A brief response to the papers provided by Anne Rainsberry following her meeting with the NW London Commission of 25 August 2015

1 Introduction

Anne Rainsberry agreed to make the following materials available to the Commission.

1. A briefing on the new NW London capital business case (technically referred to as the Implementation Business Case (ImBC)), to include:
    i. What the ImBC is (in terms of the NHS capital approvals process)
    ii. Which capital schemes its covering
    iii. Reconciliation back to the numbers in the 2013 DMBC (the business case the JCPCT decision was based on);
2. A note on the content of the A&E and maternity changes already undertaken and why they were able to proceed in advance of the capital case above;
3. NHS England London Region assurance reports in respect of the A&E and maternity (Ealing) changes;
4. The benefits realisation report for A&E and the draft for maternity.

The following documents have been provided by Anne Rainsberry to the Commission:

- Document 1 - a brief account of the business planning process with some updates on timing and on expected costs;
- Documents 2-10 – pre-closure assurance reports on the A&E closures and the Ealing maternity closure;
- Documents 11-12 – two documents that had already been received and do not provide reassurance that the A&E closures have been a success;
- Document 13 – Anne Rainsberry's letter to Michael Mansfield.

We have considered whether these documents should materially alter the conclusions and recommendations in the Commission's draft report, and we find that they add very little to the overall picture already attained.

2 The content of the latest information

2.1 The Business Case

No draft of the Business Case has been provided. The NHS has revealed that it has still not produced a draft business case. The most recent offer is to provide an umbrella Strategic Outline Case (SOC) in March 2016. Given their failures in the past we are not confident that even this deadline some three years after the DMBC will be achieved. The NHS appears to be content to kick the can down the road rather than face the reality that the original scope and complexity of the SaHF proposals render the plans unaffordable, undeliverable and unlikely to result in the benefits originally claimed. In the meantime the reality of piecemeal implementation is that major reductions are being made to local services before coherent plans can be presented.

Document 1 suggests that the scheme will be disaggregated into a number of individual schemes in order to facilitate the production of further business cases which would be spread over an unspecified period. In our view such a plan is in clear breach of normal financial regulations contained in standing orders and standing financial instructions which forbid such arrangements. These rules have been established over time for good purposes. Evading capital controls to avoid strategic oversight can result in errors being made, particularly if plans are financially unaffordable at times of stringency. It can result in partial delivery of incomplete, incoherent and ambitious plans when other more modest and deliverable plans were more appropriate.

Even if the Treasury does approve the SOC (which seems to have not even been discussed with them yet) then it is likely the Treasury will insist on approving the OBC and FBC produced subsequently; particularly at a time of increasing financial stringency. Given the complexity and difficulty in producing the SOC this can only herald the likelihood of further delay and expense.

In addition, the NHS seems resolutely to have set its face against the mandatory Treasury guidance that there should always be a 'Do Minimum' option used in comparing the preferred option presented by managers. Continuing failure to do so will only introduce further delays.

What is also further underlined in the NHS response is the continued insistence on the status of the DMBC and of the Secretary of State in relation to SaHF: that a decision to approve the SaHF plans has already been made. This is nonsense. Such decisions could only be made after the production of a business case complying with DH, NHS and Treasury guidance and processes. That has not happened and the 'decisions' by the JCPCT look like a last ditch attempt to tie the hands of successors rather than an appropriate thing for bodies being wound up to attempt.

2.2 The impact of closures of A&Es at Central Middlesex and Hammersmith

Documents 2-10 are copies of pre-closure documentation supporting decisions to close A&E at Central Middlesex and Hammersmith, and the maternity unit at Ealing; documents 11-12 are documents that the Commission had received earlier and included in its review. The Commission concluded that these decisions were premature and unsupported and should be reviewed. We can see no reason to amend that position based on these documents.

The detailed assurance documents make it clear that the crisis precipitating closures was the shortage of intermediate grade clinicians. In other words there is no reason for the closures other than a national and regional planning failure. This has belatedly been recognised by the government at a national level, after pressure from the Royal College of Emergency Medicine, and government has approved the creation of more A&E posts but this does not go far enough as far as NW London is concerned. Put bluntly the quality problems supposedly calling for major reconfiguration are really an engineered staffing shortage for which the obvious answer is not to plan on the basis of staff shortages but to plan to recruit and train additional staff. Such a conclusion is reinforced by examining clinical staffing

numbers in the UK compared to other countries and the surge in population taking place in London.

The documentation provided cannot hide the fact that the A&E closures took place before adequate capacity was in place and resulted in a major deterioration in performance. Moreover there is continued denial by the NHS concerning ongoing problems for patients attending type 1 A&E units in the area. The NHS also misleads by presenting gross staffing figures for particular hospitals rather than across NW London as a whole. Consolidation does nothing for quality if gains in some places are matched by losses in others and overall access problems increase. Again the misleading presentation of information from the NHS reinforces the case for independent review.

Similarly the premature closure of a high quality maternity unit at Ealing has not been prompted by quality concerns but by shortages of middle grade staff. Given the continued surge in population in London we are not persuaded of the need for its closure which is likely to precipitate the rapid run down of other services at the site as staff see the writing on the wall. It is ironic that the most economic site in London should be the most threatened in this way; with expensive re-provision mooted on crowded central London sites to accommodate reductions in outer London where the population is increasing rapidly.

2.3 Out-of-hospital programmes

The NHS has provided little or no further information on the impact of OOH programmes on the ambitious targets contained in the PCBC and the DMBC.

2.4 Governance

Finally we again raise the issue of confidence in the governance and management of the SaHF process. We have a number of concerns:

1. There is continuing turnover in senior project management;
2. There are clear local winners and losers in the process and it is difficult to justify the winners being at the expense of the most deprived areas that are growing in population;
3. There is no effective local government involvement to ensure genuine integrated planning and that changes in OOH services will adequately cope with reductions in acute services and social care;
4. The leadership at NHS England (London) would appear to be compromised by having championed the SaHF process earlier;
5. There is a continued evasiveness and unwillingness to face reality;
6. There continues to be a refusal to share information eg the draft business case or detailed modelling;
7. There are potential conflicts of interest at CCG level.

3 Concluding remarks

The report of the Commission could be amended to incorporate the latest factual information and we recommend this is done. On the other hand we see no reason to change the main conclusions and recommendations. Indeed there is a case for strengthening these in the light of our findings above.

The following remain major concerns:

1. The failure to complete a satisfactory business case despite two and a half years having passed since the DMBC was published in February 2013, and over three years since the public were consulted in July 2012;
2. The refusal to share the draft business case with the Commission and to make it more widely available to the NHS's partners within the NW London health and care economy;
3. The substantial increase in estimated capital costs since the PCBC was consulted upon calls into question SaHF's original claim that for a small capital investment there would be clear financial benefits and major quality improvements: it is only now being made clear what the true capital costs will be, and the extent of these will inevitably reduce local services and overall quality will get worse not better;
4. The continued claim that there have been only minor glitches with A&E closures so far.

Roger Steer & Seán Boyle

24 September 2015