A Critique of 'Shaping a Healthier Future'

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Section 1 Introduction

This report provides a detailed critique of the 'Shaping a Healthier Future' (SaHF) proposals and resulting developments in North West London. We consider the following four key areas of concern with the workings of the SaHF programme:

- Impact on access to care;
- Evidence on quality of care;
- The business case; and,
- The consultation process, and engagement and involvement since a decision was made.

These are covered in some detail in four separate sections, each of which will be based on four types of evidence:

- Documents from SaHF and the local NHS;
- National policy and planning documents;
- Documents reflecting expert opinion and evidence; and,
- Interviews with local stakeholders.

We draw a range of conclusions from this body of evidence, and base our recommendations on the evidence before us.

But first we introduce SaHF, the process that underpins the changes taking place in North West London.

1.1 Shaping a Healthier Future

SaHF is a strategy presented in various stages by healthcare commissioners and providers within North West London with the stated objective of providing sustainable and high quality clinical services in the future. Work on SaHF began in 2009 and a proposal went to public consultation in 2012. It is clear that a key influence on the process was the report by McKinsey (2009) which briefed senior figures in government and within the NHS that the NHS spends too much on acute care and could save billions by shifting care away from acute settings. This led to major reconfiguration proposals being promoted in many parts of England and London.

The main content of the SaHF proposals was to downgrade four of the nine hospitals in North West London, to centralise services in the remaining five, and to develop 'out of hospital' (OOH) and primary care services in order to reduce the demand on acute services.

The consultation

The SaHF consultation document (NHS North West London 2012a) was issued in July 2012 (with a minor revision in August 2012) setting out a range of proposed changes to the NHS in North West

London. These changes reflected the Pre-Consultation Business Case (PCBC) that was published in June 2012 (NHS North West London 2012b).

The decision to reduce the number of hospital sites from nine to five was not taken as part of the consultation but was pre-determined based on an NHS view of appropriate care models to deliver high-quality care in financially viable (in the medium-term) settings using current hospital sites. The key decision then became to determine the distribution of the remaining sites to obtain a good geographic distribution and to minimise the impact on local people.

Again, before going to consultation, a decision was made to retain the full range of acute services at Hillingdon and Northwick Park hospitals, and to reduce Central Middlesex hospital to an elective centre[1] with in addition some local facilities. The decision then became which three of the remaining five sites should retain a full range of acute services, and which should effectively be closed as an acute hospital site.

A further restriction was introduced. The remaining options were only allowed to be compared as pairs: either Charing Cross or Chelsea & Westminster, Ealing or West Middlesex, and Hammersmith or St Mary's. This allowed eight options in total to be considered which are listed in Table 1.1 below (p50, NHS North West London 2012a).

Table 1.1: The SaHF acute hospital options

Site	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7	Option 8
St Mary's	Local	Local	Local	Local	**Major**	**Major**	**Major**	Major
Hammersmith	Major	Major	Major	Major	**Specialist**	**Specialist**	**Specialist**	Specialist
Charing Cross	Local	Major	Local	Major	**Local**	**Major**	**Local**	Major
Chelsea & Westminster	Major	Local	Major	Local	**Major**	**Local**	**Major**	Local
West Middlesex	Major	Major	Elective	Elective	**Major**	**Major**	**Elective**	Elective
Ealing	Local	Local	Major	Major	**Local**	**Local**	**Major**	Major
Central Middlesex	Elective	Elective	Elective	Elective	**Elective**	**Elective**	**Elective**	Elective
Northwick Park	Major	Major	Major	Major	**Major**	**Major**	**Major**	Major
Hillingdon	Major	Major	Major	Major	**Major**	**Major**	**Major**	Major

But only options 5, 6 and 7 were presented for public consultation (and were renamed options A, B and C respectively). The consultation document recommended Option A (option 5 in Table 1.1 above) as the preferred option ie the closure of Charing Cross and Ealing, and the reduction of

[1] The fact that this decision to close Central Middlesex A&E unit was taken prior to consultation is open to challenge, and perhaps should have been challenged at the time.

Hammersmith to a purely specialist hospital and Central Middlesex to an elective centre (p57, NHS North West London 2012a).

By reducing the choice in this way, the consultation did not actually allow people to choose to keep more than five hospitals open, although there was an open-ended invitation to suggest other options. Some information was provided on the value for money of the three options presented although with the detail included elsewhere – in the PCBC.

Sets of other questions were included but most were at a general level akin to '*do you want better health care closer to your home*'. For example, '*How far do you agree or disagree with our plans for urgent care centres*'.

So in these circumstances the consultation became a choice for the public between which hospitals should be closed. At the same time, the use of the terms 'major' and 'local' to describe hospitals may have served to confuse some members of the public. NHS officers (and the Secretary of State) persist in this strange use of language to claim that no hospitals are actually closing. Members of the public who once used Central Middlesex and Hammersmith A&E may take a different view.

Governance of the SaHF programme

Initially, in 2012 the governance of the SaHF programme was exercised through a joint committee of North West London PCTs, with additional assurance of the work provided by NHS North West London. The Joint Health Overview and Scrutiny Committee (JHOSC) of the local authorities first met in July 2012 at the request of NHS North West London as part of the statutory consultation process (see *JHOSC Board papers July 2012* (London Borough of Harrow 2012) to consider a joint response to the plans of the PCTs. The JHOSC's stated purpose is to consider issues with cross-borough implications arising as a result of the SaHF reconfiguration of health services, taking a wider view across North West London. Individual local authority members of the JHOSC continue their own scrutiny of health services and their participation in the JHOSC does not preclude any scrutiny or right of response by individual boroughs.

Following the acceptance by the combined PCTs of the recommendations of the SaHF PCBC in February 2012 (NHS North West London 2013a) governance arrangements were put in place on the basis of the arrangements as described subsequently in Chapter 17 of the DMBC (see in particular section 17.3 on programme design and governance) and as discussed in the SaHF Project Initiation Document dated May 2013 (NHS North West London 2013e).

The CCGs have agreed to act in common to implement the SaHF programme. In a sense this circumvents the intention of the legislation that established CCGs as stand-alone bodies with responsibilities toward their local stakeholders. Legally this may pose a problem if the collective acts against the interests of a single participant, although the legislation is complicated and as yet untested on this matter (NHS Commissioning Board 2013). A CCG is able to withdraw from the collaboration at any time although this may be viewed as unusual.

A Governing Board in Common was formed consisting of eight CCGs – Brent, Harrow, Hammersmith and Fulham, Camden, Hounslow, Ealing, Central London, West London, Richmond, and Wandsworth; plus the National Commissioning Board. An Implementation Programme Board was also established

whose membership comprised North West London Provider CEOs, CCG Officers and Chairs, NHS England and the Trust Development Agency, Imperial College, Programme Medical Directors, and a press and publicity adviser.

The Governing Board's function is to oversee the implementation of the SaHF programme to ensure it is consistent with the decisions that were made by the Joint Committee of PCTs (JCPCT). The Board is to take decisions where necessary on how to implement the proposed changes and who to involve at each stage, including Wandsworth, Camden and Richmond CCGs where appropriate.

It appears that local authority involvement and participation in the programme is limited despite such participation being crucial to the success of the overall programme. Although the JHOSC received reports from the Programme Executive there has been no scope for direct involvement.

Appendix 1 provides a timeline showing significant developments in the SaHF process.

We now go on to examine the SaHF programme itself in more detail.

Section 2 Access to care

2.1 Introduction

This section provides:

1. A description and assessment of how the SaHF consultation process addressed the issues around access to care for the population of North West London, and in particular how the impact on people from disadvantaged areas was measured;

2. Consideration of the needs assessment that underpinned the work of SaHF, and how robust it is in the light of changes since it was produced;

3. An assessment of the modelling of demand and required capacity that underpins the decisions to close several acute sites in North West London; and,

4. An analysis of the impact of proposed changes, and those that have already taken place, on access to care for the population of North West London.

2.2 How the consultation process addressed access to care

It is quite common in NHS consultations for the public's views on access to care to be given little weight when it comes to actual decision-making although the language used in consultation documentation often belies this fact. Ipsos MORI's report on the response to the consultation identified access to care as the prime issue to have emerged from the public consultation (Ipsos MORI 2012a).

Access to care was one of the five evaluation criteria used in assessing the options for change in the PCBC. The SaHF project team had established a Transport Advisory Group that included local authority representatives. SaHF claimed that 91% of activity would be unaffected by the SaHF proposals and that travelling to the right location for the right care has more impact on outcomes than travel distance (p733, Chapter 19, Volume 2, NHS North West London 2013a).

However, the decision to go from nine to five acute hospital sites in North West London was certainly not based on ease of access for patients, and was never a choice given to the public in the consultation. It was in fact driven by financial concerns[2] that it was claimed made the delivery of safe, high-quality care on nine sites impossible. The SaHF team[3] claimed that five major hospitals were needed to balance access with meeting the clinical standards. In their words (p xi, Executive Summary, Volume 1, NHS North West London 2013b):

> *For access to care, we analysed the distance and time to access services based on blue light, off-peak car, peak car and public transport travel times. The analysis showed that*

[2] Often this was expressed as a resource issue: an inability to increase consultant staff numbers.

[3] When interviewed, clinicians in the SaHF team expressed a view that just three facilities were required, but in the words of one, 'we would not get away with it'.

any impact on travel times as a result of the proposed options would be clinically acceptable and that changes in travel times across all options were so similar it did not enable any differentiation between the options so all options are evaluated identically.

Given that the reduction to five sites was presented as a fait accompli it is not surprising that most of the feedback from the public at the consultation stage focused on general issues around improvements to public transport required to support access to all sites rather than whether this cut in services was acceptable.

Thus although access was a key issue to emerge from the public consultation it was regarded as immaterial in the decision to choose between the options for hospital reconfiguration presented. Once the decision was made that there could only be five acute hospitals in North West London the issue became which to close as acute sites, and access for patients did not figure as a major deciding factor.

Rideout, who was engaged as an independent expert by two of the local boroughs, criticised the methodology used by North West London saying there was insufficient exploration of alternatives to hospital reconfiguration. He went on to note the lack of supporting detail and/or a compelling evidence base for the decision to propose the reduction to five 'major' hospitals; and he pointed to the use of high-level rather than detailed travel times and other measures of access to determine the location of the eight options that were presented in the consultation document (Rideout 2012a).

The proportion of Ealing CCG work affected by the SaHF proposals according to the SaHF team is (p33, Appendix L, Volume 18, NHS North West London 2012c),

- 53.9% of inpatient admissions
- 9.6% of outpatient attendances
- 30% of A&E attendances.

Similarly high proportions are affected in Hammersmith and Fulham with figures of (p35, Appendix L, Volume 18, NHS North West London 2012c),

- 40% of inpatient admissions
- 11.5% of outpatient attendances
- 23% of A&E attendances.

As a result of the A&E closures at Hammersmith and Central Middlesex hospitals, already implemented as part of the SaHF programme, there are reports of congestion and increased waiting times at the existing A&E departments; and this is before two further A&E closures are to take place. It seems the target of reducing A&E attendances by 100,000 (NHS North West London 2013c) is being met by forced closure of A&E departments whatever the progress in achieving better out-of-hospital (OOH) care, and whatever the wishes of local people for access to local A&E departments.

In evidence submitted to this Commission on 25 February 2015 (Evidence to the Commission, Volume 1, p7), Jonathan Ramsay, Director of professional affairs at the Royal College of Surgeons, and a member of the SaHF Clinical Reconfiguration Board, is now concerned that:

> *Since that time* (when the Board considered its decision) *it has become clear that 1. Emergency surgical volumes have increased 2. Complexity and Co morbidity have increased. 3. Capacity elsewhere in the region is saturated (C W and NWP). Currently therefore provision of satisfactory emergency surgical services alongside increased surgical activity in general seems to require the capacity currently only available on* ***all*** (our bold) *of the Imperial Sites.*

Also telling is his description of how the Clinical Reconfiguration Board approached its recommendations. Thus:

> *The Reconfiguration board considered sites, but then assumed that the Trust responsible for the 'reconfigured' site would manage the diverted cases on their remaining facilities.*

If this was the case, we can have little confidence in the planning process around reconfiguration.

Disadvantaged sectors of the population

Little serious consideration was given to the impact of these proposals on people from the most disadvantaged areas of North West London. SaHF commissioned a survey from a consultancy, Mott McDonald, although it only appeared after the PCBC was published. This survey looked at the equalities aspects of the SaHF proposals and found that in terms of the most disadvantaged groups there was little available research and information. The report recommended the following steps (Mott Macdonald 2012),

> *As specified at the outset this report does not signify the completion of the research into the needs of and impacts on those with protected characteristics. This has been a rapid review of the key issues based on available secondary evidence, socio-demographic data and travel and access information. The minimum next steps required are set out below:*
>
> - *Consultation with the PCT and provider equality leads;*
> - *Direct engagement with communities highlighted in this report;*
> - *Continued collaboration and liaison with the Travel Advisory Group and PPAG;*
> - *Examining the other EDS goals and outcomes to ensure the programme is being assessed against all relevant criteria;*
> - *Refresh of this report following further engagement and also the wider public consultation findings; and*
> - *Update the evaluation against the EDS and Public Sector Equality Duty compliance.*

We are not in a position to carry out such an analysis but SaHF's own consultants make it clear that this is a shortcoming that should have been addressed before any changes were implemented. We would expect therefore that the final business case presented for approval would include further work on the implications for disadvantaged groups in the areas most likely to be affected including those around the Ealing and Charing Cross sites, and details of the engagement to address such problems would be reported.

2.3 Needs assessment

SaHF does not provide a formal needs assessment for the population of North West London. Instead it relies on general statements about national trends, for example:

> *The population of North West London … is facing major changes in its health needs and these are placing ever greater demands on the local NHS. People are living longer, the population as a whole is getting older, and there are more patients with chronic conditions such as heart disease, diabetes and dementia.*

(p4, Case for Change, NHS North West London 2012d)

SaHF goes on to state that the population is growing and will increase by 113,000 (5.9%) in the next ten years (we assume this means between 2012 and 2022), from 1.9 million to 2 million (p7, Case for Change, NHS North West London 2012d).

Based on a review of QoF returns, SaHF notes that some 300,000 people in North West London, have one of the following five conditions: diabetes, asthma, coronary heart disease (CHD), chronic obstructive pulmonary disease (COPD), or cystic fibrosis disease (CFD). Obesity is identified as a particular problem with 29% of 10-11-year-olds in Westminster obese. Diabetes prevalence in North West London rose from 3.6% to 5.7% between 2004/5 and 2010/11.

SaHF points to improvements in hospital treatment and begins to build a case for more specialisation, and hence in the view of the SaHF team, less hospitals. For example it refers to the increasing use of percutaneous coronary intervention (PCI) in treatment of AMI, with an implication that PCI cannot be delivered at all existing hospital sites.

However, there is no formal attempt to present a needs-based analysis of the population of North West London that might be used to assess the level of services required, and where. Instead we find that SaHF relies on a model of services in North West London based on current use combined with a series of ill-evidenced assumptions that seem designed to lead to the conclusion that less care in acute settings and hence less capacity is required. This is strange when at the same time, SaHF states:

> *…the financial pressures caused by the increasing age of the population, the increased burden of more ill health and the need to keep pace with new technology would need growth of 5% each year unless we change the way services are delivered. As a result, the 2010 Spending Review committed the NHS to finding £20bn in productivity improvements by 2015 to reinvest in services to meet increasing demand.*

(p9, Case for Change, NHS North West London 2012d)

The evidence that there will be growth in activity of 5% per year at the national level is not based on a thorough needs-based analysis: these are more guesstimates than estimates of what is likely to happen. But we begin to see here the true nature of the problem: a desire to reduce spend by cutting services with insufficient regard for the needs of the population.

Turning to the Decision Making Business Case (DMBC), we find a set of assumptions about how current levels of activity will be reduced by improving and increasing OOH services (p18, Appendix N, Volume 7, NHS North West London 2013c).

Table 2.1 below shows forecast decreases in activity according to the SaHF plans. This may be as close as SaHF comes to a needs assessment, but it is in fact just a set of assumptions about what reductions in demand are needed to allow SaHF's pre-determined capacity reductions to work.

Table 2.1: Reduction in activity forecast as result of investment in OOH

	Spells		**Implied total activity**	**Beds**	**Investment**
Elective	-10,000	14%	71,429		£7 - 9 million
Non-elective	-55,000	19%	289,474	391	£35 - 38 million
A&E	-100,000	14%	714,286		£3 - 5 million
Outpatients	-600,000	22%	2,727,273		£35 - 38 million

1 These are reductions relative to the pre-QIPP baseline as of 2011/12.
Source: NHS North West London 2013c, Volume 7, Appendix N, p18.

The net effect of the SaHF proposals (and the concurrent Quality, Innovation, Productivity and Prevention (QIPP[4]) savings plans) would be a reduction of approximately 25% in total beds in North West London, as shown in Table 2.2 as resources are shifted from the acute sector to OOH settings.

Table 2.2: Planned reduction in acute bed numbers

Hospital	**Current beds**	**Planned reduction**	**Projected beds**
St Mary's	364	-69	295
Hammersmith	414	-79	335
Charing Cross	498	-112	386
Chelsea & Westminster	394	-144	250

[4] QIPP is an initiative the aim of which is to reduce costs and improve quality in the NHS. Providers and purchasers are expected to indicate cost savings plans.

West Middlesex	323	-119	204
Ealing	327	-104	223
Central Middlesex	227	-71	156
Northwick Park &St Mark's	576	-186	390
Hillingdon	326	-95	231
Paediatrics & maternity	610	-26	584
Total	**4,059**	**-1,005**	**3,055**

These beds include adult general and acute beds, adult daycase beds and critical care beds: paediatric and maternity beds are discussed elsewhere in the document (Figure 6.8, p64, NHS North West London 2012b). Over half of this reduction is based on the assumption that average length of stay in hospital (LOS) will be reduced by 15%.

In the DMBC (P29, Volume 7, Appendix N, NHS North West London 2013) a revised table was produced with a total of 3,160 beds proposed for 2015/16; however we regard neither table as a reliable guide to the eventual beds that will be proposed in the final business case, and the likelihood is that bed numbers at Ealing and Charing Cross Hospitals will be reduced further.

It is also intended to reduce the number of hospitals providing maternity services from nine to six, with the closure of Central Middlesex, Ealing and Charing Cross. SaHF estimated the required number of maternity beds (under Option 5 the recommended option) as 356 beds. This would be achieved while downgrading services at Ealing, Charing Cross and Central Middlesex. The number of hospitals providing paediatric services would also be reduced from nine to six, with the removal of services from Central Middlesex, Ealing, and Charing Cross. SaHF estimated the required number of paediatric beds (under Option 5 the recommended option) as 157 beds. This would also be achieved while downgrading services at Ealing, Charing Cross, Central Middlesex as well as Hammersmith.

Rideout indicated in his report (Rideout 2012a) that the focus of SaHF was almost entirely on organisations and institutions rather than the needs and preferences of local populations. He points out (p22, Rideout 2012a):

> *North West London, and indeed Hammersmith & Fulham in particular, are home to a highly diverse and complex set of communities and groups. Ultimately any proposals to substantially reshape health services in the area need to be developed, at least in part, on a sufficiently detailed needs basis. This is a major omission in the current methodology.*

Alternative assessments of need

Each borough, in partnership with the local NHS, is expected to produce an assessment of the health needs of its population. Most of these provide a picture of the population demographic and some of the key disease patterns in the area, as well as drivers of disease such as alcohol and drug use,

obesity, deprivation. However they do not map this systematically to the need for specific services and thus we are not able to provide a full picture of the care required in North West London using these materials.

For example, Ealing produced a Joint Strategic Needs Assessment (JSNA) in 2012. Looking at the population, it revealed that the latest ONS mid–year population estimates of Ealing suggest a rise from 286,400 in 1994 to 339,300 in 2011. ONS population projections suggest that by 2020 Ealing's population will be 372,400, with most of the increase due to a 14.8% rise in the number of people aged between 0 and 14 years old. There will be a 19.5% rise in the number of people aged over 65 years of age, whereas the number of over 85s is expected to rise by 48%. The JSNA points out that black and minority ethnic (BME) communities, including individuals of mixed ethnicity, constituted 46% of Ealing's population in 2012, compared to approximately 35% of Greater London's population. The 2010 Index of Multiple Deprivation ranked Ealing the 61st most deprived borough and within the top 20% most deprived English Local Authorities (London Borough of Ealing and NHS Ealing 2012).

To summarise

It is not clear that there is currently a fair allocation of resources between the different parts of North West London. There is a considerable divergence in the actual budget per capita allocated to the eight CCGs. Although this is based on a national allocation formula, the allocations to some, eg Ealing, are below the target levels suggested by this formula (National Audit Office 2014). An analysis of needs at local level would give some reassurance that the issue of fairness in allocation of resources is being addressed.

Any attempt at wholescale reconfiguration of services across a large geographic area must be based on a thorough assessment of the needs of the population in that area which is then used to justify the level and location of services proposed in each part of the geography. This is completely lacking in the case of SaHF and therefore in our view invalidates the whole process.

Moreover we find that even a cursory look at the likely level and distribution of needs in North West London would suggest that the options put forward by SaHF will not meet the needs of the population – options that amount to a reduction in service provision based purely on an assumption that demand for care will fall even though SaHF's own documents recognise there is an increasing population with growing health needs. Indeed the evidence speaks for itself in terms of the deterioration in performance introduced into the emergency care system in North West London by the peremptory closure of A&Es at Central Middlesex and Hammersmith hospitals in September 2014. The evidence suggests that the distraction posed by the SaHF process may lie behind the steady deterioration in performance over this period which only became more pronounced with the closure of two A&E units.

2.4 Modelling demand and capacity in North West London

In this section we consider the assumptions that underpin the decisions to reduce acute capacity in North West London. First we provide an account of what was in place in 2010 before changes started to happen. We focus primarily on maternity and emergency services. The retention of

paediatric services on an acute site is to a large extent dependent on the existence of maternity services on that site. However we are clear that local access for children's services is a high priority for most families, and hence should be a key factor when looking at access to services.

We do not provide any detailed analysis of the location and quality of general practice as there seems to be general agreement that there is much need for improvement in this area.

We note how dependent the case for change is on assumed reductions in demand for acute care as a result of investment in OOH care. We are concerned that recent evidence suggests a lack of effectiveness of additional investment in OOH services, and equally the lack of effectiveness of integration of social care and community care as a solution to the need for improved care for people with acute needs (see section 3 for further discussion).

Provision in North West London in 2010

The North West London health economy covers eight of the 33 London boroughs, and eight CCGs, each contiguous with a London borough. It comprises a population that was estimated in SaHF's Case for Change (NHS North West London 2012d) to be 1.9 million people, with growth 'in the next ten years', which we interpret as until 2022, of 5.9% to 2 million people. In fact the latest estimate (ONS 2014) of the population in North West London (mid-year 2013 estimates) suggests there are already 2.01 million people, and that this grew by over 15,000 (0.77%) between 2012 and 2013.

The SaHF analysis is therefore based on an underestimate of the population which will continue to increase beyond SaHF's expectation. Local authorities in their JSNAs have noted that growth rates are increasing particularly in outer London, and alongside the HS2 route. As far as we are aware this is currently not reflected in projected bed numbers.

According to SaHF, the NHS in North West London spends £3.4 billion per year: there are nine acute sites, five specialist hospital sites, four community care providers, two mental health providers, as well as 423 GP practices and 505 pharmacies.

The nine acute sites are Hillingdon, West Middlesex, Ealing, Northwick Park, Central Middlesex, Hammersmith, Charing Cross, Chelsea & Westminster, and St Mary's; the five specialist sites are Harefield, Mount Vernon, Royal National Orthopaedic, Royal Brompton, and Royal Marsden; the community providers are Hounslow & Richmond Community Healthcare, Ealing Integrated Care Organisation[5], Central London Community Healthcare, and Central & North West London NHS FT; the mental health providers are Central & North West London, and West London Mental Health.

Central London Community Healthcare provides seven walk-in centres or UCCs; three of these are not in North West London. Hounslow & Richmond Community Healthcare as the name suggests also provides services outside of North West London, in Richmond.

[5] The current status of the Ealing Integrated Care Organisation is unclear.

Catchment population for A&E departments

SaHF claims that North West London is overprovided with A&E units relative to the rest of England. We examine this proposition.

In 2010 there were nine A&E departments in North West London. The SaHF team claims that the average catchment population for A&E in North West London is 238,000 compared with 259,000 in England as a whole; in addition it is stated that Hillingdon, West Middlesex, Northwick Park, and St Mary's have above average catchment while Charing Cross, Ealing, Chelsea & Westminster, and Central Middlesex have below average. This assumes that the Hammersmith catchment travels to St Mary's (p25, North West London 2012d; p52, North West London 2012b).

SaHF states that this assumes there are just 200 A&Es in England. But the House of Commons reported there were 590 NHS A&E departments of all types in England (House of Commons 2009). At the same time, there were 225 minor injury units and 93 walk-in centres implying that there were 272 Type 1 A&E departments (NHS Choices 2010). So SaHF's figures require some scrutiny. The reference given (ERIC 2010/11) does not actually specify the number of A&E departments there are nationally, so it is unclear how this assumption of 200 A&Es was arrived at.

More recent data suggest that the number of A&E departments in England is still closer to 272, although these are managed by 141 acute trusts as some trusts have multiple sites.

Rideout in his report (Rideout 2012a) found similar evidence that the over-provision of A&E departments in North West London is not as marked as claimed. Based on Royal College of Emergency Medicine[6] figures, he claims the whole UK population is served by 240 Type 1 emergency departments for a population of 62.3 million people (ONS estimate for 2010). That equates to 259,425 people per A&E. He goes on to claim that North West London currently has 8 Type 1 emergency departments, serving a population of just under two million people. That equates to 247,150 people per A&E, 5% less than the national figure. He concludes that if the reconfiguration proposals proceed North West London will be served by five Type 1 emergency departments that would equate to 395,440 per A&E, 52% more than the national average.

A similar argument is put forward by Councillor Rory Vaughan, Chair of the Health, Adult Social Care and Social Inclusion Policy and Accountability Committee of LB Hammersmith & Fulham, in his submission to this Commission (Evidence to the Commission, Volume 1, p11). He suggests that a reduction in the number of A&E units to five would result in 402,700 people per A&E unit in North West London, 51% more than the national average.

Whatever the precise number of A&E units nationally, the case put forward by SaHF seems to lack validity: there is at least a need to reanalyse this all on the basis of agreed sets of data and definitions of Type 1 A&E units.

In section 2.5 we indicate, perhaps more importantly, what the utilisation of these A&E departments has been over time. But first we turn to bed capacity in North West London.

[6] At the time of publication of the report it was the College of Emergency Medicine.

Total beds in North West London

It appears that bed availability has increased in North West London at a time when it is falling across England and also in the rest of London (see Tables 2.3 and 2.4). Looking at individual acute hospitals in the sector, each hospital has seen an increase in the number of beds.

Table 2.3: Bed availability, 2009/10

	Total	General & Acute	Mental Illness	Maternity
London North West	6,050	4,302	1,371	361
London	24,912	17,926	5,373	1,526
Rest of London	18,862	13,624	4,002	1,165
England	158,461	121,756	25,503	8,392

Source: Analysis based on NHS England 2015a.

Table 2.4: Bed availability, 3rd quarter, 2014/15

	Total	General & Acute	Mental Illness	Maternity
London North West	6,442	4,370	1,607	429
London	22,716	16,188	4,866	1,587
Rest of London	16,274	11,818	3,259	1,158
England	134,591	103,851	21,446	7,804

Source: Analysis based on NHS England 2015b.

Table 2.5 shows there are more beds per head of population in North West London than in England as a whole – in total 28% more; looking in more detail, there are 13% more general & acute beds; and there are 47% more maternity beds. The rest of London has less general & acute beds than England as a whole.

Table 2.5: Bed availability per 1,000 resident population, 3rd quarter, 2014/15

	Total	General & Acute	Mental Illness	Maternity
London North West	3.20	2.17	0.80	0.21
London	2.70	1.92	0.58	0.19
Rest of London	2.54	1.85	0.51	0.18

England	2.50	1.93	0.40	0.14

1 Based on above bed figures plus 2013 mid-year estimate of populations (ONS 2014).

The SaHF team provided different figures for the current number of beds in North West London. These may be based on slightly different definitions. Thus, it was claimed there were 4,065 beds currently[7]; these were total adult, critical care, maternity and paediatric beds (p32, Appendix C, Volume 8, NHS North West London, 2012b). SaHF's chosen option would result in a reduction in this number of over 1,000 beds.

SaHF had estimated the required number of maternity beds in North West London as 356 under the chosen option. Our analysis of national bed data suggests there were 361 maternity beds in total in North West London in 2009/10; this had increased to 429 beds in the third quarter of 2014/15. Our analysis also suggests that North West London has more maternity beds per head of population than the rest of the country (see Table 2.5). However when we look at the number of beds per birth we find there are still comparatively more beds but the difference is not as great. The Healthcare Commission reported in 2008 that the median average trust had 11.4 beds per 1,000 births (Healthcare Commission 2008). In 2013, considering just live births, North West London had 14.3 beds per 1,000 births compared with 11.7 in England as a whole, around 22% more, and 12.4 beds per 1,000 births in London.

Table 2.6: Maternity beds in London trusts, 3rd quarter, 2014/15

Trust	Number of beds
Barts Health NHS Trust	192
King's College Hospital NHS Foundation Trust	151
Imperial College Healthcare NHS Trust	124
London North West Healthcare NHS Trust	114
West Middlesex University Hospital NHS Trust	103
Guy's And St Thomas' NHS Foundation Trust	98
Epsom And St Helier University Hospitals NHS Trust	97
Lewisham And Greenwich NHS Trust	94
University College London Hospitals NHS Foundation Trust	78
Royal Free London NHS Foundation Trust	77
St George's Healthcare NHS Foundation Trust	66

[7] We assume SaHF's definition of 'adult' beds includes 'general' as well as 'acute' beds.

Barking, Havering & Redbridge University Hospitals NHS Trust	62
Croydon Health Services NHS Trust	61
Kingston Hospital NHS Foundation Trust	54
The Whittington Hospital NHS Trust	50
Chelsea And Westminster Hospital NHS Foundation Trust	45
The Hillingdon Hospitals NHS Foundation Trust	43
Homerton University Hospital NHS Foundation Trust	41
North Middlesex University Hospital NHS Trust	37
TOTAL	**1,587**

Source: NHS England 2015b.

Table 2.6 shows the number of maternity beds in London trusts in the 3rd quarter of 2014/15. We find that most hospitals have less than 100 beds, and many less than 50 beds including Chelsea & Westminster and Hillingdon.

The issue is how North West London compares with the rest of the country. Two key questions remain unanswered: whether the growth in population has been sufficiently factored in to the calculations of beds required; and, whether areas where North West London is in excess of average requirements merely reflect their different status as centres for specialist care and for training and research, or whether it does indicate overprovision of local services for local people.

We are not convinced by SAHF's approach to this. We would expect to see in the final business case a much better case targeting the true sources of excess capacity, if this is shown to exist at all.

2.5 Impact of changes on access to services

We consider now the impact of acute capacity closures on access to services. We focus on A&E services particularly since the closure of Central Middlesex and Hammersmith A&Es. We consider the performance of North West London on one or two key indicators of emergency performance, and how this performance may have been affected by the changes taking place under SaHF.

Before considering these matters we outline the availability of emergency care provision in North West London. It is important to differentiate between three types of immediate emergency response: that provided by acute A&E departments and designated as Type 1 in Department of Health terminology; that provided by specialist A&E departments and designated as Type 2; and that designated as Type 3 which is provided by a range of centres that are characterised by having more limited access to testing facilities, tend to be run by nurses or GPs, and often are not open 24 hours a day. This last category encompasses Urgent Care Centres (UCC), Minor Injury Units (MIU) and Walk-in Centres (WiC), as well as services provided directly by some GP practices. They were designed to deal with less serious health issues; there was a considerable expansion in their numbers after 2004

when UCCs were introduced in an effort to divert activity away from acute A&Es, but there has recently been a reduction in their numbers.

In North West London in 2011/12 there were nine acute A&E departments: Hillingdon, West Middlesex, Ealing, Chelsea & Westminster, Northwick Park and Central Middlesex (both run by North West London trust), and St Mary's, Charing Cross and Hammersmith (all run by Imperial trust). Ealing became a part of North West London trust in October 2014[8]. Central Middlesex and Hammersmith A&E departments were closed in September 2014.

In addition to all of these providing Type 1 services, Hammersmith provided specialist A&E services (A&E), and all trusts provided UCCs (Type 3 services) apart from West Middlesex prior to quarter 4 of 2011/12, ie January 2012, and Chelsea & Westminster which records all attendances as Type 1[9].

Two community trusts also provide UCCs: Central London Community Healthcare, and Hounslow & Richmond Community Healthcare. In addition there have been several other providers of Type 3 services over this period. These include Victoria Station WiC, Westminster PCT, Hammersmith & Fulham PCT, Practice Heart of Hounslow, Brent UCC (at Central Middlesex), and Ealing mini-UCC (all 2011/12); the Ridgeway Surgery WiC (2012/13; 2013/14; 2014/15).

By 2014/15, all UCCS or WiCs except one (of those not associated with the acute trusts) were provided by the community trusts with Central London Community Healthcare having seven WiCs and UCCS in Hammersmith & Fulham, Kensington & Chelsea, Westminster, and in Barnet, four out of these seven serving North West London; and, Hounslow & Richmond Community Healthcare[10] having a UCC in Hounslow and a WiC in Richmond.

What SaHF claimed

In the *Case for Change* (p15, NHS North West London 2012d), SaHF claimed that the rate of A&E use is high across outer North West London, and referred in particular to Brent, Ealing, Harrow, Hillingdon and Hounslow. It was claimed emergency admissions are much higher in Ealing and Hounslow (595 and 495 per 100,000 population against a national average of 410 per 100,000).

We examine this proposition further.

[8] However, Ealing hospital data ceased to be reported in the national dataset from the first quarter of 2014/15, ie April 2014. Our subsequent analysis is based on data published by NHS England on A&E attendances and emergency admissions (NHS England 2015c).

[9] In an interview with a senior A&E consultant at Charing Cross we were told that Chelsea & Westminster provides a UCC but the attendances are recorded as Type 1. Its UCC opened in October 2010, alongside the acute site. This suggests the recording of data as all Type 1 is wrong; this affects the data for this hospital and the sector, and is a serious concern if true.

[10] West Middlesex UCC is managed by Hounslow & Richmond Community Trust. A new UCC opened at West Middlesex hospital in March 2012. This shows up in the data which show a sudden increase in the first quarter of 2012/13, although there was some activity before that.

Use of emergency services

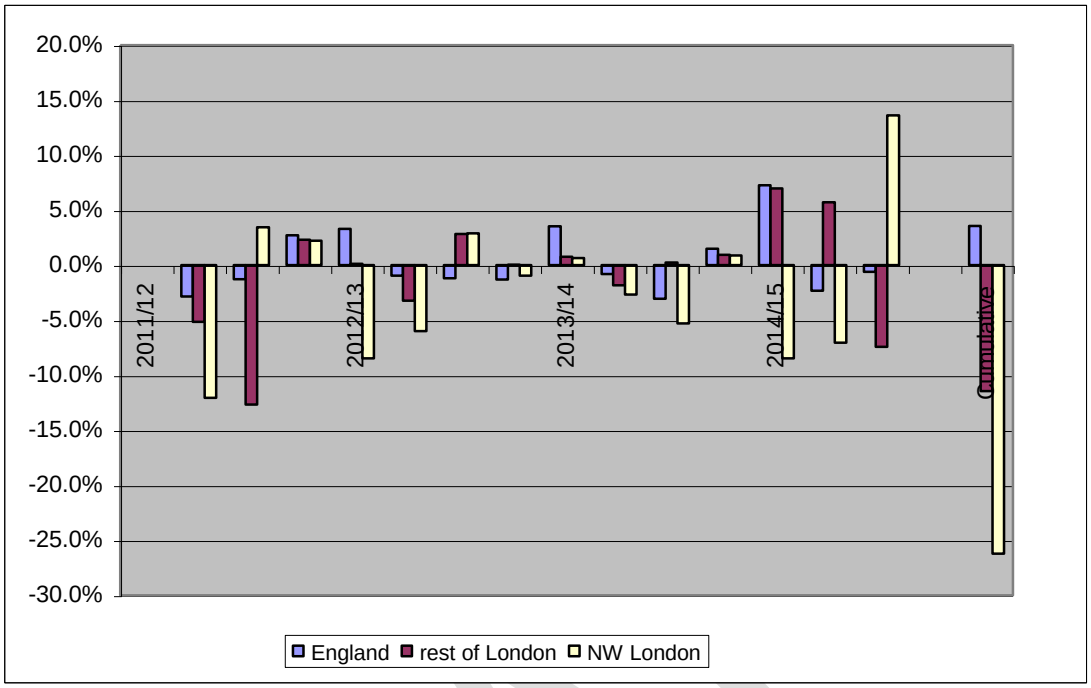
First we look at the number of A&E attendances in North West London, how many of these become admissions as emergencies, and how this profile has changed in the recent past. We then look at performance as measured by the NHS in terms of numbers of people attending A&E who are dealt with in less than four hours. For each of these indicators, we consider performance in North West London compared with the rest of London, and the rest of England.

North West London has a very different pattern of use of A&E services compared to the rest of the country and to the rest of London. There is a much larger proportion of attendance at non-acute centres (Type 3) and this has been growing in recent years. So we find that in 2011/12 some 68% of A&E activity in England was Type 1 whereas in North West London the figure was just 51%; by the third quarter of 2014/15 the England figure remained at 68% whereas in North West London just 38% of attendances were at acute A&E centres. For the rest of London the figure remained at 73%[11].

So patients in North West London appear to be able to distinguish very clearly their need for urgent care with now just over a third of them attending A&E departments when they perceive they have an urgent need for care. Patients in the rest of England, as in London, are being encouraged to behave like this, but there is no evidence of changes in patterns of demand. There has been no change in behaviour elsewhere over the last three years whereas North West London has witnessed a significant change.

[11] We have excluded Type 2 attendances from these figures.

Figure 2.1: Percentage quarterly changes in Type 1 A&E attendances, April 2011 – December 2014



Source: Analysis based on NHS England 2015c.

The question is what does this mean for the retention of A&E services in North West London. Figure 2.1 compares percentage change in Type 1 A&E attendances comparing England (excluding North West London), London (excluding North West London), and North West London. Data are provided on a quarterly basis and the final bar on the right-hand side is the cumulative change over this period.

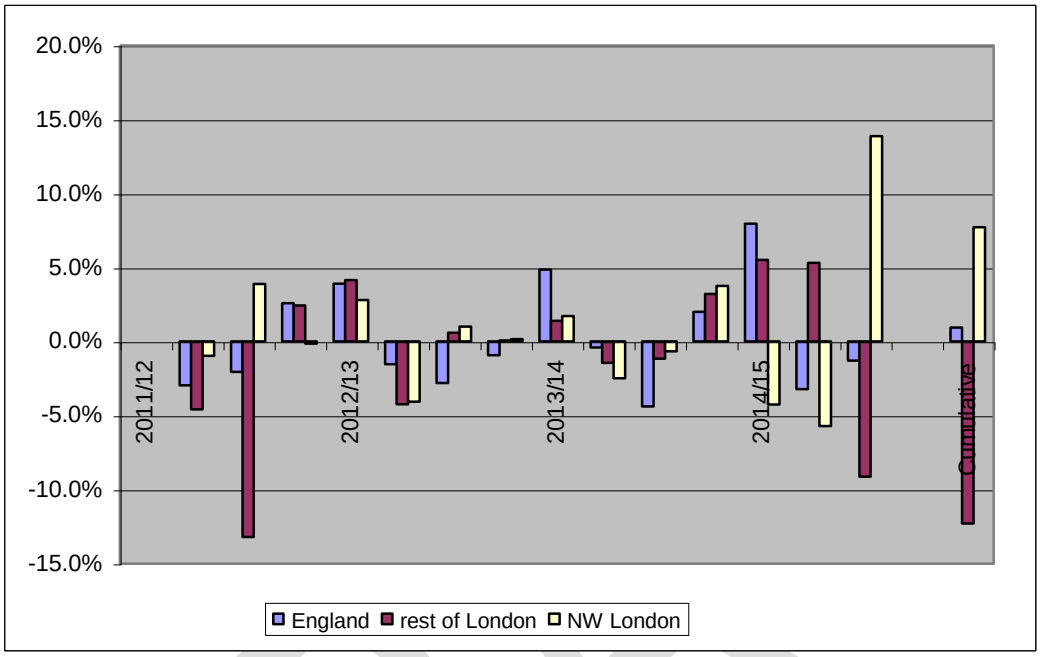
These data reflect the position up to the end of December 2014, and hence include a quarter since September 2014 when Central Middlesex and Hammersmith A&Es were closed. Data for four years are presented (2011/12, 2012/13, 2013/14, and 2014/15 just three quarters), and the cumulative effect over the whole period.

We observe that there has been a small cumulative increase in A&E attendances in England over this period of 2.2%. However the picture seems very different in London where there has been a cumulative fall of 11.4% and in North West London where the reduction is even larger at almost 26.2%. This represents a fall of over 120,000 in attendances in North West London hospitals over this period.

However, the growth in the use of urgent care centres in North West London would seem to provide most of the explanation for this fall in Type 1 attendances. Thus we find that in April 2011 Type 1 attendances were 55% of total Type 1 and Type 3 taken together, but by the end of December 2014, this proportion had fallen to 38%. This compares to the very different position in the rest of England where the proportion has remained at around 68% during this time, and in the rest of London where it has been around 73%.

If we look instead at total A&E attendances including UCCs and specialist units we find a different picture as Figure 2.2 shows. Attendances in North West London have increased by 7.7%, and in England by 1.3%, whereas those in the rest of London have actually fallen by 12.3%.

Figure 2.2: Percentage quarterly change in all A&E attendances, April 2011 –December 2014



Source: Analysis based on NHS England 2015c.

Taking a population view, we compare use per 1,000 population[12]. We find that in England, utilisation of Type 1 services has gone up marginally between 2011/12 and 2013/14, from 260 to 264 per 1,000 resident population; in North West London on the other hand utilisation has fallen from 302 (when it was above the England average) to 255 (now below the England average). The rest of London exhibits greater use of Type 1 A&E services and although this has also fallen, from 369 in 2011/12 to 343 in 2013/14, it remains above both England and North West London figures.

On the other hand we find that North West London residents make considerably more use of UCCs and WiCs, over twice as much as England or the rest of London, and this has increased over these three years, from 292 to 348 attendances per 1,000 population: the equivalent figures for England are 127 and 129, and for the rest of London, 141 and 136.

This can be read in many ways. Certainly North West residents are not over-using acute A&E services when compared with residents of the other London boroughs, or indeed with the rest of England. So this cannot be used as an argument for removing services or closing down A&E units. On the other hand, North West London residents are making considerably more use of UCCs and the like, approaching three times as much usage as England in 2013/14. This could be a sign that the message

[12] We use the 2013 ONS mid-year population estimate for ease of comparison.

has got through to North West London residents in a way that it has not in other parts of the country, that A&E departments should only be used in an emergency. It may also indicate a paucity of GP services, or poor quality services that cause residents to go to UCCs as an alternative to primary care. As one medical director in North West London said in an interview, for a younger more mobile population, UCCs may be a sensible alternative to the traditional GP practice.

So we have a situation in North West London where total attendances have been increasing but Type 1 A&E attendances have fallen in recent years. What has been the impact of this on performance?

A&E performance

The indicator normally used to measure performance is the proportion of people attending A&E who are not dealt with within four hours. Figure 2.3 compares the position in North West London with the rest of London and the rest of England for Type 1 attendances.

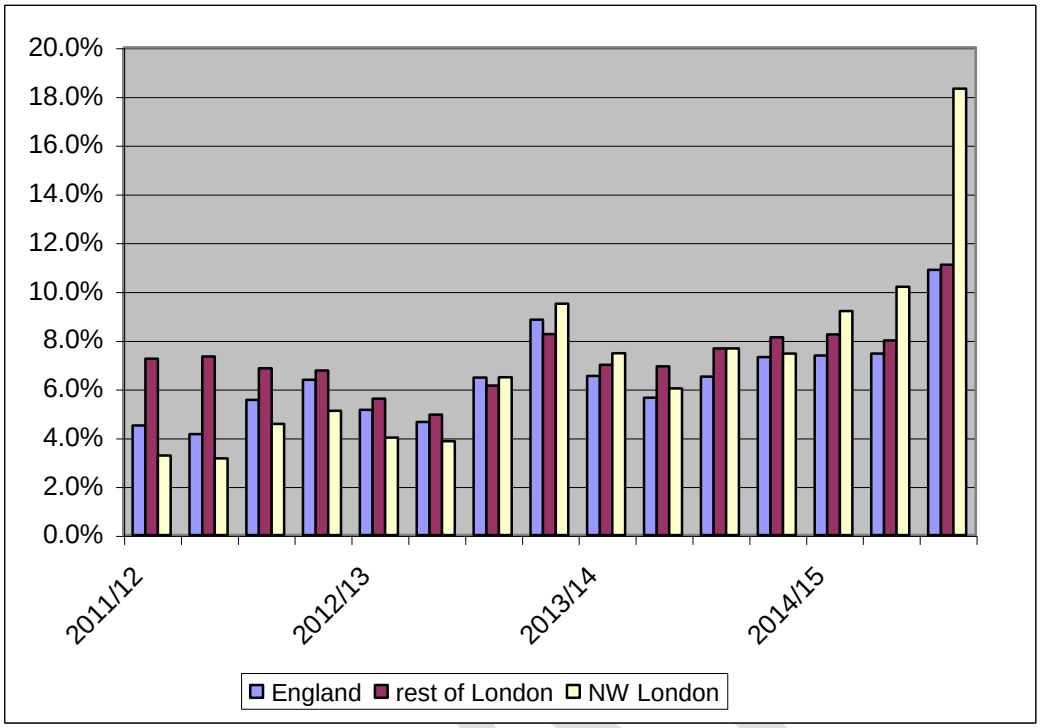
We find that the position in North West London at the beginning of this period, in the first quarter of 2011/12, was better than the rest of England and the rest of London, and at just over 3% was well within the margin of the target of 5% set by the government. However the position gradually worsened during this period – a period when attendances were in fact falling – so that by the last quarter of 2013/14, North West London was worse than the rest of England and almost as bad as the rest of London: in the final quarter 7.4% of people were not seen within four hours.

However when we look at performance in more recent months and in particular since the closure of two A&E units in North West London (on 10 September 2014) we find a considerable deterioration in performance.

The situation continued to get worse in 2014/15 so that we find North West London much worse than the rest of country and the rest of London: in the third quarter of 2014/15 the figures were 18.3%, 10.9% and 11.1% respectively. This is a dramatic deterioration in performance with the biggest change coming between October and December 2014 (just after the closure of two A&Es) when the proportion failing to meet the target increased from 10.2% to 18.3%.

In the first quarter of 2014/15 (1 April to 29 June), the proportion of Type 1 A&E attenders not seen within 4 hours in North West London hospitals was 5.8% compared with a figure for the rest of London of 9% and for England of 7.4%. However, by the second quarter (30 June to 28 September), performance in North West London had fallen to 10.1% whereas the comparable figures for the rest of London and for England were 7.8% and 7.5% respectively.

Figure 2.3: Proportion of patients not seen at Type 1 A&E within 4 hours, April 2011 – December 2014

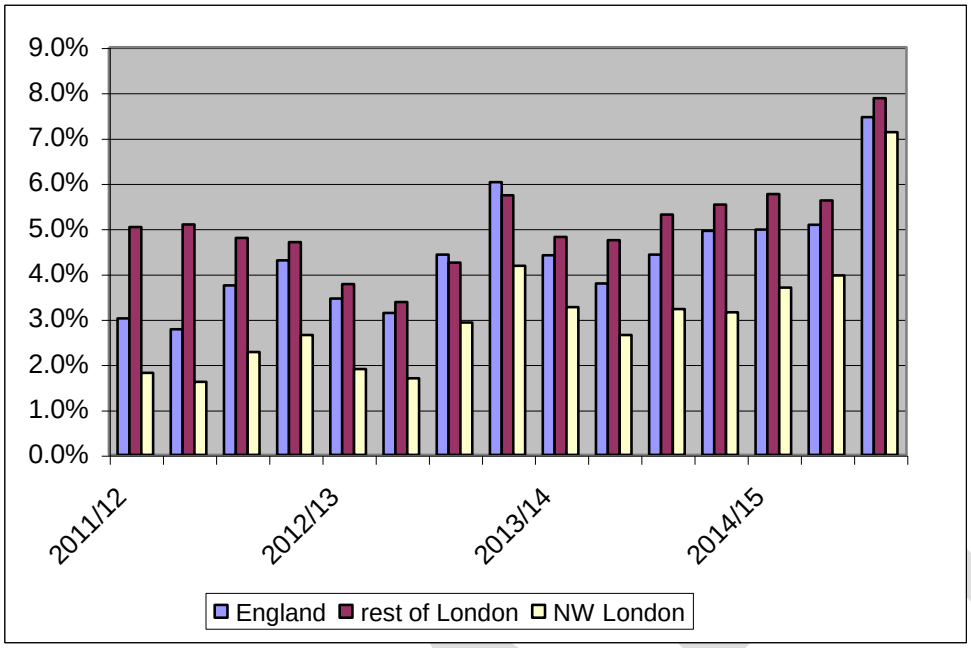


Source: Analysis based on NHS England 2015c.

If we include all A&E attendances (Types 1, 2 and 3), we get a somewhat different picture. We find that North West London performs better than the rest of London and the rest of England, and continues to do so throughout this period, although performance is gradually deteriorating in all areas of the country.

Confusion has been introduced by the way in which Type 3 services are often referred to as A&E services, both in national and in local documents, and in the press. This can sometimes lead to apparently contradictory statements if a system is able to meet targets across all types of service but fails on the key service, Type 1, which is what most clinicians and members of the public would regard as key to a well-functioning emergency service. It is the inability to meet the target for Type 1 A&E services that is of most concern.

Figure 2.4: Proportion of patients not seen at all types of A&E within 4 hours, April 2011 – March 2014



Source: Analysis based on NHS England 2015c.

Conversion from A&E to emergency admission

An indicator of the potential pressure on emergency capacity is the conversion rate between A&E attendances and emergency admissions to hospital ie the proportion of patients who attend A&E who have a condition that is serious enough to warrant admission to an acute bed.

There have been some interesting changes in this rate in North West London hospitals during this period. Looking first at England we find the conversion rate increased from 25% to 28% considering just A&E Type 1 attendances. But if we look at North West London we find that this rate has increased from 24% to 32%. In absolute terms the number of emergency admissions each year from this source increased from 162,370 to 168,000 even though the number of A&E Type 1 attendances had fallen by nearly 95,000, between 2011/12 and 2013/14. We can only speculate as to what is happening but given the shift from Type 1 attendances to Type 3 (UCCs) that we observed, it would appear that those patients attending Type 1 A&E are more acutely ill as a group than was the case previously.

This would seem to be confirmed by the fact that taking all attendances at all types of A&E we find the proportion in North West London admitted has remained at around 17% or 18% throughout this period whereas in England it has increased from 16% to 18%. In London (not including North West London) the conversion rate for Type 1 A&E has varied between 23% and 25% during this period while the rate for all A&E attendances has remained around 15%.

In an apparent response to the issues arising in the North West London emergency care system NHS England, Monitor and the Trust Development Agency commissioned a report from the consultants McKinsey on recent A&E performance. In interviews, SaHF officials claimed that this report showed

that poor performance in North West London was not related to the recent closure of units at Central Middlesex and Hammersmith. But it was also suggested that the SaHF modelling had underestimated the number of extra beds required at the Northwick Park site to deal with additional patient flows (with a figure of 30 beds mentioned) which seems to contradict this view. Although we were promised access to this report by SaHF officers, so far it has not been forthcoming.

Our results would suggest that poor performance and closure of A&E units are linked albeit we acknowledge that a much more detailed study would be required to confirm this.

2.4 Development of out-of-hospital care

SaHF proposed the transformation of OOH care across the sector, setting out a vision for how more care would be delivered at home, in GP practices, in community health centres and at local hospitals. It was claimed that within five years, £190 million more per year would be spent on OOH services, together with £105 - 120 million in improvements to premises. It was recognised that this should be coordinated with the implementation of the CCG OOH strategies.

The DMBC (Appendix L, Volume 6, NHS North West London 2013d) provides copies of the OOH strategies of each CCG. Although each of the eight produced a slightly different mix of initiatives and proposed developments over a three-year period the format and content was similar. For example each CCG proposes to invest small sums in improving Care at Home (between £0.5 - 5.0 million), largely on increasing staffing levels (20 - 75 WTE); slightly more in GP practices (£1.5 - 10.5 million) and similar amounts on hubs/health centres (£0 - 7 million).

All provide graphic representations of how the various initiatives described in each locality to provide easy access to high-quality services, simplified care pathways, rapid response to needs, integrated care for those with long-term conditions and older people, and appropriate times in hospital would be phased in – all to be completed by March 2015.

Table 2.7 provides key implementation dates for the current plans for OOH services (NHS North West London 2013d) in terms of initiatives and enabling strategies.

Table 2.7: North West London OOH strategy implementation plans

Initiatives	**When services will be operational**
1.Urgent Care Centres working to new specifications	end 2015
2.Rapid response /Admission avoidance	
Service in operation	Mid 2013/14
Fully operational	Later in 2013/14
3.Integrated Care/Case Management	Fully operational 2013
4. Planned Care in the Community	Mid 2013/14

Pathway specifications developed	Mid 2013/14
Referral management in place	2012/13
5. End of Life Care	
Pathway in operation	Mid 2013/14
6. Supported Discharge Care Co-ordination	From Mid 2013
Enabling Strategies	
7. GP Access Collaborative working	
Practices aligned to networks	2012/13
More appointments with more variety	Mid 2013/14
8. Remodelling workforce	
Education commissioning	Early 2013/14
9. Information sharing	
Boroughs working on single systems	End 2014/15
Interfaces between all parts of local healthcare and social care system	From late 2013/14 to end 2015
10. Network Hub Development	
Phase 1 FBC and refurbishment work completed	end 2013/14
Further phases	2014/15/16/17/18

Each CCG thus presented what seem to be thoughtful plans on how services would be improved substantially, if not transformed, over a relatively short timescale. What is lacking however is any presentation of the local problems, trends in performance and a better gauge of what difference any of these developments would make which would incentivise acute trusts to reduce capacity before the actual impact of these strategies can be assessed. As matters stand in March 2015 there is little to show for this activity.

2.5 Primary care provision and performance

A key element of access for people in North West London is the ability to consult with their GP as they need to. Parts of London have long had problems with the availability and quality of primary care. We now turn to the quality of general practice in North West London compared with other parts of London and with the rest of England, and attempt to relate this to the improvements that the SaHF programme is supposed to bring.

SaHF claimed that patient satisfaction with primary care is low in all eight North West London boroughs when compared with national levels. Thus 25% of patients in North West London GP practices are dissatisfied with access, and feel unable to see their doctor fairly quickly within the next two working days. Most (79%) of GP practices in North West London have below national average satisfaction scores.

Similarly, 25% of patients in North West London do not feel that they are being treated by their GP with care and concern. In terms of communication and access (such as communications by the doctor, level of empathy, satisfaction with out-of-hours service), five of the North West London boroughs rank in the bottom 10% of all parts of the country. As SaHF's *Case for Change* (p15, NHS North West London 2012d) points out, '*The effectiveness with which services are being delivered by GP practices is also highly variable and often below national averages'*.

These findings point to a need to improve GP services in North West London. They are not evidence to suggest there should be a reduction in acute services. In fact, if anything they suggest not, since any removal of acute services would be likely to damage patient health at a time when GP services are so unsatisfactory. What is needed is an improvement across the board in primary and community services followed by an assessment of the impact this has on demand for acute services: the assumption that demand will fall has no basis in the literature (for example see Purdy *et al.* 2012).

2.6 Findings and recommendations

Key findings

1. The lack of needs assessment invalidates the SaHF process;
2. There is little evidence that account has been taken of the needs of disadvantaged populations;
3. Access to services for patients was given little weight in decisions on SaHF compared with the need to cut costs throughout the system;
4. The SaHF analysis has failed to take adequate account of likely increases in population over time;
5. North West London has a different pattern of use of emergency services with greater use of UCCs than other parts of London, and the rest of England;
6. There is no evidence that North West London uses more A&E emergency services than other parts of England, or London; and,
7. Partial implementation of a programme of closures of acute services before an adequate business case has been produced, has had a detrimental effect on the delivery of services in North West London.

Recommendations

1. Closure of acute services at Charing Cross is halted and sufficient resources are made available to retain existing services and staff;

2. Closure of acute services at Ealing is halted and sufficient resources are made available to retain existing services and staff; and,

3. There should be an appraisal of the reintroduction of A&E services at Hammersmith with joint staffing across the three Imperial sites.

Section 3 Quality of care

3.1 Introduction

One of the key arguments used by SaHF is the need to improve the quality of primary and community care and the quality of hospital care. It is claimed that there is poor access to GP services, poor patient satisfaction levels with GP services, poor communications skills at practice level, too much variation in the quantity and quality of GP services, and inconsistency in levels of support to people with long-term conditions and the old and frail in particular.

It is also claimed that there is variation in the quality of acute care across North West London, with high mortality rates because of poor weekend cover in A&E departments. The catchment areas of the nine A&Es are marginally smaller than those nationally.

At first glance it is not immediately apparent that large-scale reconfiguration is vital to address these quality concerns.

Improvements in out-of-hospital (OOH) services are not reliant on reconfiguration of hospital services. Moreover if hospital reconfigurations are premised on reductions or shifts in demand as a result of improved OOH, then clearly improvements in OOH services should precede major reconfigurations. The risk otherwise is that patients will be deprived of services if the expected reductions in acute demand fail to materialise.

This section provides:

1. A description and assessment of the evidence supporting greater centralisation of services to fewer sites;
2. A description and assessment of evidence on what is required to deliver safe high-quality maternity services;
3. A description and assessment of evidence on what is required to deliver safe high-quality emergency services; and,
4. A description and assessment of evidence on what the impact of OOH services is likely to be on the demand for acute services.

3.2 General issues

It is the central contention of SaHF that reconfiguration of hospital services across North West London is essential to achieve the objective of improving the quality and safety of clinical services. There are two key elements to this consideration.

First there is evidence that increased specialisation in the provision of services leads to better outcomes for patients, and this tends to be an argument in favour of reducing the number of hospital sites providing the same service. This may be true of planned services where delay in getting to a hospital is unlikely to have any detrimental effect on the outcome for the patient (although it is an inconvenience for patients and visitors). It is more problematic in situations where a patient is in

urgent need of care – sometimes in life-threatening situations – where delays in getting to hospital may be the main determinant of the outcome.

Second it may not be physically possible to offer a full range of services on a large number of sites due to shortages of clinicians, nurses or other specialist staff, or of expensive equipment. Being able to staff facilities is an issue that was brought to the fore with the introduction and gradual implementation of the European Working Time Directive which restricts the number of hours that clinical staff can work, and hence increases the numbers required. However, in our view this usually comes down to a matter of cost, as equipment and human resources can often be made available if required but perhaps at a cost that the health economy is unwilling or unable – due to political constraints – to bear.

Evidence for centralisation

Taking the first point, the general evidence for specialisation as the key to improved quality does not support the claims made by SaHF. In a review of the evidence base for specialisation, Harrison (2012, p5) concluded:

> *We have argued that volume and outcome studies do not provide, in themselves, an adequate justification for centralizing hospital services. Further studies focusing purely on hospital or surgeon volumes will not advance understanding of why quality of outcome varies between hospitals, why some small units seem able to produce the same quality as much larger ones, why large units sometimes perform badly or on the circumstances which determine whether the hoped for gains from centralizing services are actually achieved.*

Naïve comparisons between hospitals according to size and performance can be misleading. For example small specialist units may appear to have lower quality but this could be attributable to a different case-mix; similarly although unit costs may be greater in smaller units, the clinical quality can be greater.

In a Nuffield Trust report, Hurst and Williams (2012, p59) made a similar observation:

> *There is also a large literature on the effect of changes in size on unit costs in hospitals. Reviews suggest that cost per case declines as hospitals increase in size to about 200 beds. There appear to be roughly constant returns to scale between 200 and 600 beds; however, above approximately 600 beds diseconomies of scale seem to set in, possibly because larger hospitals become more difficult to manage.*

On this basis none of the hospitals in North West London are small hospitals. It is perfectly feasible to provide high-quality services from these sites.

In fact, SaHF's Pre-consultation Business Case (p48, NHS North West London, 2012b) notes that, '*the clinical quality of hospitals in NW London compares well to the national average in terms of mortality rates*'. We observe in Table 3.1 below that hospital-based mortality rates in North West London hospitals were actually better than average (p49, NHS North West London, 2012b).

Table 3.1: Mortality rates in North West London hospitals, 2009/10

Hospital	Average mortality ratios
Chelsea & Westminster	88
Imperial	79
Hillingdon	92
Ealing	93
West Middlesex	85
North West London	86
England	100

This is based on an analysis of hospital mortality rates by Dr Foster.

There is variation across the hospitals, but based on this indicator quality seems good across North West London with all hospitals better than the England average and many considerably so. It also belies the notion that any variation in healthcare outcomes in North West London should be a cause for concern, as has been claimed.

In addition the costs to hospitals adversely affected by the withdrawal of services are often not identified or calculated. Again Harrison (2012, p3) found that:

> *Most studies have focused on a narrow range of procedures, usually surgical interventions. They take no account of the implications for both the losing and the receiving hospitals of the effects of moving services between sites. Implicitly such studies assume that the higher-volume hospitals can absorb extra activity and maintain their supposed higher-quality levels. But staffing and physical constraints may make that impossible or if possible, very slow to realize.*

More recent evidence from the King's Fund, *The reconfiguration of clinical services. What is the evidence?* (Imison 2014), assessed the impact of centralisation thus:

> *There have been very few studies to assess the impact of centralising A&E services. The limited evidence available suggests that if services are centralised, there are risks to the quality of care where the centralised service does not have the necessary A&E capacity and acute medical support for the additional workload. A proportion of A&E attenders can safely be seen in community settings, but there is little evidence that developing these services in addition to A&E will reduce demand.*

The report concluded:

> *The reconfiguration of clinical services represents a significant organisational distraction and carries with it both clinical and financial risk. Yet those who are taking forward major clinical service reconfiguration do so in the absence of a clear evidence base or robust methodology with which to plan and make judgements about service change.*

In particular Imison found that evidence to support the impact of large-scale reconfigurations of hospital services on finance is almost entirely lacking; and evidence on the impact on quality is mixed, being much stronger in relation to specialist services than other areas of care.

Another study, this time from the Nuffield Trust, *The Effect of the British Red Cross 'Support at Home Service' on Hospital Utilisation* (Georghiou and Steventon 2014), was designed to show that better integration of social care and hospital care would reduce demand for acute care. It concluded however:

> *Our research did not detect lower use of hospitals for the British Red Cross group compared with a matched control group over the longer term. In fact, the evidence suggested that emergency admissions may have been slightly higher in the British Red Cross group.*
>
> *The results reinforce the challenges around reducing rates of emergency hospital admission. This is a common concern across health services, and one that has proved difficult to convincingly address. In the absence of well-accepted, evidence-based solutions to reducing emergency admissions, there is a need to subject promising new interventions and models of service provision of this type to thorough evaluation.*

So to summarise, we find the most recent evidence does not support the case that centralisation of acute services will result in increased quality and efficiency, and if anything it may work the other way.

Staffing issues

Taking the second major strand of argument, this makes much of the difficulties of recruiting sufficient numbers of consultants to work in certain specialties as an argument for rationalisation and reconfiguration. It is often claimed that this has been exacerbated by the European Working Time Directive (EWTD). But as the Chairman of the Independent Reconfiguration Panel (IRP) in reviewing the Panel's work states (Barrett 2012, p5):

> *With the benefit of hindsight, I think it is fair to say that the EWTD did not turn out to be the insurmountable obstacle it was originally perceived to be. Instead, in many cases it forced the NHS to think more imaginatively about how best to utilise its staff.*

This conclusion was supported in our own informal discussions with colleagues from the College of Emergency Medicine who felt a combination of tactics, including recruitment from overseas could bridge staffing shortages until adequate numbers of staff were trained in the UK. If anything it is a failure of NHS planning not to ensure sufficient staff; this is not a reason in itself for reconfiguration. Indeed there has been concern expressed in the past that there were not enough posts being created for junior doctors completing their training.

In fact England has substantially less specialists per head of population than many other leading European countries: 0.91 per 1,000 in England compared with 2.39 in Denmark, 2.29 in Germany, 1.75 in Belgium, 1.71 in France and 0.98 in the Netherlands (Kok *et al.* 2012).

The obvious answer to shortages of staff to fill new rotas that result from the EWTD is to plan to recruit to do so – as surely should have happened if there were genuine safety concerns. This is not a new phenomenon but there has been a reluctance to address it that can only be due to financial or professional considerations.

Rideout made a similar argument in his reports to the London Borough of Ealing and to the London Borough of Hammersmith & Fulham (Rideout 2012a; 2012b) but these were discounted by the SaHF team. He states (p15, Rideout 2012a):

> *One of the key arguments for hospital reconfiguration and rationalisation is that the limited availability of senior medical personnel (particularly at weekends) has a detrimental impact on clinical outcomes.*

He goes on to say that this should have been tested against actual outcomes achieved at North West London hospitals, and points to the fact that many of the current outcomes are satisfactory, notwithstanding the limited availability of senior medical personnel and specialist teams.

Again, as Rideout (p15, 2012a) pointed out:

> *The business case does not explore other ways of securing sufficient cover that are not dependent on service rationalisation. The business case states that "there is insufficient staff available to provide such increased cover across all units, even if it could be afforded and skills could be maintained". However evidence is not provided to support this statement.*

In general the evidence on quality of care used to support SaHF was based on a link between high quality clinical care and numbers of senior staff, patient volumes to maintain skills, technology and the interdependencies between different acute and support services. This resulted in a decision taken before going to consultation that only five out of the nine hospitals should remain as what would effectively be acute hospital sites.

SaHF refers to standards developed by the Royal Colleges and their incorporation in a set of London Quality Standards. These have been used as immutable requirements when in fact they are more like 'gold standards' to which it may be reasonable to aspire but non-compliance would not have the kind of catastrophic impact that SaHF is wont to suggest. Moreover there is little strong evidence to support the link between these standards and improved quality of care. There is certainly no evidence that investment in such standards would prove cost effective.

As Rideout has also pointed out (p23, Rideout 2012a):

> *Although explained in summary terms, the detailed evidence base for this decision to propose five major hospitals is not provided with the business case and is therefore open to challenge.*

The SaHF team argues that there are not enough emergency surgeons available to support safe rotas at each of the nine sites, and points to the relatively low population catchment per current rota, which we have already indicated is subject to challenge. Moreover SaHF's work, as we have discussed in the section on needs assessment, takes no account of the specific and differential needs of the North West London population nor of increases in population that have already outstripped the forecasts used by SaHF.

Interestingly, the business case quotes the current lack of training in some key aspects of care amongst North West London's emergency surgeons, eg the ability to conduct laparoscopic procedures. Of the nine surgeons in Chelsea and Westminster 89% are laparoscopic-trained compared with 100% at Charing Cross (the average across London is 87%).

3.3 Maternity services

SaHF pointed to an increasing demand for maternity services, expected to increase by 12% by 2016, with, generally speaking, pregnancies becoming more complicated as the average age of women giving birth is going up, leading to a higher risk of complications. Obesity among women is also rising, which tends to increase the risk of complications during pregnancy and birth. According to the National Clinical Advisory Team's (NCAT) report into maternity and paediatric reconfiguration in North West London (NCAT 2012), the number of births in the whole of North West London was around 31,200 in 2010/11, and this was projected to increase to 36,000 by 2015/16.

SaHF claimed that standards vary between units as there are not enough senior doctors present during childbirth. The Royal College of Obstetricians and Gynaecologists (RCOG) recommends levels of senior doctor (consultant) presence at a maternity unit related to the number of births taking place.

Hence SaHF states there is a 'compelling case' for increasing the number of consultants on site on the labour ward 24 hours a day, seven days a week. SaHF claims that workforce estimates indicate it is unlikely there are sufficient staff to have a full consultant rota on the labour ward all the time in seven sites.

Thus, SaHF concludes that it is unlikely that seven obstetric units will be sustainable in 2016/17. This recommendation is further supported by the views of obstetric anaesthetists, reflecting the loss of training posts and similar pressures on consultant staffing for anaesthetics.

NCAT reviewed SaHF's plans for maternity and paediatric services and while being broadly supportive pointed to several failures of strategic planning (NCAT 2012). Thus NCAT felt the SaHF proposals would benefit from a minimum of an overall strategic direction for maternity and paediatric services with a supporting workforce strategy. It was also pointed out that the overall capacity of maternity and paediatric services had not been described with supporting data of facilities to support the service strategy. In addition there was a lack of clarity regarding how the changes will affect antenatal and postnatal care: the focus was purely on the number of births.

SaHF has claimed there is not enough one-to-one midwife care during childbirth in North West London arguing there is evidence that one-to-one care has a positive impact on the health and wellbeing of mother and child. SaHF points to challenges in recruiting enough midwives with many

midwives leaving, and claims it unlikely there will be enough midwives to provide one-to-one care at all seven maternity units for the increasing numbers of women giving birth in the next few years. However it is not clear how a reduction in the number of physical sites will change this as the standard that SaHF aspires to is 'one midwife per 30 births', which depends on total number of births and the total number of midwives.

Local clinicians developed a set of clinical standards for maternity services in North West London as indicated below. SaHF describes these standards as 'aspirational' and states that during implementation, North West London will review these standards as further work on maternity standards is done pan-London.

The standards are listed below (p28, NHS North West London 2012a).

1. Units with > 6,000 births per annum should provide 24/7 consultant cover ie 168 hours; units with 2,500 - 6,000 births per annum should provide 98 hours per week of consultant cover; units with < 2,500 births per annum are strongly recommended to have 40 hours per week of consultant cover;

2. In addition to a minimum of 40 hours of cover, a consultant should conduct ward rounds at least twice a day on Saturdays, Sundays, and Bank Holidays, as well as once in the evening during the week;

3. All women's care should be midwife-coordinated although a consultant should retain clinical responsibility for women with complex needs;

4. Consultant-delivered care should include a co-located midwife;

5. On-site support services should include on-site access to emergency surgery, interventional radiology and critical care, and support from an on-site neonatal unit but not necessarily paediatrics;

6. There must be 24-hour availability of a clinical worker fully trained in neonatal resuscitation and stabilisation of a new-born baby for immediate advice and urgent attendance;

7. Midwifery staffing levels should be implemented according to birth setting and case-mix categories to ensure 1:1 midwife-to-woman ratio during active labour, interpreted in North West London as one midwife to every 30 hospital births; and,

8. Access to emergency theatre when required.

It is often claimed that the unpredictable nature of maternity services means that births can sometimes require an 'emergency' response and it is increasingly unsustainable for the senior clinician not to be on-site but at home (available 'on call'). However, clinicians also agree that the true number of adverse incidents related to a delayed response is extremely small, but still go on to claim the decrease in experience of junior doctors on-site at night is likely to lead to an increase in adverse incidents.

As evidence for their conjecture the SaHF team cites the increased prominence given to the presence of a consultant on-site by the Clinical Negligence Scheme for Trusts (the insurance scheme for hospitals, with extremely high premiums for sites without RCOG-compliant rotas), and the focus of Serious Incident and Confidential Enquiry reports on this issue, while failing to recognise that these are merely a reflection of the views of the Royal Colleges for which hard evidence is somewhat lacking.

Thus, a report by the King's Fund in 2011 found that while staffing levels in maternity units are important, they are not necessarily associated with improved safety (Sandall *et al.* 2011). It is not just about absolute numbers of staff it is about how they are deployed. The report points to a lack of evidence in two significant areas. Thus (p vii, Sandall *et al.* 2011):

> *National recommended midwifery staffing ratios are based largely on the Birthrate Plus planning tool, which analyses workforce requirements in terms of what women need, and does not take into account the contribution of other staff apart from midwives. Despite the tool's popularity and widespread implementation, there is an absence of evidence about whether its use contributes to improved safety.*
>
> *New standards for obstetricians call for an increased consultant presence on delivery suites in response to the growing complexity of case mix, increased intervention rates and reduced availability and experience of trainees. There is an absence of evidence about whether an increase in consultant presence contributes to improved safety. Significant expansion of consultant numbers does not look achievable at present unless funding is diverted from other parts of the service.*

Sandall and colleagues go on to point out that international evidence suggests midwives could play a much more significant role without compromising patient safety. On the cost implications of different models of maternity care, they found that evidence of the financial implications of different staffing models is limited, and that isolating the staffing component of maternity costs is complex. Much of the available data originates in different countries, making comparisons particularly difficult.

In other words although there may be some consensus around the RCOG guidelines there is no strong evidence base to support them.

Nevertheless the SaHF team seems to have taken as given that it is impossible to maintain care across all sites in North West London with all that implies for accessibility of services and the implications for other services on the site losing services. There is an acceptance that it is impossible to recruit extra consultants to fill posts despite the evidence of increased birth rates suggesting more staff are required. SaHF saw as compelling the arguments that it would not be possible to attract, recruit and retain clinical staff unless there was a reduction in the number of sites. It saw as insuperable the problems posed by the shortage of consultants exacerbated by the need to develop sustainable EWTD-compliant rotas and the loss of junior medical training places, with around 30% of training posts estimated to disappear over the next five years.

SaHF's decisions are based on the cost of significantly increasing consultant requirements across North West London. But this proposed increase does not seem to have been based directly on safety concerns around any one hospital in North West London but on a set of general principles that as we have shown have no strong basis in evidence.

Safety concerns could be managed if appropriate funding was provided. The smallest unit, Ealing, has been dealing with around 3,000 births per annum although this number has fallen in recent years[13]: this is the norm in many parts of the UK and Europe (no unit in Germany delivers more than 3,500 babies per year). Around 62% of units in England in 2012 provided less than 4,000 births per annum (National Audit Office 2013). So in our view there is no precipitate reason to suggest that patients are at risk.

It was recently clarified by the SaHF team in a report presented to Central London CCG on 12 November 2014 on the planned transition for maternity and gynaecology services from Ealing that the costs of maintaining consultant cover in Ealing are £1.9 million. The report stated (NHS North West London 2014):

> *Ealing Hospital has already received £1.9m supplementary funding to ensure it continues to deliver a safe maternity service for the residents of Ealing for 2014/15. The introduction in 2014/15 of the Better Care Fund, transfer of funding to councils and the need to use any additional investment funding to develop new out of hospital services, mean that continued investment in the maternity service at these levels until 2017/18 is not sustainable.*

This is a matter of choice but it not a choice that has been given to the people who use Ealing maternity services. Moreover, while this report indicates an additional cost of £1.9 million associated with retaining services at Ealing, it is unclear how this figure has been arrived at.

It may be that the full national tariff for maternity cases is not sufficient to pay for the levels of cover newly set as minimum standards in London. The tariff reflects average costs across the country and as these still reflect lower levels of cover[14] it may be that the tariff paid is insufficient to pay for the higher standards being promoted in London. But if higher standards are being promoted in London, then this raises the question whether the additional costs of adhering to these are not a price worth paying.

To understand this fully would require an analysis of the precise nature of the payments to Ealing hospital for maternity services, and costs thereof, over the last five years, and a comparison between these and payments across North West London, London, and the rest of England. As far as we are aware, such an analysis has not been forthcoming from SaHF.

[13] This may be connected to the uncertainty about Ealing maternity unit that has been created by the SaHF process. Falling numbers become a self-fulfilling prophecy.

[14] The National Audit Office reported that in September 2012 half of the maternity units in England were not meeting RCOG guidelines on the level of consultant presence, with similar findings on midwives per birth (National Audit Office 2013).

Box 3.1 The European Working Time Directive

The European Working Time Directive (EWTD) has been cited as a key issue relating to the sustainability of services across several sites and has been influential in determining views taken on clinical sustainability.

The guidance issued by the Department of Health in January 2003 (Department of Health, 2003) on implementing the European Working Time Directive offered several solutions. These included:

1) reduction in the number of rotas – there was seen to be a need for fewer but more intensive resident rotas, which could be achieved by cross-cover and fewer tiers of cover;

2) new working patterns for consultants and specialist registrars;

3) expansion of staff numbers;

4) different forms of team working; and,

5) new service models.

A Compendium of Solutions to implementing the Working Time Directive for Doctors in Training was published by the Department of Health in May 2004 (Department of Health, 2004). This gave more detailed advice on measures available to cope with EWTD beyond centralisation of services. These included: hospital-at-night; rota redesign; more effective use of doctors in training, consultants and other staff; and creating networks of care.

It should be clear that woman-friendly services would be delivered by shorter travel times, closer proximity, and that more individualised care could be generated by the existing configuration. A more rational response to shortages of skilled staff would be to reverse past decisions to reduce junior staff and to plan for increased consultant numbers. Meanwhile, alternatives exist for managing the pressures associated with implementing the EWTD (see Box 3.1 for more discussion of this issue). Finally, there appears to have been no serious consideration of the risks associated with the loss of services that provide a more local service for the most deprived groups in the locality, those also most dependent on public transport.

3.4 Emergency services

In the case of emergency care, centralisation may have a negative impact with mortality increasing the greater distances that have to be travelled. Thus Harrison (2012, p4) has found:

> *Even if gains in outcomes are achieved by centralization, the longer journey times that it entails for some patients may offset them to some extent. One study of stroke care found that the clinical risks of longer journeys outweighed the benefits of centralization. Nicholl et al. found that for every mile a seriously injured person had to travel to hospital, the risk of death increased by one per cent. Other work has found that the longer journeys discouraged use of health-care services.*

The SaHF documentation points to '*over 500 avoidable deaths in London a year due to different consultant hours at weekends and in evenings at hospitals across the capital*', and uses this as justification for centralisation of services. Unfortunately no commensurate calculation has been provided of the deaths that may be caused by the closure of many A&E departments in London.

Moreover this assertion that these extra deaths are due to a lack of 24/7 coverage in A&E departments is based on a limited number of studies which in themselves cannot be taken as a clear indication either way. Thus for example, Freemantle and colleagues (2012) found an increase in 30-day mortality for patients admitted as emergencies at the weekend when compared with those admitted during the week. They hypothesise that the reasons behind this may include aspects of the care associated with weekend admissions as well as the fact that patients admitted at the weekend may be more ill. The authors conclude:

> *It may be that reorganised services providing 7-day access to all aspects of care could improve outcomes for higher risk patients currently admitted at the weekend. However, the economics for such a change need further evaluation to ensure that such reorganization represents an efficient use of scarce resources.*

Freemantle *et al.* go on to suggest that:

> *Some urgent conditions require prompt treatment and in some cases the way weekend care is organized may lead to delays, which adversely affect the outcome. An example of such a condition is fracture of neck of femur, for which it is known that delay in treatment is associated with poorer outcomes. However, in our dataset, this condition had similar outcomes for patients admitted on weekend to those that were admitted during the week.*

This seems to suggest that there may be other factors at play that are equally important in explaining outcomes. Nevertheless these limited findings have led some commentators and the SaHF team in particular, to argue on this basis that patients receive poorer quality care over the weekend and are therefore more likely to die as a result. However this is not clear and is certainly not a definitive claim made by Freemantle and colleagues.

Moreover, if staffing is an issue, it is unclear why better cover has not been provided in the past despite unprecedented growth in NHS resources in the period to 2010. Between 1996/97 and 2010/11, net government spending on the NHS in the UK increased from 5.4% to 8.2% of GDP corresponding to an almost threefold increase in cash terms from £42.8 billion to £121.3 billion (Harker 2012).

In fact A&E services are something of a 'Cinderella' service providing care disproportionately to the underprivileged; it is difficult to attract consultant staff partly because there is little opportunity for private earnings as exist in most other clinical areas.

The crucial assumption justifying further reductions in the provision of A&E services in North West London, and hence savings in capacity and staffing, is that investment in out-of-hospital care will reduce demand. But the evidence for this does not stand up as we discuss in section 3.5. Indeed there is even some evidence that readmission rates significantly increased for older patients with a mixture of conditions who were allocated to hospital-at-home services (p8, Purdy *et al.* 2012).

Carson *et al.* (p19, 2011) found no direct link between A&E attendance and hospital admission, and moreover diversion schemes were generally ineffective. They state (our **bold**):

There is some evidence that when A&E departments become overwhelmed junior staff will admit more people – the primary failure is in the A&E system not the volume presenting. There are a number of key factors driving hospital admission numbers. These are: the number of individuals referred by GPs, 999, 111 and NHS Direct staff and out-of-hours services (which are all influenced by access to GP urgent care), and the efficiency of the process in A&E and acute medicine, including the availability of senior staff. ***There is little or no evidence for the effectiveness of diversion schemes on admissions; some have had serious safety questions raised; while diversion schemes tend to focus on people who were never likely to be admitted because all they needed was advice or more basic care.***

Carson *et al.* (p22, 2011) also examined the use of urgent care centres and walk-in clinics. They found that:

> *There is a lack of published evidence to support the hypothesis that urgent care centres and walk-in centres will reduce attendances at emergency departments; in contrast, indications suggest they increase total burden on the NHS. Where the vision of the urgent care centre is that it is fully integrated part of the A&E service … it will take time to establish and much longer for the relationships and mutual trust to grow so that the centre functions with full effectiveness.*

All of these research findings point to the lack of evidence supporting the claims of the SaHF team.

SaHF assume that 14% of A&E attendances can be diverted from A&E with 19% of emergency admissions avoided (see section 2 on access). But Carson *et al.* (2011) found that when a consistent definition of primary care is used and a consistent denominator of all emergency department cases, the proportion of A&E cases that could be classified as primary care was between 10% and 30%. Carson and colleagues (p18, 2011) state,

> *Whilst it is undoubtedly true that primary care clinicians can relearn the skills needed to deal with the minor injuries that were excluded from the definition of primary care cases, there seems little value in this when A&E nurses already do this work well.*

These findings rebut some of the myths surrounding A&E services and seriously undermine the arguments put forward by SaHF.

What SaHF clinicians specified

We list below the standards that SaHF is setting for the delivery of emergency services in North West London. While these all may make sense in the best of possible worlds, there is little evidence to support them as necessary requirements for the delivery of such care; it is certainly not clear that if adherence to these standards requires the closure of four out of nine emergency sites (and SaHF medical directors are inclined to say that it really should be just three sites remaining), this is going to give a better more safe solution. No account is taken of the impact of greater travel times, and

the mortality associated with that, nor the convenience and desires of local populations to have care delivered close to them.

The following standards for emergency care were set out by SaHF in the consultation document (p27, NHS North West London 2012a).

1. All emergency admissions to be seen and assessed by a relevant consultant within 12 hours of the decision to admit or 14 hours of time of arrival at hospital
2. Acute medicine patients should be seen twice daily by a relevant consultant
3. When on-take, emergency / acute medicine and surgery consultants and teams must be available and free of other duties
4. Any surgery at night should be by consultant surgeon and meet NCEPOD standards
5. All hospitals admitting emergency surgery patients must have access to theatre and **aspire** (our bold) to have trained consultant surgeon on site within 30 minutes at all times
6. Critical care unit should have dedicated medical cover present 24/7
7. Units admitting medical and surgical emergencies should have access to all key diagnostic services in a timely manner 24/7
8. Prompt screening of all complex needs patients 7 days a week
9. Single call referral for mental health emergencies 24/7 with aspired maximum response time of 30 minutes
10. Most emergency surgery should be done on planned emergency lists on the day planned, and any surgery delays recorded
11. On a site without 24/7 emergency surgery cover there must be clear process for transfer of patients to emergency surgery site without delay if surgical emergency is suspected.

In our view these recommendations are all commendable. However they do not in themselves provide an argument for the closure of four A&E departments in North West London. Instead we would interpret these as meaning that there should be more investment and better organisation of A&E services.

From the evidence we have seen, North West London does not have excessive spend on A&E services and there is not higher utilisation than would be expected.

Given the pivotal and crucial existence of A&E services at the four sites for residents of the North West London boroughs and for support to maternity, paediatric and complex surgery, we would have expected a much stronger case to be put forward before closure of one site was seriously suggested let alone four.

3.5 Out-of hospital services

We recognise that there may be a theoretical case for the diversion of A&E cases to community services yet there remains little convincing empirical evidence to suggest that the assumption of reductions in demand for A&E services will be realised (see Purdy *et al.* 2012 for a summary of the research evidence). As we feel this is a key issue, we summarise the findings of Purdy and colleagues.

Overall case management did not have any effect on unplanned admissions. Specialist clinics for heart failure patients reduced unplanned admissions but there was no evidence to suggest that specialist clinics reduced unplanned admissions in asthma patients or older people. Overall, the evidence on community interventions is too limited to make definitive conclusions. However, there is a suggestion that visiting acutely-at-risk populations may result in less unplanned admissions, eg failure-to-thrive infants, heart failure patients.

There is no convincing evidence to make any firm conclusions regarding the effect of care pathways and guidelines on unplanned hospital admissions. Also, there was no evidence of an effect of medication reviews on unplanned admissions in older people and on those with heart failure or asthma carried out by clinical, community or research pharmacists. But education with self-management reduced unplanned admissions in adults with asthma and in COPD patients, but not in children with asthma. There is weak evidence for the role of education in reducing unplanned admissions in heart failure patients.

Pulmonary rehabilitation is a highly effective and safe intervention to reduce unplanned admissions in patients who have recently suffered an exacerbation of COPD. Exercise-based cardiac rehabilitation for coronary heart disease is also effective in reducing unplanned admissions in shorter-term studies. But therapy-based rehabilitation targeted towards stroke patients living at home did not appear to improve unplanned admissions and limited data on the effect of fall prevention interventions for older people at risk suggest they did not influence unplanned admissions.

Telemedicine appears to lead to reductions in unplanned admissions for heart disease, diabetes, hypertension and older people. Reviews of asthma patients, COPD patients, healthy older people and health workers who work with the older people, all showed no effect from vaccine programmes on unplanned admissions. In fact, readmission rates were significantly increased for elderly patients with a mixture of conditions allocated to hospital-at-home services. There was insufficient evidence (a lack of studies) to draw any conclusions on the role of finance schemes, emergency department interventions and continuity of care for the reduction of unplanned admissions.

To summarise, there was evidence that education/self-management, exercise/rehabilitation and telemedicine in selected patient populations, and specialist heart failure interventions can help reduce unplanned admissions. However, the current evidence suggests that the majority of the remaining interventions do not help reduce unplanned admissions in a wide range of patients. There was insufficient evidence to determine whether home visits, pay-by-performance schemes, A&E services and continuity of care reduce unplanned admissions.

Researchers at the Nuffield Institute (Bardsley *et al.* 2013) who surveyed a range of community-based interventions across a large number of sites in England found the limited success of various community-based innovations disappointing. Interestingly they also noted, '*the impatience in the system to show changes on what may be an unrealistically short timescale'*. Perhaps the SaHF team would do well to learn from this, and be more realistic about how long it might take for their own OOH interventions to take effect.

A more recent study from the Commission on Hospital Care for Frail Older People (2014) concluded:

> *There is a myth that providing more and better care for frail older people in the community, increasing integration between health and social care services and pooling health and social care budgets will lead to significant, cashable financial savings in the acute hospital sector and across health economies. The commission found no evidence that these assumptions are true. The commonly made assertion that better community and social care will lead to less need for acute hospital beds is probably wrong.*

In our view therefore much more evidence needs to be available that demonstrates that measures planned in North West London will have the impact on A&E services as suggested in the SaHF proposals.

The NCAT report (p10, NCAT 2012) also pointed to issues around the provision of care outside of hospital. Thus:

> *In order to reduce the number of in-patient units, enhanced community services would be required to reduce the number of admissions and to shorten length of stay. At present there is a shortage of community paediatric nurses, possibly because of the high cost of housing in NW London and the easy availability of employment elsewhere. We were told that NE Thames and S Thames have far fewer problems with recruitment and retention. In addition there is a shortage of health visitors and variable standards of primary care with only 40% of GPs having any paediatric training and 40% of children having no GP. Yet such services would need to be much more robust prior to attempts to manage more sick children out of hospital.*

The NCAT report (p 12, NCAT 2012) went on to comment thus:

> *In going forward there is a need to ensure that community services are in place before closing acute services, particularly given the challenges in recruitment and retention of community staff.*
>
> *Further work* (is) *required on public and patient involvement re paediatrics and maternity services prior to consultation, in particular more detailed plans for community support services and the longer term vision for paediatric services. Ensure that plans are made for a robust community service to support the reduction in acute care provision.*

We find similar reservations from the OGC Gateway Review of the SaHF programme. Thus the review (p12, OGC 2012) recommended that SaHF clarifies the service models for UCCs and for A&E units saying:

The future service models for Urgent Care Centres (UCC) and Accident & Emergency (A&E) must be explained fully. The public need to understand what the UCCs will offer, and feel assured that they will be fit for purpose. Information about when and how existing UCCs will be modified should be provided. The current focus appears to be on closing A&E departments and not on the availability of UCCs meeting the needs of many patients locally, or the fact that patients are already taken to specialist centres by ambulance for trauma, stroke etc, by-passing their local A&Es.

3.6 Findings and recommendations

Key findings

1. The evidence on maternity services does not support the conclusion that only six units are viable in North West London;

2. The evidence on A&E services does not support the conclusion that only five units are viable in North West London;

3. The problems of recruitment and retention of key staff are not insuperable, can be addressed in a range of ways and do not require rationalisation; and,

4. The evidence on the impact of OOH services on the demand for acute services does not support the conclusion that five acute units will be able to provide for the needs of the population of North West London.

Section 4 The Business Case

4.1 Introduction

This section provides a discussion of:

- The financial context including international comparisons of resource utilisation;
- The latest information on the business case;
- The extent to which the business case hinges on the unproven results of expansion in OOH services, and the implications of this for the NHS and local people;
- The affordability of the business case; and,
- Risks, uncertainties and deliverability of the programme.

4.2 Financial context

Our analysis of the documents available suggests that financial considerations have been the ultimate driver for the changes proposed by the SaHF programme. The primacy of the financial pressures in North West London is exemplified by the use of graphics in the PCBC (Figure 6.1, p56, NHS North West London 2012b) showing a projected funding gap of £1 billion by 2014/15. The case in the DMBC is similarly based on alarmist projections of spending required to cater for expanding needs, faced with the desire to improve productivity and achieve 4% per annum efficiency targets.

The UK is dealing with the consequences of the financial crisis in 2008. The coalition government of 2010 sought to restrain public sector spending. However it acknowledged the special place of the NHS and announced it would preserve real levels of funding while at the same time attempting to achieve unprecedented levels of efficiency savings to fund the increased levels of service expected. Thus the coalition government reinforced the need for the NHS to meet the Nicholson challenge, associated with the then Chief Executive of the NHS, David Nicholson, to make £20 billion of efficiency savings by 2015. The Department of Health had required all NHS bodies to make substantial efficiency savings, thus:

> *To meet the rising costs of healthcare and increasing demand on its services, the NHS will release up to £20 billion of annual efficiency savings over the next four years, all of which will be reinvested……*
> (Department of Health 2010).

This then translated into very large efficiency targets in North West London and was a theme taken up in the SaHF Case for Change (NHS North West London 2012d).

The SaHF programme has adopted what has become a common template across the NHS: to project huge financial problems thereby generating a sense of urgency to do something, and for that something to be in essence severe reductions in acute capacity onto fewer larger sites, and when challenged to say that local doctors' leaders are in favour and so it must be a good thing. This appears simplistic because it is.

Key questions left unanswered by the analysis produced by the SaHF team are:

- Are costs under control, and is it possible to reduce costs further?
- Are QIPP programme savings being double-counted?
- Is too much being spent on healthcare?

We address each in turn.

Controlling costs

Despite the warning in the *Case for Change* (NHS North West London 2012d) that without urgent change there would be a large deficit in North West London by 2014/15, spending has remained very close to the funding allocated by government with surpluses in aggregate spending in 2013/14 and projected for 2014/15 for the UK as a whole, London and North West London. Pressures in one area seem to be balanced by surpluses in another. Thus, notwithstanding the major efforts made to achieve savings and the claims of sub-standard levels of service being provided, the picture is not one of uncontrolled spending, and until recently quality measures in North West London were good compared to other places.

For the NHS as a whole there was a revenue surplus of £305 million in 2013/14 as there has been since 2010/11 with reported surpluses in 2010/11, 2011/12 and 2012/13 of £1,098 million, £826 million and £1,527 million respectively (p30, Department of Health 2014). The same is true of NHS London which was in overall surplus in 2013/14 and is expected to be so again at the end of 2014/15 (Bauman 2014). An extract from the year-end audited accounts of the CCGs and provider organisations in North West London showed an overall surplus of £100.1 million in 2013/14 as shown in Table 4.1. In fact NHS England reported London as £189 million in surplus (Annex 1, Bauman 2014). This would seem to indicate that North West London contributed more than its fair share (over 50%) to the overall London surplus.

Table 4.1: North West London summary financial information, 2013/14

Commissioners in North West London	**£ million surplus**
Brent	33.6
Harrow	-10
Hammersmith & Fulham	12.3
Ealing	6.9
Hounslow	1.9
Central London	16.9
West London	29.6

Hillingdon	-5
Total Commissioners	**86.2**
Main providers in North West London	
Hillingdon	-0.7
North West London	-23.3
Ealing	17
Imperial	15.1
Chelsea & Westminster	6.2
West Middlesex	-5
C&NW NHS Trust	4.6
Total Providers	**13.9**
Total Surplus	**100.1**

Source: our analysis of year-end audited accounts of the CCGs and provider organisations in North West London.

The reported financial picture for 2014/15 is more difficult to collate and interpret as board papers are not consistently available and there is some scope for interpretation. Table 4.2 reflects the comprehensive financial position of trusts and CCGs and would show a much larger surplus but for a £30.7 million asset impairment write-down at Imperial Hospitals. We see an emerging problem within North West London Hospitals which now includes Ealing hospital. There have been negotiations for financial help from the centre to the North West London Trust's position: this is not incorporated as yet in year-end projections. Despite this, overall the health economy is breaking even, and we note that this includes very high levels of spending on the SaHF process itself: the planned budget for SaHF as announced in 2014/15 is £62.9 million, a sum that perhaps could have been usefully applied elsewhere.

According to the latest Board reports of NHS England, London is expected to show a surplus of £79 million by the end of 2014/15 thus reinforcing the view that the health economy is in overall balance (Baumann 2015).

Table 4.2: North West London summary financial information, to latest month 2014/15

	Latest 2014/15 £ million surplus	Based on latest information to month	Projected £ million surplus
Commissioners in North West London			
Brent	7.5	11	9.5
Harrow	-0.85	10	2.9
Hammersmith & Fulham	13.2	10	13.9
Ealing	16	10	17.8
Hounslow	4.7	10	6.9
Central London	9.4	10	13.4
West London	-0.05	9	-1.2
Hillingdon	2.7	10	3.4
Total Commissioners	**52.6**		**66.6**
Main providers in North West London			
Hillingdon	-1.2	11	-0.8
North West London	-54.7	11	-55.9
Ealing	-	-	-
Imperial	-4.7	11	0
Chelsea & Westminster	1.7	11	2.2
West Middlesex	-3.8	8	-7.9
C&NW NHS Trust	-4.8	10	-1.1
Total Providers	**-67.5**		**-63.5**
Total Surplus	**-14.9**		**3.1**

Source: our analysis of latest summary financial information from the CCGs and provider organisations in North West London.

1 Ealing has merged with the North West London trust and hence is included in that line which is now in fact London North West Healthcare NHS Trust.

To amplify the point made earlier about the costs of the SaHF programme, we are concerned that there is no clear audit trail of these costs or of future cost estimates. We note that a request has been made by an Ealing resident to SaHF to produce an up-to-date analysis of the programme costs since its inception.

Based on the evidence we have to date, we provide Table 4.3 showing costs and projected costs associated with the programme. The cumulative cost will be over £235 million; and probably much more. This raises questions as to who benefits from this process, whether SaHF has provided value for money and who is monitoring that, and whether this level of costs was planned or is a response to the project failing to deliver.

Table 4.3: Estimated costs of the SaHF programme, 2010/11 to 2017/18

	Identified programme costs/budgets £ m	Of which, identified consultancy costs £ m
2010/11	0.50	0.50
2011/12	2.55	2.55
2012/13	8.60	8.60
2013/14	27.30	10.34
2014/15	62.90	13.44
2015/16	53.70	
2016/17	40.00	
2017/18	40.00	
TOTAL	235.55	35.43

Sources: SaHF reports to JHOSC, CCG reports and Colin Stansfield.

Figures for 2016/17 and 2017/18 are estimates.

Thus, while the business case for SAHF remains unavailable and we assume unfit as yet to be presented for Treasury approval, the finances of North West London are in overall balance. Yet we find the urgent implementation in 2014 of capacity closures at Hammersmith and Central Middlesex hospitals and trust mergers proceeding quickly. This is unsatisfactory as services are being reconfigured before it has been proven that plans are affordable, deliverable and will be financed.

The risk is that the wrong things will be done; counterproductive action will be taken and instead of improving quality and saving money the reverse will be achieved: services will be destabilised and costs overall will increase. This is precisely what occurred in South East London (Palmer 2011; Office of the Trust Special Administrator 2013) where the excessive and unfunded costs of bad PFI deals at the Bromley and Woolwich sites resulted in services at Queen Mary's Sidcup being undermined to support those hospitals. This precipitated a crisis as staff and patients lost confidence in local

hospital services. Eventually extra funds were found but not before a major deterioration in local services had been allowed to develop.

We are particularly concerned at testimony from Ealing Hospital staff to the Commission which suggests that SaHF's desire to close services as soon as possible, and before a formal business case has been agreed, has served to destabilise staff morale.

QIPP savings

Providers and commissioners are already committed to savings programmes (known as Quality, Innovation, Productivity and Prevention or QIPP) that may have already succeeded in making the necessary savings within the forward projections provided by the trusts and CCGs without recourse to the closures proposed by the SaHF team. It is only when reconciled plans are finally presented that this will become clear. For the moment we do know that most of the savings achieved have been made outside of the SaHF programme rather than because of it.

There is a danger that the savings being confidently predicted by SaHF as justification for the demolition of efficient, working hospitals at Charing Cross and Ealing, and the construction of St Mary's and additional capacity at the other acute hospitals, on top of considerable sums to be invested in OOH services, may already have been achieved in order to fulfil QIPP targets. We cannot be sure that there is not 'double-counting' ie the attribution of one set of savings for two separate purposes. It is only by checking the detail of current financial projections that this will become clear, but the latest business case has not been made available to us or the Commission.

However, there must be limits to the productivity improvements that can be extracted from the NHS. We calculate that the cumulative efficiency targets imposed by the Government for the period between 2010 and 2015 were about 21% and by 2020 these will be 44.5% (National Audit Office 2011).

Such large efficiency savings are unlikely to be achieved without undermining the quality and reliability of services. We dispute whether the changes proposed are necessary or desirable and feel that the onus is on those proposing change of this magnitude to justify the requirement. In particular we calculate the capital costs of restructuring are very large, onerous and avoidable (see the discussion in section 4.5), and moreover that the investment in OOH services that SaHF suggests will enable a reduction in acute capacity is unlikely to do so (see the discussion in section 4.4).

What is an appropriate level of expenditure on healthcare?

Table 4.4: Health expenditure per capita, UK and comparable countries, 2012

Country	**Health spending per capita $**	**Health spending % of GDP**
UK	3,289	9.3
US	8,745	16.9
France	4,288	11.6
Germany	4,811	11.3

Netherlands	5,219	12.1

Source: Anderson 2014.

On the question of whether it is possible to reduce costs further it is important to note that the UK spends less on healthcare as a proportion of GDP and in absolute terms than most of its major EU neighbours. Table 4.4 shows that the UK spends considerably less than France, Germany or the Netherlands, as well as the US.

Table 4.5 shows that the UK also uses less resources per head than comparable countries. It is a matter of political choice how much it is decided to spend on the NHS, and whether the UK matches that spent in countries like Germany, France and the Netherlands. However, a comparison with other countries reinforces a view that the UK underspends on, and underprovides for, health care.

Table 4.5: International comparisons of resource inputs per 1,000 population, 2012

	Nurses	Doctors	Total Beds	Acute Beds
UK	8.2	2.8	2.8	2.3
US	11.1	2.5	3.1	2.6
France	9.1	3.1	6.3	3.4
Germany	11.3	4	8.3	5.4
Netherlands	11.9	n/a	4.7	3.3

Source: OECD 2014.

This stands in sharp contrast to McKinsey's report in 2009 (McKinsey 2009) which identified the UK as having high hospital costs and high hospital utilisation rates. International comparisons are notoriously difficult to reconcile to ensure like is being compared with like but it seems unlikely that the consistent picture from the OECD is wrong. This has not prevented the view that the UK is relatively well endowed with acute services; the opportunity to make savings by shifting expenditure to the community has become an established myth. Research is still going on to refine international comparisons but it is clear to us that policy makers may have acted on incomplete if not erroneous information.

In the recent past it has been possible to justify considerably more expenditure on the NHS and from its inception to 2010/11, spend has grown by around 3.8% per annum, although there have been periods of greater and lesser spend. Since 2010, under the current government, the increase in real spending has been almost zero in real terms.

If the new Chief Executive of NHS England achieves his objective of limiting the efficiency drive in the NHS to more manageable levels, the need for draconian cuts to NHS capacity may be limited. He recently announced a five-year plan for the NHS, *Five Year Forward View*, where he called for 1.5% real-term growth (NHS England 2014a).

To summarise

In looking at how to achieve savings in North West London the need to take peremptory and hasty decisions to prevent deficits is not borne out by the facts. All areas of overspending in the NHS are balanced by surpluses elsewhere. International comparisons show that the UK spends significantly less than other countries on healthcare and modest increases in spending are affordable.

There have been large savings achieved already though the implementation of QIPP. We conclude, based on the evidence available to us at this stage, that the background financial situation in North West London is under control, despite the unprecedented demands being made. Potential shortfalls have been addressed through targeted QIPP programmes focussed on achieving specific improvements in quality and productivity.

The continuation of the SaHF programme is at this stage an historical anomaly and distraction. It is a residue from the plans developed by NHS London to restructure London healthcare, plans rejected by the last Secretary of State, Andrew Lansley (Ramesh 2010) but somehow allowed an afterlife in North West London.

4.3 The business case

The key issues arising around the business case are:

- the decision making business case was published two years ago and since then no business case has been made public or available for independent scrutiny[15];
- capital costs are said to have increased to over £1 billion;
- the consequences of this increase in costs are likely to be substantial revisions to proposals to ensure they remain affordable;
- this in turn may invalidate the public consultation that has taken place; and,
- it is not clear that sufficient capacity has been retained to cope with the rapid population growth in North West London.

Table 4.6 summarises the costs and benefits identified from the proposed SaHF investments: these are discussed below.

[15] We have asked to review it even in draft form, but having had agreement, this has now been refused.

Table 4.6: Summary of costs and benefits of SaHF proposals

	PCBC £ m	DMBC £ m	Latest estimates[16] £ m
Capital investment	112	206	1,000
Revenue cost OOH	84	190	250
Savings NPV (20-yr)	271	114	Not known
Savings per annum over 'Do Nothing'	55	42	-38
Cost of quality improvements	17	17	17

Source: Figures are taken from the PCBC, from Volume 7 of the DMBC Appendix N, and our estimates of current situation.

According to the SaHF proposals as presented in the Pre-Consultation Business Case (PCBC) (p60, Volume 1, NHS North West London 2012b), the savings resulting from reductions in acute beds and services would be £219 million per annum, but with a requirement to invest in OOH services amounting to £84 million per annum, the net saving would be £135 million. In February 2013 NHS North West London published the Decision Making Business Case (DMBC) (NHS North West London 2013a). This gave both a fuller elaboration of plans as well as details of adjusted calculations of the costs and benefits of the proposals.

Thus the capital cost of the preferred option increased from £112 million to £206 million (both net of reinvested capital receipts of around £168 million). The net benefit was reduced by £13 million per annum due to the cost of the extra capital, and the Net Present Value (NPV) of the benefits of the preferred option were reduced from £271 million to £114 million, calculated over a period of 20 years.

Nevertheless the preferred option has remained the same (Option A) with its implied closure of acute services across four hospitals – Central Middlesex, Ealing, Hammersmith and Charing Cross. This option was claimed to provide savings to the health economy of £42 million per annum, more than any of the other options but less than that calculated in the PCBC of £55 million.

This reflects the position over two years ago. We have not been given access to subsequent revisions of the business case although SaHF's former programme director, Daniel Elkeles, confirmed to us the net capital investment costs are now of the order of £1 billion, although this reduces to £700 million if a like-for-like comparison is made with the original proposals. Our interpretation of this is that costs have been underestimated by around £500 million, or £800 million if the additional costs of requests for expanded facilities are now also taken into account. In our view this latter figure is

[16] These were supplied in an interview with the former Director of the SaHF programme. The impact on savings is interpolated from the revised capital budget.

appropriate because one of the reasons for the additional costs is the need to provide sufficient capacity only required because of the bed closures proposed by SaHF in the first place.

This means that the ongoing charges for this capital expenditure, previously estimated at 10% of capital costs, would increase by a commensurate amount ie an extra £50 million or £80 million per annum respectively. This would eliminate the putative savings of £42 million (see p64, volume 7, DMBC, NHS North West London 2013c), and would render the plans unaffordable and result in failure to secure capital funding.

It is clear that the figures presented to the public supporting the Case for Change and the Pre-Consultation Business Case were misleading. To have expressed disapproval may have seemed illogical in the face of the massive savings being offered and the improvements in quality being introduced. This misrepresentation was compounded by not presenting figures consistently. Annual revenue savings were prominently claimed in one section as £135 million while this figure reduced to a 20-year saving of £271 million in another section (p64, Volume 7, DMBC, NHS North West London 2013c). It may be that they were talking about different things but to the lay person this distinction would be lost and the headline figure of £135 million relied on.

It is likely that there will have to be further adjustments to the SaHF business case, and so we are cautious about making definitive comments until the final version is made available. Our belief is that the plans unveiled will have to be significantly different from those presented for local consultation with major implications for access and quality of local services.

For example hope has been given that significant investment can be made at Charing Cross and other acute sites with the suggestion that £150 - 200 million may be invested at Charing Cross; but this will be unaffordable within existing budget projections. If significant changes are made there may be a case for renewing the mandate the public gave for the SaHF proposals through a further public consultation.

We are also concerned that the business case fails to take sufficient account of the increasing population of North West London. Local authorities have drawn attention to likely large increases in population resulting from large-scale housing projects linked to HS2 gaining planning approval. Therefore it still may be that projections are understated (London Borough of Brent, Submission to Commission, 24 February 2015, p3). If this increase in population has not been anticipated then a reappraisal of local needs is required.

It seems risky to contemplate planning on the basis that additional capacity will not be required and that services can be removed from four hospital sites, on the assumption that these levels of reduction in demand can be achieved even with the increased activity implied by demographic factors. The DMBC claims it is based on a model that assumes 2.8% per annum activity growth across North West London to 2018 (p14, Volume 7, NHS North West London 2013c). This has the potential to eliminate any savings in acute capacity from the expansion of the OOH programme as, extrapolated over six years to 2018, this would compound to almost 20% extra activity.

Having not been given access to the underlying SaHF model, we can only take it on faith that any modelled increase in activity has fed through into assumptions of additional beds required. For the

Commission to be reassured on this point, we would need to examine the new model used to support the final business case once it is made available, including assumptions of the increased capacity that is required to meet demand arising from a substantial increase in population.

4.4 The extent to which reductions in acute capacity depend on the success of OOH developments?

It is often claimed that shifting care from the acute sector to care in local community settings will save money, but the evidence for such claims is sparse. Indeed recent reviews have shown that savings are unlikely to occur, and that the case for improved quality is also unproven (we go into this in more detail in section 3 of this report).

Table 4.7: Reduction in activity forecast as result of investment in OOH

	Spells		Implied total activity	Beds	Investment
Elective	-10,000	14%	71,429		£7 - 9 million
Non-elective	-55,000	19%	289,474	391	£35 - 38 million
A&E	-100,000	14%	714,286		£3 - 5 million
Outpatients	-600,000	22%	2,727,273		£35 - 38 million

1 These are reductions relative to the pre-QIPP baseline as of 2011/12.
Source: NHS North West London 2013c, Volume 7, Appendix N, p18.

Table 4.7 demonstrates the scale of change being proposed by SaHF. These are large reductions in activity and beds; if the investment in OOH does not achieve its objective, this would expose large gaps in service provision. Improvements in OOH services are not reliant on reconfiguration of hospital services although reductions in acute capacity are premised on reductions or shifts in demand as a result of improved OOH. Therefore improvements in OOH services should precede major reconfigurations. The risk otherwise is that patients will be deprived of services if the expected reductions in acute demand fail to materialise. A prudent way to proceed would be to reduce demand first before taking the risk of reducing capacity.

We have attempted to extract a financial analysis of the impact of investment in OOH services from reports presented to the JHOSC since the DMBC received approval. This has proved difficult, a fact that was acknowledged by the SaHF team in interviews with us. We were promised a summary of specific plans and progress to date but this has not been forthcoming. We are not clear if SaHF has such a summary and is unwilling to share it, or if it has not summarised what is a key element of the programme.

We have seen no convincing evidence that sufficient progress is being made in OOH services to justify pre-emptive reductions in acute capacity. Only one CCG – Ealing CCG – has attempted to link these essentially estates-driven plans to activity implications and reductions in acute commissioning.

The most recent submissions by CCGs on OOH services to this Commission are in effect press releases extolling good news concerning progress in developing their strategies. This is as may be but what they are failing to do is provide a clear plan for how investments will be made that will have clear impacts on acute activity and capacity and which demonstrate that the new ways of providing care are more cost-effective than before.

For example Hillingdon CCG is pleased to receive £1 million from the Prime Minister's Challenge Fund to improve access to GP practices. But it is not clear in the evidence submitted as to what difference this will make. Similarly patients are being redirected to receive outpatient appointments in community settings but it is not clear what the impact is on patient care or on the acute sector. The work of the rapid response team is said to avoid five admissions per day but it is not clear whether this has enabled any savings in Hillingdon hospital, or what the economics of the work of the rapid response team is. The work of the Integrated Pathways team is expected to reduce emergency admissions by 300 but no evidence is supplied for this, nor is there an attempt to connect it to actual reductions, or discuss the associated cost benefits.

Documentation produced in draft OBCs for OOH plans reported to JHOSC have attempted to be more business-like but again reconciliation to acute plans and the impact on objective quality indicators are not contained within these drafts.

We would argue that the onus is on the SaHF team to justify and explain its confidence that there can be large reductions in acute capacity as a result of the extension of OOH services. This has not been shown so far.

Rideout in his review of the SaHF business case (p97, Rideout 2012b) made similar observations:

> *…specifically there is currently insufficient capacity and capability in primary and community services to support the proposed changes (which include the removal of 1,000 adult beds from the acute sector). While the proposals include plans to strengthen "Out of Hospital" care, these developments are currently not planned to be fully implemented until some time after the hospital reconfigurations have commenced. No decisions should be finally made about hospital reconfiguration until the Out of Hospital strategies have been implemented and performance assessed as successful against a number of appropriate metrics.*

He went on to recommend to the London Borough of Ealing (p97, Rideout 2012b):

> *Linked to this, there is clearly an urgent priority to engage (or continue to engage) in the detailed development of the Out of Hospital Strategy. In particular LBE* (London Borough of Ealing) *should seek to understand the metrics that should be developed to ensure that implementation can be subject to independent verification. This could be used to support the development of conditions to be met before hospital reconfiguration could proceed.*

The final business case presented by the SaHF team will also need to demonstrate affordability, be readily financed and deliverable. We go on to consider these issues next.

4.5 Affordability

According to latest estimates the SaHF programme requires an investment of £250 million in OOH services and £750 million in the development of acute services (interview with Daniel Elkeles).

Even if the projected benefits of these investments exceeded their costs, there remains the question of affordability. This mainly reflects the impact on the income and expenditure and balance sheets of the organisations affected, and will incorporate an assessment of the commercial, competitive and unit cost implications of investments. The regulator Monitor is likely to be interested in whether future FTs will be viable, competitive and sustainable and will be likely to assess the impact of the proposed investments on unit costs, whether this will be covered by tariffs, how unit costs compare to historical costs and other providers' costs in a competitive London market.

But the business case should also consider whether the impact on other investment proposals would result in other positive and desirable investments being 'crowded out' to the detriment of patients, and whether the total impact assessment of the changes is proportionate to the total costs and risks involved.

We have seen no analysis of whether, as a result of the increased investment in what are already expensive acute sites in central London, unit costs may exceed tariff reimbursements. In other words Imperial runs the risk of losses on its activity. Similarly a longer term financial plan would need to be presented which shows how all the demands for capital can be met including paying for newly built hospitals. We have mentioned the squeeze that such large-scale developments have exerted on budgets elsewhere in London.

Finally we are still to see presented the impact of the plans on the income and expenditure statements and balance sheets of the NHS organisations in North West London. Without assurance that these have been calculated and that they show the investments and plans are affordable there are large doubts on this score, compounded by delays and rumours of escalating costs.

For example, although SaHF may have projected savings from transferring outpatient services into the community, this could impact on the unit costs of acute hospitals making provision of their services unaffordable. Although trusts are not allowed to withdraw provision of services this cannot but have an adverse effect on the hospitals concerned.

An independent evaluation of the financial modelling within the PCBC identified affordability issues relating to GP hubs and local hospitals, and called for more work on these issues (Rideout 2012a; 2012b). These reports recommended more work on manpower planning issues saying there were no convincing plans to justify confidence in the manpower plans presented. These issues, estates particularly, could impact significantly on affordability.

The SaHF plans were also referred to the Independent Reconfiguration Panel which made a number of recommendations relating to the proposals (see appendix 2) including the need for more work by SaHF to justify its OOH plans, more work on workforce issues, and work relating to supporting A&E services at Charing Cross and at Ealing, and planned care at Charing Cross and Central Middlesex.

There are well-documented examples of stress being introduced to local health economies as a result of very expensive capital investment (Palmer 2011; Office of the Trust Special Administrator 2013; People's Inquiry into London's NHS 2014). There may indeed be a need to modernise and replace old, fully depreciated assets on the St Mary's hospital site, and investment may also be required to ensure there is sufficient acute hospital capacity to cope with expected levels of increased demand in future years. However we urge caution in looking to address these issues by wholescale reconfiguration of services, as SaHF is proposing.

Instead a more conservative restructuring of services retaining more of the existing infrastructure would help to present more affordable plans. The retention of local A&E and maternity services at Ealing and Charing Cross would result in a scaling back of the need to build new facilities elsewhere.

We therefore advocate the identification of a 'do minimum' option, maintaining the investment objectives of improving quality and meeting budgetary constraints, but with greater retention of existing sites (see section 5 of this report for further discussion of 'do minimum').

In addition we advocate the provision of assistance to provide for the additional costs of PFI-financed replacement of old hospitals, along the lines advocated by Palmer (2011), or the provision of direct capital funding from release of Public Dividend Capital (PDC). PDC is a form of long-term government finance that was initially provided to NHS trusts when they were first formed to enable them to purchase the trust's assets from the Secretary of State. It represents the Department of Health's equity interest in defined public assets across the NHS. It is meant to be sufficient for normal purposes to capitalise the future of the organisation. The intention was that new capital should be financed from retained earnings, depreciation and through the PFI route. Exceptionally however trusts in financial difficulties have been allowed access to further PDC. We would argue that the demands in North West London are exceptional.

Palmer advocated the effective pooling of costs of major developments and for these to be funded through an adjusted Market Forces Factor (MFF), the adjustment made to tariff prices to compensate providers for higher local costs effectively out of their control.

For example the MFF compensates the major inner London hospitals for their higher staff and non-staff costs as a result of being in London. It should be emphasised that this could be done for little or no additional cost to the NHS as a whole as the current capital charging system effectively generates fortuitous savings for many trusts who may have had their hospitals rebuilt in earlier times. Thus large cash balances are sitting on the balance sheets of many FTs. For example cash balances of £135 million are retained at Guy's and St Thomas' (Guy's & St Thomas' NHS Foundation Trust 2014) and total cash balances held by FTs in 2013/14 were £4.3 billion (Monitor 2014).

There are thus ways of ensuring that plans can be affordable but we await the final business case that demonstrates this.

4.6 Risks, uncertainties and deliverability of the SaHF programme

There has been a history of problems with large-scale public planning, procurement and implementation which has resulted at times in judicial review, lengthy and costly public inquiries, planning blight, construction of the wrong facilities in the wrong place, and excessive costs. As a

result there is considerable guidance for NHS bodies on how to take such programmes forward (see section 5 of this report for detailed discussion of this guidance).

One key part of such guidance is that the economic costs associated with the risks and uncertainties of the project must be calculated and incorporated into the costs of the scheme or allocated to the parties to the scheme.

In all projects of this nature it is a requirement to review the strategic context, ie to ask the question, do these proposals make strategic sense.

SaHF is an exceedingly complex multi-stakeholder process requiring the co-ordination of many different organisations all of which have been in the throes of major reorganisation and restructuring. Boards tasked with the completion of these plans have only recently been in existence. Very large savings plans of an unprecedented scale are envisaged with major risks attached to the impact of their successful implementation. Provider organisations are in the process of putting together plans to become FTs, meeting rigorous standards of commercial viability independently assessed by Monitor, or have only just received assent to become FTs. New Chief Officers have only recently been appointed. Very large amounts of capital resources are required, in the region of £1 billion according to latest estimates, normally only available after the private sector has been given the chance to provide funding. Only the Treasury can approve such large sums of capital expenditure however financed and the Treasury's positive assent cannot be guaranteed. Experience suggests that delay and additional planning are often required before assent is provided.

There are therefore very large deliverability issues attached to this project. Although aspects of the deliverability of the proposals were supposedly considered in draft business cases, in practice the SaHF team has assumed the availability of capital and that CCGs will continue to support the implementation team. We believe that neither assumption should be made without a risk being attached. In addition, there are a wide range of other deliverability issues associated with the strength of the SaHF proposals and how these can be implemented that must be addressed separately.

Deliverability

Evidence of deliverability is very important in any business case. For example in business cases to support significant capital investment, plans would provide a long list of information demonstrating deliverability including the following factors where the SaHF plans were lacking:

1. Details to show resources to manage the process to project commencement are sufficient and clearly set out;

2. Evidence that all workstream milestones are set out and discussed (workforce, estates, Information Technology (IT), equipment, service changes);

3. Evidence that an internal risk register is established, risks assessed and management arrangements reviewed and regularly updated;

4. Evidence that highest risk items are identified and plans to manage them are included in a formal planning document;

5. An outline benefits realisation plan covering all benefits – strategic, savings or efficiencies; and,

6. An indication as to whether the Gateway Risk Potential Assessment has been made.

We assume all these will be in place in the latest iteration of the business case but we do not draw comfort from the very large budget set for the project (£63 million according to the 2014/15 budget). It raises the issue of whether costs may be out of control and the project is being effectively managed.

We have seen no adequate manpower or estates strategy and without this it is difficult to comment on the deliverability of the plans. Without much more detail on workforce plans to achieve objectives, deliverability must be in doubt. The financial case and assumptions of affordability and the availability of finance seem poorly grounded.

Similarly we note that estates work is still on-going looking to confirm the provisional figures used for the design and configuration of new build and redevelopment projects across the health economy. This implies that detailed plans are not yet in place. Similarly, although for smaller sums, the plans for development of GP hubs are encountering slippage and delay and face risks and uncertainties. An implementation plan remains in scant detail. With regard to IT it is not clear how integrated working can occur without an integrated IT infrastructure.

The DMBC includes a discussion of the dependencies of the SaHF programme on other strategic programmes underway in North West London and across London but these dependencies (listed below) are very significant and mostly unresolved. These include:

1. The development of CCG plans;

2. The creation of FTs;

3. Integration with local government;

4. QIPP planning processes and further efficiency measures; and,

5. Cross-boundary changes, eg in South West London and North Central London.

It is unclear what the sequencing of decisions on these matters will be: each bears heavily on the SaHF process. For example decisions on FT status for the individual acute providers in North West London may put obstacles in the way of achieving agreement to the centralisation and integration of planned care services; or the plans of CCGs may start to diverge from the consensus enforced to date.

We note that deliverability comprised only one small element of the non-financial appraisal in the work accompanying the consultation document but already profound questions are being posed on these aspects of the project.

The PCBC had to some extent identified programme risks in implementation but a comprehensive programme risk register has not been shared or quantified or taken into account in the financial appraisal. If the risks had been made clearer we believe the 'do-minimum' option would have been assessed as being more attractive and would potentially have been weighted more heavily in appraisals. The benefits realisation plan has yet to be completed and indeed the benefits of the SaHF programme have yet to be finally quantified. This makes it difficult to believe that any options appraisal conducted so far can be a reliable guide to a decision on the project.

Deliverability should be demonstrated in a number of ways:

- The strength of the plan;
- The strength of the team implementing the plan, and;
- Availability of resources to ensure the plan is realised.

Strength of the plan

As far as the strength of the plan is concerned the evidence suggests there is much further work to be done before the plan is finalised and in a position to be approved. Major questions on the option formulation, the calculation of the capital costs and benefits, and the realism and achievability of activity targets remain to be answered authoritatively. As do the governance issues associated with obtaining agreement to the programme from organisations in a state of flux that may legitimately oppose some of the recommendations and proposals from SaHF for commercial reasons let alone for the impact on local patients. Without a strong plan there is a very high risk of delay and difficulties in obtaining Treasury approval, an essential for a programme of this size.

Decisions on reconfigurations are often finely balanced. Complex decisions of this nature should only be made after a careful consideration of all the facts and issues in a fully worked-out and robust business case. Attempts to go to early formal consultation seem to reflect the idea that managers need to be seen to be addressing problems rather than because there is a compelling case for change. Our view is that the SaHF proposals could be one of many initiatives to be assessed by CCGs and providers for resolving problems in the area, but the size of the current QIPPs (£228 million) and the immediate financial problems should be a greater priority. Given the marginal impact on overall finances in North West London of these proposals when compared with the overall savings required of £243 million (p58, Volume 1, NHS North West London 2012b), a legitimate concern is that the SaHF proposals are a distraction from achieving the productivity improvements vital to achieving financial balance.

At present we believe there are too many unanswered questions to enable local people to make a confident judgment on the deliverability of the SaHF proposals. In these circumstances it is not surprising that the local population is responding defensively. In our view it is entirely legitimate therefore to resist any changes until a final plan can be produced.

Strength of the team

On the question of the strength of the team we note that Local Authorities have been excluded from the Programme Board despite being integral to the achievement of OOH care changes. This anomaly has only recently been questioned. This does not inspire confidence in the governance of the project.

It remains who owns the project: the NHS Commissioning Board or local CCGs or key local providers. The fact that the programme director has changed several times and a new one has only recently started is also not a positive sign.

Availability of resources to deliver the plan

Finally, on the question of whether the resources will be available to deliver the plan there must be confirmation that a robust business plan can be delivered that will secure the finances from public funds, or through the PFI route, within the timetable assumed. We see the possibility that FT status for nearby hospitals and the achievement of short-term financial balance may intrude upon the SaHF programme. There are several examples in England of approvals from local consultations to ambitious plans that have not been realised because of the difficulties of securing funds. This can blight other developments for a considerable time.

We acknowledge that considerable efforts have gone into attempts to build a consensus on the viability and deliverability of the new service models but we also note that the London Reconfiguration Guide (p8, NHS London 2011), and other documents since, states that reconfiguration plans should only be implemented once the enabling plans for community services have been successfully introduced. In our view this could prove to be problematic for the SaHF programme as not only is the implementation of the enabling plans not yet approved and financed but major question marks continue to be raised on whether those plans, even if implemented, would produce the assumed reductions in demand for A&E and other services.

The early difficulties with demonstrating a successful impact on local acute demand from OOH developments show that these risks should not be dismissed.

We conclude that there remain major deliverability issues around SaHF, and also believe that the assumptions made by SaHF that finance will be readily available for the project are over-optimistic.

Risk assessment

As the project is large and complex a rigorous form of risk assessment and management must be demonstrated. As indicated in earlier sections there are considerable risks involved in this programme. Based on a combination of the National Patient Safety Agency's NHS Risk Matrix (National Patient Safety Agency 2008) and a typical risk matrix in large hospital developments, we consider risks in ten broad categories.

Service planning risks

It is not demonstrable that the OOH strategy adopted by local CCGs will deliver the benefits expected.

After much promotion LIFT and polyclinic developments seem to have stalled as the preferred model for development. It is clear that GPs prefer to see GP practices developed, and it is quite likely that GP-led commissioning will lead to a rethink.

Neither is it yet demonstrable that health service co-ordination across an area as large as North West London involving the co-operation of eight London boroughs, eight CCGs and potentially four main independent and competitive acute providers can achieve the pooling of interests in the way envisaged by SaHF. Each organisation is established as a legally independent entity and encouraged through localism to pursue local strategies. Other attempts to forge collaborative arrangements, eg for the provision of NHS laundries or more recently incinerators, fell apart when all interests could not be satisfied.

The strategic direction of travel in the provision of healthcare is for more localism in commissioning and more competition in providing – exactly the opposite of the SaHF process. As far as we know there is no other equivalent and successful example of the reconfiguration changes proposed that would provide confidence to those involved in the planning. On the contrary the creation of the South London Healthcare Trust combining three major acute trusts in South East London into a new acute hospital configuration proved to be a financial disaster with patients losing confidence and staff leaving. Similar arrangements in East London involving the centralisation of acute providers have failed to address problems there. More recently attempts in South West London to reconfigure have been abandoned.

We perceive a very high risk of plans not achieving the benefits predicted and deterioration in the quality of services delivered. This risk is both very high in the ability to provide reliable and high-quality clinical services and in financial investment terms, and we would assess as high in probability. Nowhere in the DMBC is there a full discussion of the risks of the programme, or a calculation of risk impacts if risk events occur. There is some discussion of risk in implementation in the DMBC but this does not convey a full picture of the risks nor does it quantify the risks.

Safety risks

There will be increased risks to patient safety as a result of increased travel required to access A&E services, maternity and paediatric services. We have already cited evidence that every extra mile of travel can increase mortality risks by 1%. There are also risks that patients may be deterred from travelling to attend A&E or the maternity unit.

Quality risks

Although claims are made for additional quality from centralisation it is not explained how this will be achieved and there appears to be no consideration of other options such as a the 'do-minimum' option of increasing consultant cover in certain areas. We also perceive a risk from the breaking-up of well-established teams eg the successful maternity and children's unit at Ealing hospital.

There is no recognition that there can be diseconomies from attempting to plan and deliver planned care over North West London from fewer sites. From the patient's point of view additional travel is time-consuming and costly and inconvenient for visitors, carers and patients.

Any change is disruptive. The draft DMBC indicates that over 19% of posts are expected to be lost. This implies major change, and possible dissatisfaction and concurrent impact on patient care.

Human resource risks

Given the changes in service configuration, there is a risk that staff will seek opportunities elsewhere and gaps will emerge causing service gaps or the requirement for expensive temporary replacement. The experience at Queen Mary's Sidcup, following the closure of A&E there, followed this pattern compounding problems at the hospital. Already these same issues are present at Ealing.

Financial risks

Financial claims could emerge if for example accidents occurred in maternity attributable to changes, or if gaps in service resulted in harm to patients. Other financial risks would be associated with failures in plans to achieve savings, or reductions in patient flows resulting in the retention of existing services despite investments in the community to reduce demand, or investment at other hospital sites. We note in the NHS London reconfiguration guidance that changes to services should only occur after re-provision is provided. This creates a risk of double provision if initial changes do not reduce A&E attendances and admissions as planned.

Statutory risks

Statutory risks might occur if a facility's performance ratings slipped thereby producing a need for additional expenditure or intervention in order to comply with licensing or minimum standard stipulations such as those determined by Monitor, the CQC or the Department of Health. We have recently seen the impact of deteriorating A&E performance on national priorities and adverse quality assessments for services at Imperial and North West London Hospitals.

Business interruption risks

There are risks in any large-scale changes of interruptions, delays and discontinuities in service provision.

Estates and construction risks

The plans rely on estate re-provision and facilities construction on a number of sites, requiring planning permission, financing and construction according to tight timetables on constricted and busy sites. There are inevitably high risks and additional expenses as a result. Also price risks will exist reflecting the overheated London construction industry; albeit land sales receipts may be buoyant the increases in construction costs may be more so.

Delay risks

In any scheme of this complexity it is almost inevitable there will be planning delays and financing delays as Treasury and other financial parties investing in the proposals assure themselves that risks have been properly identified, quantified and mitigated. The size and complexity of this scheme and the contingent risks will inevitably cause further delays.

Adverse publicity risks

The NHS is dear to the heart of the public and changes are notoriously controversial. A political party dedicated to support the principles of the NHS has recently been set up as the National Health Action Party. We know that public concern can both delay schemes and result in the cancellation of schemes damaging the reputation of all those associated, and introducing unnecessary stress for patients, public and staff. Local concern is said to have influenced the outcome of local elections and may yet national elections.

To summarise

In any business case promoting change of this scale, the public and decision-makers will expect to see how all risks are assessed, quantified and are to be managed. As yet the DMBC is deficient in this respect; presumably this will be addressed in the business case that will be submitted for approval.

There is a strong presumption that guidance should be followed wherever possible to help avoid potential pitfalls and risks associated with complex and controversial schemes. However, as the most recent documentation has been withheld from the Commission and its advisers it is not possible to know whether all of the issues listed above have been dealt with.

Overall summary

It appears from the evidence we have considered that the costs of SaHF will exceed the putative benefits although we must reserve judgement until we have seen the final business case. Our expectation is that there will have to be significant reductions in investment for a coherent plan to be presented. But this will run the risk of presenting such a different picture to the people of North West London that a new public consultation would be appropriate.

If the plans are unaffordable, or entail unacceptable risks for patients of reductions to quality of services it is likely that more conservative options, corresponding to a 'Do Minimum' option, are more appropriate. These would be easier to finance and be more manageable to implement.

4.6 Findings and recommendations

Key Findings

1. The financial context in North West London is one of good overall financial control and success in meeting targets. There is no reason for undue haste or to ignore due process in planning large projects;

2. An independent review of UK healthcare conducted by a new government is likely to release more spending and increased inputs (doctors, nurses and beds);

3. The application of cumulative 4% efficiency targets to the NHS over ten years is punitive and damaging;

4. SaHF has not yet presented a compelling business case;

5. The final business case supporting the SaHF proposals has not been made available but on the basis of the documentation we have considered and our interviews with SaHF officers we consider it is likely to be unaffordable, undeliverable and fraught with risks;

6. SaHF's reliance on the positive effects of very large investments in OOH services is unsafe and inconsistent with the latest evidence on the impact of such changes on acute care, and;

7. More conservative options for service change, retaining more of existing services and premises are likely to be less disruptive, easier to achieve and considerably cheaper.

Recommendations

1. There should be a comprehensive assessment involving commissioners, local authorities and providers of all services in North West London and how best to improve them. This would build on the work already undertaken but should also include all those areas previously set aside: specialist services, mental health and primary care performance;

2. Where possible there should be an avoidance of large-scale capital building programmes under PFI;

3. If it is decided to invest in the modernisation of St Mary's hospital and expand capacity, this should be financed through Public Dividend Capital (PDC) or if through PFI then with adjustments to the tariff to reflect the excess costs of PFI, and not at the expense of other services in Ealing or in Hammersmith & Fulham, and;

4. There should be no reduction in acute capacity until the impact of OOH service improvements has been accurately assessed and demonstrated.

Section 5 Process

5.1 Introduction

This section explores in more detail the following themes:

- The nature of the SaHF programme;
- The objectives of the programme;
- The options appraisal process;
- The public consultation;
- Recent engagement and involvement of local authorities and other stakeholders;
- Ensuring there are no conflicts of interest, and;
- Implementation proceeding without agreement to plans or finance being in place.

We provide conclusions and recommendations at the end of this section.

5.2 The nature of the SaHF programme

We believe the process itself has been flawed in a number of crucial ways: in the framing and diagnosis of the problem; in setting the options for appraisal; in failing to adequately appraise a 'do minimum' option; in a lack of prior consultation with the local authority over consultation; in consulting without adequate information to present to the public; and, in a failure to follow guidance and due process.

In addition the SaHF plan is being partially implemented in North West London before the business case has been completed and approved.

Framing the problem

First, the problem was framed as one owned within the confines of North West London, as a problem of overcapacity, and how to choose the best sites to reduce capacity. This view leads to a top-down attitude determining a decision to close hospitals closest to the centre of the area. It aims to produce the maximum of savings with the minimum of impact on cross-boundary flows to other regions.

But the reality is that the London Strategic Health Authority (SHA) has been abolished and regional planning disavowed. The current framework should be one of local CCGs determining what is best for their local populations. In our view the artefact of the establishment of a collaboration of CCGs is one designed purely to give life to the SaHF project in order to take forward the past work of the PCTs working hand in glove with NHS London.

CCGs were only formally established on 1 April 2013, and had little time or opportunity to produce their own needs assessments or plan their future commissioning in advance of the SaHF proposals. Similarly providers not yet awarded Foundation Trust (FT) status are in the process of recalibrating their competitive responses to the shifting healthcare marketplace and most are in the throes of seeking FT status or involved in merger plans.

Newly established FTs will be likely to consider afresh whether collaboration on the establishment of planned care centres remains a viable strategy. Choice and competition only recently heralded as the driving forces behind the Health and Social Care Act 2012 are after all embedded into the infrastructure of the new NHS with both Monitor and the Competition and Markets Authority statutorily obliged to reinforce market disciplines.

There is therefore no stable strategic platform to plan major changes in service delivery. If for example the decision is looked at from an Ealing perspective, it is doubtful that Ealing CCG or Ealing GPs would approve the closure of their local hospital. Similarly if a London perspective was adopted it is doubtful whether investment in expansion at Chelsea & Westminster hospital would be regarded as a priority. Nor would it be regarded as good use of scarce capital resources to spend £500 million on teaching hospital facilities at St Mary's within two miles of another recently built teaching hospital. It is only by clutching onto an organisational relic of the past that it has been possible to give life to the SAHF project.

A similar project in South West London, 'Better Services, Better Value' (Better Services Better Value 2011), was abandoned in the face of its unsustainability because of opposition from local stakeholders, and the difficulties of reaching agreement amongst so many stakeholders, themselves in the throes of major change. In our view it is only a matter of time before a similar fate befalls the SaHF project. What is different in North West London is that the SaHF team has pressed on with service closures without having completed an adequate business case to support these actions. This will be discussed in more detail later in this section.

In addition the evidence base for the assertion that London and North West London in particular has excess capacity seems to be based on general estates reviews conducted in the past; but a study compiled recently by the London Health Commission, *Unlocking the value of NHS estates in London* (London Health Commission 2014), shows that the most efficient site in London is Ealing Hospital and among the least efficient are Chelsea & Westminster, and those that constitute the Imperial College Healthcare NHS Trust. It would seem perverse therefore to close Ealing and build afresh at Chelsea & Westminster and Imperial.

Given that any rationalisation of acute capacity relies mainly on progress in OOH services as a way of reducing demand on this acute capacity, we believe the problem should be refocused as one of CCGs delivering OOH care at a local level, working closely with local authorities and local providers. It has been accepted that any changes to acute services should only come when these OOH services have been proved to work: hasty closures as we have seen already are premature and risky.

Diagnosing the problem

Recent guidance on reconfiguration proposals states that these should be soundly based and supported by evidence from local needs assessments and local Health and Wellbeing Board commissioning strategies. In our view such assessments either do not exist or are underdeveloped; instead the SaHF programme has been used as a substitute for a proper local appraisal of needs.

There should also be an attempt to discover where costs in the system are relatively high. We have seen no comprehensive analysis centred on North West London that attempts this task. The SaHF proposals are based on assertions that only five major hospitals are affordable and sustainable but with little real evidence at a local level that this is the case, and that North West London has an

underdeveloped primary care sector and overdeveloped acute sector. The need to improve the quality of primary care does not of itself imply that there should be a reduction in acute capacity.

There is a danger that without a deep analysis of the nature of the problems in North West London, the proposed changes may exacerbate the problems rather than alleviate, putting the level of healthcare available to local people at risk. For example, reducing the status of a hospital such as Ealing may make problems of recruitment and retention worse; by reducing A&E services the real access problems to healthcare will be exacerbated not improved; by reducing facilities on existing sites there may be a requirement to build new ones at greater expense elsewhere; or diverting healthcare from a low cost site at Ealing to high cost sites such as St Mary's may increase total costs to the health economy not save money.

The mere fact of a trust being in financial difficulties may reflect income distribution issues at a higher level; for example, London teaching hospitals had major financial issues in earlier years but succeeded in negotiating additional resources to reflect non-tariff workload. It could be argued that the Market Forces Factor used to adjust NHS tariffs has been used to direct income to 'expensive trusts'; more recently, in the case of the South London Healthcare NHS Trust, it was suggested that relief should be provided to hospitals suffering high PFI costs (Office of the Trust Special Administrator 2013). We believe the work involved in properly understanding and reacting appropriately to surface level 'financial difficulties' is a difficult and demanding one and there are high risks of expensive errors if this is not done properly. Moreover, given the burgeoning population in London, it is by no means clear that North West London continues to be over-resourced and if it is that SaHF addresses the root causes.

Similarly if the primary care sector is poorly structured and dysfunctional, the expectation that it can be easily 'transformed' seems to be a function of hope and prayer rather than sound planning. We would require much more evidence that the correct problems are being addressed, the options to tackle them are properly identified and well chosen, and that these options are being effectively quantified, assessed, delivered and implemented.

5.3 The objectives of the programme

The objectives of SaHF are neither clearly stated nor logically followed through. For example we have heard that the desire to improve quality is what has animated the project, and yet the area that has been chosen for most attention, A&E services, represents a small proportion of total healthcare spending. If solving the issue of A&E quality was regarded as important it would cost relatively little to do so. It would only take a minor shift in priorities to address issues more directly rather than embarking on major reconfiguration.

Similarly the relative success of the QIPP programme in extracting savings from the NHS belies the additional need for the SaHF programme. We are not in principle against examining the scope for achieving savings through reconfiguration but we see it as illogical to presume that reconfiguration, with the high costs implicit in this path, is the only way to achieve the objective of balancing budgets in North West London.

If improvements in quality were the objective there are much cheaper and more effective ways of doing so than reconfiguration. If achieving productivity improvements and balancing budgets is the objective it makes no sense to exclude specialist hospitals and services from the picture or to

contemplate investing up to £1 billion of capital, with all the cost consequences attached to that course of action.

The process makes more sense if the true objective was to achieve reconfiguration of acute capacity rather than to improve quality or save money, and we believe that to be the case.

It is possible to look at other parts of London (East London and South East London) and see the consequences that large capital projects have had for the sustainability of services for local people. In both areas PFI hospital schemes have proved to be financial burdens that have prompted cuts in local services and resulted in declining quality, access and performance (see section 4.5 of this report). This is the real risk facing North West London.

The objective of redeveloping St Mary's hospital and replacing its aged infrastructure may make sense, but under current rules for financing capital developments the full costs have to be met from current budgets, ie the revenue costs associated with the extra investment have to be paid for through tariffs based on national average costs. PFI costs are usually agreed on a rising scale linked to inflation and there is a risk, as in other areas, that such projects can plunge local economies into financial crisis if savings linked to such projects fail to materialise. Thus a sensible objective is to minimise and delay capital expenditure for as long as possible providing this does not contradict other objectives.

Clarity of investment objectives is regarded as fundamental within the guidance issued by HM Treasury in *The Green Book Appraisal and Evaluation in Central Government Treasury Guidance* (HM Treasury 2003). Without such clarity the wrong options may be pursued or the full range of options not properly appraised. We will return to this point below.

5.4 The options appraisal process

We believe that in looking at how to improve quality and reduce costs only a narrow range of options were considered by SaHF. Given the radical and interventionist path chosen, there is a high risk of error and counter-productive action. In 2012 a report from NHS London (2012) identified around £1.2 billion of savings possible in London through improved productivity. But there are a range of options that could be considered other than centralisation and closure of services.

In an earlier report, McKinsey had suggested that reconfiguration is only likely to deliver between £0.8 - 1.6 billion of savings nationally from a budget of £92 billion (McKinsey 2009). On the other hand, McKinsey suggested that there were potential technical efficiency savings from provider costs of £6.0 - 9.2 billion; potential allocative efficiency savings of £4.7 - 6.6 billion from no longer commissioning low value-added healthcare interventions and ensuring compliance with commissioners' standards; and, savings of £2.7 - 4.1 billion from a shift in the management of care away from hospitals towards more cost effective out-of-hospital alternatives.

Moreover a recent King's Fund report (Imison 2014) concluded,

> *The reconfiguration of clinical services represents a significant organisational distraction and carries with it both clinical and financial risk. Yet those who are taking forward major clinical service reconfiguration do so in the absence of a clear evidence base or robust methodology with which to plan and make judgements about service change. In particular*

evidence to support the impact of large-scale reconfigurations of hospital services on finance is almost entirely lacking.

It therefore seems odd that 'reconfiguration options' have been chosen rather than the wider range of options available. Perhaps this might be excusable if the SaHF exercise was really just a clinical initiative representing a particular view from certain clinicians, but not if it is to be seen as a comprehensive answer to the complex health care issues within North West London. More serious consideration should have been given to all possible options. In particular there appears to have been no proper consideration of a 'do minimum' option.

The failure to appraise a 'do minimum' option is in breach of the guidance in the Treasury's Green Book (HM Treasury 2003); without a 'do-minimum' option, it would be unlikely that the SaHF proposals would gain Treasury approval. Treasury guidance specifically states that a 'do minimum' acts as a check against interventionist options. A 'do minimum' is not the same as 'do nothing' or the status quo. It requires a conscientious examination of how the investment objectives (in this case quality improvements and financial savings) could be achieved with the minimum of capital investment.

Instead SaHF's objective seems to have been to pursue reconfiguration as the answer, a preconceived solution, leading to an options appraisal that merely chooses between a limited number of ways of doing the same thing, ie reducing the number of acute hospital sites. In our view there is no way to escape the requirement for a 'do-minimum' option if the business case is to proceed. The sooner this is addressed the sooner the project can advance and local stakeholders can see the real options.

An independent consultant, Tim Rideout, was engaged as an expert assessor on behalf of both the London Borough of Hammersmith & Fulham and the London Borough of Ealing. He concluded that the methodology used to identify and choose between the various reconfiguration options is open to challenge as it contains a number of fundamental flaws. He states (p3, Rideout 2012a),

The options appraisal and the resultant preferred option (and secondary options) are open to challenge, on the grounds of the sequential approach (which potentially distorts conclusions), the selective choice of indicators, the absence of an assessment of actual quality and performance, the lack of sufficiently detailed assessment in critical areas (eg travel times) and the practical application of the indicators (including a high level of double counting).

More fundamentally in his report to the London Borough of Ealing he questioned the assumption that North West London has an over-provision of acute hospitals (and A&Es).

5.5 Public consultation

Despite the volume of paper that was made available in and around the consultation the information available to the public fell short of requirements. In fact a revised business case (NHS North West London 2013a) was submitted after the consultation was completed and only a week before approval of the proposals by the North West London PCTs. This revised business case showed that capital costs had doubled and the benefits were significantly reduced; nevertheless the recommended option was unchanged.

It remains the case that the business case has not yet been approved, even to Strategic Outline Case (SOC) standards (the first tier) and without a firm basis for its progression it may yet have been an expensive, alarmist and fruitless activity.

Local authorities are entitled to require a robust business case to be in place before public consultation takes place. We believe the PCBC was in no sense a robust business case. It was certainly not approved by local authorities although the SaHF team would point out that such approval was not required under the rules in place in 2012. More to the point perhaps, it has not proved a reliable gauge of costs and affordability and thus it was not good enough. The London SHA whose duty it was to assure the process, was being disbanded at the time, and perhaps had other concerns.

Failure to follow guidance and due process

The requirement to follow guidance and due process is a clearly understood stipulation. Guidance has been prompted by a history of problems with large-scale public planning, procurement and implementation which has resulted at times in judicial review, lengthy and costly public inquiries, planning blight, construction of the wrong facilities in the wrong place, and excessive costs. There is therefore a strong presumption that guidance should be followed wherever possible to help avoid potential pitfalls and risks associated with complex and controversial schemes.

Seven significant sources provide guidance on how investment proposals and NHS reconfigurations should be presented and consulted upon:

1. The Green Book Appraisal and Evaluation in Central Government Treasury Guidance (HM Treasury 2003);
2. NHS London Reconfiguration Guide Version 3 issued December 2011 (NHS London 2011);
3. Changing For the Better: Guidance When Undertaking Major Changes To NHS Services (Department of Health 2008);
4. Independent Reconfiguration Panel (IRP) 'case law' and guidance;
5. NHS England Business Case Approvals Process Capital Investment, Property, Equipment & ICT (NHS England 2013a);
6. Planning and delivering service changes for patients (NHS England 2013b); and,
7. Capital Regime and Investment Business Case Approvals Guidance for NHS Trusts (Trust Development Authority 2014a).

In summary, these sources spell out onerous duties for those undertaking public consultations on major healthcare reconfiguration proposals. Our assessment is that the information supplied to date has not fully met the requirements of this guidance and as a result the consultation process was flawed. Despite this, both the Secretary of State and the Independent Reconfiguration Panel have given their support to the decision of the combined PCTs to approve the project and to allow the proposals to be implemented.

It should be noted however that the last piece of guidance from the NHS Strategy Unit introduced a note of ambiguity to the decision-making process (NHS England 2013b). The process described in this document reads as though the decision is not dependent on the outcome of the Business Case

Approvals Process. Yet a close reading of *NHS England Business Case Approvals Process Capital Investment, Property, Equipment & ICT* (NHS England 2013a) and the subsequent *Capital Regime and Investment Business Case Approvals Guidance for NHS Trusts: Trust Development Authority* (Trust Development Authority 2014a) makes it clear that the higher authority on the decision to invest is the Department of Health and the Treasury. As ever, the Treasury will still have the final word on approval of major capital investment.

Our interpretation therefore is that whatever the views of the Secretary of State, Independent Reconfiguration Panel or the representatives of the CCGs currently acting as the champions of the SaHF project, until the business case is approved and finance made available for the project by the Treasury, it would be unwise to proceed to implementation. Nevertheless the SaHF team has in our view prematurely started implementation without securing a final business case: a recipe for disaster.

In a statement to the House of Commons on the matter in October 2013, the Secretary of State, Jeremy Hunt said (column 922, House of Commons 2013),

> *None of these changes will take place until NHS England is convinced that the necessary increases in capacity in north-west London's hospitals and primary and community services have taken place.*

It is clear therefore from this statement that there is no mandate for proceeding until all the elements are agreed and aligned. And yet, as we have said, that requirement has been ignored.

5.6 Recent engagement and involvement of the local authority and other stakeholders

Following the Secretary of State's approval of the SaHF project, we have further concerns about the strength of the processes for taking the project forward. There does not appear to be an open and engaging process with the North West London local authorities. Local government is supposedly working with the NHS in partnership and involved in the integration of services. However, local authorities are not represented on the SaHF Project Board, are not privy to the Project Board papers, and are not involved in the ongoing debates on the programme.

In our limited discussions with senior local government officers and councillors involved in the process and with senior figures leading the SaHF programme it was clear that the SaHF team saw no reason to involve their local authority colleagues in any decisions around changes to health services in North West London. There was also some evidence that NHS bodies found it difficult to work together at a time when new organisations and boards were finding their feet.

An example of the difficulties of getting agreement to common working among so many local bodies is the following excerpt from CCG papers within the Brent area, which exemplifies the frustrations and the tenor of action being taken (paragraph 2.32, Brent CCG 2015):

> *The Clinical Directors stressed the need to use financial penalties and decommissioning to achieve better services from LNWHT (London North West Healthcare NHS Trust) and expressed great concern that despite assurances over the years from LNWHT there was still a deterioration in performance and services and that additional funding under Winter Pressures may not improve performance. A broader debate was called for to bring to the attention of the LNWHT the frustrations and anger the GPs had at the service provided to*

their patients over the last 20 years. The GPs had no confidence in the LNWHT managerial side, nor in the manner its clinical teams run their departments, nor in the A&E service (Our emphasis).

This tension, expressed in more muted terms, is evident in submissions from local authorities to this Commission. Despite promises that the business case would be available over a year ago it is still unseen. We understand that costs have escalated and that adjustments may have to be made to gain Treasury acceptance. It is likely therefore that the picture presented to the public at the time of the public consultation may now be changed significantly.

It is therefore vital that public representatives, the Overview and Scrutiny Committees, and indeed officers of the councils involved, are clear both on what is being proposed and the costs involved, and are fully committed to delivering their contributions.

The feedback we have had from senior officers, councillors and representatives of the SaHF programme is that there have been internal issues distracting the SaHF team; new relationships being forged with higher level authorities, themselves in a state of flux, and it has been unfortunate but deliberate that local authorities were kept at arm's length until matters were resolved. Despite warm words being exchanged expressing regret and a new willingness to share information three vital pieces of information have been withheld from this Commission:

- The latest business case;
- The results of an attempt to summarise the CCG plans for OOH services and the successes so far in reducing acute demand; and,
- The results of an independent investigation of recent local A&E problems.

Despite this, the SaHF team continues to claim unprecedented levels of engagement around the programme and its various initiatives. These claims are beginning to ring hollow to members of the JHOSC committee and to senior local authority officers and members who have come to doubt whether the programme can deliver what it has promised.

5.7 Ensuring there are no conflicts of interest

In any major programme of change with a wide geographic sweep, as SaHF is, there will be winners and losers. It is important that when decisions as far-reaching as these are made, those involved have both the ability to examine the evidence with a cool analytic head, and without reference to any commercial or vested interests that may exist.

We have suggested that both the clinical and financial cases for the changes put forward by SaHF are badly flawed. Yet it remains the case that many local clinicians, at both CCG and hospital provider level, have supported these proposals, as indeed have the management teams. This Commission has received written evidence from some clinicians that runs counter to the received SaHF wisdom, although overall there has been a lack of response particularly from the GP population. The reason for this is unclear.

The already powerful larger acute hospital trusts (and their staff) who stand to attract capital to rebuild and expand facilities not readily financed otherwise might be seen as potential winners in the SaHF process; in addition the closure of rival hospitals may put them in a better competitive

position. GPs and community service providers may also stand to receive investment funds and revenue streams that may have been difficult to secure otherwise through traditional routes. Such vested and commercial interests should not distort decision-making. While we have no evidence that this has been the case it is an issue that merits some consideration.

Evidence submitted to this Commission by Perrin and Lloyd (Evidence to the Commission, Volume 3, pp 801-1075) suggests there are aspects of the tendering processes for significant services that do not follow best practice and have led to the appearance of personal interests intruding into the decision-making realm. The NHS has recently issued guidance to those put into positions of conflicted interests (NHS England 2014b) but disquiet continues to mount nationally on this score.

We suggest that the quality assurance of the decision-making process needs to be sufficient to withstand accusations of undue influence by those that stand to gain personally or professionally.

5.8 Implementation has proceeded without agreement to plans or finance being in place

What is most disturbing about the SaHF programme is that the normal process of agreeing a plan before implementing the plan is being flouted. Not only have A&E services at Hammersmith and Central Middlesex been closed – in September 2014 – but steps are now being taken for early closure of maternity services at Ealing as a precursor to further cuts in services at Ealing.

In our view such actions are premature while the business case (at Strategic Outline Case level) is not yet capable of receiving approval. We have been told that costs have risen to £1 billion and that this is having an effect on the services that can be proposed. Equally, evidence of the impact on demand for acute services from extensions of OOH services has not been forthcoming. These inadequacies in information and due process would be less of a problem if time were being allowed to rectify problems. Instead the reverse is the case in North West London.

Under cover of the consultation, the Secretary of State approved the proposals in advance of the approval of the business case and now the NHS is implementing crucial aspects. It is not clear what the remaining obstacles are to a continuing series of ad hoc closures consistent with the SaHF strategy. The risk is that A&E services will deteriorate further into crisis before the case for closure has been properly assessed and approved or rejected: rejection becomes more and more unlikely as piecemeal implementation continues.

It has long been the ambition of the Imperial College Healthcare NHS Trust and St Mary's hospital to renew the buildings on the St Mary's site. This would be expensive and incur high PFI charges. But the requirement to fund renewal of the estate at St Mary's is not a good reason for closing Ealing hospital. Using the argument that the building at Ealing is old is disingenuous when other hospitals around London date from Edwardian times and pre-Second World War.

The danger we see is that for all the talk about engagement and integrated working the programme is being managed as a tight, top-down process on a need-to-know basis. The programme is thus failing to inspire confidence in the strength of its plans and their deliverability, or to secure support for the immediate actions taking place or being planned. The clear danger is that a Queen Mary's Sidcup situation will develop whereby once the future of a hospital's key services are undermined then staff will leave and precipitate a downward spiral.

Our conclusions and recommendations therefore address these risks.

5.9 Findings and recommendations

Key findings

1. The nature of the project is unprecedented in scale, strained and at odds with the direction of the NHS policies of localism, bottom-up planning, and patient choice and competition. It is now late in delivering its final business case and we understand costs have increased to £1 billion;
2. The options appraisal process was inadequate with no proper consideration of a 'do minimum' option;
3. The public consultation process was misled on the scale and significance of the changes planned. Current plans are much more expensive and the benefits are much less than initially proposed;
4. The Secretary of State, advised by the Independent Reconfiguration Panel, was in error in allowing the implementation of key aspects of the SaHF programme before an adequate plan was prepared and approved, and a reappraisal is justified;
5. Engagement and involvement with patients and local authorities has been unsatisfactory since the Secretary of State's approval of the SaHF programme. There is now a loss of confidence in the SaHF process; and,
6. Implementation of closures before plans are completed and agreed is unacceptable and risks unravelling services before alternatives are available.

Recommendations

1. There should be local authority representation on the SaHF Programme Board;
2. The Business Case should be completed and made publicly available as soon as possible;
3. Development of OOH services can continue but the business case and clinical evidence base needs to be reviewed as it is likely that savings are exaggerated;
4. If the changes proposed to the Business Case are significant, a new set of proposals should be presented for public consultation and approval;
5. Alternatively it may be better for CCGs and FTs to focus on how best they want to address their own affairs independently of the SaHF process. CCGs may know best how they want to commission local services, and FTs how to plan their own service development;
6. In the event of agreement on the next course of action being difficult to achieve, the JHOSC and individual OSCs may call for a fresh referral to the Secretary of State to intervene on the decision to close Ealing Hospital maternity unit and for any further implementation of the SaHF programme until the business case is agreed, OOH services can effectively substitute for acute capacity, and a local consensus supporting the programme is in place;
7. Confidence must be restored in vital local services. No further changes should be made that would reduce the level of local services at Charing Cross or Ealing for five years, at a minimum, and;
8. There should be an independent review of the decision to close A&E units at Central Middlesex and Hammersmith and the proposed closure of Charing Cross and Ealing A&E units.

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