Rory Vaughan, Councillor John Coombs, Councillor Liz Jaeger and Councillor Barbara Arzymanow

**ALSO PRESENT:** Susan LaBrooy, Clare Parker, Juliet Brown and Rob Larkman

**1. WELCOME AND INTRODUCTION**

Councillor Collins as Chairman welcomed those present and asked those present to introduce themselves. He said that it was important that JHOSC continued to scrutinise the direction of travel with regarding to the reconfiguration of health services in North West London.

Councillor Coombs as a member from the host borough also welcomed those present to the venue.

Councillor Collins said it was intended that there should be two more meetings of the JHOSC before the local elections in May 2018.

**2. APOLOGIES FOR ABSENCE**

Apologies for absence were received from:

Councillor Holder  
Councillor Sheth  
Councillor Pitruzella  
Councillor Crawford  
Councillor Mullins  
Councillor Borio  
Councillor Mithani  
Councillor Mehrban  
Councillor Faulks  
Councillor Freeman  
Councillor Glanz

Members were informed that the vice-Chairman Councillor Williams had become a member of the Cabinet at Royal Borough of Kensington and Chelsea. He was therefore no longer a member of the Committee.

**3. DECLARATIONS OF INTEREST**

There were no declarations of interest on this occasion.

**4. MINUTES**

**RESOLVED** that the minutes of the joint meeting held on 20 April 2017 be approved and signed by the Chairman.

**5. MATTERS ARISING**

Officers said the following:

- 1) An Equalities Impact Assessment (EIA) had been added to the work programme to be considered at a future meeting.
- 2) The London Ambulance Service would be invited to a future meeting for an update.
- 3) Accident and Emergency performance would be covered in the meeting

The combined GGC workforce strategy wasn't in the Matters Arising but would be brought to a future meeting.

Councillor Collins said that the election of a new vice-Chairman to replace Councillor Williams would be dealt with later in the meeting.

## **6. EXPLANATION OF THE ACCOUNTABLE CARE SYSTEM**

Officers presented the paper on the Accountable Care System. There was a frailty service which would look to prevent the admission into hospital of frail older people and instead support them at home where this was the appropriate course of action. Models regarding alternatives to admission were being assessed.

Councillor Arzymanow asked whether older people staying in hospital inappropriately was a cause of bed blocking. Officers said that the frailty service wasn't looking to impact on Delayed Transfers of Care (DToC)s. If a patient was presented at (Accident and Emergency) A&E there would be a review of their care package and a needs assessment to see whether they could be returned home with the appropriate support. Numbers are being collated regarding readmissions and this would be brought to a future meeting.

Councillor Coombs asked as to why patients were being presented to A&E. Officers said that the reasons were being investigated. If a patient's needs are complex it wasn't always clear what the issues were. Work was also being undertaken with London Ambulance Service.

Councillor Vaughan enquired as to the extent of interaction with boroughs. Officers said that a care path would be identified with community services who would work in an integrated way that was best for patients. Health and social care services should be bought together. Patients would have an assessment done in hospital and a decision would be made on support.

Councillor Jaeger asked whether there were enough geriatricians. Officers said that NW London was reasonably staffed in this regard. It was important to use staff as effectively as possible. Recruitment was difficult as there was a shortage but it was envisioned that extra geriatricians would be recruited.

Councillor Collins said there'd been complains regarding late night discharge of elderly patients and suggested that the discharge programme should be looked at to ensure there was the support to prevent this. He added that there was staff uncertainty at Ealing Hospital and also noted that there was no closure of accident and emergency at Charing Cross Hospital in the 5-year programme.

Ms Parker said that the Accountable Care approach was looking to solve the issue of fragmentation of services through increased joining-up of services. Care would be provided in a holistic way. Misaligned incentives were another issue with different organisations and different contracts. Duplication would be reduced. There was also an issue of unclear access with silo working and uncertainty as to how to access care. There was a challenge to integrate care around the individual. There would also be a focus on patients looking after their own health as part of a preventative approach. There was a need to focus on different needs across different demographics. There would be a focus on outcomes. Misaligned outcomes would be changed. There would be more integrated care including education and housing.

Ms Parker outlined areas where boroughs in North West London were developing new care models supported by CCGs. It was explained that Hillingdon CCG was leading the development of the most advanced accountable care model in North West London and was having an impact on reducing unnecessary hospital admissions.

Councillor Collins asked how a preventative approach could be developed when local authorities' budgets were being hit. Ms Parker said it was difficult as public health since its move to local authorities had been cut.

The diabetes prevention programme would help patients understand the risks and take mitigate including weight loss and physical and psychological therapies.

The Better Care Fund was operating on a local authority basis and would subsequently have differential impacts but would present an opportunity for accountable care. BFC had driven integrated care in Hillingdon and the voluntary sector was a part of this model.

Councillor Jaeger asked whether Richmond residents were taken account of in the development of the programme. Ms Parker said that there was work with the Chelsea and Westminster Trust and services would take account of residents across borough boundaries including those on the periphery of the North-West London system such as those in Richmond.

Councillor Collins asked how work with the voluntary sector was funded. Ms Parker said that there was commissioned activity which included social prescribing to the voluntary sector.

Councillor Vaughan asked about the ambition of social prescribing and whether there was a shared strategic view within the accountable care system. Officers said that this was dependent on what happens locally. Discussions would include how to provide the best outcomes for patients. Councillor Vaughan said that it was important to get the ambition right for the individual and asked how data was captured. Officers said that information was key to inform commissioners as to the success of the accountable care system and was an important part of the development work. There would be a shift towards patient reported outcomes. There was work towards an indication dashboard to allow frontline staff to look at date. It was agreed a demonstration should be brought to the March JHOSC meeting.

Councillor Vaughan asked about an any impact on budgets. Ms Parker

said that there would be conversations regarding joint use of resources to ensure that the financials systems right.

Councillor Collins asked for an update on the status of accident and emergency. Ms Parker said there was no change to Charing Cross but changes at Ealing Hospital were going ahead.

## **7. UPDATE ON HUBS**

Officers said that the hubs were a key element of the transformation. There were 27 hubs across North West London. There was some capital investment needed in out of hospital services. Operational hubs were providing a number of community based services. Evidence would be collated regarding how to improve care of patients. GPs were not being replaced; there would be a space for multidisciplinary teams including GPs. They would provide an extended hours service. Evidence suggested that this would be a better service for patients.

Cllr Collins asked where the St Charles Centre was. Officers said it was near Grenfell Tower.

In response to a question from Councillor Arzymanow, officers said that a site hadn't yet been identified in Westminster. Ms Parker said that finding appropriate buildings in Westminster was a challenge. There was little space at St Mary's but a vacant site at Marylebone. The Western Eye Hospital would move to St Mary's. The Samaritan and Western Eye Hospital sites would be sold. A question was asked as to whether Samaritan Hospital was a bequeathed site. Clare Parker said she's check with the Trust.

Officers said it was envisioned that services at hubs would try to direct patients away from A&E. Offices said that the business case had been submitted to NHS England and it was assumed that once it had been through their assurance process it would come back to the Board in 2018. The next step would be preparatory work to take the model forward including an accelerated business case.

## **8. UPDATE ON NHS MATTERS**

Officers said that transformation of maternity and paediatrics would only take place once the system was fully ready for a change and appropriate indicators were identified so the impact on patients and the system could be measured.

Officers said it was important to get services right for members of the population aged over 65 years. This would include reducing the numbers attending accident and emergency and readmission rates. This would also look at getting the best social care outcomes for patients and also give patients choice as to the place of death.

Councillor Collins asked officers what the impact of the reduction and removal of services at Ealing Hospital would have given population growth in Ealing and Hounslow. Officers said this could be brought back to a future meeting. Councillor Collins replied that future population growth should be taken into account and members may wish to input into this. He also suggested that members may also wish to discuss further the impact of withdrawal of services to existing populations at forthcoming meetings. Members agreed this would be something they'd like to explore.

## **9. UPDATE ON ROYAL COLLEGE OF NURSING'S CONCERNS**

Officers present were invited to respond to the published letter from the Royal College of Surgeons addressed to Councillor Collins. They said there'd been evidence based changes. There's been work with the Royal Colleges including new models of care which had received messages of support. Vacancy rates had fallen from 20% to 5%. Recruitment in London was always difficult due to accommodation issues. Roles would develop further and staff would work differently and would enjoy what they do.

The letter suggested that there'd been a loss of nurses and the role was becoming less attractive. Officers said in response that this wasn't something they recognised. Vacancy rates could be an issue in different providers but this wasn't due to the transformation work. There'd also been a clear engagement and consultation process including an Equalities Impact Assessment. Councillor Collins said that he'd respond to the letter and requested that officers present assisted him with it.

Members noted that the Royal College of Nurses had suggested that there wasn't enough being done in terms of consultation. Councillor Collins said that it was important that concerns were addressed. Officers said that detailed engagement would happen on a service by service basis.

## **10. ANY OTHER BUSINESS**

Councillor Collins said there'd be two more meetings this year. The next meeting would be held on 23 January 2018. A discussion was held regarding the possibility of holding one meeting in the evening. It was noted that the March meeting should occur prior to purdah.

A discussion was held regarding the items for the next two meetings

- Accident and emergency review
- STP update
- Combined workforce strategy
- London Ambulance Service
- Performance/Patient Dashboard
- Evaluation of services.

It was **RESOLVED** that the election of a new vice-chairman to replace Councillor Williams would be deferred to the next meeting. Councillor Collins said that it would be desirable that the new vice-chairman was a member from a different political party.

### **CHAIRMAN**

The meeting, which started at 9.37am, ended at 12.19pm.

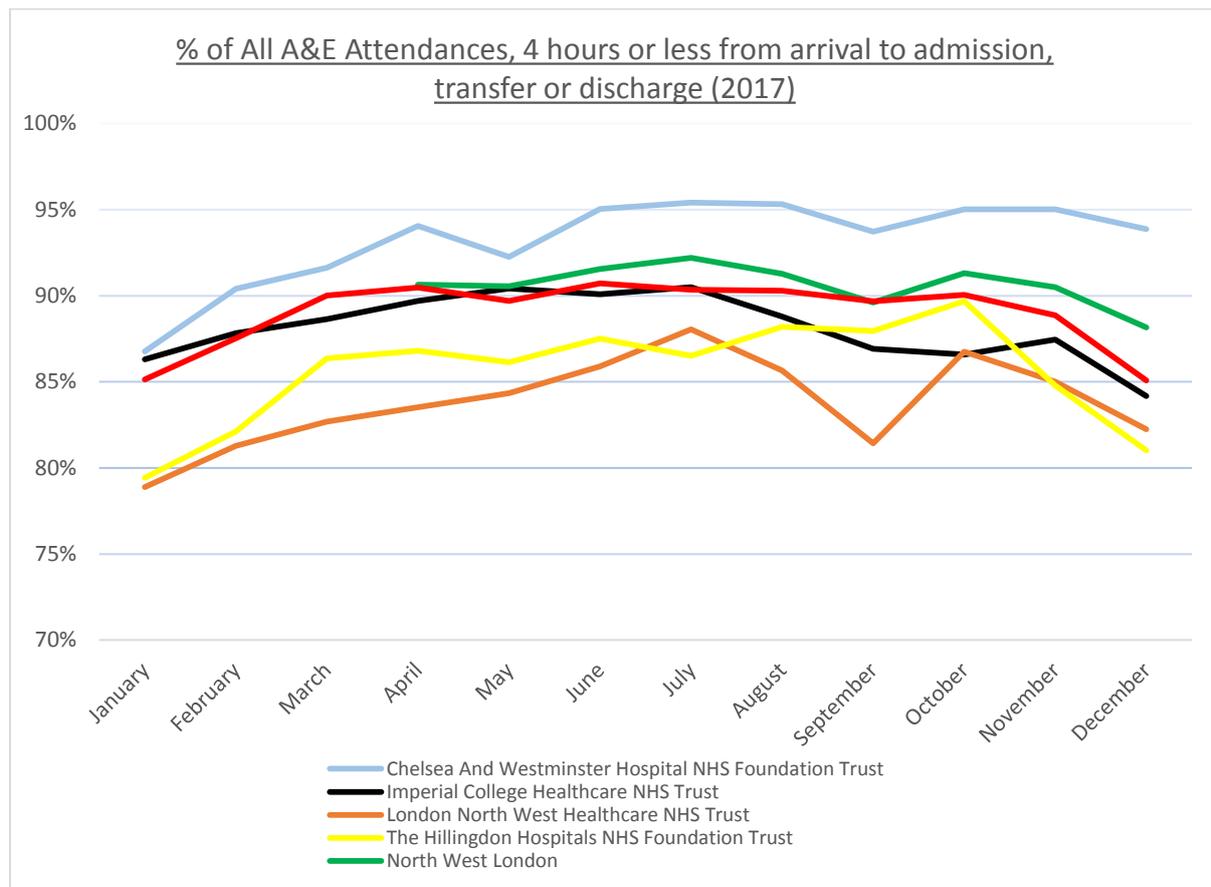
## NW London JHOSC

23 January 2018

### 5.1 A&E Attendances and Emergency Admissions 2017-18

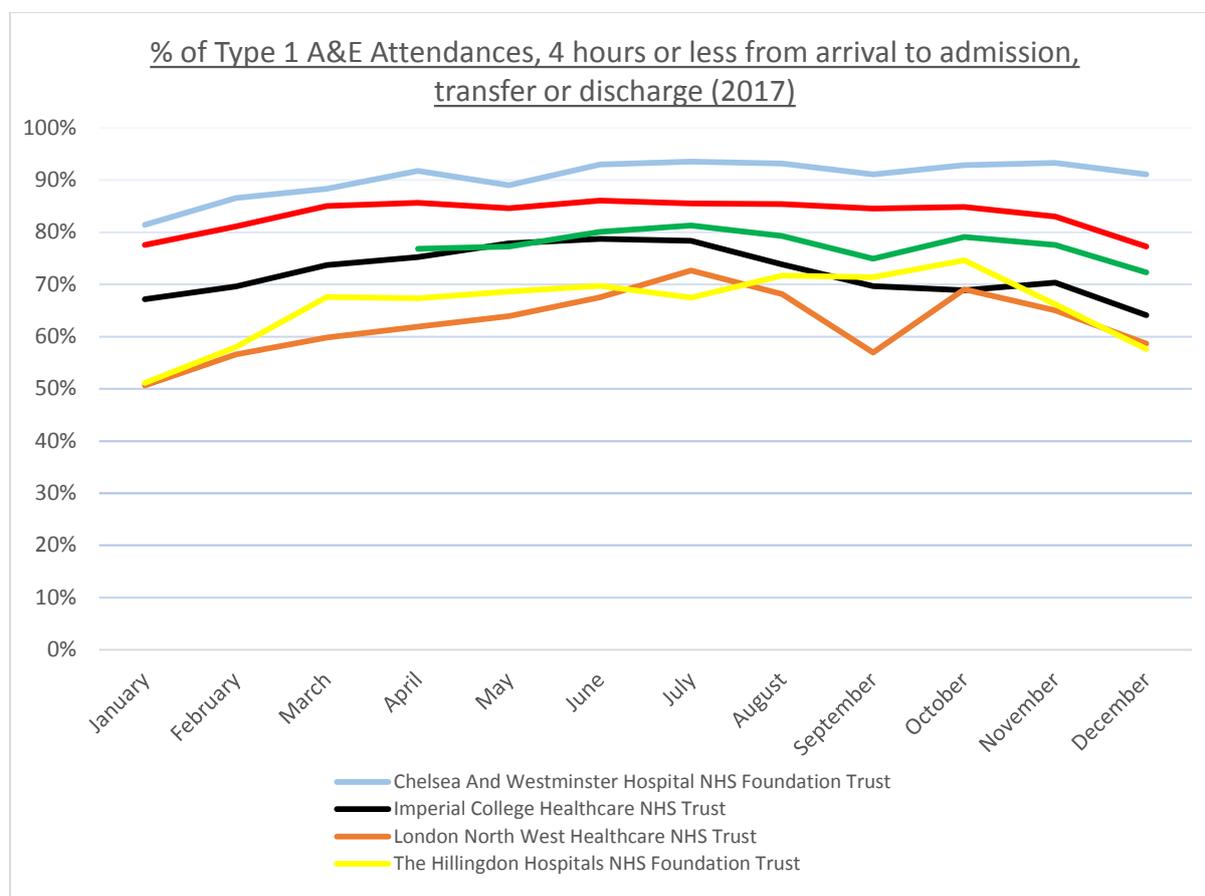
The data presented below is underpinned by monthly A&E attendances and emergency admissions over 2017, including all A&E types. The data has been sourced from publicly available NHS data and summarised by the London Borough of Hounslow.

The graph and table below outlines the percentage of **all** A&E (major A&E) attendances which resulted in admission, transfer or discharge of the patient, 4 hours or less from arrival.



Month	Chelsea And Westminster	Imperial College	London North West	The Hillingdon Hospitals	North West London	England
January	86.8%	86.3%	78.9%	79.4%		85.1%
February	90.4%	87.8%	81.3%	82.1%		87.5%
March	91.6%	88.6%	82.7%	86.4%		90.0%
April	94.1%	89.7%	83.5%	86.8%	90.6%	90.5%
May	92.3%	90.4%	84.3%	86.1%	90.5%	89.7%
June	95.0%	90.1%	85.9%	87.5%	91.5%	90.7%
July	95.4%	90.5%	88.0%	86.5%	92.2%	90.3%
August	95.3%	88.8%	85.7%	88.2%	91.3%	90.3%
September	93.7%	86.9%	81.4%	88.0%	89.6%	89.7%
October	95.0%	86.6%	86.7%	89.7%	91.3%	90.1%
November	95.0%	87.5%	85.0%	84.8%	90.5%	88.9%
December	93.9%	84.2%	82.3%	81.0%	88.2%	85.1%

The graph and table below outlines the percentage of **Type 1** A&E (major A&E) attendances which resulted in admission, transfer or discharge of the patient, 4 hours or less from arrival.



Month	Chelsea And Westminster	Imperial College	London North West	The Hillingdon Hospitals	North West London	England
January	81.4%	67.2%	50.7%	51.2%		77.6%
February	86.6%	69.7%	56.6%	58.0%		81.2%
March	88.3%	73.7%	59.8%	67.6%		85.1%
April	91.8%	75.2%	61.9%	67.4%	76.9%	85.7%
May	89.0%	77.9%	63.9%	68.6%	77.3%	84.6%
June	93.0%	78.7%	67.5%	69.8%	80.1%	86.1%
July	93.5%	78.4%	72.7%	67.5%	81.3%	85.5%
August	93.2%	73.9%	68.2%	71.7%	79.3%	85.4%
September	91.1%	69.7%	57.0%	71.4%	74.9%	84.6%
October	92.9%	68.9%	69.1%	74.6%	79.1%	84.9%
November	93.3%	70.4%	65.0%	66.2%	77.6%	83.0%
December	91.1%	64.1%	58.7%	57.6%	72.3%	77.3%

**Note:** The data presented above does not necessarily reflect a positive or better outcome for patients, as providers may have procedures in place to ensure patients are admitted, transferred or discharged within the 4-hour target, regardless of whether they need to be or not.

## London Ambulance Service

### Update on progress

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#### Background

- Demand increased in 2016/17 – we attended 200 more incidents a day than 2015/16
- Recruited over 350 frontline staff – approved an action plan to improve diversity and culture
- CQC visited again in Feb 2017 – rated us ‘requires improvement’ with our patient care being rated as outstanding
- Our performance has also improved
- Moved to the new Ambulance Response Programme on 31 October 2017.

#### CQC report

The CQC noted improvements in all areas of the Service. In particular they noted:

- Significant improvements in medicines management, staffing and levels of incident reporting
- Staff went above and beyond to offer a patient-centred service
- Impressive efforts made to improve experience of patients with specific needs eg mental health, maternity and falls
- Good use of care pathways and guidelines
- Significantly improved Emergency Preparedness Resilience and Response function and appraisal
- Good provision for patients with complex needs and improved Hazardous Area Response Team compliance

They also identified areas for improvement:

- Continue to improve medicines management
- Improvements to the 999 system
- Recruitment – placing a particular focus on meeting targets to recruit more people from the community we serve
- Improve training compliance
- Leaders need to be more visible
- Limited learning from complaints and further work needed on business continuity

How we are responding:

- We are continuing to improve our medicines management processes, including trialling new storage facilities and changing the way staff access medicines.
- Following issues with our CAD system we had an independent external review and have implemented over half the recommendations already. Appointed a new Chief Information Officer to strengthen our leadership in this area.
- We launched a workforce strategy and we are working on a recruitment campaign to boost recruitment. We have also been focusing on improving our BME representation. We developed an action plan and have taken a number of actions to improve equality and diversity – including: employing a lead for equality and diversity, securing £500k from Health Education England to: fund outreach in schools to raise our profile as an employer; provide coaching and mentoring for our BME talent; and support and build the BME staff network
- Improved system for training and we’re making it easier for frontline staff to access training

## Performance

- We've seen improvement in our performance this year
- We are handling **200 more incidents a day** across the capital compared with 2015/16
- We answer **5,000 calls every day**. This is a 1.4% increase on 2015/16.
- **Performance in Hounslow** has been above the average for London. In December 2017 we reached the majority of category 1 patients in Hounslow within the target time of seven minutes and reached category 2 patients within the 15 minute target time.

## Managing Demand

- The number of people we **manage over the phone is the highest in the country**. We receive over **35,000 emergency calls** a week
- **We do not send an emergency ambulance to around 3,500 callers**. After an initial clinical assessment, these callers will either be referred to NHS 111, be given clinical advice over the phone, or be sent a taxi to take them to an urgent care centre or emergency department.
- **We are working with wider NHS to reduce pressure on our Service**- health care professional calls, GP admissions and NHS 111 requests for assistance. We have set up a multidisciplinary team to work with West Middlesex Hospital to address frequent callers to the ambulance service and frequent attenders to the ED.
- Working with NHS England to **improve hospital handover times**
- We work closely with Hounslow ICRS, the **rapid response team for Hounslow**, to allow more patients to be referred to their team by our crews and treated out of hospital, when safe to do so.

## Ambulance Response Programme

On 13 July, NHS England announced a new set of performance measures for ambulance services that will apply to all 999 calls for the first time. London Ambulance Service implemented these changes overnight on 31 October.

This will see:

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

The new standards will save lives and remove hidden and long waits suffered by millions of patients, including reducing lengthy waits for the frail and elderly. The new system is backed by the Association of Ambulance Chief Executives, the Royal College of Emergency Medicine, the Stroke Association and the British Heart Foundation amongst others.

You can find out more about this national system on NHS England's website at [www.england.nhs.uk/urgent-emergency-care/arp](http://www.england.nhs.uk/urgent-emergency-care/arp).

## Winter

We have been working with the wider NHS to plan for winter. Our planning has seen us perform well so far, with us ranked third nationally for category 1 response times. Although we have seen high levels of demand, particularly in call volume, we have plans in place and have implemented them as required – for example increasing the number of staff on our clinical hub to provide advice over the phone where an ambulance is not required or to refer people to more appropriate pathways.

Other actions we have/ are taking:

- The Ambulance Response Programme will support us in reducing the wait for non-urgent calls and is expected to save 250 lives a year
- We are working with hospitals and NHSE around hospital flow
- We will continue to use our communications channels throughout winter to encourage people to stay well and access advice and support from NHS 111, pharmacists and online
- We are encouraging all our staff to have the flu vaccine to protect themselves, patients and their families.

### **Hospital handovers**

We have been working closely with the wider NHS to manage hospital handovers. We have put in place a significant number of measures to manage hospital handover delays and have seen a reduction from the delays experienced last year.

The measures we have put in place include:

- We have seconded a senior Manager to work specifically with the rest of the NHS system and the Emergency Care Improvement Programme (ECIP) on hospital handovers
- We are working with individual EDs on local measures.
- We have made a number of improvements to our Intelligent Conveyance function to help manage the flow of ambulance arrivals at Emergency Departments to help prevent delays in handing over to the hospital.
- The Director of Operations and the Medical Director have a weekly meeting with NHSE and NHSI to tackle hospital handovers
- We have been sharing data on predicted conveyances to each Emergency Department (ED) with NHSI and NHSE so that EDs can incorporate this into their winter planning

West Middlesex has performance very well so far this winter in terms of hospital handover delays and is the third quickest hospital for taking ambulance handovers in London.

### **Staffing**

We have made significant efforts to recruit more staff and we are currently planning a recruitment campaign to increase this even further. In 2016/17 our staffing level was 5,164.

Our frontline vacancy rate has improved, due to UK and international recruitment.

We have been attending job fairs across London, promoting the Trainee Emergency Ambulance Crew role and Emergency Medical Dispatcher role.

### **Cross-border working**

The London Ambulance Service's Emergency Preparedness, Resilience and Response Team is in charge of planning for events and managing serious and major incidents when they are declared. In certain circumstances ambulance services may be requested to provide mutual aid. Examples of when this may occur include when the service is under extreme pressure, in preparation for severe weather or pandemic flu or during a major or catastrophic incident.

Mutual aid is co-ordinated by the National Ambulance Service Co-ordination Centre which ensures that resilience is not stripped away from other Trusts that may also be experiencing pressure.

Apart from mutual aid arrangements, the London Ambulance Service regularly visits other Trusts to see how they are doing things, and we host other Trusts in London. We recently worked closely with Yorkshire Ambulance Service when implementing the Ambulance Response Programme.



**Update on Charing Cross Hospital**

**Report from Imperial College Healthcare NHS Trust to the North West London Joint Health Overview and Scrutiny Committee**

**1. Summary**

This report to the North West London Joint Health Overview and Scrutiny Committee is in response to the request for an update on recent and proposed investments at Charing Cross Hospital and future plans. The Trust regularly attends the London Borough of Hammersmith & Fulham’s Health, Adult Social Care and Social Inclusion Policy and Accountability Committee to provide updates on a range of issues and developments including Charing Cross Hospital. Most recently our interim chief executive Professor Julian Redhead attended the committee’s meeting held on 12 December 2017.

**2. Imperial College Healthcare NHS Trust overview**

The Trust provides acute and specialist healthcare for a population of nearly two million people in North West London, and more beyond. We have five hospitals – Charing Cross, Hammersmith, Queen Charlotte’s & Chelsea, St Mary’s and Western Eye – as well as a growing number of community services.

With our academic partner, Imperial College London, we are a founding member of one of the UK’s six academic health science centres (now expanded to include Royal Brompton & Harefield NHS Foundation Trust and the Royal Marsden NHS Foundation Trust), working to ensure the rapid translation of research into better patient care and excellence in education. We are also part of Imperial College Health Partners, the academic health science network for North West London, spreading innovation and best practice in healthcare more widely across our region.

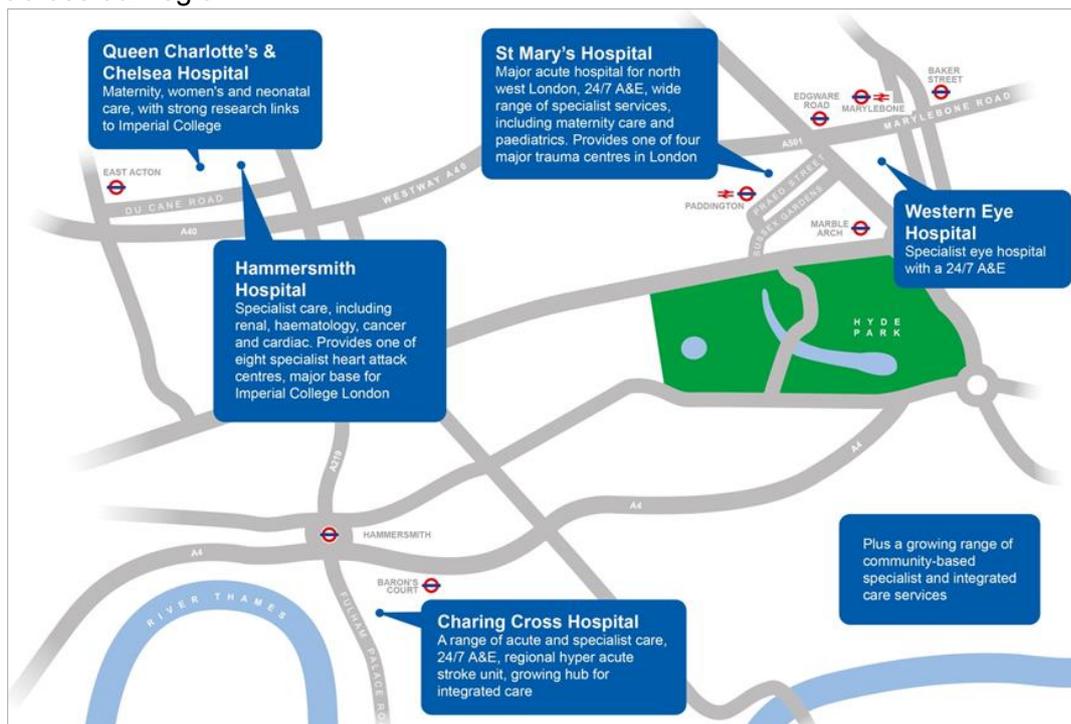


Figure 1 – Map of hospitals in Imperial College Healthcare NHS Trust

### **3. Charing Cross Hospital**

Charing Cross Hospital provides a range of acute and specialist services, a 24/7 accident and emergency department and hosts the hyper acute stroke unit for the region of North West London. It is also a growing hub for integrated care in partnership with local GPs and community providers.

Charing Cross was originally a voluntary hospital called the West London Infirmary. It was also an undergraduate teaching hospital. It was founded with only 12 beds by Dr Benjamin Golding in 1818 near the Strand in Charing Cross, in buildings now occupied by Charing Cross police station. In 1827, it changed its name to Charing Cross Hospital and later set up a medical school. It moved to its present location on Fulham Palace Road in West London in 1973.

### **4. Proposals and decisions about Charing Cross Hospital**

In 2012, the local healthcare commissioners for North West London (then the primary care trusts) published proposals for the 'Shaping a healthier future' service reconfiguration programme. There was a full public consultation on plans for a more integrated approach to care, with the consolidation of specialist services onto fewer sites, where this would improve quality and efficiency, and the expansion of care for routine and on-going conditions, especially in the community, to improve access.

Charing Cross Hospital was envisaged as developing a 'local hospital' within this network of services, building on its role as a growing hub for integrated care offered in partnership with local GPs and community providers. The proposals were supported by NHS providers across north west London, including Imperial College Healthcare.

After developing the proposals further with feedback from the consultation, the PCTs approved the reconfiguration plans. In October 2013, on the recommendation of the Independent Reconfiguration Panel, the Secretary of State supported the proposals in full, though adding that Charing Cross Hospital should continue to offer an A&E service, even if it was a different shape or size to that currently offered. He also made clear that there would need to be further engagement to develop detailed proposals.

The Trust published its own clinical strategy and estates plans in 2014 that included outline proposals for Charing Cross to become a 'local hospital' in line with the Shaping a healthier future proposals.

Since then, the Trust and local commissioners (now the clinical commissioning groups or CCGs) have put a hold on subsequent work to engage patients and the public in the development of detailed plans for Charing Cross due to increasing demand for acute hospital services. This continuing rise has meant we need to focus first on the development of new models of care to help people stay healthy and avoid unnecessary and lengthy inpatient admissions.

A commitment to not progress plans to reduce acute capacity at Charing Cross unless and until we could achieve a reduction in acute demand was formalised in the North West London Sustainability and Transformation Plan (STP) published in 2016. STPs are five-year plans for the development of health and care services across geographic areas produced by a range of NHS, local authority and third sector organisations. The STP for North West London added that Charing Cross will continue to provide its current A&E and wider services for at least the lifetime of the plan, which runs until April 2021. To quote the STP:

*"There will be no substantial changes to A&E in Ealing or Hammersmith & Fulham, until such time as any reduced acute capacity has been adequately replaced by out of hospital*

*provision to enable patient demand to be met. NHS partners will review with local authority STP partners the assumptions underpinning the changes to acute services and progress with the delivery of local services before making further changes and will work jointly with local communities and councils to agree a model of acute provision that addresses clinical safety concerns and expected demand pressures.”*

## **5. Investments at Charing Cross Hospital**

We have recently seen some of our largest ever investments in new facilities and equipment at Charing Cross Hospital, much of which has been made possible by the support of Imperial Health Charity.

Over the past 18 months, some £6 million has been spent on major new developments including: Riverside theatres; main outpatient clinics; a new acute medical assessment unit; our first patient service centre; and the main new facility for North West London Pathology. In addition, we are spending almost another £8 million on replacing imaging equipment and installing two state-of-the-art LINAC radiotherapy machines so we can provide the most advanced cancer treatments.

And our maintenance spend at Charing Cross this year is another nearly £6 million, around a third of our total Trust spend on backlog maintenance.

As part of our investment in urgent and emergency care services and theatres at Charing Cross, we have co-located our acute medicine beds on the ground floor of the hospital, near to the A&E department, and closer to the imaging department. This has enabled medical patients to be admitted more quickly.

In addition, we are currently working up a multi-million pound refurbishment and expansion of the A&E department at Charing Cross, to begin in the early part of 2018. The likely timescales however, mean that the improvements will impact after the current winter period.

## **6. Urgent and emergency care attendances and admissions**

Our urgent and emergency care services continue to be under significant pressure, particularly during the current winter period. We are seeing more patients, and sicker patients, which means more admissions to our wards.

We also have more patients who, once they have been treated, need extra support to be put in place before they can go home or to community-based care, which often causes a delay to discharge from hospital. Many of our patients, and particularly those who endure delays in discharge from hospital, are older, frail people with complex health and care needs including dementia or people with mental health problems who need specialist mental health care.

We are seeing some real improvements though, through more collaborative working in particular. Our integrated discharge team includes hospital-based specialist discharge nurses and co-ordinators working in partnership with hospital-based social workers to address issues of complex social care. The service works in collaboration with adult social care teams, local CCGs, community health partners, including the Community Independence Service, and voluntary sector providers to facilitate patient discharge.

We are part of the ‘Home First’ initiative where suitable elderly patients, who do not require an acute hospital bed, have their health and social care needs fully assessed at home rather than while they are still in hospital, with additional support put in place if required. The scheme aims to reduce length of stay for elderly hospital inpatients and reduce their risk of requiring residential care.

Consequently, we have seen a reduction in our Trust-wide average patient length of stay over the past few years - as of December 2017, it was 3.1 days.

Overall, recent figures for emergency attendances and admissions show:

- Emergency attendances grew by 16 per cent between 2015/16 and 2016/17 then, for the first half of 2017/18 (April to September 2017), by a further 4.5 per cent. (These figures include patients seen in our emergency departments, which is recorded as 'type 1' activity, as well as in our ambulatory emergency care units that now accept patients who would previously have been seen in our emergency departments.)
- Emergency admissions increased by 3.8 per cent for the first half of 2017/18 compared with the same period in 2016/17. Admissions have been increasing more rapidly since September 2017. This indicates that while alternatives to hospital admission have had a significant and important impact on reducing the rate of increase in emergency admissions, they are not yet able to provide a sustainable reduction in demand for inpatient care.
- Emergency attendances for patients 65 years and older increased by 5 per cent in the first half of 2017/18 compared with the same period in 2016/17, with an increase in emergency admissions of 2.3 per cent. Overall, patients aged 65 and older accounted for 29 per cent of all emergency attendances and 42 per cent of emergency admissions in the first half of 2017/18, an increase of 1 per cent compared to the same period in 2016/17.

Given these trends, we can currently predict that it will be some years into the future before acute demand has reduced sufficiently for us to look to reduce inpatient bed numbers or A&E capacity.

## **7. Looking to the future**

As with any of the Trust's hospitals, we cannot say that there will never be any change at Charing Cross. What we can say is that we will be open about the challenges and opportunities that face us and will use the insight, views and ideas of our staff, patients, partners and wider stakeholders to help develop the best possible plans for the future.

Change happens in different ways. Transformation in healthcare is often driven by research discoveries or new technology and our Trust has been at the forefront of these sort of developments – not least at Charing Cross. We have pioneered the iKnife, enabling surgeons to know instantaneously whether the tissue they are cutting is cancerous, and we will soon be one of the first centres to offer a 24/7 thrombectomy service, a revolutionary treatment for some types of stroke.

We also learn from insights and service improvements that work elsewhere, such as our initiative with partners to test an 'accountable care' approach with the population in Hammersmith and Fulham. This is where we are working in partnership with local GPs and other health and care providers to create genuinely integrated services that help people stay as healthy as possible and to get fast access to care when it is needed.

Other developments emerge from how we adapt to changing needs and demands. At Charing Cross, for example, we have growing expertise in providing care for frail, older people. Today, there are half a million more people in England aged over 75 than there were in 2010. And there will be 2 million more in ten years' time. No one wants to have an unplanned stay in hospital but for this section of our community, it brings real risks – especially around a rapid loss of functional ability and permanently reduced independence. Yet, more than two fifths of emergency admissions at Charing Cross Hospital are now of

patients aged 70 or more, many with a number of chronic health conditions.

It is particularly important that frail, older people whose health is deteriorating get to the specialist care they need as quickly as possible, bypassing A&E altogether, if possible. Amongst our more recent service developments here is OPRAC – the older person's rapid access clinic - on the ground floor of Charing Cross Hospital. It provides fast, direct access to specialist assessment, diagnostics and treatment. The clinic has established great partnerships with community, social and primary care; it has specially trained, multi-disciplinary staff; and its facilities are tailored for older people with frailty. The team now see an average of 12 patients a week, two fifths of whom are able to avoid a hospital stay.

There are no current plans to sell any land on the Charing Cross Hospital site. If and when we develop proposals for a new hospital building on the Charing Cross site, we would anticipate that the costs would need to be partially funded by selling any land that was surplus to requirements. This is the same approach that we would expect to take at any of our hospitals. There is no plan and has never been a plan to fund the redevelopment of St Mary's Hospital through the sale of land on the Charing Cross site.

A strategic outline case (SOC) 1 is north west London NHS's funding proposal for the changes set out in 'Shaping a healthier future' relating to outer north west London. It does not relate to changes at any of our Trust's hospitals. Funding to support changes relating to our hospitals will be part of a strategic outline case (SOC) 2. The development of SOC2 will require a significant amount of work – including widespread engagement with all of our stakeholders. We do not yet have a clear timeline for this process.

## **8. Summary**

Charing Cross Hospital continues to be a leading provider of acute and specialist care and forms a very important part of Imperial College Healthcare NHS Trust's services and the wider health economy of North West London.

We understand that hospitals are part of the fabric of the community and touch people's lives in many ways – as a staff member, volunteer, patient or visitor. In November 2017, we organised an open door event at Charing Cross Hospital – to mark and celebrate the hospital's past, to share and clarify current plans and to look to the future.

At the open door event, we made it clear that there has been no decline at Charing Cross, despite any uncertainty about its future. One way this is evidenced is in the very significant investment, particularly in the last 18 months, in our buildings and infrastructure. In fact, the most recent Care Quality Commission inspection of Charing Cross, focusing on medical care, saw the hospital's rating progress from 'requires improvement' to 'good'.

Questions and concerns about proposals to change local health services are entirely valid and understandable. We encourage and welcome open discussion, especially with patients and the public. We have to create a shared understanding of the huge challenges we are facing in the NHS - and social care - if we are to address them effectively. We very much wish to work with all of our local authorities as key partners in this endeavour.