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THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

HEALTH, ENVIRONMENTAL HEALTH AND ADULT SOCIAL CARE SCRUTINY COMMITTEE – 27 SEPTEMBER 2012

REPORT FROM THE TRI-BOROUGH EXECUTIVE DIRECTOR FOR ADULT SOCIAL CARE

SHAPING A HEALTHIER FUTURE – CONSULTATION

The NHS started a formal consultation process on major NHS reorganisation in North West London on 2 July 2012. NHS North West London has produced a 'Shaping a healthier future - Consultation document'[1]. A draft consultation response for the Royal Borough of Kensington and Chelsea is set out in Appendix A.

FOR DECISION

1. BACKGROUND

1.1 There are 1.9 million people living in North West London – this covers the eight boroughs (Brent, Ealing, Harrow, Hillingdon, Hounslow, Hammersmith and Fulham, Kensington and Chelsea and Westminster). The NHS in North West London covers nine acute and specialist hospital trusts, two mental health trusts, four community health providers, 423 GP practices and 1,187 GPs. The annual health budget of the NHS in North West London is in the region of £3.4 billion.[2]

1.2 NHS North West London is made up of a 'cluster' of Ealing, Hounslow, Hillingdon, Brent, Harrow, Chelsea and Westminster, Hammersmith and Fulham and Westminster primary care trusts. This is London's largest primary care trust cluster. There are 8 shadow Clinical Commissioning Groups in North West London.

1.3 McKinsey was selected in November 2011 to complete the 'North West London service reconfiguration pre-consultation

[1] Shaping a healthier future - Consultation document http://www.healthiernorthwestlondon.nhs.uk/sites/default/files/documents/Shaping%20a%20healthier%20future%20-%20Consultation%20document_0.pdf

[2] Taken from Dr Mark Spencer's slide presentation to NWL OSC Chairs at the informal meeting with NHS NWL on 16 January 12.

preparation' exercise. McKinsey then developed 'options for acute service configuration but also options for different models of community, mental health and primary care' [3] and drew together other work being done in the sector.

1.4 The NWL cluster in its 'Commissioning Strategy Plan 2012-15'[4] described the proposal for a sector wide service change programme to deliver improved services to patients in NWL. The covering letter to 'NWL Commissioning Intentions 2012-13'[5] (presented to NWL Board in November 2011) said 'In 2012-13, we need a step-change in delivering new models of care in order to address the clinical and financial context and elements of our existing plan that we have not yet made progress with.'

1.5 Projections show the £3.4bn health economy is unsustainable in its current form, with a potential overspend of £1bn by 2015. The plan is to move the local health economy to a more sustainable clinical and financial basis.

2. SHAPING A HEALTHIER FUTURE[6]

2.1 'Shaping a healthier future' is the programme to reorganise healthcare in North West London, including changing the number and functions of the major hospital sites. This will include reducing the number of sites offering A&E and Maternity services.

3. MAJOR HOSPITAL SITES

Current Major Hospital sites

3.1 North West London currently has nine sites providing an A&E service. These are:

- Charing Cross (Imperial College Healthcare NHS Trust)
- Chelsea & Westminster NHS Trust

[3] HSJ article: London cluster to consult on 'ambitious' reconfiguration plans http://www.hsj.co.uk/news/exclusive-cluster-to-consult-on-ambitious-plans-to-make-health-economy-sustainable/5038194.article

[4] NWL Cluster 'Commissioning Strategy Plan 2012-15' is available at: http://www.northwestlondon.nhs.uk/publications/?search=&pct=0&category=1604&pp=20]

[5] 'NWL Commissioning Intentions 2012-13'is available at: http://www.northwestlondon.nhs.uk/publications/?search=&pct=0&category=1604&pp=20]

[6] Shaping a healthier future http://www.northwestlondon.nhs.uk/shapingahealthierfuture/

- Central Middlesex (North West London Hospitals Trust)
- Ealing Hospital NHS Trust
- Hammersmith (Imperial College Healthcare NHS Trust)
- Hillingdon Hospital NHS Trust
- Northwick Park (North West London Hospitals Trust)
- St Mary's (Imperial College Healthcare NHS Trust)
- West Middlesex University Hospital NHS Trust

Five Major Hospital sites[7]

3.2 To deliver the volume of activity needed the consultation options are for five Major Hospitals. Accident and Emergency (A&E) services across NWL are set to be significantly reconfigured. The 'Shaping a healthier future - Consultation document' asks whether there is public support for one of the three options.

Box I: Three options for five Major Hospitals in North West London

Option a – The preferred option

Along with Hillingdon Hospital and Northwick Park, Major Hospitals are:

- Chelsea and Westminster
- St Mary's
- West Middlesex

As a result, Hammersmith would become a specialist hospital (similar to its current status) and Charing Cross downgraded to a local hospital.

Option b

Along with Hillingdon Hospital and Northwick Park, Major Hospitals are:

- Charing Cross
- St Mary's
- West Middlesex

As a result, Hammersmith would become a specialist hospital (similar to its current status) and Chelsea and Westminster would be downgraded to a local hospital.

Option c

Along with Hillingdon Hospital and Northwick Park, Major Hospitals are:

- Chelsea and Westminster
- Ealing
- St Mary's

As a result, Hammersmith would become a specialist hospital (similar to its current status) and Charing Cross downgraded to a local hospital.

We have been informed that, whichever option is chosen, 'all nine hospitals are likely to remain open as hospitals providing, at the least, around 75% of their original activity.'

[7] The consultation document (page 9) defines a major hospital as providing full A&E, emergency surgery, maternity and inpatient paediatric services.

4. JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

4.1 Local Overview and Scrutiny Committees[8] have joined together to form a joint committee to scrutinise the proposals for the NHS in NWL. The first formal meeting of the North West London Joint Health Overview and Scrutiny Committee took place on 12 July at Kensington Town Hall.

4.2 Attendees at JHOSC meetings from the Royal Borough are Councillor Mary Weale and Councillor Charles Williams.

5. CONSULTATION RESPONSE

5.1 Subsequent to the 11 September Public Meeting, a Royal Borough of Kensington and Chelsea consultation response has been produced (Appendix A). Box II summarises the main conclusions.

Box II: Royal Borough of Kensington and Chelsea's main conclusions

Support

We support the clinical case for change and the direction of travel towards improved out of hospital care. For NHS NWL to be able to deliver its plans they have to get the out of hospital part right. **We support the preferred option - Option A.** The Chelsea and Westminster Foundation Trust has a modern hospital building which achieves excellent clinical outcomes on the Fulham Road. It should continue to provide a full Accident and Emergency Service.

Concerns

However, there are a number of concerns for which we seek reassurance:

- That all NHS and Foundation Trusts in NWL post-implementation of the proposals are financially robust.
- That the new system will have sufficient capacity to provide services to what is likely to be a growing and ageing population. This relates to reduction in bed numbers especially but also to out of hospital provision.
- We would like external reassurance that Chelsea and Westminster and St Mary's have the capacity to meet increased demand from A&E closures at other hospitals
- If the A&E Department was to close at Charing Cross we wish to be reassured that there are satisfactory plans for the future use of the Charing Cross site and relocation of specialties currently interdependent with the A&E Service.
- We are concerned at the poor quality of buildings at St Mary's so we would like to see the detail on the plans to build capacity there
- That there were robust plans in place to stop bed blocking and delayed discharge. It is recognised that this Council needs to contribute towards this.
- That the out of hospital recommendations (as set out in section 5) are addressed by NHS NWL. We really want the out of hospital part of NHS NWL's plans to be successful.
- On the timings for the delivery of the programme. What are the triggers for

[8] This includes: City of Westminster, LB Brent, LB Ealing, LB Hounslow, LB Harrow, LB Hammersmith & Fulham, RB Kensington & Chelsea, LB Wandsworth, LB Richmond and LB Camden. It does not include LB Hillingdon.

making changes to the plans if things are not working out as expected?

6. RECOMMEMDATION

6.1 The Health, Environmental Health and Adult Social Care committee is asked to approve the consultation response, as set out in Appendix A (subject to any additional suggested changes the committee wish to add).

6.2 The finalised consultation responses will be sent to the JHOSC to aid them with their deliberations.

6.3 The formal consultation ends on the 8 October 2012. The finalised consultation response can be submitted to: consultation@nw.london.nhs.uk [9]

FOR DECISION

Andrew Webster
Tri-borough Executive Director of Adult Social Care

Background papers used in the preparation of this report: None other than those mentioned through this report.

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[9]Those to be copied into the response include: Leader (RBKC), Tri-borough colleagues (Cabinet Member and Chair HOSC), Dr Anne Rainsberry (London Regional Director, NHS Commissioning Board), Chair (C&W), Chair (ICHT) Chair (WL CCG) and Daniel Elkeles (Accountable Officer for INWL CCGs).

APPENDIX A:

ROYAL BOROUGH OF KENSINGTON AND CHELSEA

CONSULTATION RESPONSE

'SHAPING A HEALTHIER FUTURE IN NORTH WEST LONDON' (NHS REORGANISATION IN NORTH WEST LONDON)

1. BACKGROUND

1.1 We welcome this opportunity to comment on 'Shaping a healthier future - Consultation document'[10] - NHS North West London formal consultation on major NHS reorganisation in North West London (NWL). It is imperative that NHS NWL is able to ensure that all its 1.9 million residents are able to enjoy the best care available, wherever they live.

1.2 This Overview and Scrutiny Committee (OSC) is composed of democratically elected councillors who are in close touch with the views and wishes of people living in the local areas they represent. Its membership represents a body of opinion with considerable experience of health matters. Additionally, a number of our members have had direct experience of working in the health service in various capacities. However, we have taken the view that, as a body, we would not wish to in effect pass a clinical judgement on whether individual hospitals are equipped to deliver a particular service under the proposals.

1.3 On Tuesday 11 September the Royal Borough of Kensington and Chelsea hosted a Special Public Meeting on 'Shaping a healthier future in North West London' in the Small Hall, Kensington Town Hall. There was in excess of 150 people in attendance.

1.4 This response looks in detail at the case for change, the criteria used, acute care, travel and transfers, out of hospital services and future work. Box 1 sets out a summary of our main conclusions.

[10] Shaping a healthier future - Consultation document http://www.healthiernorthwestlondon.nhs.uk/sites/default/files/documents/Shaping%20a%20healthier%20future%20-%20Consultation%20document_0.pdf

Box 1: Royal Borough of Kensington and Chelsea's main conclusions

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- That the new system will have sufficient capacity to provide services to what is likely to be a growing and ageing population. This relates to reduction in bed numbers especially but also to out of hospital provision.
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- We are concerned at the poor quality of buildings at St Mary's so we would like to see the detail on the plans to build capacity there
- That there were robust plans in place to stop bed blocking and delayed discharge. It is recognised that this Council needs to contribute towards this.
- That the out of hospital recommendations (as set out in section 5) are addressed by NHS NWL. We really want the out of hospital part of NHS NWL's plans to be successful.
- On the timings for the delivery of the programme. What are the triggers for making changes to the plans if things are not working out as expected?

2. CASE FOR CHANGE AND CRITERIA USED

Case for change

2.1 On 30 January 2012, NHS North West London released 'Shaping a healthier future - Case for Change'[11]. NHS NWL presents a compelling case why NWL's health services must change. Clinical quality is a major factor in the 'case for change'. Box 2 sets out highlights from the 'case for change'.

Box 2: 'Shaping a healthier future - Case for change' includes[12]

- NHS North West London has a £3.4 billion annual health budget and needs to find £1 billion of required savings by 2014/15.
- Some local units are already having to reduce the hours they are open because not enough clinical staff, of the right level and expertise, are available.

[11] 'Shaping a healthier future - NHS North West London - Case for Change (30 January 2012)' is available at:
http://www.northwestlondon.nhs.uk/shapingahealthierfuture/

[12] All these facts were taken from 'Newsletter 1: Shaping a healthier future - Service change in North West London (31 January 2012)' available at:
http://cavsacommunity.posterous.com/shaping-a-healthier-future

- Fewer than half of emergency general surgery admissions in London are reviewed by a consultant within 12 hours.
- 130 extra lives could be saved each year in North West London if better consultant cover could be provided at A&Es on weekends.
- In some NW London hospitals, more than half of staff do not recommend them as a place to work or to be treated.
- No maternity services in North West London score more than the national average in terms of care during labour and birth, postnatal care, and support for breastfeeding.
- Six of the eight boroughs in NW London are in the bottom 10% nationally for patient satisfaction with out-of-hours GP service.
- Life expectancy in different parts of NW London varies by as much as 17 years.
- We are living longer but not always healthier; there is an increasing prevalence of lifestyle-related diseases that, if we can't prevent, we need to manage better.

2.2 Many of the reasons for reform are not new, and past attempts to address these and reform NWL's health services have failed. We are alarmed that the healthcare system in North West London has been allowed to deteriorate (as reflected in the 'Case for Change') despite its problems having been known about for many years.

Institutional inertia

2.3 The NHS must be bold and make difficult decisions about much loved institutions. Furthermore, care must be designed around the needs of the patient and not those of NHS institutions. To deliver a truly 'patient centred' NHS, all reforms must improve access to, and the accessibility of, health services.

Criteria for NHS reconfigurations

2.4 The Secretary of State identified four key tests for service change[13], which are designed to build confidence within the service, with patients and communities.

2.5 We are pleased that clinicians have a major role in developing proposals, and expect them to be involved in explaining to the public that proposals strive to improve patient care rather than save money.

2.6 We consider that the criteria used to develop the proposals are fundamentally sound. We are able to support the direction of travel underlying the consultation paper.

[13] NHS Chief Executive Sir David Nicholson outlined the criteria for NHS reconfigurations in the letter 'NHS Reconfiguration guidance' available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_117899

2.7 Whatever option is finally chosen for changing the NHS in NWL, we believe the remaining trusts must be financially sound.

3. ACUTE CARE

Major hospital re-organisation

3.1 NHS NWL has proposed options with five Major Hospitals. No sites are reported to currently have the capacity to deliver the volume of activity needed with less than five major hospitals. The most favoured hospital configuration (Option A), based on quality of care, transport, value for money and quality of estate was continuing Major Hospitals at: Chelsea and Westminster; Hillingdon; Northwick Park; St Mary's; and, West Middlesex. As a result, this would mean a cessation of major, acute services (24/7) at Ealing Hospital, Hammersmith Hospital, Charing Cross Hospital and Central Middlesex Hospital. The consultation also proposes that the Western Eye moves to St Mary's.

3.2 The implementation plan suggests changes to acute provision could be completed in full by March 2016.

Chelsea and Westminster Hospital

3.3 In the course of our committee's deliberations we have visited the Chelsea and Westminster Hospital to gain a better understanding of how the Foundation Trust will respond and accommodate the NHS NWL's proposals if Option A is chosen. We looked at capacity at the Chelsea and Westminster and discussed the potential at the site for expanding A&E and for the provision of extra beds. We have heard how they wish to positively respond to NHS NWL's Option A. Professor Sir Christopher Edwards, Chairman, Chelsea and Westminster Hospital NHS Foundation Trust, told the 11 September meeting at Chelsea and Westminster had 'Clear plans for the development of A&E.'

Centralising specialist care

3.4 We broadly support the principle to centralise specialist care where this will lead to improved clinical outcomes.

3.5 We agree with NHS NWL's clinical case for reducing the number of major acute hospitals in North West London to five.

3.6 However, we will not give blanket approval to all the proposals for centralising specialist care as we would have to examine the clinical benefits of each particular proposal.

3.7 We are concerned that the care for people with multiple health needs (often referred to as 'co-morbidities') are not adversely affected by the increased specialisation of hospital care. We recommend that NHS NWL clearly outlines how people with multiple health needs are affected by the changes.

3.8 Having considered all the evidence we support Option A (subject to concerns expressed elsewhere). This option has serious ramifications for Charing Cross Hospital.

Charing Cross Hospital and St Mary's Hospital

3.9 Councillor Linda Wade asked about the future of Charing Cross Hospital at the 11 September meeting. Dr Tim Spicer, Medical Director, Shaping a healthier future programme, told the meeting that if Option A is accepted Charing Cross will become a 'local hospital'. If this was to happen complex elective surgery and complex elective medicine would close at the Charing Cross and need to be moved elsewhere.

3.10 Councillor Robert Freeman asked questions on: (1) the future of the specialist services currently provided at Charing Cross; (2) the suitability of the built environment at St Mary's if specialist services are to be transferred there.

3.11 Imperial College Healthcare Trust has substantial infra-structure constraints (e.g. Imperial has significant financial problems, they are not a foundation trust and the majority of the St Mary's estate is old and in many cases unsuited for contemporary patient care needs). For Imperial to cope with the influx of these specialised departments there will need to be substantial funding made available to increase and improve the physical infrastructure.

3.12 Dr Julian Redhead, Clinical Programme Director, Medicine, Imperial College Healthcare NHS Trust, responded by talking about the benefits of co-location of service on the St Mary's site, which would improve services/outcomes for patients.

3.13 Mr Brendan Farmer, Director of Strategy at Imperial College Healthcare, said there was a large amount of space at Imperial that could be redeveloped, the financial situation at

Imperial was improving and it was hoped in time to move to Foundation Trust status.

3.14 We believe patient care must not be downgraded if/when Charing Cross departments - such as hyper-acute stroke care, neurology, elective orthopaedics, rheumatology – are moved. We would like to see the detail of the future plans for all the specialist services currently based at Charing Cross.

3.15 We would also like to see more detail on the plan for the Charing Cross site. We note 'recommendation 3' of the Health Gateway Review[14] was 'Develop and agree the future vision for the Charing Cross site, with the engagement of local clinicians, prior to consultation.'

Emergency care

3.16 The report, 'Acute medicine and emergency general surgery – case for change'[15] pointed out that there were many avoidable deaths in emergency care due to understaffing. The report pointed to 'stark' differences in consultant hours across hospitals at evenings and weekends, and named those with the patchiest cover. We support NHS NWL's actions to tackle the problems caused by understaffing in emergency care.

3.17 We note 'recommendation 6' of the Health Gateway Review[16] was 'Clarify the service models for Urgent Care Centres and Accident & Emergency Departments.'

Bed capacity

3.18 The implementation plan suggests that if they are chosen as Major Hospitals: St Mary's would need 62 new beds, West Middlesex 58 and Chelsea and Westminster 9.

3.19 The OSC has visited Chelsea and Westminster to find out more about their plans. They told us they were planning 30 extra beds and gave their reassurance that they will be able to deliver their new beds. Chelsea and Westminster is planning to increase capacity but we still need reassurance that they will be able to cope with the additional admissions

[14] A Health Gateway Review 0: Strategic assessment was carried out on NHS North West London Shaping a Healthier Future in April 2012 (It reported on 4 May 2012).
[15] HSJ: 500 avoidable deaths a year in London due to understaffing http://www.hsj.co.uk/exclusive-500-avoidable-deaths-a-year-in-london-due-to-understaffing/5034589.article
[16] A Health Gateway Review 0: Strategic assessment was carried out on NHS North West London Shaping a Healthier Future in April 2012 (It reported on 4 May 2012).

resulting from a larger A&E without reducing the availability of the hospital for non A&E admissions. We would also like to know more about the plans for 62 new beds at St Mary's (in addition to all services transferred from Charing Cross). How will they deliver their contribution to NHS NWL's plans?

Hyper-Acute Stroke Unit

3.20 In 2009 it was obvious the hyper-acute stroke unit should be co-located with the major trauma unit, like all the major trauma units in London. During the consultation RBKC's OSC wrote, 'The OSC supports the proposal for a hyper acute stroke centre to be based at St Mary's hospital alongside a major trauma centre. Healthcare for London should again clearly articulate the need and benefits of co-location on the St Mary's site to the relevant commissioners and Imperial Healthcare NHS Trust.'[17] We question the decision-making that placed the hyper-acute stroke unit at Charing Cross Hospital for such a short time.

Paediatrics services

3.21 The issue of paediatrics came up a couple of times at 11 September meeting. We would like more detail on future plans for paediatrics services.

3.22 Professor Sir Christopher Edwards, Chairman, Chelsea and Westminster Hospital NHS Foundation Trust, told meeting that the Chelsea and Westminster were to make major investment in paediatrics and so all services will be provided from the 1st floor of the hospital.

Maternity services

3.23 NHS NWL's Case for Change highlighted the poor maternity service in NWL. More than 100 mothers have died in childbirth in London in the last five years, twice the rate in the rest of the country.[18] Two inquiries have been held into the high

[17] Overview and scrutiny committee on health - 18 March 2009 http://www.rbkc.gov.uk/COMMITTEES/Document.ashx?czJKcaeAi5tUFL1DTL2UE4zNRBcoShgo=d786M36KuepWa9SZOICDyY6qo3MQJCRiI64uEHiL6UeEu7MFehVWqA%3d%3d&mCTIbCubSFfXsDGW9IXnlg%3d%3d=hFflUdN3100%3d&kCx1AnS9%2fpWZQ40DXFvdEw%3d%3d=hFflUdN3100%3d&uJovDxwdjMPoYv%2bAJvYtyA%3d%3d=ctNJFf55vVA%3d&FqPlIEJYlotS%2bYGoBi5olA%3d%3d=NHdURQburHA%3d&d9Qjj0ag1Pd993jsyOJqFvmyB7X0CSQK=ctNJFf55vVA%3d&WGewmoAfeNR9xqBux0r1Q8Za60lavYmz=ctNJFf55vVA%3d&WGewmoAfeNQ16B2MHuCpMRKZMwaG1PaO=ctNJFf55vVA%3d

[18] Independent: Doubling of maternal death rate blamed on shortage of midwives http://www.independent.co.uk/life-style/health-and-families/health-news/doubling-of-maternal-death-rate-blamed-on-shortage-of-midwives-7689172.html

maternal death rate in London in the last four years and both have found maternity services wanting compared with the rest of the UK.

3.24 The Care Quality Commission report 'Our Market Report'[19] (June 2012) pointed out midwife numbers are not increasing in line with demand at a number of maternity services in London. NHS NWL could re-examine the allocation of funding for midwifery and commits appropriate expenditure.

3.25 We note 'recommendation 8' of the Health Gateway Review[20] was 'Clarify the service model for Maternity services.'

3.26 The NHS NWL's pre-consultation business case only considers home or hospital births. However, the recent Birthplace Study found freestanding midwifery units are both safe and clinically and cost-effective.

3.27 NHS NWL must ensures that there is a range of birthing options available to meet varying local need, one option is freestanding midwifery unit for low risk women.

Mental health

3.28 Two questions were raised about the impact of proposals on mental health services at the 11 September meeting. We recommend that NHS NWL clearly articulates how it will ensure sufficient resources will be allocated to meet the challenges facing NWL's mental health services.

Workforce

3.29 The major changes proposed will require professionals to acquire new skills and work differently; notably many current hospital nurses could be required to transfer to the community setting.

3.30 There is a danger that the Major Acute Hospital and specialist units may have a magnet effect, drawing the more experienced and better trained staff away from other NHS services.

[19] CQC: Our Market Report (28 June 2012) http://www.cqc.org.uk/media/cqc-publishes-first-full-analysis-performance-and-risk-health-and-social-care

[20] A Health Gateway Review 0: Strategic assessment was carried out on NHS North West London Shaping a Healthier Future in April 2012 (It reported on 4 May 2012).

3.31 We recommend that NHS NWL publish a workforce strategy that will enable the delivery of any changes to health services. This should include the exploration of flexible working arrangements, allowing opportunities for staff rotation within, and between, networks.

Nursing in hospital

3.32 We note that hospital trusts in London have been advised they can safely cut spending on nursing staff, in some cases by 50%, according to reports obtained by Nursing Times.[21] NHS London suggests 'aligning staffing levels with clinical need' and reducing agency spend. Nursing Times obtained the NHS London's trust-by-trust breakdowns of where it sees the potential for nursing budget reductions, following a freedom of information request. The suggested savings include: £54m at Imperial College Healthcare Trust.

3.33 We seek a reassurance that any planned changes to the nursing workforce in NWL is not going to negatively impact on the quality of care and patient mortality rates.

4. TRAVEL AND TRANSFERS

4.1 A gentleman raised a question about transport times at the 11 September meeting.

Travel arrangements

4.2 If ill people have to travel further it takes time, it costs money. If people choose not to do so they might get ill and die earlier. Some relatives, friends and carers will have to travel greater distances to a hospital destination.

4.3 With the preferred option there will be increased activity around the major hospital sites: Chelsea and Westminster; Hillingdon; Northwick Park; St Mary's; and, West Middlesex. This will need to be carefully accommodated/managed.

4.4 Every hospital should have updated travel plans, developed in liaison with Transport for London (TfL) and the relevant local authority (ies). This should include provision of clear travel information and car parking.

[21] Nursing Times (3 April 12): Trusts in London told they can slash nurse budgets by up to half http://www.nursingtimes.net/exclusive-trusts-in-london-told-they-can-slash-nurse-budgets-by-up-to-half/5043366.article?blocktitle=Latest-news&contentID=6840

Cross-border co-ordination

4.5 North West London is not a self-contained entity, and patients travel in either direction across the boundary to receive NHS care. We recommend that NHS NWL works closely with colleagues from the surrounding area and NHS London to explore the implications of any reforms on patients crossing boundaries.

4.6 NHS Clusters and Ambulance Services serving areas adjacent to North West London's borders need to be fully involved in forward planning for the new arrangements. Joint working 'across the borders' will need to be undertaken to produce transfer protocols which will provide clarity to Ambulance Services and hospitals.

London Ambulance Service

4.7 Centralisation of specialist care may involve critically ill or injured patients spending longer in ambulances. We understand, where appropriate for better care, the ambulance service will bypass hospitals to go to better specialist services provided elsewhere. However, the need for additional and longer journeys must not impact negatively upon the service provided to other emergency patients.

4.8 We recommend that the London Ambulance Service (LAS) and TfL are involved from the outset in developing proposals for specialist care in order to advise on travel times. NHS NWL must work with these organisations to agree the updating of travel plans to underpin any expansion of a hospital's services.

4.9 Any centralisation of specialist care should only take place once the LAS receives the necessary resources for additional vehicles and training that these new care pathways will require. These resources will need to be available on a continuing basis to ensure that training in the best triage methods is offered by paramedics at scene.

Transfers

4.10 Traditionally, transfers between hospitals (and from hospital to community-based care) have not been an area of strength. This can result in distress to the patient (and their relatives, friends and carers), and can adversely affect recovery.

4.11 It is important that the proposed new arrangements for transfer from specialist centres to Major Acute Hospitals, and from Major Acute Hospitals to community, operate smoothly from inception. Patients need to be transferred at the clinically correct time, and robust protocols will need to be in place to ensure smooth transfers between hospitals, and an adequate bed base to cope with demand. Patients and their carers should have arrangements explained clearly to them.

4.12 We recommend that clear clinical and administrative protocols for the transfer of patients are agreed with all relevant service providers, and established before the new systems go 'live'. We also recommend that there are systems in place for monitoring transfer arrangements, to allow early corrective action to be taken where necessary.

5. OUT OF HOSPITAL

5.1 The importance of getting out of hospital services right was stressed on several occasions at the 11 September meeting. An improvement in out of hospital services will lead to a significant improvement in people's health. We fully support the focus on out of hospital and all the analysis showing the work needed to improve out of hospital services.

Large scale move to primary/community care

5.2 NHS NWL's plans for A&E activity is to reduce the level across NWL to about 70 per cent of what it is now (Pre-Consultation - Business Case[22]).

5.3 The implementation plan claims out of hospital improvements will reduce the need for 391 acute beds.

5.4 The proposed move from acute to primary/community care is predicated on the success of: prevention; new out of hospital services; and, integrated care services. The next three sections of this response will look at these subjects in turn.

5.5 Given the scale of the shift to the community, NHS NWL should have given far more thought to social care. A whole-systems approach needs to be taken. We are particularly concerned about the lack of understanding of the financial

[22] Pre-Consultation - Business Case
http://www.northwestlondon.nhs.uk/publications/?category=4924-Shaping+a+healthier+future+-+Pre+Consultation+Business+Case+-+21+June+2012-d

impact of the proposals on social care. Section 6 of this response will look at finance.

Prevention

5.6 The main focus of the consultation proposals is heavily upon achieving clinical outcomes. Much of NHS NWL's plan is to ensure patients receive high quality care once they become sick. The pathways and working groups all have had a medical/ill-health focus.

5.7 We would like to underline the crucial role of prevention in the broader healthcare context. Intervention 'upstream' can prevent the need for hospital treatment later. Increasing the public's awareness of healthy lifestyles and tackling the root causes of ill-health is crucial. Such as an increased provision of 'plain English' advice aimed at promoting a better understanding of the personal health factors (e.g. lack of exercise, smoking, eating too much of the 'wrong' sort of foods) which may contribute to a greater likelihood of ill-health. The benefits to society, individuals, and in terms of long-term cost-effectiveness, cannot be over-emphasised.

5.8 We recommend a long-term strategy to promote healthy, sensible lifestyles, particularly among the young, should be developed for the NHS in NWL, in collaboration with local government (inc. Public Health). More joint working could take place between NHS and local authorities around the promotion of healthy lifestyles.

Helping people stay out of hospital

5.9 We also need to do more to support people to take control of their own health conditions. NHS and social care staff working in the community can help people manage their long-term conditions and prevent the need for emergency hospital admission. Sufficient resources will be required to fund key professionals who provide rehabilitation and treatment in the community following the proposed (by NHS NWL) earlier discharge from hospital.

5.10 We recommend the NHS in NWL should ensure a suitable investment is made in rehabilitation and prevention in order that the benefits to acute-end care can be maximised.

New out of hospital services

5.11 We agree that North West Londoners could benefit from the provision of a broader range of services in the community. We are fully supportive of the move to provide more services out of hospital. A description of the CCG Out of Hospital strategies is contained in Box 3. NHS NWL need to ensure change improves the accessibility of health and social care services and the physical access to facilities where these are provided.

Box 3: Out of Hospital Strategies[23]

NWL NHS has developed four out of hospital 'quality standards':

1. Individual Empowerment & Self Care - Individuals will be provided with up-to-date, evidence-based and accessible information to support them in taking personal responsibility when making decisions about their own health, care and wellbeing
2. Access, Convenience & Responsiveness - Out-of-hospital care operates as a 7 day a week service. Community health and care services will be accessible, understandable, effective and tailored to meet local needs. Service access arrangements will include face-to-face, telephone, email, SMS texting and video consultation.
3. Care Planning & Multi-Disciplinary Care Delivery - Individuals using community health and care will experience coordinated, seamless and integrated services using evidence-based care pathways, case management and personalised care planning. Effective care planning and preventative care will anticipate and avoid deterioration of conditions
4. Information & Communication - With an individual's consent, relevant parts of their health and social care record will be shared between care providers. Monitoring will identify any changing needs so that care plans can be reviewed and updated by agreement. By 2015, all patients will have online access to their health records

Out of Hospital Strategies are being developed by each of the clinical commissioning groups (CCGs) in the NWL sector to turn aspiration, as set out in the standards, into action. Developing themes include:

- Easy access to high quality, responsive care to make out-of-hospital care first point of call for people
- Clearly understood planned care pathways that ensure out-of-hospital care is not delivered in a hospital setting
- Rapid response to urgent needs so fewer people need to access hospital emergency care
- Providers working together, with the patient at the centre to proactively manage Long Term Conditions, the elderly and end of life care out-of-hospital
- Appropriate time in hospital when admitted, with early supported discharge into well organised community care

CCG out-of-hospital care strategies will need to deliver (from the implementation plan):

- A reduction in demand for acute services, which will enable the proposed changes to acute sites to take place Improvements in urgent care, with Urgent Care Centres (UCCs) in place on all local hospital sites and all UCCs operating at the level of the best UCCs in NW London – treating minor illnesses and injuries and therefore delivering around 70% of former A&E activity
- Improvements in access to care, with out of hospital care operating a 24 hour, 7 days a week service, with practices working in networks, and community and social services aligning provision to these networks
- New ways of working with staff organised within multi-disciplinary groups across providers to deliver improved, integrated care for patients
- A clinician-led system for making sure that out of hospital standards are consistently met by all providers, regardless of type, size or location.

[23] Taken from Powerpoint presentation found at:
http://www.northwestlondon.nhs.uk/shapingahealthierfuture/

Standards

5.12 The standards suggested by NHS NWL should be weighted more heavily towards the quality of the care (this is actually being delivered) rather than on providing information. For example there could be standards to ensure clinical quality, the availability of quality facilities and an able workforce.

5.13 If the 4 standards, plus savings and activity impact, are to be used as the basis to develop a set of performance matrixies we suggest you also add - what actually happens to health outcomes.

CCG Out of Hospital strategies are still at too high a level

5.14 The implementation plan suggests out of hospital improvement work needs to start immediately and be complete by the end of March 2015. We agree with the Shadow Joint Health Overview and Scrutiny Committee (JHOSC) and Health Gateway Review that much more detail on action is needed:

- When the Shadow JHOSC fed-back on NHS NWL's Draft Consultation Document they said, 'It is vital to include detail on the out of hospital strategy in the document as the proposed reconfiguration will rely on it if it is to be successful.'
- Recommendation 7 of the Health Gateway Review[24] was 'Provide more detail on proposed Out of Hospital services with a focus on implementation.'

5.15 We recommend NHS NWL provides far more detail on the implementation of the Out of Hospital service. CCGs need to set out detailed implementation plans for their Out of Hospital Strategies.

Integrated Care

5.16 We agree that North West Londoners could benefit from a move to more integrated care. The early results from the integrated care pilot are promising.[25] However, it has not yet been fully evaluated.

[24] A Health Gateway Review 0: Strategic assessment was carried out on NHS North West London Shaping a Healthier Future in April 2012 (It reported on 4 May 2012).
[25] The 'early signs of success' of the NWL integrated care pilot can be found in the BMJ article, 'Integrated care: a story of hard won success' (31 May 2012) available at: http://www.bmj.com/content/344/bmj.e3529

5.17 It is unusual to roll-out a service before the pilot has been fully assessed.

5.18 Much of plans in 'Shaping a healthier future' have been predicated on success coming from roll-out of integrated care in NWL:

- The consultation document highlights, 'The GP practices taking part in the pilot have so far reduced emergency admissions to hospital for elderly people by 7% and have created 20,000 individual care plans for their patients.' (Page 21 of the consultation document)
- The financial model predicts large savings.

5.19 When integrated care pilots have been evaluated there has been 'no evidence of the anticipated reduction in emergency admissions' and 'no significant impact of the pilots on secondary care costs.' Details on the Department of Health's evaluation is set out in Box 4.

Box 4: Report on evaluation of integrated care pilots[26]

National evaluation of Department of Health's integrated care pilots This two-year study, commissioned by the Department of Health, looked at 16 sites across England which formed the Integrated Care Pilot programme. The research carried out by Ernst & Young, RAND Europe and the University of Cambridge considered the impact of better integrated care on elderly people at risk of emergency hospital admissions and the treatment of conditions including dementia and mental health problems. It analysed staff and patient views on the work of the pilots as well as the impact on hospital admissions and length of stay.

The research found no evidence of the anticipated reduction in emergency admissions for patients who received an intervention. Balancing the unanticipated persistence of emergency admissions, there were reductions in outpatient attendances, which may have been due to moving services into primary care settings, an aim of several of the sites. Reasons for the observed reduction in elective admissions (especially in chemotherapy for cancer) are less clear. Taking these changes together, there was no significant impact of the pilots on secondary care costs.

In conclusion, integrated care activity throughout the 16 pilot sites has to date resulted in changes to the delivery of care that have led to improvements in staff experience and organisational culture. The interventions had high appeal to staff involved, and it is suggested that if continued they may bring about improvements in outcomes relating to patient care and longer-term cost savings.

5.20 We question the assumption that the roll-out of the INWL integrated care pilot across the whole of NWL will give the level of benefits predicted (i.e. an assumption that emergency admissions to hospital for elderly people will be reduced by 7%).

[26] DH: Report on evaluation of integrated care pilots (DH, 22 Mar 12) http://www.dh.gov.uk/health/2012/03/report-on-evaluation-of-integrated-care-pilots/

Social care 'marginal' to integrated care schemes with NHS

5.21 We note social care professionals were 'marginal' to flagship government integrated care pilots designed to integrate support for people with long-term conditions.[27] Most of the 16 integrated care pilots concentrated on joining up different parts of the NHS with no change in the role of social care in providing support. This is despite the pilots being targeted at improving care for people with social care needs, including those with dementia, other mental health problems, end-of-life care needs, substance misuse and other long-term conditions.

5.22 'Most of the pilots focused on the integration between primary and secondary care, with social care often playing a marginal role in the wider integrated care agenda,' said the evaluation. 'In fact, the role of social care in integration had been regarded as unchanged for most sites.'

Joint Working

5.23 Sustainable reform will require effective partnerships with local authorities - as the distinction between 'health' and 'social' care becomes increasingly blurred. Barriers to good joint working should not be erected. We recommend the three local boroughs should look at jointly commissioning appropriate services with the NHS across all three boroughs.

5.24 The NHS and local authorities must work together in partnership, and steps must be taken to prevent partners working to different (and potentially conflicting) priorities. Disagreements about who pays for which aspects of care can undermine patient well-being. Partners must have a shared understanding of their required contribution to avoid disputes over 'cost-shunting' (see next section on finance).

5.25 Health and wellbeing boards will develop a high-level joint health and wellbeing strategy that spans the NHS, social care, public health, and could potentially consider wider health determinants. The values underpinning a good strategy, taken from paragraph 5.7 of the Draft Guidance[28], are set below.

[27] DH: National evaluation of Department of Health's integrated care pilots http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_133124

[28] Draft guidance on joint health and wellbeing strategies http://healthandcare.dh.gov.uk/draft-guidance/

Box 5: Values that underpin good joint health and wellbeing strategies

The values are:

- setting shared priorities based on evidence of greatest need
- setting out a clear rationale for the locally agreed priorities and also what that means for the other needs identified in JSNAs and how they will be handled with an outcomes focus
- not trying to solve everything, but taking a strategic overview on how to address the key issues identified in JSNAs, including tackling the worst inequalities,
- concentrate on an achievable amount – prioritisation is difficult but important to maximise resources and focus on issues where the greatest outcomes can be achieved
- addressing issues through joint working across local the local system and also describing what individual services will do to tackle priorities
- supporting increased choice and control by people who use services with independence, prevention and integration at the heart of such support.

5.26 We recommend health and social care professionals work more closely together to both improve outcomes and reduce the costs of care for people whose needs cut across both sectors. Health and Wellbeing Boards need to take the initiative to increase joint commissioning between of local authority and CCG - to better coordinated care which promotes independence and avoids costly hospital admissions. Joint Health and Wellbeing strategies need to be focused on affecting real change rather than explaining what already exists.

Finance

5.27 The figures for the reduction in acute services are optimistic unless there is substantial investment in primary/community care.

5.28 In section 6.3 'Recurrent investment to transform out of hospital services' (Chapter 6 - Financial base Case – version 4) it says 'Based on 3 year planning assumptions regarding the overall scale of the change, investment of around £105-£120 million has been allocated.' [*However, in the accompanying picture the figures used are £84m + £54m contingency = £138m.*]

5.29 Then the document goes on to say, 'The £80-£90 million [*presumably the £84m figure*] relates to the transitional funding that each CCG has identified that they need. The £25-30m other investment relates to costs to support delivers of Out of Hospital standards, inducing increased primary care access, care planning, IT etc. This £25-30m figure is based on the sum of all the CCG plans.

5.30 The CCGs have estimated the additional investment required in Out of Hospital care to meet the new Quality Standards agreed by local clinicians. These are based on 'high level assumptions'. Additionally some of the investment planned will overlap with existing CCG investment.

5.31 The investment in Out of Hospital care to meet Quality Standards is planned as £25-£30 million, split across the standard domains as follows:

- Access, convenience and responsiveness ~ £12-15 million
- Care planning and multidisciplinary care ~ £10-£12 million
- Individual empowerment ~ £1 million
- Information and communication ~ £2 million'

5.32 It is unclear whether the sums to be provided will be adequate to address all aspects of implementation, allowing for unforeseen circumstances, and possible areas of additional expenditure. Under-funding of the proposals could serve to seriously undermine NHS NWL's aspirations.

5.33 We recommend that the NHS ensures that 'the money follows the patient' and resources are reallocated from acute trusts to primary and social care to reflect changes in the way that patients are treated.

Social Care

5.34 The plans will have a major impact on social care. NHS NWL should have quantified the impact on social care.

5.35 North West London Health Scrutiny Chairs and support officers met with NHS NWL on 29 February. A Tri-borough officer categorically stated to Dr Anne Rainsberry (now Regional Director [London], NHS Commissioning Board) that the financial modelling should be for health and social care because only then would the impact on social care be quantified.

Question: (1) What is the financial impact of NHS NWL's proposals on social care? If not quantified, why not? How have NHS NWL factored in any increased burden on social care? (e.g. paying for the additional costs be put upon local authorities)? How does NWL NHS know this level of funding is appropriate? What level of social care do NHS NWL require to make their plans work? (2) Underfunding in social care could

lead to costs being shunted to the NHS in NWL, has this been quantified?

5.36 We recommend that the proposals for NWL's health services, fully quantify the impact on social care services. The NHS need to ensure that local authorities are funded for any increased demands for social care services following on from the proposed reductions in hospital treatment.

Other out of hospital comments

Access to Primary Care Services

5.37 The Royal College of Physicians has called for 'access to primary care to be improved so patients can see their GP out of hours, relieving pressure on A&E services'.[29] The General Medical Council has reported a record number of complaints about doctors.[30] We recommend the improvement of access for residents at GPs and other local primary care services - to a high quality. Patients need to be able to be seen more quickly at a time convenient to them.[31] All health professionals promote patient-centred care and treat all patients with dignity at all times.

Carers

5.38 Greater health and social care in the community will place additional demands on unpaid carers. We recommend NHS NWL analyse the impact of their proposals on carers, and state the actions that they will take to ensure their proposals do not increase the burden on this often 'hidden army' of dedicated individuals.

Workforce

5.39 The major changes proposed will require professionals to acquire new skills and work differently; notably many current hospital nurses could be required to transfer to the community setting. We recommend NHS NWL publish a

[29] The RCP report on 'Acute hospital care could be on the brink of collapse' (13 September 12) is available at: http://www.rcplondon.ac.uk/press-releases/acute-hospital-care-could-be-brink-collapse-warns-rcp

[30] Independent (18 September 12): Complaints about doctors reach record high http://www.independent.co.uk/life-style/health-and-families/health-news/complaints-about-doctors-reach-record-high-8151975.html

[31] Almost a quarter of Britons would not see a doctor for a complaint because of the hassle of getting an appointment, according to Cancer Research UK. Independent (18 September 12): http://www.independent.co.uk/life-style/health-and-families/health-news/public-putting-off-visiting-gps-8151973.html

workforce strategy that will enable the delivery of the proposed changes to the health and social care services. Resources for workforce development must not be diverted in these times of financial difficulty. We suggest flexible working arrangements are explored, allowing opportunities for staff rotation within, and between, networks.

Planning longer-term care pathways

5.40 Adult Social Care need to be engaged fully in developing plans for a seamless care pathways, following front-end clinical treatment. We recommend there is early involvement of hospital social work teams in planning longer-term care pathways.

6. FUTURE WORK

Timing of delivery

6.1 A number of questions were raised on 11 September about the timing of the delivery of the proposals. Dr Susan LaBrooy, Medical Director, Shaping a healthier future programme, told us that delivery would be 'over the next 5 years'. The implementation plan suggests changes to acute provision could 'be completed in full by March 2016'. We seek clarity on the timings of the delivery of the different parts of NHS NWL planned actions.

6.2 The timetable for implementation of the proposals is a challenging one. It will be critically important to ensure that the transition period is managed well, and that the service to patients does not suffer.

6.3 The plan for NWL includes specialists, acute hospitals, community health services, mental health and prevention of ill-health. It is a master plan that encompasses everything. 'Big bang' reform can be risky, and 'teething problems' with new health services could have fatal consequences. We recommend that a staged approach is undertaken to implementing new care pathways. Results must be evaluated with learning fed into any subsequent roll-out.

6.4 The scope 'for change' to be built into the plans was raised when Cllr Louis Mosley asked about the possibility, or not, of phasing in the delivery (e.g. changing proposals depending on the early successes/failures).

6.5 A detailed action plan will need to be drawn up which sets out measures to ensure the new networks are achieved. The action plan will need to include contingency provisions covering steps that would need to be taken if arrangements fail.

Financing the change over

6.6 We have not heard whether additional 'pump-priming' resources will be available to run the existing services at the same time as pilot pathways are developed and tested. The new services that support patients need to be in place and operating effectively before any changes or closures of existing units are made.

Monitoring and Evaluation

6.7 The consultation proposals are far-reaching in reshaping services in North West London, and there is clearly a need for their implementation to be carefully scrutinised.

6.8 We recommend that NHS NWL ensures there are robust arrangements for data collection and analysis in place by December 2012.That the proposed changes are monitored closely, in order to identify the impact on service provision, health outcomes, patient experience, and to ensure that other services provided have not experienced an adverse impact. We would expect a review report on the findings to be published 12 months after implementation.

7. CONCLUSION

7.1 In conclusion, we support the clinical case for change and the direction of travel towards improved out of hospital care. For NHS NWL to be able to deliver its plans they have to get the out of hospital part right.

7.2 **We support the preferred option - Option A.** The Chelsea and Westminster Foundation Trust has a modern hospital building which achieves excellent clinical outcomes on the Fulham Road. It should continue to provide a full Accident and Emergency Service.

7.3 However, there are a number of concerns for which we seek reassurance:

- That all NHS and Foundation Trusts in NWL post-implementation of the proposals are financially robust.
- That the new system will have sufficient capacity to provide services to what is likely to be a growing and ageing population. This relates to reduction in bed numbers especially but also to out of hospital provision.
- We would like external reassurance that Chelsea and Westminster and St Mary's have the capacity to meet increased demand from A&E closures at other hospitals
- If the A&E Department was to close at Charing Cross we wish to be reassured that there are satisfactory plans for the future use of the Charing Cross site and relocation of specialties currently interdependent with the A&E Service.
- We are concerned at the poor quality of buildings at St Mary's so we would like to see the detail on the plans to build capacity there
- That there were robust plans in place to stop bed blocking and delayed discharge. It is recognised that the Council needs to contribute towards this.
- That the out of hospital recommendations (as set out in section 5) are addressed by NHS NWL. We really want the out of hospital part of NHS NWL's plans to be successful.
- On the timings for the delivery of the programme. What are the triggers for making changes to the plans if things are not working out as expected?

7.4 Our experience of the consultation process delivered by NHS NWL has been a positive one. We wish to be kept informed throughout the delivery of the 'Shaping a Healthier Future in North West London' programme and given an early indication if plans did not progress as hoped.

Councillor Fiona Buxton Cabinet Member for Adult Social Care, Public Health and Environmental Health *Royal Borough of Kensington and Chelsea*	**Councillor Mary Weale** Chairman, Health, Environmental Health and Adult Social Care Scrutiny Committee *Royal Borough of Kensington and Chelsea*