Joint Health Overview & Scrutiny Committee (JHOSC)

Minutes

Tuesday 4 September 2012

PRESENT

Committee members:
Councillors Lucy Ivimy (Chairman)
Ms Maureen Chatterley (LB Richmond, Co-opted Scrutiny Committee Member)
Councillor Sheila D'Souza (City of Westminster)
Councillor Pamela Fisher (LB Hounslow)
Councillor Abdullah Gulaid (LB Ealing)
Councillor Pat Harrison (LB Brent)
Councillor Sandra Kabir (LB Brent)
Councillor Anita Kapoor (LB Ealing)
Councillor Sarah McDermott (LB Wandsworth)
Councillor Mary Weale (RB Kensington & Chelsea)

Also Present : Dr Ruth Brown (Vice President (Academic and International) of the College of Emergency Medicine), Dr Marilyn Plant (GP and PEC Chair of NHS Richmond), Dr Adam Jenkins (Chairman of Ealing, Hammersmith and Hounslow LMC), Dr Mark Spencer (Medical Director, NHS NW London), Dr Tim Spicer (Chairman, Hammersmith & Fulham Clinical Care Commissioning Group), Dr Susan LaBrooy (Medical Director, Hillingdon Hospital), Luke Blair (Communications Lead, SAHF), Lisa Anderton (Assistant Director of Service Reconfiguration), Mark Butler (JHOSC Support)

Officers: Jacqueline Casson (LB Brent), Kevin Unwin (LB Ealing), Sue Perrin (LB Hammersmith & Fulham), Lynne Margetts (LB Harrow), Deepa Patel (LB Hounslow), Gareth Ebenezer (RB Kensington & Chelsea), Ofordi Nabokei (LB Richmond), Mark Ewbank (City of Westminster)

Apologies:
Councillor John Bryant (LB Camden)
Councillor Mel Collins (LB Hounslow)
Councillor Krishna James (LB Harrow)
Councillor Sue Jones (LB Richmond)
Councillor Vina Mithani (LB Harrow)
Councillor Sarah Richardson (LB Westminster)
Councillor Caroline Usher (LB Wandsworth)
Councillor Rory Vaughan (LB Hammersmith & Fulham)
Councillor Charles Williams (RB Kensington & Chelsea)

1. WELCOME AND INTRODUCTIONS

The Chairman welcomed those present to the meeting.

2. MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 2 August 2012 at LB Harrow were approved and signed as a correct record, subject to the following amendment:

Ms Maureen Chatterley to be shown as having given her apologies, instead of as present at the meeting.

3. DECLARATIONS OF INTEREST

There were no declarations of interest.

4. MAIN THEMES OF THE MEETING

Main themes of the meeting:

- Core change proposals and centralisation of care
- Proposals on Urgent Care Centres and Accident & Emergency provision
- Impact on local populations
- Out of Hospital Care – community and service preparedness
- Levels of professional support for proposals

Dr Ruth Brown, Vice President (Academic and International) of the College of Emergency Medicine presented the views of officers of the College. Dr Brown had been a consultant in Emergency Medicine since 1996 and worked in North West London for ten years. However, she was not speaking on behalf of any organisation within the North West London sector.

Dr Brown stated that there was an inherent risk in any emergency and urgent care service of identifying the exact level of service for patients. There was an overlap between the case mix that might be seen in an Emergency Department and those patients who could be seen in an Urgent Care Centre (UCC).

The College standard for an Emergency Department included the presence of a ST4 (higher specialty trained) doctor or equivalent 24 hours a day, as well as consultant presence and leadership. Whilst a consultant presence 24 hours a day was advantageous, it might not be possible or optimal use of resources in smaller departments. The College believed that there should be sufficient consultant numbers to provide a presence 16 hours a day, every day.

The model of a network of Emergency Departments, some of which would not have a full range of supporting specialties, but all of which had immediate

access to diagnostics, specialist advice and rapid transfer was recognised to be the model of the future by the College.

Dr Brown noted the lack of an agreed or validated national definition of an UCC, or of the cases, or definition of the cases and conditions that might be treated in such a facility. The College viewed an UCC as a suitably designed physical facility with appropriately trained staff able to see and manage a limited range of conditions. These conditions usually included: the minor exacerbations of chronic illness, which did not require life saving treatment or admission; and minor illness requiring limited procedural interventions followed by outpatient or community treatment. The College believed that UCCs must be part of an Emergency Care network, and must have the same immediate access to diagnostics, specialist advice and transfer where required. In addition, if the UCCs were to see the full range of ages, appropriate provision for safeguarding children and vulnerable adults would have to be in place, as well as access to mental health, drugs and alcohol services.

The College believed that the Emergency Department staff (doctors and nurses) would usually be capable of providing care for the full range of conditions suitable for an UCC. However, whilst the College recognised that GPs were trained and competent in managing the conditions that might be expected to present at the UCCs, it considered that the majority of GPs did not manage the full range of UCC conditions on a day to day basis. The College believed that many GPs did not have the ongoing recent experience of managing minor injuries or illnesses that required direct interpretation of diagnostic tests such as X-rays and ECGs. In addition, the College believed that many GPs in inner city practices did not routinely undertake minor procedures in their surgeries.

Whilst emergency nurse practitioners (ENPs) were a valued and effective workforce in Emergency Departments, the majority of ENPs worked within a limited range of protocols. In addition, not all ENPs were nurse prescribers, limiting their ability to autonomously treat patients.

The College agreed that in North West London, the optimal number and configuration of Emergency Departments might be fewer than the current number. Integrating the Emergency Departments and UCCs into one network might in future prove to be the best model.

Dr Brown outlined some of the practicalities of such a network, including workforce aspects which required further modelling and requirements for additional staff and refresher training. The College considered the lack of middle grade (ST4 and above) doctors to provide safe 24 hour care to be a priority and high risk area.

The College recommended a carefully planned phased approach to allow the system to adjust to an individual closure or change before embarking on a further closure. However, for departments with an uncertain future, this would lead to difficulties in staff recruitment.

The College considered that the wholesale changes proposed carried an inherent risk for patients, and that the public health and public education impact was considerable.

The financial impact of change from an Emergency Department to an UCC and the physical demands of reconfiguration of facilities was complex. In the experience of the College and the limited available evidence, the provision of care in UCCs was not necessarily lower cost than that of junior doctors within an Emergency Department. The College believed that provision of 24 hour staffing in an UCC to provide consistently rapid assessment and treatment, regardless of surges in activity, would be considerably more expensive.

Dr Brown commented on the impact on the London Ambulance Service, and specifically the need to model the impact of re-direction of ambulances and the increased number of inter-hospital transfers. In addition, there was a need to model repatriation of patients to their local hospital and patient pathways and bed numbers. Whilst early discharges were welcomed, there was a need for robust and reliable community services to be in place.

The network relationships would be key, and governance, including protocols, pathways, agreed management plans and shared care arrangements were essential.

The College considered that the proposals must take into account the provision of care and information to the transient population, both of commuters into London and overseas visitors.

The impact on education and training might be profound.

In conclusion, Dr Brown stated that the documents reviewed by the College suggested that there was further work to demonstrate the clarity of evidence and inform the issues.

Dr Brown then responded to questions.

A member queried whether the proposals had been driven by Accident & Emergency department requirements and whether the needs of patients and hospitals generally had been though through. Dr Brown responded that there was a lack of clarity in respect of the delivery of services, which needed to be addressed immediately.

A member queried whether an UCC could function effectively without an Accident & Emergency department. Dr Brown responded that there was not a definition of cases treated in UCCs or proposals for ensuring that the 'right patients' attended and the arrangements for patients who could not be treated. Workforce and financial modelling was needed to determine if an UCC without an Accident & Emergency Department was viable.

A member queried whether there were adequate trained doctors to run UCCs and the finance to provide these services. Dr Brown responded that there was a major workforce problem in respect of middle grade doctors. Modelling of

GP and nurse recruitment was required to show the risks and specifically to address the management of surges throughout the day. Whilst Dr Brown was unable to comment on finance, she considered that the proposed reconfiguration was likely to cost more.

A member queried attendances at an Emergency Department by patients who could have been treated at a GP surgery. Dr Brown responded that the issue was one of patient education. Existing UCCs had removed the less intense cases from Accident & Emergency Departments. Whilst the challenge was to reduce attendances by a further 40/50%, it would not be possible to reduce staff in the same proportion as the residual cases would be more intense. In addition, such a staffing reduction would make rosters unstable.

A member queried whether recruitment of middle grade doctors was easier in those hospitals with a reputation as a centre of excellence in teaching and research. Dr Brown responded that this was normally the case, but there were also candidates who were seeking a lesser role if, for example, they had other commitments. In addition, the role of non-trainee doctors was fundamental. Whilst ENPs could play a leading role in UCCs, there was a spectrum of patients, outside their competencies.

A member queried the timescale. Dr Brown estimated that it would take three/five years for the re-education of patients and at least five years for the reconfiguration of services.

A member queried the functioning of networks and whether there would be disparity of access. Dr Brown responded that the concept was well developed with stakeholders, and the structure included provisions for the evaluation of Accident & Emergency Departments/UCCs. Strands of work were required to look at training, patient pathways and complaints. The networks, including virtual networks, would face the challenge of putting in place standards which ensured equal access.

Dr Marilyn Plant then presented her views as a GP and PEC Chair of NHS Richmond, and from her experience of service redesign at Queen Mary's Hospital, Roehampton.

Dr Plant referred to variations in the quality of emergency care and unacceptable variations in patients outcomes. Data had demonstrated over 500 excess deaths in London annually attributable to differential staffing between weekday and weekend working.

Dr Plant referred to the problems in modelling and evaluation of data, and specifically the lack of information in respect of emergency care delivered in GP surgeries. Organising services in such a way to deliver emergency care consistently over 24 hours, 7 days a week was not affordable in the current configuration.

In London, there was an over reliance on hospital care and substantially higher rates of Accident & Emergency Department attendance, and inadequate provision of primary care. There was a need to consolidate

emergency services on fewer sites to deliver high quality care and move towards a community based model.

Dr Plant highlighted the workforce risk of a delay between a decision to implement change and actual implementation.

In conclusion, Dr Plant stated that it was not possible for the status quo in the NHS to be maintained.

A member asked Dr Plant's opinion on the issues which the JHOSC should raise and whether UCCs were the weakest link in the proposals. Dr Plant responded that the UCCs were an area of controversy. The JHOSC must listen to the evidence and take a view. The proposals were not evidence based and it would be difficult to educate the public. The telephone number '111' was a single point of access and, if used correctly, would direct a patient to the right place for care. Dr Plant stressed the importance of integrated working, and the desire to improve services, including proposals for the estate, which was of variable quality.

A member queried the impact on GPs of the proposals. Dr Plant responded that patients would be able to access GPs without necessarily being registered. UCCs would augment, not replace, GPs; they would provide a more responsive service and meet increasing demand. GPs needed to provide a more flexible accessible offer, for example in respect of opening times.

In respect of the consultation documentation, Dr Plant considered that neither the pre-consultation business case nor the consultation document were comprehensive, and did not clearly explain the issues or the options to the public.

A member queried the biggest risks of the service reconfiguration. Dr Plant responded that the biggest risk was that the service reconfiguration did not happen and secondly that it happened badly, through for example, disputes across boundaries. Dr Plant spoke of the need for the NHS to address the challenges and for vision to transform the service from one where every hospital aimed to provide everything.

A member referred to the threat to Ealing of the downsizing of the estate and the re-provision of a smaller facility plus a substantial housing development.

Dr Adam Jenkins, Chairman of Ealing, Hammersmith and Hounslow LMC, presented the opinion of GPs. Dr Jenkins stated that similar but less extensive plans had been the basis of earlier proposals in 'Healthcare for London' in 2008, whereby care such as outpatients, urgent care and diagnostics was to be transferred out of hospital into 150 'polyclinics'. Dr Jenkins believed that 15 extra healthcare centres had been provided.

Although the proposals were led by CCG Chairmen, there was concern amongst GPs that they were actually management driven for the explicit purpose of cutting costs. The preferred option would decrease the nine

general hospitals to five major hospitals, one specialist hospital, an elective hospital and two local hospitals, and decrease the number of beds from 3500 to 2500. Current bed occupancy in these hospitals varied between 93 and 97%, and on occasion reached 100%. The decrease in the number of beds in NW London seemed ambitious and contingent on some very big assumptions about the reduction of acute admissions due to changes in chronic disease management in primary care and the development of Out of Hospital Care.

Some of the reconfigurations seemed less controversial: Central Middlesex Hospital becoming a local/elective hospital; Hammersmith Hospital becoming a specialist hospital retaining maternity services; and moving the Western Eye Hospital into the St. Mary's site.

The proposals to remove Accident & Emergency facilities from Ealing and Charing Cross Hospitals, leaving UCCs to deal with walk-in emergencies would completely remove Accident & Emergency facilities from the boroughs of Hammersmith & Fulham and Ealing. Analysis showed that approximately 10-30% of Accident & Emergency attendees could be dealt with at an UCC and worked best with the back up of an Accident & Emergency Department. Under the proposals, patients who needed Accident & Emergency expertise would have to be transferred to a major hospital. With the removal of an Accident & Emergency Department, a hospital would lose general surgery, paediatrics and maternity and this would be the first stage of being down graded to a local hospital with diagnostic facilities, a few overnight beds and outpatient services. Current buildings were too large for such a reduced service, and it was assumed that a smaller facility would be build.

There would be an impact on the remaining Accident & Emergency Departments and increased demand for beds in the major hospitals and increased pressure on waiting lists and waiting times in Accident & Emergency Departments.

GPs agreed that a critical mass of staff and activity was required to produce high quality care. However, the elderly, frail and disabled were likely to be disadvantaged, and might be denied access to services because of transport difficulties.

Dr Jenkins considered that since 2004, there had been a progressive disinvestment in both community and GP services, and little capital investment in infrastructure and buildings for years prior to this.

Dr Jenkins stated that the number of GPs close to retirement age was substantial and that the number of 'training' GP registrars was falling. GP practices were not replacing staff when they left, in order to reduce costs. A number of the proposed new services were already available in Ealing (GP extended hours, Ealing hospital 24/7 UCC, primary care minor operations, the ARISE team, Integrated Care Pilot and pre-discharge planning), but hospital admissions were not declining. GPs did not have confidence that the proposed investment would be made prior to these proposals going ahead.

Dr Jenkins stated that mental health services were not addressed, whilst a number of Accident & Emergency attendances had mental health issues.

The proposals referred to 750-900 extra staff to run new community services, who were already working in NW London. It was assumed that these were the staff who had been made redundant from hospitals who had little or no training in primary care.

In conclusion, Dr Jenkins stated that GPs accepted that there was a need to change and evolve, but there was an underlying concern that 'Shaping a Healthier Future' was making significant assumptions about how costs would be saved. It was hoped that CCGs would ask their practices whether they supported the proposals.

A member noted the lack of support from GPs for the closure of Ealing Accident & Emergency Department. A member suggested that use of an UCC was a failure on the part of primary care and noted the cost of £52 per attendance. Dr Jenkins responded that UCCs provided a range of diagnostic facilities, not available in GP practises and removed minor procedures from Accident & Emergency Departments. Dr Jenkins outlined the way in which his practice worked to provide dedicated sessions for patients requesting emergency appointments. However, patients might attend an UCC if a GP did not provide the required response or because an UCC was more convenient.

A member commented on the high percentage of Accident & Emergency Department attendees who were admitted. Dr Jenkins responded that 'Payments by Results' was an inappropriate payments system.

The Committee received written witness statements from:

Axel Heitmueller, Director of Strategy and Business Development, Chelsea and Westminster NHS Foundation Trust
Hillingdon Hospitals NHS Foundation Trust
Julie Lowe, Chief Executive, Ealing Hospital NHS Trust
James Reilly, Chief Executive, Central London Community Healthcare NHS Trust
Alison Elliott, Director of Adult Social Services, Brent Council
Councillor Julian Bell, Leader of the Council and Councillor Jasbir Anand, Portfolio Holder, Health and Adult Services, Ealing Council
Barry Emerson, Emergency Preparedness Network Manager, NHS London
R.L. Wagner, Programme Manager, Better Services, Better Value, NHS South West London

Members noted the importance of the alignment of the 'Shaping a Healthier Future' proposals with Social Services.

Members requested a copy of the risk register. Dr Spencer responded that there was a programme risk register, but he did not believe that this would meet the committee's requirements.

5. PUBLIC CONSULTATION: PROGRESS REPORT

Mr Luke Blair updated on the public consultation, which was now in its second phase with further road shows. There had been some 460 attendees at the first round of road shows.

The consultation documentation had been translated into 15 languages and current circulation figures were: 60,000 full consultation documents; 548,000 summary consultation documents; 18,000 postcards and 5,000 posters.

The NHS would check that the consultation documents had been received and displayed by libraries.

850 responses had been received.

Action:

NHS NW London would provide:

1. A breakdown of responses by borough.
2. The independent review of the consultation.
3. The Equalities Impact Assessment.

The NHS would not agree to an extension of the consultation, on the basis that a 14 week period was adequate.

Action:

All boroughs/OSCs would provide a summary of the main issues relevant to the JHOSC by 18 September.

6. DATES OF NEXT MEETINGS

26 September, LB Brent

Meeting started: 10am
Meeting ended: 1pm

Chairman .....

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