www.ealing.gov.uk

Health and Adult Social Services Standing Scrutiny Panel, Ealing Council

Submission to the JHOSC

The Health and Adult Social Services Standing Scrutiny Panel wishes to submit the following points on the Shaping a Healthier Future programme to the JHOSC. These points are drawn from consideration of the Pre Consultation Business Case (PCBC), and from the Panel's meeting on 26 July, which considered the programme's proposals and heard views from concerned residents and local clinicians.

The response is comprised of a number of points, based firstly around concerns relating to the approach and deliverability of the programme itself, and secondly on how the programme impacts on Ealing. Much of the latter debate refers to Ealing Hospital, on behalf of which the Panel has heard many representations. However, the Panel also wishes to state clearly that it opposes the downgrading of any hospital which serves residents, with Charing Cross, Central Middlesex and Hammersmith being valued assets in the local health economy.

Deliverability of the Programme

A fact that has struck Panel Members, and which has been reflected in discussions as part of the JHOSC, is the scale of change required in primary and community care. It is of course key to the programme that investment in primary and community care proves successful in shifting activity away from acute settings, to realise the goals of improving care quality whilst at the same time reducing costs, in order to respond to the demanding financial environment that the NHS in North West London is faced with.

The PCBC states that this improvement work needs to be completed by 2015, and as the Panel have seen through scrutiny of Ealing's Out of Hospital Strategy, initiatives are already underway. Moreover, it welcomes the PCBC's assertion that no reforms to shift activity from acute services will be implemented until capacity improvements to primary and community services are in place. However, the Panel has a number of concerns relating to the deliverability of this aspect of the programme, and the time frame it is required to happen within.

The backbone of this transformation will be an additional 765 – 890 staff working in primary and community settings, and the Panel notes the PCBC's assertion that many of these staff will come from the acute sector. However, the Panel feels there may be a conflict between this proposal and that outlined in the PCBC, re-stated by programme representatives on 26 July, that no acute reforms will take place until capacity improvements have been realised. The Panel queries how this additional community capacity can be realised without releasing staff from acute care first, and whether there may be, for example, an intended reliance on agency staff to ensure adequate staffing levels. This is not clear from the PCBC, and the Panel considers this a potential risk to the timely delivery of this aspect of the programme, a risk which is arguably made quite real when it

talks about the importance of having to develop successful workforce transition policies – policies which are not elaborated on any further.

The Panel also feels that there are risks around the scale of change required. As the PCBC highlights, there will be investment of approximately £138m into out of hospital care, which is expected to deliver 100,000 fewer spells of activity in A&E, 55,000 fewer non-elective procedures, 10,000 fewer elective spells, and 600,000 fewer outpatient appointments. However, the Panel feels that the standard of some current services, plus the importance of making this capacity available rapidly, presents a significant obstacle. Realising improvements in primary care, for example, seem particularly large – of the 80 GP practices across Ealing, only 4% were meeting statutory requirements and guidance in terms of estates at the time of the last review, and satisfaction with access to GP services low for North West London are considerably below national averages. And yet building this capacity quickly is vital to the maintenance of safe acute services.

There is also a potential challenge in terms of public education to ensure that residents access the right facilities at the right time, and that they are aware of different care settings and the standards that apply to them. The Panel notes proposals for the 111 Service in this regard, which is due to go live in Ealing early next year, and which is aimed at supporting people to make informed and appropriate choices. Nevertheless, the number of potential options open to people within the care environment, set against a background of rising attendances at accident and emergency departments, means this will be no easy task within the time frame available.

These challenges become even more pressing when it is considered that, as the PCBC points out, once a course of reconfiguration is decided on it can be increasingly difficult to recruit and retain staff as vacancy rates increase, sites become less attractive to trainees, and planned improvements are halted. This, in turn, could impact on safety in particular as smaller units struggle to retain their staff. Taking these points into account, the Panel therefore feels that greater time should be given to developing out of hospital care, accompanied by an effective monitoring programme (proposals for which are not set out in the PCBC), to ensure that this investment is being appropriately delivered and capacity transfers are in place, before any decision to reconfigure acute services is taken. It seems that NHS North West London is taking a significant risk in setting itself the timetable outlined in the PCBC.

The Panel also queries the criteria that will be used to decide whether reforms to primary and community services have been successful. Programme representatives and the PCBC itself state that this is an issue of capacity and efficiency – the sector should be seeing increased levels of activity with sufficient capacity to absorb transferred cases from the acute sector. However, the Panel also asks whether patient experience should also be a factor. If the ultimate aim of the programme is to improve services, then the views of patients about the accessibility and quality of primary and community services should be taken into account before acute services are reformed.

Finally, there is also a question of deliverability around maternity and paediatric services *after* these reconfigurations are in place. It is acknowledged that meeting the requirement for additional workforce in order to meet expected clinical quality standards will be 'extremely challenging' and that 'there may need to be further work to review service configuration in maternity and paediatrics in the future.' The Panel would like to place on record its concern at this, and query what future maternity services might look like if appropriate staffing levels are not met.

Sensitivity Analysis and Risk Management

The Panel is concerned as a result of its own analysis and evidence submitted to the JHOSC that a risk register for delivering the programme has not been compiled for any of the three possible options. The JHOSC heard evidence that the reason this work has not been undertaken is because no decision about a particular course of action has yet been taken, with detailed risk analysis being completed once an option has been decided on – sensitivity analyses in the PCBC are pointed to instead.

Panel Members do not, however, agree with the logic of this approach. In view of the scale of the programme to be undertaken, with such a large shift of care into the community and fundamental re-modelling of acute services, they feel that an analysis of the risks to delivery, complete with mitigations, should have been provided in the PCBC to give a credible and detailed picture of how the dangers to delivering the programme will be managed. As will be discussed elsewhere in this submission, there are a number of risks that the Panel feel should have been assessed and presented as an integral part of the arguments in the PCBC, such as equalities impacts and risks around staff recruitment and retention once the decision to reconfigure is taken.

Moreover, the sensitivity analysis provided in the PCBC offers no mitigation for a potentially dangerous combination of risks. It is acknowledged that if a combination of scenarios occur simultaneously, it would result in a situation which is worse, by the programme's own parameters, than the base case or 'do nothing' scenario. This includes underperformance on reducing length of stay, delivery of QIPP savings at 60%, and underperformance on consolidation savings and reduction of fixed costs. However, no description of how likely these risks are to occur is given, and no possible mitigations are offered. Given how serious such an eventuality would be and the potential implications for services that might follow, the Panel does not feel this is acceptable.

GP and Community Support, and Early Implementation of the Consultation

The Panel was concerned to hear at its meeting on 26 July that not all GPs across Ealing supported the programme's proposals. Representations made at the meeting drew the Panel's attention to a recent meeting of Ealing Hospital consultants and 35 general practitioners, out of a total population of 340, which was convened to discuss the plans. At this meeting, 33 GPs resolved that they were not in favour of the preferred option and the proposed downgrade of Ealing hospital. Concerns were expressed about the potential for Urgent Care centres to function as stand-alone facilities (which will be discussed further on in this submission) and the ability of the out of hospital sector to realise the additional capacity required.

Subsequent input from the local Save Our Hospitals campaign has stated that the many of the GPs that attended were those who used Ealing hospital the most, but also that there was representation from GPs in Acton, predominantly concerned about the future of Charing Cross. It has been emphasised that many GPs who attended were representing their whole practice, which would be between 4 and 8 GPs. The Panel heard that the consultants had received a number of emails expressing similar concerns from a number of GPs who could not attend that meeting.

Taking the above into account, and acknowledging the work to engage with clinicians described in Chapter 10 of the PCBC, Panel Members remain concerned about a possible lack of broad based GP support for the programme, particularly as their buy-in and co-operation will be a key element in

driving improvements to out of hospital care. The Panel queries how the programme and CCGs will take on board the views of GPs it engages with throughout the consultation process, and what the programme's response will be if it transpires that significant numbers of GPs do not support the proposals. The JHOSC itself heard similar queries about consultation between CCGs and local GPs expressed by Dr D. Adam Jenkins, Chairman of Ealing, Hammersmith and Hounslow Local Medical Committee, at its meeting on 4 September.

Regarding the consultation process itself, the Panel heard representations from concerned members of the public that, three weeks after the opening of consultation, copies of the full consultation document had not been distributed to key locations such as local libraries, and were not available in alternative languages. Panel Members also heard disappointment from a representative of a faith group that the programme had not contacted them in order to raise awareness of the consultation amongst their members. Whilst the JHOSC signed off the consultation plan, and the Panel appreciates how programme representatives have engaged with it over the previous months, it is nevertheless disappointed to hear of these issues with the implementation of the consultation some weeks after it opened. Similarly, Panel Members were concerned that, in the first round of eight engagement events, only 300 people had attended. The Panel heard at its meeting in July that consideration was being given to extending the consultation period as a result of the difficulties in circulating the full consultation document, a proposal which was subsequently discounted at the JHOSC meeting on 4 September with the reason that it was felt the 14-week consultation period remained adequate. The Panel wishes to place on record that its disappointment with that decision.

Finally, one Panel Member has discovered problems when attempting to use the journey planner on the programme's website, which advises members of the public how long a journey by ambulance, private car or public transport might take to hospital sites. The Member in question entered a range of postcodes for which the journey time from their home was known, and received results which they knew not to be realistic, and which differed from TFL's journey planner. The Member reported that 'having put through a series of postcodes in close proximity to a number of hospitals, errors of this type are commonly found.' On contacting the programme, these faults were acknowledged, and said to result from the individual geographical areas around which the programme's database is built. The Panel understands that this is being worked on, and supports the programme for its approach in building such a calculator in the first place, as a means of making transport impacts more transparent. However, it nevertheless wishes, in a similar manner to the above, to register its concerns about the errors in the route finder, for reporting likely incorrect travel times to users of the route finder in the early part of the consultation.

Presentation and Use of Data

Many of Members' concerns in this area centre on how figures are presented in the consultation document and PCBC, when contrasted with some of the more detailed statistics in the appendices to that document, particularly Volume 18, Appendix L. For example, in the main consultation document, figures are used to show that 14% of A&E attendances would be affected under the preferred option. However, the more detailed breakdown of possible impact presented in Chapter 17 and Appendix L shows that for major and standard A&E admissions (as opposed to minor admissions, which are assumed to be seen in Urgent Care Centres at local hospitals), 28% of total activity (admissions) will be affected under the preferred option. The Panel feels that the more detailed breakdown of activity impacts, including the figure for major and standard A&E cases,

should have been presented in the consultation document, to provide a full, accurate and easily accessible picture for members of the public seeking to engage with the consultation.

Panel Members have also expressed concerns that the full consultation document does not mention the potential for reduction in staff numbers, or the fact that Ealing hospital services will be supplied in one-fifth of the current area. The document also quotes figures stating that impact on overall care activity across North West London will be low, rather than additional figures in the PCBC which show how activity will move by hospital site under each of the options, which Members do not feel is being as transparent as possible about local activity impacts.

The Panel also queries the division of A&E attendances into 'major and standard' and 'minor' in Chapter 17 and Appendix L. It is clear that the latter are those which will be dealt with by Urgent Care Centres, but no definition is offered of what 'major' and 'standard' cases are respectively. Although the Panel understands from the PCBC that Urgent Care Centres will treat patients that do not require hospital admission, there is potential for confusion about the nature of an A&E admission when looking at the activity figures provided in the PCBC - numbers of admissions assigned to these categories come in at 49.7% of total A&E admissions for major and standard admissions, and 50.3% for minor admissions, but Panel Members have been informed by programme representatives that Urgent Care Centres will handle up to 70% of all A&E cases, and no mention is made in chapter 8 of the PCBC or Appendix L of UCC's handling 'standard' A&E cases. Similarly, in Chapter 17, it is stated that 55% of A&E activity would remain at Ealing under the preferred option. It would therefore have assisted Panel Members and members of the public in their understanding of how Urgent Care Centres will work and the activity levels they will handle if these categories had been elaborated on, and this information incorporated into the main body of the PCBC along with what proportions of each type will be handled by UCCs.

Finally, Panel Members note that the activity modelling in Chapter 17 and Appendix L uses Hospital Episode Statistics (HES) as its data source. Chapter 17 acknowledges that, for A&E attendances, there is some inconsistency in this dataset – the HES website states that is experimental, likely to be incomplete, and that there are definitional differences from the official source of A&E Data, Quarterly Monitoring of Accident and Emergency (QMAE). Whilst the Panel understands that HES data potentially provides a fuller picture of activity than QMAE, it feels that the risks associated with the use of this dataset should have been discussed in the PCBC, and that it should have set out the reasons why the advantages of this dataset outweighed these risks when compared to using the official statistics compiled by the Department of Health.

The basic point to emphasise is that the Panel feels that the consultation document and the PCBC should have explained more fully the data sources employed, the way data was used, and presented in the main clinical arguments figures which provide as much detail as possible, to enable readers to engage with and assess the arguments completely.

Community Need and Access to Services

At the Panel's meeting on 26 July it heard evidence from a consultant working at Ealing Hospital who highlighted what the Panel feels to be a significant omission in the approach to the PCBC – namely that the health needs and local characteristics of the populations around the hospital sites that are at risk of being downgraded are not discussed. This evidence is present in the separate Equalities Impact document compiled by Mott Macdonald, but as a result there is no systematic consideration

of the equalities characteristics identified and the impact of the three reconfiguration proposals in the options development and arguments put forward in the PCBC.

The communities around Ealing hospital currently experience high levels of multiple deprivation and health deprivation and disability, as highlighted by the 2010 national indices of deprivation. Dormer's Wells and Norwood Green are amongst the most deprived in Ealing on these indices, as are significant parts of South, East and Central Acton. The national indices capture, in relation to the domain of health deprivation and disability, areas with high rates of people who die prematurely or whose quality of life is impaired by poor health or disability. For example, Ealing's Joint Strategic Needs Assessment for 2010 highlights that Dormers Wells and Norwood Green, along with surrounding wards Southall Broadway and Southall Green, suffer from the highest mortality rates in the borough in relation to cardiovascular disease.

As representations from clinical staff at the Panel's meeting on 26 July highlighted, the blue light analysis presented in chapter 12 of the PCBC shows that those areas which are most affected by increases in travel times if Ealing Hospital loses its Accident and Emergency Unit coincide to a large extent with these deprived areas. This is reflected in Mott Macdonald's modelling on the Equalities impact of the changes – figures 3.1 and 3.2 of that document show that the greatest number of 'critical equality areas' in the borough are located in the vicinity of Ealing hospital and in Southall for both major hospital and maternity services. The Panel notes that this is also the case for Acton, in relation to the reduction of services at Central Middlesex that will impact on older people, over 64.

In relation to accessibility of services to these communities, Mott Macdonald's travel analysis states that 'significant' travel impacts on critical equality areas will be 'very low' if the preferred option is implemented, and that none of the population will, under blue light conditions, experience an increase in journey times of 10 minutes for either major or maternity services. Similarly 'low' impacts are modelled for private car travel. However, the analysis is clear that the impact percentages for users of public transport are 'far higher', with 20% of the populace in critical equality areas experiencing an increase in journey times of over 10 minutes to access major hospital services, and 61% of the populace having a journey of over 30 minutes (an increase of 17%). Figures for maternity services are 8% and 50% respectively. These increases would result in a total of 108,588 people across NW London, the majority of which are in Ealing, potentially experiencing significant travel impacts.

The equalities analysis goes onto state that these impacts are more likely to affect visitors than patients, as trips to affected services are more likely to be made by ambulance than public transport, 'with the exceptions of elective complex surgery and possibly maternity services.' However, no description of the likely number of patients who might use public transport for major hospital services is offered, or indeed for patients travelling by private car, where there is a 6% increase in the number of people who will have to travel for over half an hour – as the JHOSC heard at its meeting on 6 September, actual numbers of journeys likely to be taken by each mode of transport are not yet available, and are to be worked up shortly. Therefore, whilst NHS NW London points to the fact that low levels of activity overall will be affected under the preferred option (9%), it remains that, with journey numbers, the equalities impact assessment is not able to tell us exactly how many people from critical equality groups will be affected by significant travel impacts.

Moreover, the public transport modelling in the PCBC, in Appendix H (separated from the main analysis in chapter 12), seems to support the local reality that there are currently poor public

transport links between Ealing and West Middlesex Hospitals. That appendix predicts a shift of only 14% of patients from Ealing to West Middlesex if the preferred option was implemented, which arguably reflects the fact that there are no direct bus links and the subsequent difficulty of getting there. A submission from the Chief Executive of Ealing Hospital to the JHOSC also emphasises the Trust's belief that more people will travel to Hillingdon hospital because of the better quality transport links, although only 15% of patients using public transport are expected to make this journey. There is also no consideration in the PCBC about the cost impact of these longer journeys on those who must undertake them, and this extends to those using taxis, otherwise covered by private car modelling and therefore assumed to be impacted relatively minimally.

Fundamentally however the Panel feels that any arguments about the limited predicted disruption to travel times, assuming the concerns above are discounted, do not alter the inequitable fact that if the preferred option was implemented, it would make accessing major hospital services more difficult for some of the most vulnerable communities in Ealing. As Mott Macdonald point out, people living in areas of deprivation make greater use of primary care and emergency departments, and less use of preventative care. They are more likely to need emergency complex services. Moreover, these groups are more likely to use public transport and to not have access to private cars, owing to the co-prevalence of health and income deprivation in these areas.

The programme seeks to assure us that there will be better health outcomes for patients in these categories, with more routine care for long term conditions available in the community and a local hospital with facilities for treatment of conditions such as COPD and diabetes, as well as a 24/7 Urgent Care Centre. However in deprived communities there is the potential for language and other barriers to mean that care pathways might not be effectively communicated or understood, leading to a lack of clarity about how to access care and potentially to health consequences for the local population – this poses a problem of public education about care pathways which the Panel feels is a key risk to the effective delivery of the programme, discussed earlier.

Mitigations for these risks are outlined in the equalities impact report, but as this stands apart from the PCBC and there is no risk register available for the programme, the Panel is unable to see how the programme will tackle these issues and put such mitigations into practice**.** The Panel is concerned that the net result is that, as it stands, communities suffering the poorest health conditions in the borough will be hit hardest by these service changes, and it is unclear as to how the impact on these populations will be addressed.

Concern over lack of Co-Location of UCC and A&Es, and Future Quality of Care

Related to the above point are views expressed to the Panel by clinicians at Ealing Hospital about the risks involved in separating Urgent Care Centres from Accident and Emergency facilities, again taking into account the characteristics and needs of the local population in Ealing.

At the meeting on 26 July, a member of clinical staff advised Panel Members that there were a number of 'late presenters' to the A&E department in the borough – those who turn up to A&E sometime after their injury or complaint was first experienced, and where their condition may have deteriorated. This is of particular concern owing to the high rates of long-term conditions in the borough, and again in the locality around Ealing hospital. In addition, and owing to the diverse population which Ealing Hospital serves, large numbers of patients do not have English as their first

language, leading to communication difficulties – the Panel heard the example of a patient describing pain as a simple headache, when in fact this could in fact be a sign of meningitis.

Both of these factors often meant that people turned up 'late and sick', and on top of this, presented a challenge to diagnose. However, as Ealing hospital had co-located Urgent Care and Accident and Emergency services, it meant that patients, once diagnosed with a serious condition requiring emergency treatment, could be escalated to Accident and Emergency rapidly. Under the preferred option this would not be the case, with patients having to wait an additional period of time for an ambulance to take them to West Middlesex University Hospital**.**

This is not therefore purely an issue of travel time from a local to a major hospital, but about how fast the local healthcare system can respond to critical healthcare needs which may be identified late. The Panel shares the concerns expressed that this is an issue in Ealing, and feels it is another strong argument against downgrading hospital sites.

In addition to this, Panel Members have raised concerns about the programme's potential impact on patient care, as well on local hospital sites themselves. Members have, for example, queries about patient pathways after discharge from acute services, where outpatient appointments will be needed. It has been suggested that these appointments might take place in local hospitals, to make them easier to access for the local populace. However, Panel Members have expressed concerns that this could possibly lead to deteriorating standards as the consultant or team which carried out the initial procedure might not see that patient at follow up.

Why Ealing should be maintained as a Major Hospital

The Panel would also like to take this opportunity to state publicly its support for the staff and services offered by Ealing Hospital. As stated earlier, this should not be interpreted as an argument in favour of downgrading other hospitals such as Central Middlesex and Charing Cross, which is a product of the way the consultation has been constructed. These are, rather, arguments in favour of a hospital which sees the largest single group of referrals from Ealing PCT, and serves, as we have seen, key equality groups.

The first argument the Panel would like to put forward is to re-state the importance of Ealing hospital in serving the communities in which it is based, and in particular, the expertise it has built up in this respect. This is acknowledged in Mott Macdonald's report when it states that:

'In recognising that over 100 languages are spoken across their local Borough, Ealing Hospital NHS Trust has been working with members of the public and voluntary and community organisations to improve patient information and access to services. Developments include a central booking point for face-to-face interpreting and 24/7 telephone interpreting services. Within Ealing Hospital NHS Trust, a resource for all staff has been developed, which contains information about the religious and cultural needs of our local community to enable staff to provide more culturally sensitive care.'

Ealing has adapted to serve the needs of its communities and provides a strong basis on which to continue to provide culturally attuned major hospital and maternity services. Indeed, it is recognised by Mott Macdonald's report that, in terms of accessibility of services for critical equality groups, the retention of Ealing hospital as part of option 7 leads to the lowest adverse impact of all the options put forward for consultation. The Panel feels that this evidence is missing from the options

development process in the PCBC, and should have been taken into account when assessing quality of care and accessibility of services.

With regards to the quality of services provided at the site, the Panel notes that the PCBC scores every Trust equally for clinical quality, reflecting the fact that post investment, standards would be increased and that there was not felt to be sufficient variance between Trusts in terms of performance to choose between them. However, the Panel would like to emphasise a number of positive indicators related to major hospital services, taken from East Midlands quality observatory data for acute trusts, as referenced by, but not discussed in, the PCBC. These include excellent performance on SHMI for emergency and elective care, patient safety incidents, medication errors, and MRSA infection rates, indicators on all of which are considerably above the national average.

In short, the Panel feels that Ealing Hospital demonstrates performance that shows that it provides a solid foundation on which to invest and improve services. This view is reinforced by a submission to the Panel by the consultant body of Ealing Hospital, stating that:

'In national comparisons of hospitals, Ealing hospital has met all its recent clinical and financial targets and turned a surplus last year. Our recent Dr Foster review showed that we are performing as expected on all the patient safety measures and do much better than the average when it comes to managing emergency patients safely, particularly those with complex medical conditions. CQC passed Ealing Hospital without any restrictions. We are immensely proud of the excellent emergency and other services that we offer to our local people, and we are determined they should continue.'

Finally, there was a good deal of discussion at the meeting on 26 July, as there is throughout the PCBC, about the preferred option being a more effective use of estates as it retains West Middlesex University Hospital. It is noted that West Middlesex is a PFI building, and that should Ealing Hospital be retained as a major hospital, the payments on that estate will need to be maintained. This, in turn, also means that options which retain Ealing Hospital as a major site score poorly on financial options analysis. The Panel does not agree however that these considerations are what should be driving the programme's options development. It does not feel that Ealing's residents should lose highly valued and community focussed services because of a particular approach to financing taken elsewhere in London, and that the kinds of factors discussed in this submission - such as clinical quality, proximity to vulnerable groups and community focussed services - should be given greater weight.

Councillor Abdullah Gulaid and Councillor Anita Kapoor

Chair and Vice-Chair of the Health and Adult Social Services Scrutiny Panel, Ealing