healthwatch
Ealing

Concerns over Health Changes proposed in:

‘Sustainability & Transformation Plan’ (STP),

And the associated

‘Implementation Business Case – Strategic Outline Case Part 1’ (ImBC-SOC1)

A Briefing by Healthwatch Ealing prepared for the meeting of Ealing Council’s Health & Adult Social Services Standing Scrutiny Panel to be held on Wednesday 25th January 2017.

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INTRODUCTION

Local Healthwatch serve as an independent consumer champion for the users of health and social care. Our legal responsibilities and powers are set out in Section 23 of this document.

The NHS is proposing to make major changes to the health services across the eight council areas which constitute the NHS's North West London Region. These changes include the closure of A&E and all acute beds on the Ealing Hospital and Charing Cross Sites. Closures which could adversely and disproportionately affect the residents of the London Borough of Ealing.

The purpose of this briefing is to identify the concerns which have emerged from an initial study of the NHS's proposals. Many of these concerns stem from a paucity of published supporting information by the NHS managers who have prepared these proposals. It is therefore hoped that these omissions will be speedily rectified - so that an informed discussion of the NHS's proposals can take place with all stakeholders and especially patients and residents.

We have grouped our concerns into two categories:

- Firstly, those of a cross-cutting nature which impact on all aspects of the proposals, and
- Secondly those of a more specific nature.

Before reviewing the individual concerns, we take this opportunity to remind readers that the NHS has presented the proposed changes as, **"Improving Healthcare in Ealing"**. This was the title of the NHS's poorly attended 'Town Hall' engagement meeting in Central Ealing on 20th September 2016.

We suggest that the test of **"Improving Healthcare in Ealing"** should be rigorously applied to all aspects of the proposed changes, and especially to how they will impact on the tens of thousands of residents who rely on the services currently delivered on the Ealing and Charing Cross hospital sites, many of whom live in areas of above average deprivation and health needs.

CROSS-CUTTING CONCERNS

1 Risk of Failure

The implementation of the STP is a major project whose success or failure will be central to the health and wellbeing of over 2,000,000 residents in North West London.

As with all large projects the potential for failure increases in relation to the project's complexity.

A further concern is the extremely tight timescale for the project's delivery.

This is compounded by the risk that existing hospital based provision will be discontinued before replacement community based facilities have become established and with an inadequate period of 'parallel running'.

A further, and significant, concern is that the STP will not be delivered by a dedicated and accountable management structure. Instead the existing fragmented local and national NHS structures will be used, along with those responsible for local government social services. It is difficult to find an appropriate analogy for such a management structure – perhaps that of a parish fete is relevant.

To summarise, an extremely wide ranging and challenging project is being proposed in an extremely tight timescale, and in the absence of an accountable management structure.

In these circumstances the risks of failure, to some degree, must be high.

2 Need for 'bottom-up', rather than 'top-down' design process

The published versions of the STP and ImBC-SOC1 appear to be based on 'top down' high level assumptions, rather than on 'bottom up' detailed analyses based on patient data etc.

Only by preparing and using detailed 'bottom up' analyses, which can be reconciled back to patient data, can one be certain that projections are robust.

It has not been possible to locate detailed supporting analyses in the STP or the ImBC-SOC1.

The absence of detailed supporting analyses is particularly disappointing as SaHF was first published in the summer of 2012. One would have hoped that the intervening four and a half years would have provided ample time to prepare comprehensive supporting detailed analyses.

There are some indications in the text that detailed plans and analyses will only be prepared after the summary 'top-down' ones have been approved. This approach poses the threat that any errors which subsequently emerge in the 'top down' plans will have to be 'lived with' as there won't be any additional funds to rectify them.

The apparent absence of these supporting analyses must add to the risk that it will not be possible to implement the proposed changes on a comprehensive and timely basis.

3 Need for up-to-date Detailed Supporting Analyses of current and proposed activities on the Ealing Hospital site

There continues to be a lack of a "before and after" analysis of activities and patient volumes of the healthcare delivered on the Ealing Hospital site.

Table 8 on pages 59 and 60 of the Strategic Case section of SOC1 should be expanded to include a third column showing the services currently being provided at Ealing Hospital and where they will be relocated.

There should be a similar table showing current patient activity volumes by medical speciality at Ealing Hospital, with an accompanying analysis containing columns showing for each speciality where and how these patient episodes, both in-patient and out-patient, will be treated in the future, e.g. at other acute hospitals, Hubs, GP Surgeries, etc.

These workings should include the following:

Firstly quantify existing activity levels.	**XXXX**
These should then be uplifted by the following in order to arrive at the activity level in, say, ten years time.	
Uplift factors should include:	
• Ageing Population	XXX
• Population increases (new homes etc.)	XXX
• Deteriorating public health of 40-60 year olds	XXX
• Etc.	XXX
This will result in an activity subtotal	**XXXX**
This should then be reduced by the projected 'efficiency savings' including:	
• Reduced Hospital Admissions	(XXX)
• Reduced duration of the residual Hospital Admissions	(XXX)
• Reduced GP attendances	(XXX)
• Etc.	(XXX)
This will result in a residual activity subtotal	**XXXX**

The above is just an indication of the factors which will need to be considered.

Further adjustments will be necessary to reflect:

- The 2.9 day longer stay by in-patients when they have been admitted to a hospital which is outside their home CCG boundary – see note at bottom of page 27 of October 2016 version of STP. The proposed closure of all acute wards at Ealing Hospital will mean that all Ealing residents requiring this care will need to be accommodated in out-of-borough hospitals with the associated additional 2.9 days of stay.

- Initial enquiries suggest that the high level STP projections have been based on a 100% bed occupancy. Health professionals suggest that an 85% occupancy is the maximum which it is safe to achieve on a sustained basis. It may therefore be necessary to rework the projections at an 85% occupancy.

4 Need for evidence that the "efficiency" proposals can be scaled up to deliver the desired savings

A number of "efficiency" measures are proposed to reduce in-patient admissions and out-patient GP attendances.

These reductions need to be quantified by medical speciality and mode of provision.

Page 11 of the October STP refers to, *"scaling up models that we know have been successful in individual boroughs"*. Unfortunately, no details have been provided of these models, their outcomes and the scaling up envisaged. This lack of specific and comprehensive attribution is disturbing.

There therefore needs to be robust evidence that the proposed "efficiency" reductions can be delivered on the scale envisaged in the STP and ImBC-SOC1.

It is a common experience that multiple difficulties can be encountered when attempting to scale-up small scale efficiency pilots. There is therefore a high risk that the aspiration that healthcare can be delivered with reduced per capita resources will remain unfulfilled.

5 Divergences from Shaping a Healthier Future (SaHF)

There appear to be significant divergences in both the STP and the ImBC-SOC1 from the approved version of the 2013 SaHF.

These divergences need to be documented and explained in an appendix to both the STP and ImBC-SOC1.

Two immediately identifiable matters are:

- The reduction in the approved number of Out-of-Hospital Hubs in Ealing from 6 or 8 to just 3, and
- The apparent reversal of the decision to retain an A&E on the Ealing Hospital site - as set out in the Secretary of State's statement od 30th November 2013.

6 Inadequate consideration of patient access and public transport connectivity to post reconfiguration facilities

SOC1 appears to be totally silent as to how patients, their carers, families and friends will access the proposed reconfigured healthcare.

Public transport bus route connectivity will be key to the successful implementation of the proposed reconfiguration changes.

Patients living in the greater Southall area will be particularly affected following the withdrawal of services at Ealing Hospital. Travel from their homes to the following hospitals will often involve three buses: Northwick Park, Central Middlesex, West Middlesex, and Hillingdon.

The public transport implications of the proposed hospital changes and hubs need to be considered in detail at this key stage in the reconfiguration journey.

Their omission is inexcusable and unacceptable to justify, given the four and a half years which have passed since the initial SaHF proposals were published in the summer of 2012. There has been plenty of time to address this key issue.

7 Deprivation

Pages 23 to 25 of the Strategic Chapter of the draft SOC1 identify unacceptable variations in the quality and delivery of services.

There is a significant positive correlation between these areas of above average health need and the areas of high deprivation shown on the map attached in Section 23.

It therefore seems perverse that the previous proposals for Out-of-Hospital Hubs in Southall and Northolt, both areas of high deprivation and health need, appear to have been deleted.

8 Lack of clarity and accountability over the organisational structures

There needs to be greater clarity and ownership over the organisational structures which will be responsible for implementation and operating the proposed reconfiguration.

The reconfiguration is represented as an integrated pathway with seamless transitions. Yet, at the same time, there appears to be a pronounced lack of overarching accountability.

The success of the reconfiguration appears to depend on the goodwill of a diverse grouping of independent health and social care organisations – all of which are suffering from intense budget pressures.

9 Consultation, Engagement and Governance

We are concerned at the token nature of the consultation and engagement which has taken place on the STP and the non-existent public consultation over the ImBC-SOC1.

Given the tens of thousands of patients, carers, family and friends who use Ealing Hospital on an annual basis, we believe that a very large number of these key stakeholders must be consulted over the implementation proposals for the reconfiguration of the services currently delivered on the Ealing Hospital site.

There also appears to be a significant absence of robust, rather than token, democratic and patient oversight over the implementation and day-to-day operation of the proposed reconfiguration. This will be of increased concern if the delivery of key aspects of the reconfiguration is let on long term contracts shrouded in ‘commercial confidentiality’.

10 Economic and Financial Methodologies

It is difficult to understand the economic and financial NHS methodologies used in the SOC1 without a briefing on these methodologies. A briefing should be provided on the methodologies as part of the consultation/engagement when the document is published. This briefing needs to include a reconciliation as to how projected patient volumes link into the economic and financial methodologies used in the SOC1 monetary projections.

SPECIFIC CONCERNS

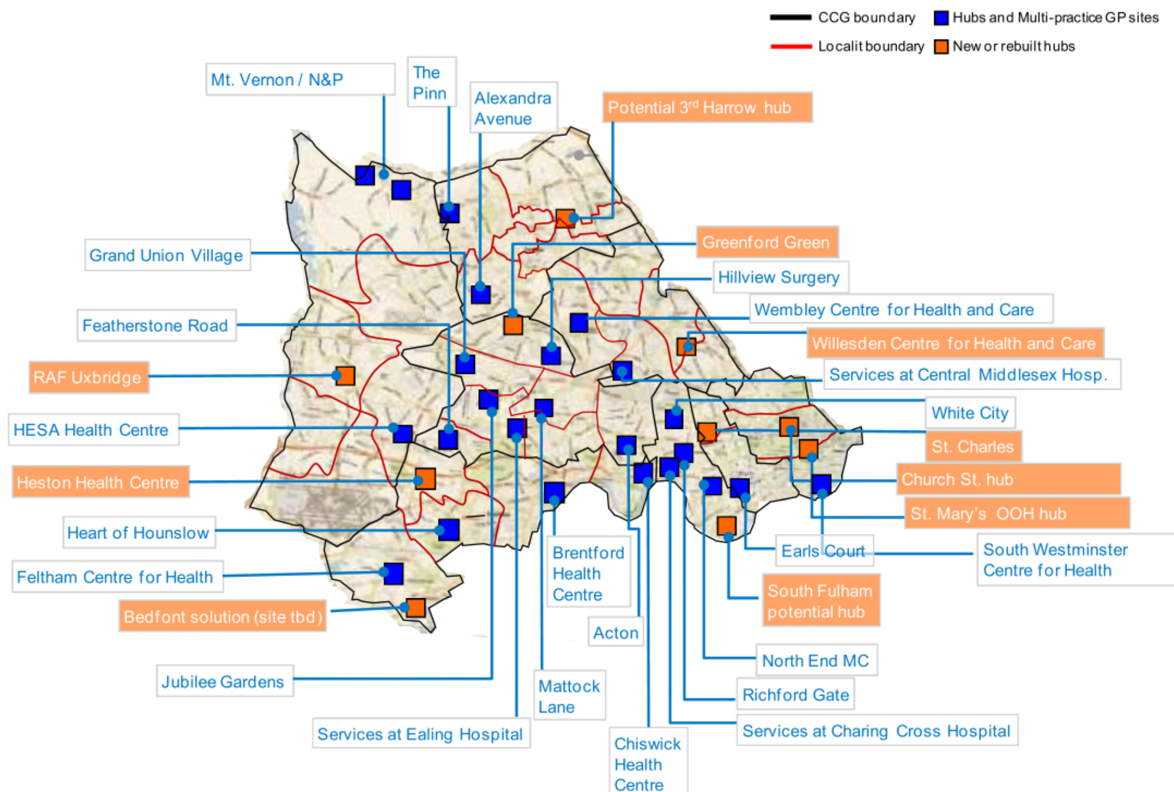
11 Out of Hospital Hubs

Page 36 of the October STP states that *"Hubs . . . are critical in enabling the reconfiguration of acute services"*. Page 34 of the Strategic Chapter of SOC1 states that *"Out of hospital hubs are key to the delivery of our model of care"*.

The February 2013 edition of the Decision Making Business Case (DMBC) contains the following two maps of the proposed Hub locations in LB Ealing.

The first map is from page 246 of the DMBC and shows <u>eight</u> Hubs in LB Ealing.

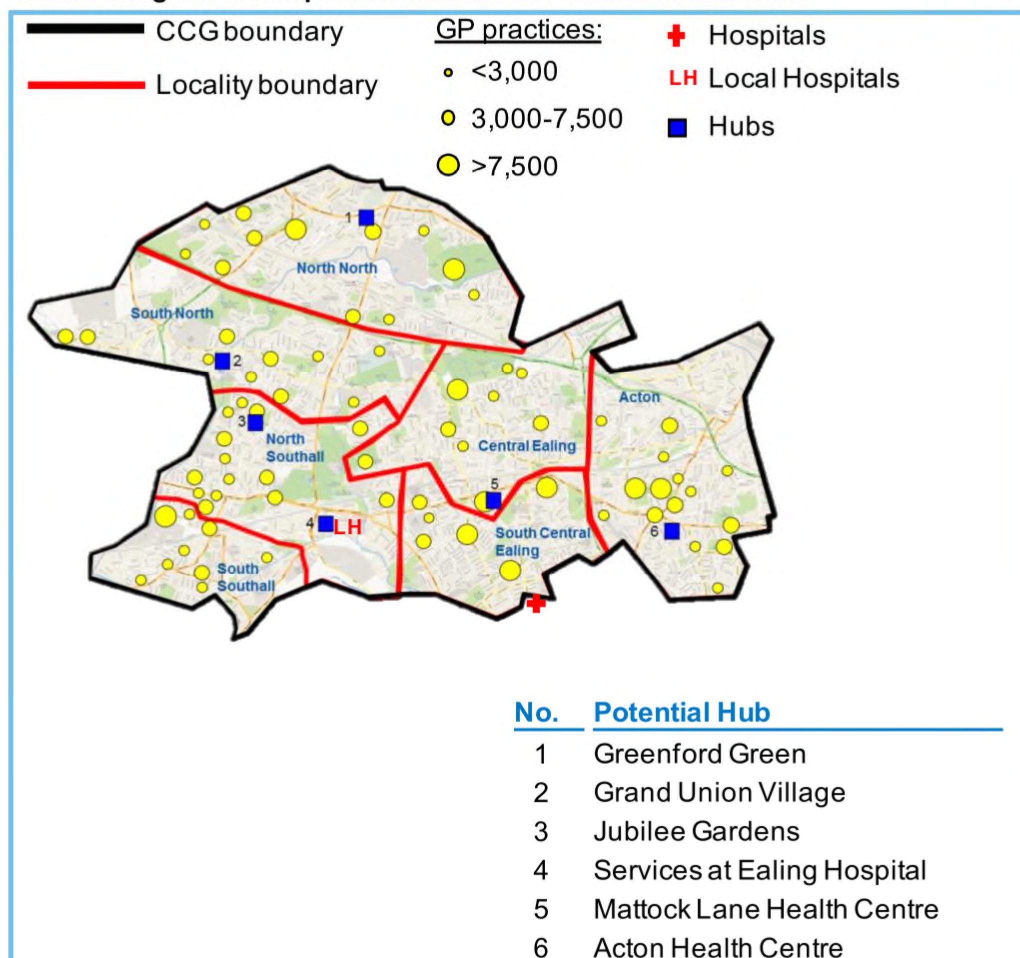
Figure 8.17: Potential hubs/health centres across NW London[3]



The above map shows the original intention of a high density of post reconfiguration Hubs across the LB Ealing. This would have been consistent with Ealing loosing key facilities from its only in-borough hospital,

The second map is from page 622 of the DMBC and shows six Hubs in LB Ealing.

Figure 16.10: Ealing out of hospital networks and hubs/health centres



No.	Potential Hub
1	Greenford Green
2	Grand Union Village
3	Jubilee Gardens
4	Services at Ealing Hospital
5	Mattock Lane Health Centre
6	Acton Health Centre

The first map, with eight hubs, locates three of them in the areas of above average deprivation and health need in the west of LB Ealing, i.e. at Grand Union Village, Jubilee Gardens and Featherstone Road.

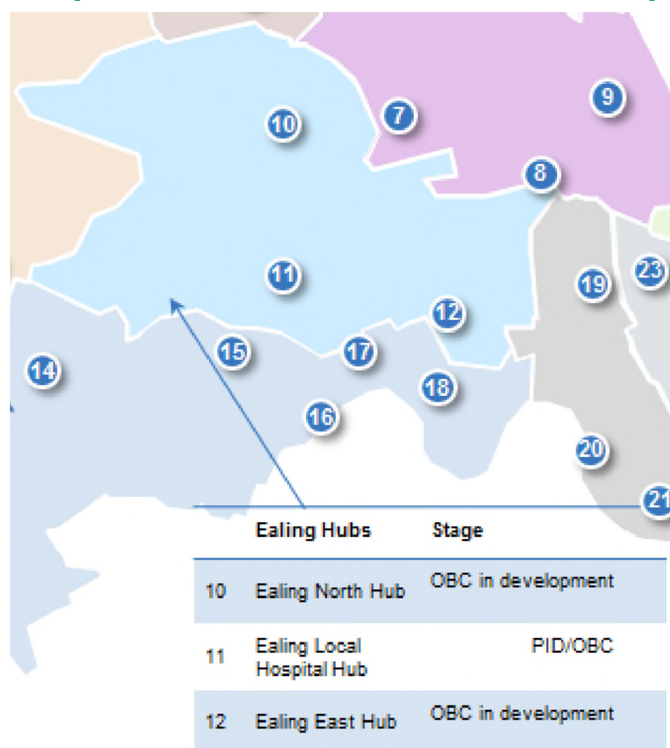
The second map, with six Hubs, locates two of them in the areas of above average deprivation and health need in the west of the Borough, i.e. at Grand Union Village and Jubilee Gardens.

It is therefore a matter of concern that these Hubs, which were destined for locations of high deprivation and health need have been deleted from the latest proposals contained in the STP and the ImBC-SOC1.

The following extract from the map on page 38 of the October 2016 STP shows a total of only <u>three</u> Hubs in the LB of Ealing, with none in the area of high deprivation and health need along the western edge of the Borough.

October 2017 STP – Only <u>Three</u> Hubs in Ealing

Proposed Local Services Hubs map



It is difficult to understand why key Hub locations in Ealing which were previously considered essential to the clinical delivery of the SaHF reconfiguration are now no longer required.

It is also difficult to understand how one of the most populous and geographically largest boroughs in London, with high levels of deprivation and health need, can be adequately served by only three Hubs – especially if the creation of Hubs is considered *"critical in enabling the reconfiguration of acute care"* and "*key to the delivery of our model of care*". The reduced number of Hubs is even more perverse as Ealing is losing its only in-borough Acute Hospital.

These concerns are exacerbated by the comparative position with neighbouring boroughs which are both retaining their Acute Hospitals and also retaining a greater number of Hubs per patient.

Appendix 8 to the IMBC-SOC1 includes an estates driven methodology which seems to suggest that Hub locations should only be made available where NHS premises currently exist. A questionable approach which ignores the medical needs of the local community.

12 GP Role and Provision

The premise behind the STP is that there will be seismic shift in care from hospital to community care.

There therefore needs to be more detail in the SOC1 about the future operation of GP services and the proposed investment in GP facilities.

13 Reduced Acute Hospital Admissions

We are unable to locate an analysis which shows, hospital by hospital, existing and projected future acute admissions.

This should include the number of admissions and their duration – with accompanying analysis columns which explain reductions from current activity levels. we note that a 30 percent reduction in acute attendances is referred to in the SOC1.

This analysis should reconcile to the economic and financial projections contained in the SOC1.

14 Reduced duration (Length of Stay) of Acute Hospital Admissions

Further information and detailed supporting analyses are needed to substantiate the 'high level' assumption that it will be possible to reduce the length of hospital stays by the equivalent of 273 beds across the NW London Region.

This reduction in bed capacity is in addition to the proposed reduction of 592 beds which will be achieved by 'admission avoidance'.

If some of the least ill admissions can be avoided, it seems reasonable to assume that the residual admissions will constitute the most seriously ill patients. It therefore seems doubtful that many of these patients will be eligible for earlier discharge than at present.

Further matters which need checking include the following.

The reconfiguration will mean that all Ealing residents who need acute hospital admission will need to be accommodated in hospitals outside Ealing. Page 27 of the October STP states: *"The average length of stay for a cross-border admission within NW London is 2.9 days longer than one within a CCG boundary."* This cross-border effect must mean that the closure of the acute wards at Ealing Hospital will add to the number of in-patient days.

It seems that the calculation of 273 bed savings due to reductions in the length of hospital stays is based on a 100% bed occupancy. We understand that problems can emerge when hospitals operate at greater than an 85% bed occupancy. It would therefore seem prudent to recalculate any deliverable bed savings at this lower occupancy percentage.

15 Reduction in A&E Attendances

We are unable to locate an analysis which shows, hospital by hospital, existing and projected future A&E attendances, and resulting admissions.

Again, this analysis needs to reconcile to the economic and financial projections contained in the SOC1.

16 Ealing Residents using Neighbouring Hospitals

There needs to be far more information and analysis/modelling on the post-reconfiguration impact of Ealing residents using the hospitals in neighbouring NW London boroughs. This could result in a significant resourcing challenge if the projected reductions in demand for acute beds do not materialise.

17 Cross-border patient flows

There doesn't appear to be any mention, or assessment of the implications, of cross-border flows.

NW London doesn't operate in a vacuum. Some hospitals, such as West Middlesex, support a large number of patients from Richmond upon Thames. Any reduction in acute bed provision in the SW London NHS region is likely to increase the pressures on West Middlesex Hospital.

With the closure of acute provision at Ealing Hospital, Ealing residents will, in effect, be competing with residents from outside NW London for acute beds at the NW London major hospitals.

18 Accelerated Reconfiguration of Ealing Hospital

Pages 61 to 64 of the Strategic Chapter and pages 114 to 117 of the Finance Chapter of the SOC1 refer to an accelerated reconfiguration of the Ealing Hospital site.

It is far from clear from the SOC1 that the replacement hospital, hub and community facilities will be fully operational in advance of the accelerated reconfiguration of Ealing Hospital.

There needs to be a far more detailed supporting analysis of this proposal than is contained in the current draft of the SOC1 and its appendices. This analysis needs to be supported with comprehensive timelines and estimated patient episodes.

19 Frail/Elderly hospital provision

Both the draft SOC1 and the October STP refer to the provision of Frail Elderly Beds on the post reconfiguration Ealing Hospital Site.

There is a lack of clarity and detail about this proposal in both the SOC1 and the October STP.

Is this provision intended for just the existing elderly patient catchment area of Ealing Hospital, or is it intended to accommodate frail elderly patients from across a far wider geographic area? If the latter it would mean that these patients will be accommodated in a hospital which is likely to be a considerable distance from their homes, family and friends, something which could adversely impact on their recovery and discharge.

There is no discussion of the on-site medical support facilities which can be needed by this category of patients, especially those whose condition can change at short notice. Currently these facilities are provided by the acute and emergency care teams based at Ealing Hospital. It appears that following the reconfiguration this medical support will not be available on the Ealing Hospital site.

20 Elective surgery

The SOC1 proposes to concentrate Elective Surgery on the Central Middlesex Hospital site in Park Royal.

Significantly more information should be included about this proposal including the number of patients, medical speciality and the locations where this surgery is currently taking place.

The Central Middlesex Hospital is relatively inaccessible by public transport from central Southall and often needs at least three buses in each direction.

The limited information in the public domain suggests that this proposal could be more a management convenience, rather than one intended to benefit patients and provide them with quality healthcare nearer their home.

21 London Ambulance Service

I can't locate any reference to the implications of the A&E and Acute Hospital reconfiguration in NW London on the operations of the LAS.

Page 52 of the October STP contains a somewhat ambiguous reference to the portion of the current LAS deficit which is applicable to NW London.

> *"There are also particular challenges in relation to . . . .The deficit in London Ambulance Service, of which only the NWL related element is included in this plan, which requires further joint working in order to agree a solution."*

It would seem likely that the reconfiguration of Ealing Hospital will result in increased usage of, and cost pressures for, the LAS.

There doesn't appear to be any mention of the additional cost pressures which must result from the proposed closure of A&E and acute hospital care on the Ealing Hospital site.

The closure of these facilities must mean that significantly more Ealing residents will need to be conveyed to out-of-Ealing hospitals by the LAS than at present.

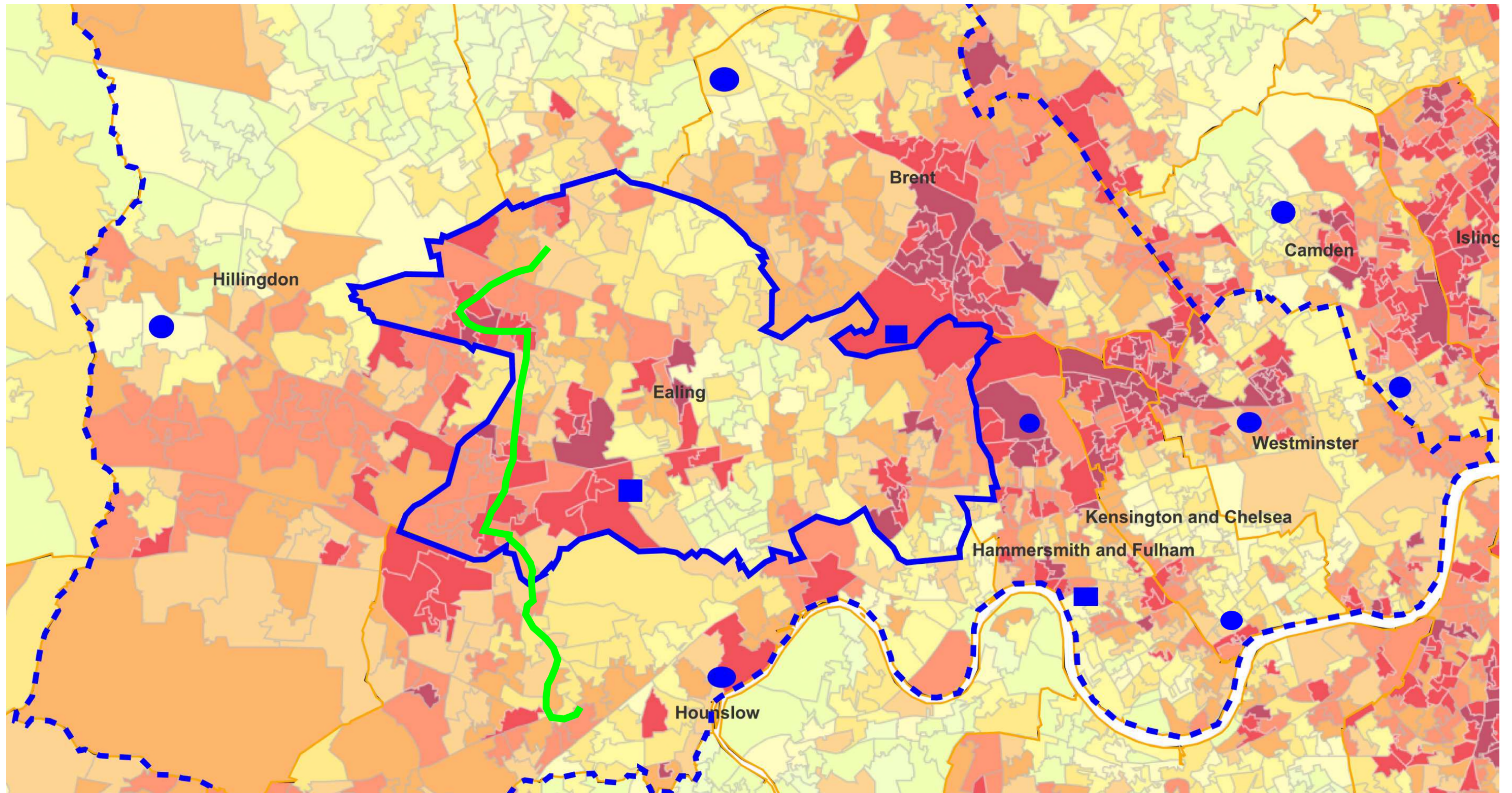
Again, detailed modelling and supporting analyses should be included in the STP and ImBC-SOC1.

LB EALING - MULTIPLE DEPRIVATION & HOSPITALS - WITH 120 BUS ROUTE

Areas shaded dark red have the highest deprivation

Ealing, Charing Cross and Central Middlesex Hospitals shown by blue squares, other hospitals shown by blue circles

120 Bus Route shown by green line

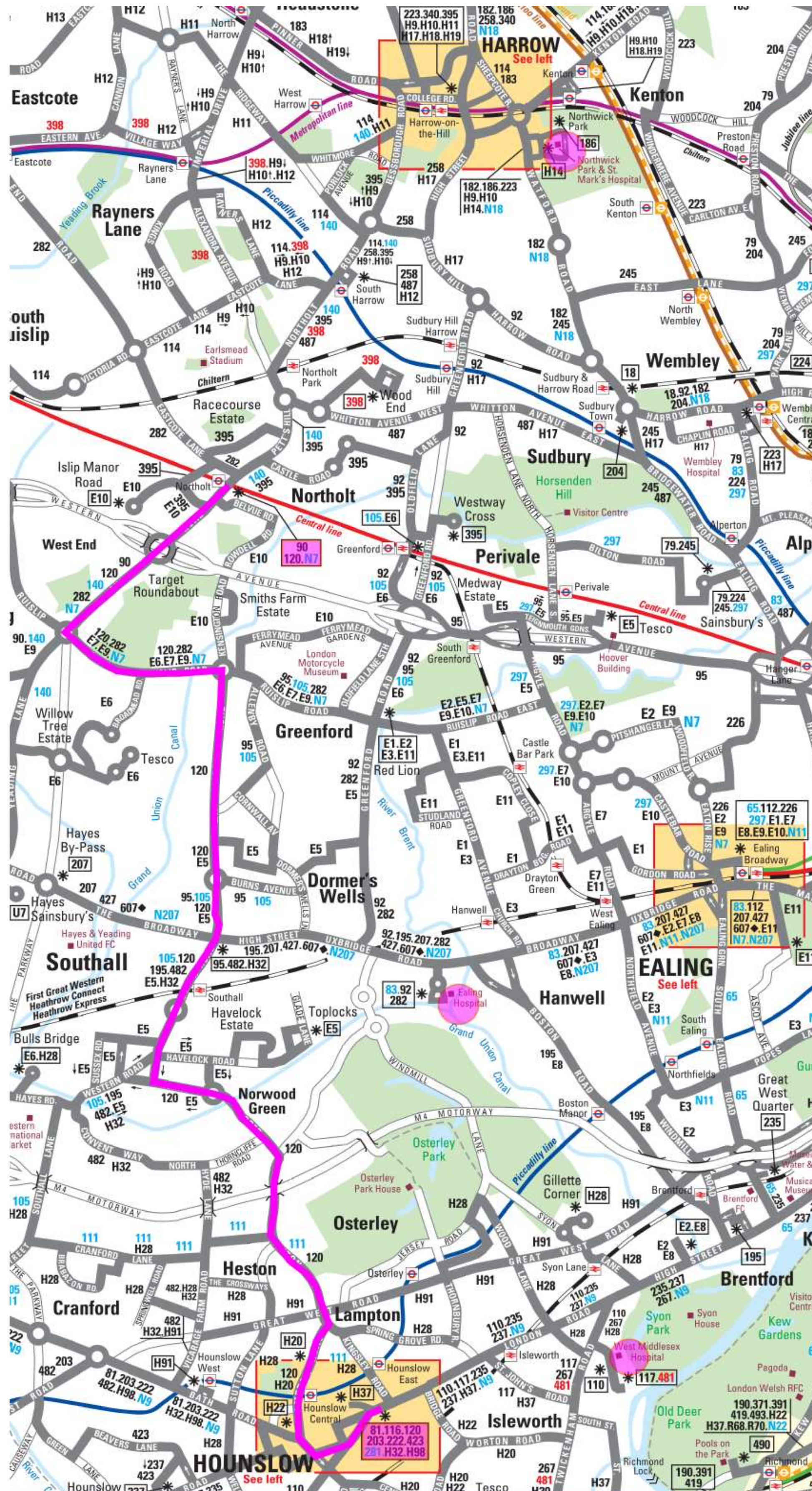


Source: DCLG http://communities.maps.arcgis.com/apps/Viewer/index.html?appid=2ebc578f03d749e18ca724e8cf2d28de

POOR BUS ACCESS FROM SOUTHALL TO NORTHWICK PARK HOSPITAL

SOUTHALL HAS ONE OF THE HIGHEST LEVELS OF DEPRIVATION AND HEALTH NEEDS IN LONDON

The 120 bus route highlighted below stops a long way short of Northwick Park Hospital.
Time consuming multiple further changes of bus are required by patients and careers.



LEGAL POWERS OF HEALTHWATCH EALING

Extracts from Healthwatch England Guidance

What does the Legislation say local Healthwatch must do?

Local Healthwatch are corporate bodies and within the contractual arrangements made with their local authority must carry out particular activities. A lot of the subsequent legislative requirements are based on these activities which include:

1. Promoting and supporting the involvement of local people in the commissioning, the provision and scrutiny of local care services.

2. Enabling local people to monitor the standard of provision of local care services and whether and how local care services could and ought to be improved.

3. Obtaining the views of local people regarding their needs for, and experiences of, local care services and importantly to make these views known.

4. Making reports and recommendations about how local care services could or ought to be improved. These should be directed to commissioners and providers of care services, and people responsible for managing or scrutinising local care services and shared with Healthwatch England.

5. Providing advice and information about access to local care services so choices can be made about local care services.

6. Formulating views on the standard of provision and whether and how the local care services could and ought to be improved; and sharing these views with Healthwatch England.

7. Making recommendations to Healthwatch England to advise the Care Quality Commission to conduct special reviews or investigations (or, where the circumstances justify doing so, making such recommendations direct to the CQC); and to make recommendations to Healthwatch England to publish reports about particular issues.

8. Providing Healthwatch England with the intelligence and insight it needs to enable it to perform effectively.

Section 1.1 of “Understanding the Legislation”, April 2015

What does the Legislation say about what local Healthwatch can do?

Local Healthwatch can ask providers for information which they must make available to you. For public bodies, local Healthwatch must rely on good relationships or use the Freedom of Information Act to get information. However, there is a separate requirement on NHS bodies and local authorities to implement the necessary arrangements to ensure that independent providers respond to your requests for information.

Local Healthwatch have an additional reporting power enabling you to refer matters relating to social care services to an overview and scrutiny committee of a local authority. These committees must then have regard to any relevant information you have sent to them.

Local Healthwatch have an additional power to Enter and View providers, so you can observe matters relating to health and social care services. These powers do not extend to services relating to local authorities' social service's functions for people under the age of 18.

Section 1.4 of "Understanding the Legislation", April 2015

What happens to your reports and recommendations?

To help make the views of people known to the people that are responsible for the commissioning, providing, managing or scrutinising of local care services, you can make reports and recommendations. These reports and recommendations can cover how local care services could or ought to be improved. The service providers must have regard to your views, reports and recommendations and respond to you explaining what action they will take, or why they are not taking action. Your reports and recommendations should also be shared with Healthwatch England.

Section 2.3 of "Understanding the Legislation", April 2015

Are there requirements relating to campaigning?

The regulations prevent a local Healthwatch from being set up as a political body or making political activities its main activity. The regulations allow local Healthwatch to speak out and to campaign (including for policy or legislative change) provided it is in support of their core purpose of being a consumer champion.

Section 2.7 of "Understanding the Legislation", April 2015