Dear Olivia

Thank you for your letter setting out a range of questions around the future of Charing Cross Hospital.

Before we get to the questions themselves, we think it useful to note the overall aim of the work we are doing here in Hammersmith & Fulham and across North West London. We want to flip the model of care from a reactive one, where we wait for people to get sick and then attend A&E, to a proactive one, which focuses on keeping people well and out of hospital, providing care in settings much closer to home wherever possible.

The *Shaping a healthier future* service reconfiguration for north west London, and the Trust's clinical strategy, set out plans for Charing Cross to evolve to become a new type of local hospital, offering a wide range of specialist, same-day, planned care, as well as integrated care and rehabilitation services, particularly for older people and those with long-term conditions. It would retain a 24/7 A&E appropriate to a local hospital.

However, we have been clear that we will not reduce acute capacity at the hospital, including within its A&E, unless and until we can achieve a sufficient reduction in acute demand. The Sustainability and Transformation Plan published in 2016 made a firm commitment that Charing Cross will continue to provide its current A&E and wider services for ***at least*** the lifetime of the plan, which runs until April 2021.

We have also made the commitment to engage with our local community, including with Healthwatch, as we start to develop the detail around the plans at Charing Cross. Your involvement in that process is essential and we look forward to continuing to work with you.

It's also worth highlighting that you raise a number of questions around the use of digital services within healthcare. Most people use health services in a local community setting where there has already been significant developments in the use of digital technology to improve patient benefits. Through the 'Care Information Exchange' Imperial College Healthcare is also leading a major initiative to build an online care record for patients and those providing their care across North West London.

Turning then to the questions themselves, please find detailed answers set out on the following pages. If you would like any further detail please let us know.

Clare Parker, Chief Officer – CWHHE, SRO – Shaping a Healthier Future

Ian Dalton CBE, Chief Executive, Imperial College Healthcare NHS Trust

A) COMMUNICATIONS AND INVOLVEMENT

Q1) What negative impacts for patients have been captured as part of your planning for this major change for example during an options appraisals?

A) The Strategic Outline Case (SOC) as the enabler for the North West London Sustainability and Transformation Plan (STP) offers an excellent opportunity to further address health inequalities and ensure a positive impact of any proposed service changes for our protected groups. We have a thorough understanding of the demographics and particular health challenges of our residents to support our inequalities work, and are of course working closely with our local authority colleagues to share and update our knowledge of specific groups and any emerging issues.

To date two Equality Impact Reviews have been completed. The first was undertaken when the Shaping a Healthier Future (SaHF) strategy was produced. This included, based on the available evidence to date, how the SaHF programme meets with the aims of the Public Sector Equality Duty.

The second was an STP-wide health inequalities impact screening analysis, which provides a framework for the detailed equalities impact assessments likely to be needed. This approach is in line with other STP regions.

The Equality Impact Reviews identify potential adverse impacts. These are all stated within the documents attached with indications of how these are or will be addressed. As we progress from the SOC to Outline Business Case and Financial Business Case, all details will be refined including the equality impacts and the actions required to mitigate these.

Full equality impact assessments will be undertaken in line with best practice for all relevant programmes and projects as part of their development.

It's also worth making the point here that there have been some really positive steps forward in the way we have transformed care across NW London as a part of the SaHF and STP plans – for example the maternity and paediatric transitions which have taken place have seen real benefits to our patients and residents. We continue to monitor and evaluate both of these transformations to ensure they remain successful. We are committed to ensuring that all service developments have effective and thorough monitoring and evaluation going forward.

Q2) Do you have evidence to demonstrate that patients and communities can be assured that possible negative impacts from future changes will be mitigated? If yes, please provide a copy of your evidence. If not, please provide us with information regarding how you are going to test and measure possible negative impacts.

A) As set out in the previous answer we have conducted Equality Impact Reviews which are available online at:

SaHF EIA
https://www.healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/Equalities%20Impact%20-%20Strategic%20Review%20%20vf.pdf

STP EIA
https://www.healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/stp_equality_impact_analysis_april_2017.pdf

Q3) What steps have you taken to communicate with the local population, your plans for Charing Cross hospital in a clear, accessible and easy to understand manner and how are you monitoring the progress? Please provide a breakdown of steps and monitoring mechanisms.

A) As indicated above, we have been very explicit about the fact that no major changes will take place at Charing Cross during the lifetime of the STP. This is a commitment that has been made publically and has not changed. At the 'town hall' style meeting held in October 2016, the CCG also committed to improving engagement with local residents more generally. To this end the CCG approved a new communications and engagement strategy at its meeting in September which sets out very clear objectives for future engagement with local people.

Additionally, the Trust uses its website and social media channels (eg Facebook and Twitter) to communicate with audiences about developments and issues regarding Charing Cross Hospital. We also use the Trust's electronic newsletters which are tailored to specific audiences: stakeholders; GPs; and patients and the public. Commissioners use the Healthier NW London website as well as the CCG twitter feeds to help keep people updated.

The Trust chief executive has regular meetings with local MPs and with Hammersmith & Fulham Council's Cabinet Member for Health and Health Scrutiny Committee Chair. The Trust chief executive also meets formally with representatives of the Save our Hospitals group. Similarly, senior officers from both Hammersmith & Fulham CCG and NW London routinely meet with the local MP, councillors and representatives from patients' groups to talk through our plans.

In addition, the Trust is planning a public event at Charing Cross Hospital at the end of November 2017 to set out the current position on Charing Cross and to share updates on recent and planned investments.

Q4) Will you be able to produce a briefing, for wide circulation, that explains what your plans are and what they mean for local people? The briefing should refer to policies from different documents to inform local people, but also provide them with the opportunity to track down the progress you are making moving forward.

A) We are happy to discuss an update which brings together all the plans (SaHF, Trust strategies and plans, STP etc) and explains where we are and the current position on Charing Cross. We would welcome involvement from Healthwatch in developing that update to ensure we make it as user friendly as possible for local people.

We will produce a concise briefing on the current position on Charing Cross and its future as part of the Trust's public event at Charing Cross being planned for November 2017.

Again, we also make the point that major change at Charing Cross is not planned until there has been sufficient reduction in acute demand, which will not be within the lifetime of the STP, that is not before April 2021. Any proposed changes will also include equalities impact assessments and opportunities for local people to be informed and involved.

Q5) How are you going to involve members of the public, as well as health professionals in the development of the plans for Charing Cross hospital? Healthwatch Central West London would like to be fully involved in the planning and consultation process and work with the Trust to ensure that any changes result in an enhanced level of healthcare provision for the local population.

A) As our plans for Charing Cross progress, we have been clear that we are committed to involving patients and the public in their development. We envisage that Healthwatch, as well as our own lay partners, will be integral to that process.

B) A&E AND WIDER SERVICES

Q1) What is the evidence that suggests that Charing Cross should become a local hospital and what is the definition of a local hospital? Please provide us with any supporting documents.

A) The case for Charing Cross to become a local hospital was set out in the SaHF consultation document. We believe that this will help us deliver services which are right for the people of Hammersmith & Fulham, matching their needs.

The consultation document (August 2012) for the plans to improve local NHS services in North West London as part of the SaHF programme, identified eight different settings for care. Section 10 of the consultation described a 'Local hospital' as follows:

"Local hospital – this type of hospital provides all the most common things people need hospitals for, such as less severe injuries and less severe urgent care, nonlife threatening illnesses, care for most long-term conditions such as diabetes and asthma, and diagnostic services. It basically provides the kinds of services that most people going to hospital in NW London currently go there for."

There is also further reference to this case within the SOC – Part 1. The strategic case in the SOC sets out a list of factors which point in the same direction:

1. Our current system is unsustainable. We cannot achieve our vision without major changes to how we deliver care, given the population health trends, coupled with

our current model of care and health infrastructure. This is therefore an opportunity for us to do something different and better for our residents.

2. We have a strategy to meet our residents clinical and social care needs in the right place at the right time. We will reconfigure health services so they are: localised where possible; centralised where necessary and in all settings integrated across health and social care providers to improve patient care.
3. We are confident that based on our experience of successfully delivering change and identified opportunities; our new model of care will address the key issues. Our strategy is to focus resources to keeping the population well through management of long term conditions, rapid access and treatment via local services with high quality acute specialist care when it matters most. This will achieve financial and clinical effectiveness.
4. Our new model of care requires major changes. Our SaHF proposals deliver much of this vision. Approved by the Secretary of State in 2013, SaHF is an inter-connected model of care which:
    - Retains activity in the community, enabled by out of hospital hubs where services are co-located and primary care is delivered at scale
    - Reconfigures our acute services to deliver high quality care and provide clinical and financial sustainability. This is principally achieved by concentrating valuable clinical capability across fewer sites

It is also important to recognise that in Hammersmith & Fulham, as well as across North West London as a whole, we face the following major challenges:

- An ageing population with increasingly complex and resource intensive health needs, with an increase in the overall population.

- Over 30 per cent of inpatient beds in acute hospitals are occupied by patients whose care would be better provided elsewhere in their own home or community. Clinical audits regularly show that over 30 per cent of patients in an acute hospital bed do not need acute care.[1] It is best for patients if they are able to return home at the optimal time for them, to be subsequently cared for in the most appropriate setting, preferably their own homes.

- Unacceptable variation in the quality and delivery of all services. There are variations in the quality of care and the proportion of patients who need to be readmitted after receiving a number of procedures varies considerably from one hospital to another. Senior doctors' availability in acute medicine and emergency general surgery at the weekends is more than halved at many sites compared to cover during the week.

- A reactive health service where resources are still focused on getting patients better rather than keeping people well to start with.

- Workforce capacity with shortages in supply expected in many professions and expected increases in demand, combined with the need for a skilled workforce to

[1] NW London Sustainability and Transformation Plan v01 21 October 2016.

deliver a 7-day service under the current model across multiple sites. The lack of skilled workforce to deliver a seven-day service under the current model across multiple sites is an issue in North West London. Workforce shortages are expected in many professions under current supply assumptions and expected increases in demand making the provision of services more fragile.

- We have more A&E departments per head of population than other parts of the country and insufficient capacity to meet demand as senior staff and resources are spread too thinly across multiple sites.[2]

- Poor quality estate in our hospitals and primary care which is increasingly costly to maintain, does not meet modern standards and is not fit for purpose for delivery of care. NW London has more poor quality estate and a higher level of backlog maintenance across its hospital and primary care sites than any other sector in London. For example, a detailed survey and compliance audit (called a six-facet survey) undertaken in 2015, suggested total investment / project costs of £1.3 billion to bring all the Imperial College Helathcare Trust estate to an acceptable condition (Source: Imperial College Healthcare NHS Trust Annual Report 2016/17, p49)

- Too many small hospitals resulting in a compromise of clinical productivity for the residents of North West London, with valuable clinical resources being spread too thinly and the inability to drive high quality specialist care which can be achieved by concentrating care into fewer large hospitals:

    - The total population in North West London is 2,086,000 as of 2015/16.[3] With a growing population in North West London it is increasingly hard to provide a broad range of appropriate specialist services at the existing nine acute hospital sites to the standards our patients expect and deserve.

    - This is because specialist teams gain skills as a result of the numbers of people they diagnose and treat. There is evidence that the more specialised doctors and other professional staff become, the better the results for patients.[4] If treated by a specialist, patients are at a lower risk of death, are likely to have fewer complications and are likely to benefit from shorter stays in hospital.[5]

    - Units therefore need to serve a sufficiently large population so they are busy enough for clinical staff in a variety of specialities and subspecialties to maintain their clinical skills for the best outcomes for patients.

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[2] "Delivering High-quality Surgical Services for the Future", a consultation document from the Royal College of Surgeons reconfiguration working party, March 2006.

[3] Office for National Statistics (ONS) population estimates.

[4] Hall, Hsiao, Majercik, Hirbe, Hamilton, The impact of Surgeon Specialization on Patient Mortality; Annals of Surgery 2000.

[5] Chowdhury, Dagash, Pierro. A systematic review of the impact of volume of surgery and specialisation on patient outcome; British Journal of Surgery, 2007.

- For example, guidance from the Royal College of Surgeons[6] recommends that for emergency surgery to be of high quality, activity from a population of 500,000 needs to be undertaken on one site. Even with the current configuration of A&E services nationally, the seven A&E departments in North West London hospitals each have a catchment population smaller than average.

- And clinical evidence has highlighted that for emergency care services, early involvement of senior medical personnel in the assessment and subsequent management of many acutely ill patients improves outcomes.

- It is known that in North West London, our hospitals are only sometimes meeting the seven-day services standards guidelines of emergency general surgery admissions seeing a consultant within 14 hours.

Q2) What evidence is there that GP hubs and other out-of-hospital provision are reducing demand on hospital services?

A) There is national evidence from the work being undertaken by Vanguards which supports the case for reduction in demand. I attach an NHS presentation from the national new models of care team which is presenting early evaluation of vanguards. Slide 5 quotes 30% reduction in NEL admissions. Locally, we have yet to secure the capital required for the majority of the hub developments. Of the hubs which we have developed the evidence is just emerging. We are in the process of compiling this and anticipate having this available later this year. We have a full strategy for this work in enclosed in these two documents.


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NW London Local Services Strategy Pre

Q3) "No reduction of A&E and wider services" – this term has been used in the Trust's responses to concerns regarding a closure plan for Charing Cross Hospital. Please provide a breakdown of all services with clarification what is included and what is not in "wider services".

A) Charing Cross Hospital provides a range of acute and specialist care services, it also hosts the hyper acute stroke unit for the North West London region and is a growing hub for integrated care in partnership with local GPs and community providers. Information on all the services at Charing Cross Hospital is provided on the Trust website.

Our approach of actively not progressing plans to reduce acute capacity at Charing Cross Hospital unless and until we could achieve a reduction in acute demand was formalised in the North West London STP published in 2016. The plan made a firm commitment that Charing Cross Hospital will continue to provide its current A&E for at least the lifetime of

[6] "Delivering High-quality Surgical Services for the Future", Royal College of Surgeons, March 2007.

the plan, which runs until April 2021. We also made the commitment to work jointly with staff, communities and councils on the design and implementation of new models of care.

The Trust does consider specific proposals for service changes from time to time in response to quality, safety and/or efficiency issues. On these occasions we are very mindful of our duty to engage with patients, the public, their elected representatives and our other partners in order to develop the best proposals and reach the right decisions for patients. We followed this approach with the successful move of the stroke unit at St Mary's Hospital to Charing Cross Hospital in 2015.

We will continue to engage with people on specific service proposals and we will also undertake equality impact assessment related work for any such proposals.

Q4) If the Shaping a Healthier Future plans go through, please clarify: a) Will there be A&E and consultants on site at Charing Cross? And b) Will there be a blue light ambulance service at Charing Cross?

A) In 2012, the NHS published plans for a reconfiguration of health services across North West London to respond to rapidly changing health and care needs. A full public consultation set out plans for a more integrated approach to care, with the consolidation of specialist services onto fewer sites, where this would improve quality and efficiency, and the expansion of care for routine and on-going conditions, especially in the community, to improve access.

Charing Cross Hospital was envisaged as a local hospital within this network of services, building on its role as a growing hub for integrated care offered in partnership between hospital specialists, local GPs and community providers..

In October 2013, the Secretary of State for Health supported the proposals in full, adding that Charing Cross Hospital should continue to offer an A&E service, even if it was a different shape or size to that currently offered. He also made clear that there would need to be further engagement to develop detailed proposals for Charing Cross Hospital.

The subsequent work to engage patients and the public in the development of detailed plans for Charing Cross Hospital was paused as increasing demand for acute hospital services highlighted the need to focus first on the development of new models of care to help people stay healthy and avoid unnecessary and lengthy inpatient admissions.

Our approach of actively not progressing plans to reduce acute capacity at Charing Cross Hospital unless and until we could achieve a reduction in acute demand was formalised in the North West London STP published in 2016. The plan made a firm commitment that Charing Cross Hospital will continue to provide its current A&E for at least the lifetime of the plan, which runs until April 2021. We also made the commitment to work jointly with staff, communities and councils on the design and implementation of new models of care.

At this stage, therefore, before the engagement process with the residents of Hammersmith & Fulham, it is too early to specify the details of services Charing Cross Hospital would offer in the future.

C) BEDS, COMMUNITY SERVICES AND ACCESSIBILITY

Q1) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: a) How many beds will there be and what type will they be when compared to now?

A) As indicated previously it is too early to specify the details of services Charing Cross Hospital would offer in the future.

Charing Cross Hospital currently has just over 400 inpatient and day-case beds.

Successful programmes have shown that high-quality interventions that support patients before they become acutely unwell can reduce non-elective admissions and slow progression of a disease. This can contribute to a reduction in overall care costs through the removal of acute beds when out-of-hospital solutions are in place. It does not necessarily mean planning to treat fewer people – it means treating people in a different way or different place.

The NHS is already working closely with local residents and patients at CCG level as we implement new services that help people stay as healthy as possible, avoid unnecessary stays in hospital (especially older patients) and support patients to return home as quickly with the support they need. We will build on this engagement activity to engage further with stakeholders specifically about the services Charing Cross Hospital should offer in the future.

The Trust's current clinical strategy was published three years ago in 2014. We see each of our three main hospitals developing their own distinctive and interconnecting character: with Hammersmith continuing on its path as a specialist hospital with a strong focus on research; St Mary's being the acute/emergency hospital for North West London; and Charing Cross as a pioneering local hospital with planned/elective surgical innovation and integrated care services. All the Trust's main hospital sites will continue to provide local services as well as their particular unique function.

At the time of the clinical strategy being published the proposed number of beds at our main hospital sites by 2020 was shown (with the July 2014 numbers in brackets) shown in the table below:

Hospital	**Total**	**Inpatient beds**	**Day-case beds**
Charing Cross	150*	24 (360)	86 (41)
Hammersmith	466	427 (406)	39 (39)
St Mary's	540	507 (401)	33 (40)
Total	1,156*	958 (1,167)	158 (120)

* In the space requirements and costings for Charing Cross Hospital, we also allowed for a further approximately 40 beds to support a new integrated care offering.

Since then, the work to engage patients and the public in the development of detailed plans for Charing Cross Hospital has been paused as increasing demand for acute hospital services at the site highlighted the need to focus first on the development of new models of care to help people stay healthy and avoid unnecessary and lengthy inpatient admissions.

Our approach of actively not progressing plans to reduce acute capacity at Charing Cross Hospital unless and until we could achieve a reduction in acute demand was formalised in the North West London STP published in 2016.

Q) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: b) If there is a reduction of beds, how will demand be met and managed?

A) Demand will be met and managed through a combination of increased capacity at other local trusts, reduced demand for services through better management of long term conditions such as diabetes, earlier intervention when people become ill and new ambulatory models in hospitals so that less people are conveyed or admitted, and discharging people home at the right time with full community support becomes the norm.

Q) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: c) If there is a reduction of beds, how are you measuring safety issues given the high bed occupancy figures at ICHT hospitals?

A) NHS England Chief Executive Simon Stevens announced earlier this year that hospital bed closures arising from proposed major service reconfigurations will in future only be supported where a new test is met that ensures patients will continue to receive high quality care.

From 1 April 2017, local NHS organisations have to show that significant hospital bed closures subject to the current formal public consultation tests can meet one of three new conditions before NHS England will approve them to go ahead:

- Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
- Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
- Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme)

All bed reduction proposals will, therefore, be subject to being evaluated against these conditions. The assessments made against these conditions will form part of any documentation that is put forward to NHS England and will be included in documents considered at Trust Board and CCG Governing Body meetings in public.

Q) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: d) Are there any estimates as to how many in-hospital patient visits that requiring bed and clinic capacity will be replaced by community based services?

A). We have made estimates in the past, for example during the 2012 consultation, and we will be updating all figures once we have implemented and evaluated the out of hospital services so that they reflect real activity and demand in the future.

Q) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: e) How many of these community based services depend on the enhanced digital capabilities and interoperability strands referred to in Local Digital Roadmap – STP January 2017?

A) Full realisation of the integrated health and care services envisaged in the local area will require a shared digital patient record, which allows transfers of care between different settings to be automated. Where these settings use different clinical IT systems, the shared digital record is dependent on interoperability between those systems.

Community based services in the area are currently supported by TPP's SystmOne Community clinical IT system, which is a common platform with the GPs in the three local CCGs, all of which use SystmOne; so the shared record is already available between primary and community healthcare.

Between primary and acute care, there are some existing interfaces between SystmOne in primary care and the Cerner acute clinical IT system in use at Imperial College Healthcare (and due to be implemented at Chelsea & Westminster): referrals can be transmitted electronically from SystmOne using the NHS E-Referrals Service (e-RS) and discharge information at the end of acute episodes of care is sent electronically from Cerner to SystmOne.

However, full realisation of the shared digital patient record will require more comprehensive interfaces between community and acute services, either directly or via the NW London Care Information Exchange currently under development. These interfaces do not yet exist in SystmOne, but fortunately TPP has recently announced that it will develop an open interface capability, and we would expect links to Cerner to be developed and in place well before 2021.

Q) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: f) In Shaping a Healthier Future 2012, there were plans to develop a separate elective orthopaedic hospital on the lines of the one in Epsom. Is this still planned and how will it affect Charing Cross?

A) There are no plans in place to develop a separate elective orthopaedic hospital. The Provider Board considered the benefits of an orthopaedic centre(s) in April 2017 and made two recommendations. Firstly to approach the Elective Orthopaedic Centres (EOC) in two phases and not assess the feasibility of an EOC in 2017/18. The first phase will be to drive up productivity and quality within each Trust and to measure performance against a sector score card, informed by existing measures that Trusts use. It was noted that the MSK clinical network will be key to supporting delivery. Secondly it was agreed to review the data in April 2018 to assess the need for a NW London EOC. This two-part approach is driven in part by the need for capital funding for an EOC.

Q) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: g) How will Charing Cross, as a local hospital be complemented by integrated care and an Accountable Care Partnership

A) NHS commissioners across North West London have agreed that Accountable Care Partnerships are the preferred model for delivering an integrated care system. Accountable care approaches are a potential way of overcoming dispersed responsibility for the commissioning and provision of care.

Imperial College Healthcare is part of a collaboration of organisations - the Hammersmith & Fulham Integrated Care Partnership - working to develop a radically better way of providing care for the population of Hammersmith & Fulham through an integrated/accountable care approach.

The programme also involves lay partners in the co-design of all aspects of the emerging care model. Healthwatch representation in the programme structure is provided by Olivia Freeman, who is a member of the steering group and a valued lay partner.

During 2017/18, the partnership plans to test its shared principles in practice by redesigning a number of care pathways for a sample of the population. The partnership is also working closely with Hammersmith & Fulham social care services.

Q2) Given that we have a growing, ageing population who live longer with periods of chronic illness and disability how can you in practice reduce planned admissions without rationing access to operations such as cataract removal, knee and hip replacements? Isn't there now an additional pressure on the STP to limit access to these procedures given their inclusion on the list of areas whose finances are deemed to require increased control through the Capped Expenditure Process?

A. The Capped Expenditure Programme (CEP) is not about cutting services - but making sure we balance our books across the NHS in North West London. We have to reduce waste and cut inefficiency across North West London and it is important we do that in a sensible, planned way, so as to avoid any unplanned cuts at a later date. By taking this approach we can ensure that we continue to deliver high quality healthcare services. The overall approach we are taking to healthcare in NW London is all about better management of long term conditions and earlier interventions to ensure that we can deal sensibly with the growing and ageing population.

D) CHARING CROSS IN THE NATIONAL CONTEXT

164,000 disabled people this year in England have had some or all of their Personal Independence Payments withdrawn and Employment Support Allowances have been cut by 33.3%. Between 2010 & 2015 there was a 31% cut, i.e. £4.6bn in English social care budgets and 400,000 fewer people receive social care in 2015 compared to 2009-10 (Association of Directors of Social Services Budget Survey 2015).

Q) Given this context and how it is reflected in the areas served by Charing Cross Hospital please answer the following: a) Have you measured how these changes on a national level have impacted residents across North West London?

A) The planning work around the SOC has not addressed this in detail as the nature of the SOC is to focus on high level growth based on historic trends and the individual plans from each Trust and each provider. If this is addressed it would be in the detail of those plans rather than in the SOC. Plans for specific service change will be influenced by the analysis of local needs and services designed in ways that meet those needs.

Q) Given this context and how it is reflected in the areas served by Charing Cross Hospital please answer the following: b) How this national landscape has been taken into account to inform your plans for the future of Charing Cross hospital services?

A). Our planning is based on actual data and the use of past trends to influence future planning. The impact of social care cuts is reflected in our planning. Also its important to point out that integrated care gives us an opportunity to mitigate the impact.

Q) Given this context and how it is reflected in the areas served by Charing Cross Hospital please answer the following: c) Given this collapse in funding, how can you ensure that STP plans are realistic

A) It is not clear what impact, if any, the changes in national policy for Personal Independence Payments (PIP) and Employment Support Allowances (ESA) will have on health needs. As the STP is very much a high level document it is the detailed planning of individual services that will need to take account of the specific needs highlighted during the service design phase.

Q) Given this context and how it is reflected in the areas served by Charing Cross Hospital please answer the following: d) How have you tested the assumptions that integrating community health and social care can generate enough extra capacity to compensate for potential loss of services?

A) The integration of community health and social care involves changing the model of care from a reactive one, where we wait for people to get sick and then attend A&E, to a proactive one, which focuses on keeping people well and out of hospital, providing care in settings much closer to home wherever possible. This will require new funding and evaluation approaches which will require modelling and testing prior to rolling out. We have made real inroads in reducing our non elective admissions across NW London – which bucks both the London and the national trend – see the graph at Appendix II for more detail.

We are continuing to work with our social care partners to develop better integrated services. The joint strategic needs assessment outputs will support the decisions made about what services are provided and how best they can be delivered to ensure that those most in need receive the level of care and support that they require.

As mentioned earlier, through the Hammersmith & Fulham Integrated Care Partnership, in addition to social care and community services Imperial College Healthcare is working with other healthcare providers - West London Mental Health Trust, the Hammersmith and Fulham GP Federation and Chelsea and Westminster Hospital - on new models of care.

Q) Given this context and how it is reflected in the areas served by Charing Cross Hospital please answer the following: e) Have you measured the impact these changes at the national level will have in the local context regarding Charing Cross provision for people that are not in employment?

A) The planning around Charing Cross is in the very early stages. We are not planning on making any changes to Charing Cross within the lifetime of the STP.

E) FUNDING

Q1) According to this article http://www.nationalhealthexecutive.com/Health-Care-News/go-ahead-given-to-support-15-stp-areas-with-325m-capital-investment?dorewrite=false/Page-1345 from 19.07.2017, NW London STP is not going to participate in a share of the £325m, funding which NHS England has targeted to "strongest and most advanced schemes in STPs" How will losing out on this bid affect the

delivery of the STP and, in particular, Charing Cross hospital provision? What are the current steps taken to face the financial challenge?

A) The £325 million was the first cohort of STP capital funding which was for schemes due to be completed within the next twelve months. We are still progressing our bid for funding and understand further funds will be available. Our bid is following an approval process requiring regulator (NHS England and NHS Improvement approval) and Department of Health approval prior to being considered by the Treasury. This is still progressing. We are still anticipating our plans being funded in due course.

Q2) On page 42, Local Digital Roadmap January 2017 states in the last sentence: "Funding for the programme is still under discussion within NHSE, and full details of programme costs and the associated funding will be published in due course." Please clarify "due course" and inform us when you will be able to provide a timeline related to the funding. Which systems will be prioritised? What are the clinical and demand implications of not providing the technology systems that cannot be funded?

A) NHSE has clarified that there will be no funding for the Local Digital Roadmap (LDR) in 2017/18. It is expected that the funding for 2018/19 will be announced at some point after the Autumn Budget and that the bidding process will be clarified in February 2018. The North West London Digital Portfolio Board will be responsible for agreeing a list of prioritised projects within the context of the national investment levels available. The implication is that aspiration to be paperless by 2020 will not be realised.

Q3) Local residents are concerned that saving £1.3bn from NW London's budget over the next 5 years could lead to job redundancies or downgrading of skills. How are you going to measure labour cost against the budget and what are the steps you are taking to show that you mitigate possible negative impacts on the quality of healthcare?

A) In 2016/17, the Trust invested £600 million in staff benefits (pay and pension contributions) from a total annual expenditure of £1,091.5 million. Appendix 1 shows the annual growth in Trust staff benefits over the past three years.

The Trust's clinical staff (including consultants, doctors and senior nurses) often work across more than one of our hospital sites and so the Trust does not hold information for the number of clinical staff by specific hospital site.

The Trust currently employs nearly 11,000 staff in total, of which around 2,500 are doctors including consultants. Five years ago the Trust had a total headcount of nearly 10,000, of which around 2,000 were doctors including consultants.

As healthcare changes so the roles our staff perform will change and people will do their jobs in different ways. However while we expect the ways of working to change we would always ensure that we had the right numbers of staff to deliver safe care.

While the savings target is challenging, it is also recognised that changing the way services are delivered should achieve economies of scale that will enable significant savings to be made. North West London is looking at the experiences in other places where efficiencies have been achieved and service quality and levels maintained. Part of service reconfiguration does involve reviewing how services are delivered and the skill mix required. This will also happen across North West London in order to ensure that the right staff at the right level and in the right quantity are available. Some staff will almost certainly be doing things in different ways in the future which could mean that certain services require fewer people. Nothing has been 'set in stone' with regard to overall staff levels across the five years of the STP. Any changes in workforce will be part of the detailed service plans that are developed at a local level.

F) TECHNICAL INFRASTRUCTURE

Q1) How robust is the technical infrastructure being put in place, which the move to the community model of service provision relies upon. How can assurance be demonstrated to the community?

A) The NHS network (N3) provides a secure and robust means to enable teams working in community locations access to the Trust's full range of clinical systems. This is demonstrated through the existing community and acute services already provided across North West London.

Q1a) How many systems that need to, can share data now and how many will be able to by 2021?

A) Community healthcare services in the three boroughs covered by Healthwatch Central West London are currently delivered by Central London Community Healthcare (CLCH) and Imperial College Healthcare, mainly using TPP's SystmOne clinical system. Other care settings which will be relevant are Urgent & Emergency Care and federated primary care services; most of these settings are also served by SystmOne, including all practices in the tri borough

Cerner is the electronic patient records system in use at Imperial College Healthcare and being implemented at Chelsea and Westminster sites. It has an interoperability tool to enable sharing of data with other clinical systems. The providers of SystmOne, which is widely used in primary care, have recently announced that they will be enabling information sharing. This will allow us to build on the work already done to develop the Care Information Exchange to create an information sharing platform that incorporates clinical information from systems across all care settings in North West London.

Q1b) What are the implication for the STP if the underlying systems cannot share data? What will be the effect of removing the productivity tools required to provide to healthcare remotely?

A) Communication between care settings is less effective and efficient if it relies on manual processes to effect transfers of care. More effective working is dependent on the ability of systems to share data between acute (Cerner), community (mainly SystmOne) and primary care (SystmOne). This capability already exists between community and primary care. SystmOne does not currently share data with acute systems, but the supplier TPP has recently announced a commitment to develop open interfaces to SystmOne and we would expect interoperability to be developed in the next one or two years.

We are not entirely clear what is meant by the second part of the question. Clinicians in primary and community care are already able to work remotely via mobile devices such as laptops and tablets – this is what is normally meant by 'productivity tools'. These are not being removed.

Q1c) What is the state of cyber security across all systems?

A) Imperial College Healthcare remained free from virus infection during the global cyber-attack on 12 May 2017. The Trust continues to maintain and strengthen its ability to protect our systems against cyber security threats.

Q1d) What is the timeline for improving or rendering obsolete technology that can be economically improved?

A) During 2016/17, Imperial College Healthcare invested a total of £6.1 million in Information, Communications & Technology (ICT) infrastructure. We are one of 16 acute Trusts that have been nominated Global Digital Exemplars with a commitment to drive digital innovation for our patients

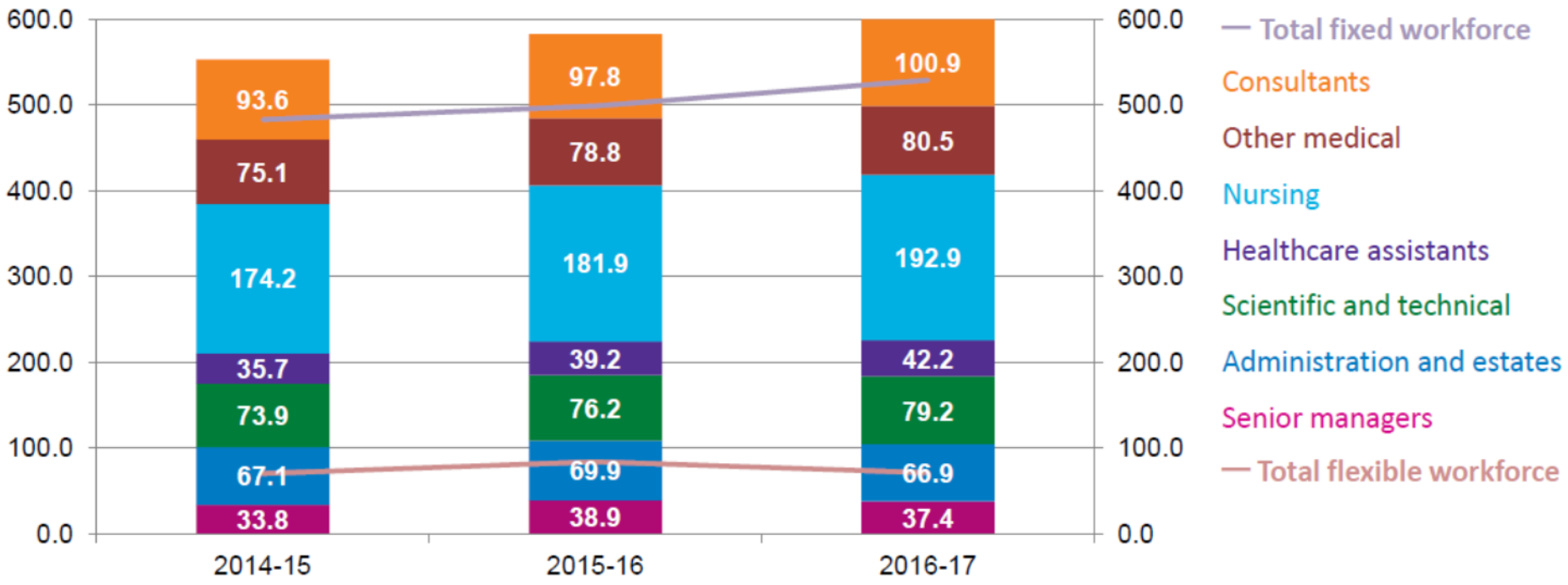
Q1e) What are your plans for raising data standards to improve interoperability of the IT infrastructure?

A) To most effectively share information between systems the data must be recorded in a structured way that is common to all systems. Snomed is the coding standard that is being adopted across the NHS to facilitate this and is being implemented across North West London.

Appendix 1

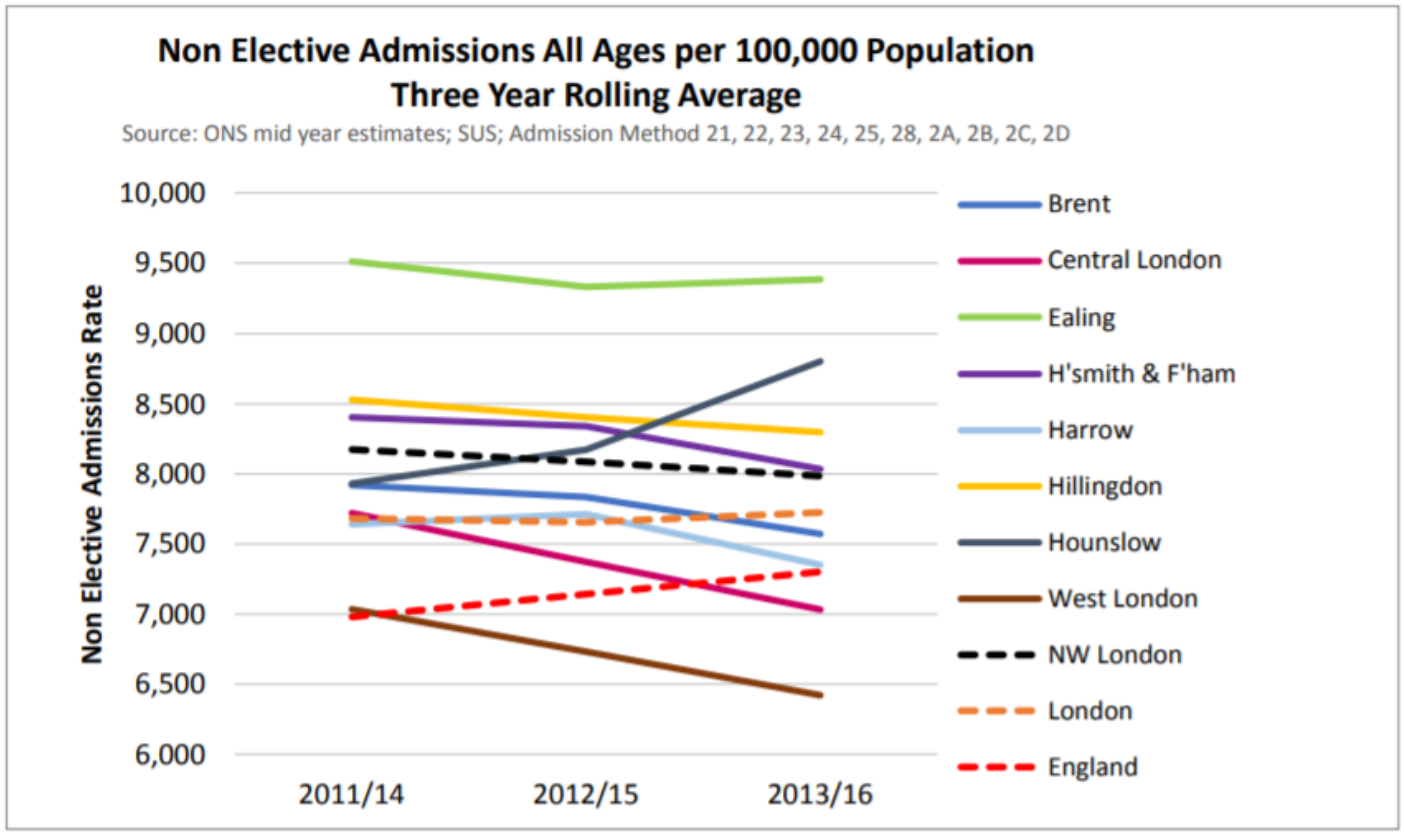
Imperial College Healthcare NHS
NHS Trust

2016/17 investing in staff (£m)



Appendix II

Figure 15: Non-elective admissions all ages per 100,000 population three year rolling average 2011/12 to 2015/16



Source: Strategic Outline Case (SOC) Part 1 – p.47