Briefing for

North West London Commission on Shaping a Healthier Future

Seán Boyle & Roger Steer

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1 Introduction

This is a briefing for the Commission set up by the four London Boroughs relating to the closure of A&E services in North West London. The remit of the Commission is to:

- Review the findings of previous studies relating to '*Shaping a Healthier Future*' and other NHS plans for the future of healthcare services in North West London.
- Consider evidence from stakeholders, experts in the field and other interested parties.
- Review and report on the likely impact of the Imperial College Healthcare NHS Trust's Clinical Strategy 2014-20, and any equivalent plans from London North West Healthcare NHS Trust or its predecessors, on the residents of North West London.
- Review the Out-of-Hospital strategy and wider plans to treat more patients in the community to see if the plans can accommodate an increase in demand as a result of reduction in acute provision.

'*Shaping a Healthier Future*' (SHF) 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 SHF began in 2009 and a proposal went to public consultation in 2012. The main content of the SHF 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 community services in order to reduce the demand on acute services.

2 Chronology of events

In this section we outline the significant events relating to the SHF.

- **6 February 2012: 'Shaping a healthier future' programme launched with publication of the Case for Change**

This document (NHS North West London 2012a) provided little in the way of detailed recommendations but argued the need for changes to services. These included provision of 24/7 access to specialist emergency care, improved access to specialised care, investment in GP and local services and a redesign of hospital services involving large-scale planning. Attention was drawn to significant estates

and financial challenges, with North West London's NHS hospital estate requiring an investment of £150 million and hospitals facing extreme financial pressures.

- 28 June 2012: Publication of the Pre-Consultation Business Case

NHS North West London published the pre-consultation business case (NHS North West London 2012b) in June 2012 after agreement by the Joint Committee of PCTs, a requirement of the NHS under legislation and according to recent guidance (NHS London 2011). This amounted to 18 volumes of material covering several hundred pages. The main thrust of the plan was to cut approximately 25% of the bed capacity in North West London with a claimed saving overall of £135 million.

- 2 July 2012: Shaping a Healthier Future consultation is launched

NHS North West London published the SHF consultation document on 2 July 2012, with a minor revision to the document on 2 August 2012 (NHS North West London 2012c). This consultation ran for 14 weeks until 8 October 2012. Views were sought on what were said to be clinically-led proposals to improve healthcare for nearly 2 million people in North West London.

- August 2012: London Borough of Hammersmith & Fulham receives an independent report from Tim Rideout on SHF proposals

Rideout's independent review (Rideout 2012a), on behalf of the London Borough of Hammersmith & Fulham, of the SHF proposals was highly critical of the consultation process and the evidence base underlying the proposals.

- **September 2012: London Borough of Ealing commissions an independent report (Rideout report) on SHF proposals that was submitted as part of the public consultation**

Rideout's independent review of the SHF proposals (Rideout 2012b) was highly critical. Rideout found the timing of decision-making, the methodologies used and the evidence base all open to challenge. He recommended the development of working out of hospital services before changes were made to acute capacity.

- **28 November 2012: Ipsos MORI analysed responses to the consultation and produced a report**

Ipsos MORI (Ipsos MORI 2012a; Ipsos MORI 2012b) analysed some 17,000 responses to a set of questions contained within the consultation document, although not all questions were answered by all respondents. There were 17 petitions included in the analysis with numbers of signatures varying from 43 to 25,193, but each of these seem to have been treated as just one response. Many of the petitions with the large numbers of signatures were opposing the closures put forward by SHF.

Ipsos MORI reported that 64% of respondents agreed there were convincing reasons to change how healthcare is delivered in North West London but that more people (38%) were against bringing more healthcare services together on fewer sites than were in favour (30%). In addition 56% of people were against delivering different forms of care in different settings. Ipsos MORI reported,

> *…there has been clear and vocal opposition to the proposed closure of A&E and other services in some areas, particularly Ealing and Hammersmith and Fulham.*

- **15 February 2013: Publication of the Decision Making Business Case**

NHS North West London published the Decision Making Business Case **(**DMBC) consisting of seven volumes, and thousands of pages of elaboration of the original PCBC which was what had been available during the consultation (NHS North West London 2013a). The DMBC introduces more accurate financial figures both increasing the costs of the proposals and decreasing the benefits; although still concluding that the option of closing services at Ealing Hospital is preferred.

- **19 February 2013: Joint Committee of Primary Care Trusts (JCPCT) agrees to all the recommendations put forward by the SHF programme**

This included 11 recommendations made in the DMBC as well as two further recommendations that refer to additional proposals for Ealing and Charing Cross hospitals.

- **4 March 2013: The London Borough of Ealing Health and Adult Social Services Standing Scrutiny Panel refers the SHF programme to the Secretary of State for Health**

Ealing Health and Adult Social Services Standing Scrutiny Panel refers the SHF programme on the basis that '*it is firmly of the view that the proposal is not in the interests of the health service in Ealing. The proposal fails to satisfy the four tests [that you have] set for reconfiguration proposals to meet in [your] document Revision to the operating Framework for the NHS in England 2010/2011. The Panel does not believe that there has been adequate consultation or engagement with the public, clinicians or Ealing Council'.*

- **23 May 2013: Secretary of State formally requests the Independent Reconfiguration Panel to review Shaping a Healthier Future**

The Independent Reconfiguration Panel (IRP) begins its review of the SHF programme.

- **13 September 2013: The IRP produces a report on SHF for the Secretary of State**

The IRP report (Independent Reconfiguration Panel 2013) is generally supportive of the SHF process and its objectives but makes several recommendations that the programme should satisfy before it can proceed although most of these are non-specific in nature.

It identifies that both Ealing and Charing Cross A&E departments may need to continue in operation for up to five years until satisfactory alternative services are developed and detailed changes agreed. It endorses plans for the establishment of a dedicated elective service at Central Middlesex Hospital. The need for additional beds for West Middlesex and Chelsea & Westminster hospitals was not identified.

The report emphasises the need to engage the public, service users, staff and the relevant local authority in any future proposed configuration of hospital services.

- **23 September 2013: The Secretary of State agrees that changes to NHS services in North West London should proceed**

The Secretary of State states that five of the nine hospitals in North West London – Hillingdon, Northwick Park, West Middlesex, Chelsea & Westminster, and St Mary's – would provide comprehensive seven-day-a-week acute emergency care. He also states that A&E departments at Ealing and Charing Cross would remain open, albeit with changes to the 'size and shape' of services.

- **10 October 2013: Ealing Council applies for a Judicial Review of the decision**

At the Oral Hearing the High Court finds no grounds for a Judicial Review. Mr Justice Mitting told the court that he would not allow the case to proceed to a full Judicial Review.

The council's legal team sought Judicial Review, arguing the JCPCT had proceeded with a closed mind and failed properly to take into account the health needs of local residents. The JCPCT was also accused of not complying with its statutory duty to ensure that users of the services were involved in the proposals for change, and also failing to fulfil its public sector equality duty.

Rejecting all the challenges, the judge ruled none of the grounds were arguable and the needs of local people had been specifically considered and addressed. He said there was no evidence of a closed mind.

- **October 2013: Secretary of State supports in full the SHF proposals to reconfigure NHS services in North West London**

This decision was based on a detailed review by the IRP which concluded that the SHF programme '*provides the way forward for the future and that the proposals for change will enable the provision of safe, sustainable and accessible services*'.

- **28 May 2014: Imperial Hospital Trust announces that it will close Hammersmith A&E services**
- **25 July 2014: North West London Hospitals NHS Trust confirms the closure of Central Middlesex A&E services**
- **30 July 2014: Imperial Hospitals Trust Board receives presentation of Clinical Strategy 2014/2020**

The strategy indicates that net capital costs (after land receipts) have risen to £408 million, far in excess of figures included in previous business cases, or in the case for change or public consultation documents. The strategy makes it clear that the Western Eye hospital, 55% of the Charing Cross site and 45% of the St Mary's site will be sold to help finance the £408 million costs of the strategy.

Key milestones in the implementation of the estates strategy include approval of the Outline Business Case (OBC) at the end of 2014/15, approval of the Final Business Case (FBC) at the end of 2015/16, the start of main construction at the beginning of 2016/17, and the completion of all construction at the end of 2019/20. This reads as a statement of intent rather than a strategy document.

- **6 August 2014: SHF team reports to JHOSC meeting that an extra 143 beds would be required mainly at Chelsea & Westminster and West Middlesex Hospitals.**

It is not clear what impact this has on the developing business case.

- **10 September 2014: A&E is closed to blue light patients at both the Hammersmith hospital and Central Middlesex hospital**
- **1 October 2014: Merger of The North West London Hospitals NHS Trust and Ealing Hospital NHS Trust**

The Trust Development Agency (TDA) announces the merger of these two trusts on the basis of a need to improve quality following a poor CQC report into North West London Hospitals NHS Trust, and also to address a substantial financial deficit in that trust of £23.3 million (5.6% of turnover) in 2013/14. The new trust will receive an initial support package of around £144 million over three years from the Department of Health and local Clinical Commissioning Groups (Trust Development Authority 2014).

- **24 October 2014: Competition and Markets Authority announces launch of inquiry into merger of Chelsea & Westminster and West Middlesex trusts.**

The Competition and Markets Authority **(**CMA) investigates the anticipated acquisition by Chelsea and Westminster Hospital NHS Foundation Trust of West Middlesex University Hospital NHS Trust, and on 19 December clears the acquisition as not creating a substantial lessening of competition (Competition and Markets Authority 2014).

- **21 November 2014: The NHS launches an investigation into A&E problems in North West London hospitals**

The press reports that NHS England, Monitor and the Trust Development Agency have announced an investigation into A&E problems in North West London (Daily Mail 2014). We have been unable to find confirmation of this in any official documents on the sites of these three NHS bodies.

- **1 December 2014: The four London boroughs establish a Commission to investigate A&E services in North West London**

Subsequent national and local press report increases in delays and queues of ambulances having difficulty accessing facilities In North West London. Continuing concerns within the local authorities prompts this Commission to be established.

- **10 December 2014: A new A&E department opens at Northwick Park hospital**

The new £21 million A&E department opened on 10 December with an increase in nursing staff from 24 to 27 per shift. A new GP-led Urgent Care Centre is housed in the same building (London North West Healthcare NHS Trust 2014). It is not clear whether more emergency beds have been added to cope with any increase in activity that may result.

3 Summary of the SBH proposals

In this section we outline the main content of the proposals providing a description of the changes (and timetable) recommended by SHF both in terms of closures or additions of acute capacity and developments of capacity in the community. We also consider the governance structures and processes for making decisions within the SHF programme, and look at the implementation plans.

3.1 Content of proposals

In this section we examine in more detail the content of the SHF programme.

The consultation

The SHF consultation document (NHS North West London 2012c) 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. A considerable amount of analysis and sifting of evidence had been carried out to arrive at this conclusion. 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 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.

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 below (NHS North West London 2012c).

Table 1: The SHF 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 recommends Option A (option 5 in Table 3 above) as the preferred option ie the closure of Charing Cross and Ealing, and the reduction of Hammersmith to a purely specialist hospital and Central Middlesex to an elective centre (NHS North West London 2012c).

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.

Proposed changes to acute sector

The net effect of the SHF proposals (and the concurrent Quality, Innovation, Productivity and Prevention (QIPP[1]) savings plans) would be a reduction of approximately 25% in total beds in North West London, as shown in Table 2 as resources are shifted from the acute sector to out of hospital (OOH) settings. These beds include adult general and acute beds, adult daycase beds and critical care beds: paediatric and maternity beds are shown separately (NHS North West London 2012b, p64, Figure 6.8). Over half of this reduction is based on the assumption that average length of stay in hospital (LOS) will be reduced by 15%.

As far as we are aware, there has been no subsequent statement of the bed numbers planned for these sites but it is likely that the eventual number of beds located at both Charing Cross and Ealing will be much reduced.

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

Table 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
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**

In addition to this general shift from acute services to OOH the number of major hospital sites would reduce to five and the proposed nature of the services on the four losing sites (Ealing, Central Middlesex, Hammersmith and Charing Cross) would change radically from the more comprehensive range of services currently offered.

This was summarised in financial terms as follows. The savings in acute beds and services would be £219 million per annum; but with the requirement to invest in OOH services amounting to £84 million per annum, the net saving would reduce to £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 costs of the preferred option increased from £112 million to £206 million (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.

Option A, involving the closure of acute services in Ealing, remained the preferred option with both positive benefits to the health economy of £42 million per annum and enhanced benefits over other options.

The DMBC laid out the same programme of change in health service provision in North West London, mostly reflecting what had been proposed earlier in 2012. The document claimed it had responded to feedback during the consultation period,

carrying out significant additional work on the analysis, in particular the clinical recommendations, options evaluation (including finance), travel, equalities and implementation planning.

The DMBC reiterated the adoption of what it termed North West London acute and out of hospital standards, North West London service models and clinical specialty interdependencies for major, local, elective and specialist hospitals, and on this basis continued to argue for the adoption of a model of acute care based on just five major hospitals in North West London delivering the London hospital standards and the required range of services, as follows:

Acute sector:

1 the current nine A&E departments across the sector would be reduced to five with Hammersmith, Central Middlesex, Ealing and Charing Cross effectively closing as blue light providers of Type 1 A&E provision.

2 transfer of the hyperacute stroke unit at Charing Cross to St Mary's Hospital

3 closure of the Western Eye Hospital and transfer of services to the St Mary's site.

Elective centres:

Establish Central Middlesex as an elective centre.

Maternity:

The current nine maternity units would be reduced to six, five of which would be on the remaining acute sites, and one at Queen Charlotte's Hospital.

Paediatric

The current nine sites providing paediatric services would be reduced to six, again on the remaining five acute sites as well as a neonatal unit at Queen Charlotte's Hospital.

Out of hospital care (OOH):

The transformation of OOH care across the sector was proposed, 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 (NHS North West London 2013a, Volume 6, Appendix L) provides copies of the OOH strategies of each CCG. Although each of the eight produces a slightly different mix of initiatives and proposed developments over a three-year period the format and content is 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 (£0-7.0 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 3 provides key implementation dates for the current plans for OOH services (NHS North West London 2013a) in terms of initiatives and enabling strategies.

Table 3: 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 has 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 a 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 impact of these strategies can be assessed in place.

A major caveat was included at the end of the strategies that these are indicative plans and were '*dependent on the release of funding from acute providers as activity transfers from acute settings to community settings*.'(see the Hammersmith & Fulham CCG OOH strategy, NHS North West London 2013, Vol6, p33). This could prove a major obstacle to implementation as the principle proposed by the IRP and agreed by the Secretary of State was that developments in community initiatives should precede reductions in acute capacity.

The effect of all these changes is to reduce capacity at acute sites and to change radically the nature of the services, although it was claimed that the fine detail was subject to elaboration and confirmation in future business cases, and these were not due to be completed until after plans for St Mary's hospital were confirmed. So, the approval of the Outline Business Case (OBC) for St Mary's is crucial to fulfilling that timetable.

The DMBC claimed OBC approval would be completed by the beginning of 2014 but this was not achieved. It was reported to the JHOSC in August 2014 that business cases for hospitals would be available within the next month (JHOSC Board papers August 2014 SHF report), although it was subsequently reported to the Hillingdon Hospital Board on 29 October 2014 (Hillingdon Hospital Board papers 29 October 2014 SHF report) that the OBC would be unlikely to be approved until the summer of 2015 because of the requirement for more estates work.

The DMBC is very explicit (NHS North West London 2013a, p678) in stating that '*acute changes must be synchronised with OOH changes to deliver full benefit*' and '*where possible OOH* (must be) *delivered prior to acute changes*', with an '*opportunity for redeployment of staff and estates in OOH*'.

It makes sense therefore for business cases for investment in OOH services to be closely coordinated with plans to restructure acute services. Given the uncertain nature of the potential outcomes from OOH investment we would expect a phasing of the implementation of plans to ensure there is solid evidence that the impact of developments of OOH services supports plans for the restructuring of acute services. As far as we are aware, no such evidence is currently being considered

and indeed the eight CCGs seem to be arguing for the reverse ie reductions in acute budgets in advance of investments in OOH strategies.

Progress toward implementation of these plans for both acute services and OOH services have been reported to the Joint Health Overview and Scrutiny Committee (JHOSC) of the North West London councils on a regular basis, at meetings in September and December 2013, in February 2014 and October 2014.

It was not until August 2014 that it was reported that OBCs for the five major hospitals and two local hospitals were due for completion within the next month, and these have still to be presented, even though the original timetable showed OBC for major hospitals being completed by the end of 2013/14.

More regular reports on progress toward implementation of OOH services took place but there was still a high level of generality to these reports and lack of convincing detail.

More significantly it was reported that A&E services at Hammersmith Hospital and Central Middlesex Hospital would close; and a plan for the early closure of Ealing maternity services was being developed.

Thus although there remained large questions and doubts about the success and impact of the OOH plans, rapid progress was being made toward the closure of acute services with large impacts for local people.

Also the detailed plans for closure of maternity services at Ealing Hospital explained that the aim was to close the inpatient maternity unit, neonatal services and gynaecology at Ealing hospital by March 2015, and inpatient paediatrics by June 2015. This was not identified in the DMBC but only emerged in later reports to the JHOSC.

Thus it seems there is both a slippage in crucial OOH service development, and in the business case preparation process affecting acute services, at the same time as a faster implementation of service cuts.

Returning to the DMBC (NHS North West London 2013a, Appendix N, Volume 7) there are some specific claims against which the plans can be held to account. Table 4 below shows forecast decreases in activity according to the SHF plans. These are reductions relative to the pre-QIPP baseline as of 2011/12 (NHS North West London 2013a, Vol 7, Appendix N, p24).

Table 4: 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

Elective

It is assumed that 3,000 elective spells will be redirected to minor surgery in primary care. It is not clear how this will be achieved although presumably it is linked to improvements to GP premises that are still to be achieved.

A further 7,000 will be reduced through contractual and other savings, presumably by increasing the thresholds of care for non-priority procedures ie by preventing some activity taking place that would otherwise have done so.

This will be achieved by a £7–9 million investment in OOH and there will be approximately 10,000 extra appointments in OOH settings. Thus far we have not discovered where this activity is intended to take place. We would expect to find detail of explicit allocation of targets attached to particular premises so that performance toward achieving those targets could be monitored.

Non-elective

It is assumed there will be a reduction of 30,000 spells due to development of rapid response teams, and that this equates to 391 beds. There will be a further reduction of 20,000 spells from development of integrated care, and 5,000 from contractual savings.

There may be an error here as the 391 beds seems to be both stated as overall reduction and as just associated with rapid response teams.

This will be achieved by a £35–38 million investment in OOH and there will be 130-140 new community beds and an extra 290,000–300,000 appointments in OOH settings.

A&E

It is assumed there will be a reduction of 50,000 attendances at A&E due to expansion of UCC (these are called spells but we assume the same meaning); 35,000 through prevention by the 111 service; and 15,000 as a result of improved primary care access. It is not clear if these are Type 1 or all A&E attendances; if the latter then there seems like there will be a 50,000 increase in UCC attendances.

This will be achieved by a £3-5 million investment and there will be 60,000–70,000 extra appointments in OOH settings.

Outpatients

It is assumed there will be a reduction of 300,000 appointments through reprovision, presumably in community settings; 140,000 through contract renegotiations, 100,000 through improved referral management schemes; and 60,000 through GPs' access to specialists by phone.

This will be achieved by a £35–38 million investment in OOH and there will be an extra 510,000 – 520,000 extra appointments in OOH settings.

One test of the current changes is to assess how much savings will have been actually achieved by the end of 2014/15; and what are the continuing claims of savings to come related to unfulfilled implementations.

3.2 Governance

In this section we outline the process by which decisions were made in North West London and how they relate more generally to NHS governance processes.

In 2012, at the time of the launch of the SHF Case for Change, large capital projects came under the auspices of NHS London, a Strategic Health Authority. SHAs had played a prominent role since guidance from the Department of Health in 2008, *Changing for the Better* (Department of Health 2008), responded to the many problems encountered in public consultations at that time by placing a greater emphasis on the strategic role of SHAs in quality-assuring the consultation process.

The Department of Health advised,

It is imperative that each Strategic Health Authority (SHA) makes sure that there is appropriate capability and capacity in the NHS – at both SHA and PCT level – to develop robust, evidence-based proposals, to undertake effective consultation processes and successfully implement the resultant changes. Each SHA and local health community should have a clear and coherent strategy in place that identifies all current and future service change proposals. These should be clearly linked to the outputs of local commissioning strategies. It is the responsibility of SHAs to ensure that all PCT-led consultations on substantive service change are robust in terms of content, timing and process. SHAs should also ensure that each scheme complies with relevant legislation and other regulatory requirements (such as Equality Impact Assessments), follows good consultation practice and is open, transparent and fair. Each SHA should also identify the wider impact of major service change, including the implications for neighbouring SHAs and the impact on providers and people who use services as well as the sustainability of the whole system.

NHS London published a reconfiguration guide, last updated in Dec 2011, specifying the guidance and required action to support reconfiguration proposals (NHS London 2011). Following the abolition of SHAs in July 2012 governance arrangements were put under review although formally NHS England, and specifically its London office, took over the responsibilities previously discharged by the SHA (NHS England 2013).

In 2012 the governance of the SHF programme was exercised through a joint committee of North West London PCTs, with additional assurance of the work provided by the 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 London Borough of Harrow (2012) JHOSC Board papers July 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 SHF 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 SHF 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 SHF Project Initiation Document dated May 2013 (NHS North West London 2013b).

The CCGs have agreed to act in common to implement the SHF 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).

Attempts by the NHS in the past to collaborate have led to the collapse of collaborative arrangements as these have not been legally binding and all disputes between NHS bodies have had to be resolved under the NHS disputes procedure. The Dispute Resolution Process between Commissioners and Providers for the 2014/15 Contracting Process (NHS England undated) covers the scope of rules on these matters.

A CCG is able to withdraw from the collaboration at any time although this may be viewed as unusual. Hillingdon CCG for example was a member of the collaboration

but withdrew in June 2012 (see minutes of the informal JHOSC meeting held on 12 June 2012). In our view the interests of the group should not override the self-interest of the individual CCG.

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 SHF programme to ensure it is consistent with the decisions that were made by the 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.

The role of the Implementation Programme Board was to:

- Oversee the implementation of the programme in line with decisions taken by the North West London JCPCT in February 2013 and direction from the North West London CCG Collaboration Board;
- Bring together local commissioners and local providers to jointly manage implementation and ensure decisions on changes to service provision are being made in a consistent fashion;
- Act as a forum to jointly manage progress, resolve issues and manage programme level risks and interdependencies;
- Collectively review key deliverables eg all OBCs and FBCs for capital expenditure; and,
- Monitor progress of the transformation of services, keeping oversight of all the multi-organisational change that is occurring, and ensuring quality, equalities and patient needs are suitably considered at all times.

The work was supported by a Programme Executive (NHS North West London 2013a; North West London Collaboration of Clinical Commissioning Groups 2014a).

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

We perceive the setting-up of a JHOSC across the boroughs has in a way acted to subdue the reaction from a locality badly affected by changes since those unaffected or that benefit tend to acquiesce.

3.3 Problems with the SHF Process

There are fundamental problems not only with the outcomes of the SHF process but also with the process itself: the way in which the proposals have emerged and how they are being taken forward.

The issue has been defined as a North West London problem, an artefact of the old regional organisational split. But regions have been abolished to be replaced by localism, patient choice and competition as the drivers of change in the NHS. If local CCGs were genuinely to shape local services it is inconceivable that one would come up with the option of closing A&E, maternity and paediatric services at the local hospital, as in the case of Ealing.

Equally if the issue were addressed as a London-wide issue (to correspond with the new organisational loci of NHS England) it is difficult to imagine that significant additional investment in Chelsea & Westminster and West Middlesex hospitals would be regarded as priorities (as they are now, in the latest iteration of proposals from SHF). This looks like an effort to resurrect old regional planning initiatives and to use levers of power to push through change before they are taken away (as they were in July 2012 but now allowed a temporary afterlife in the shape of the SHF programme).

Although the objectives of the exercise appear to be broad and non-specific, the only options appraised were variants of a single option: to centralise some key clinical services and reduce capacity within North West London. In other words the proposals are not how best to improve quality and financial sustainability in North West London but how best to reconfigure hospital services in North West London.

In our view, only a narrow set of options was considered. Given the radical and interventionist path chosen, there is a high risk of error and counter-productive action. For example if the reason for the high cost base in North West London is the high costs of specialty hospitals and teaching hospitals it makes no sense to invest more in these. Equally, if the increase in use of A&E is due to the difficulties of accessing primary care it makes no sense to close A&E departments until primary care access improves significantly.

Rideout in his report (Rideout 2012b) highlighted the paucity of convincing evidence for the lack of alternative ways of addressing financial problems. He cited the fact that other parts of the country were meeting financial targets without recourse to major reconfiguration.

Although it was clear in the public consultation that services were to be centralised on the five major sites it could be argued that the document was not explicit about what was to become of the remaining sites and the risks of closures and increased

travel times for users of services. There is therefore a question as to whether the consultation process provides a democratic mandate for all the changes now being rapidly implemented. Our view is that these grounds are unlikely to be sufficient alone but together with the degree of change implicit in the latest proposals they may justify a claim for a refresh to the mandate in due course.

A degree of ambiguity has always surrounded the purpose of SHF. On the one hand it is presented as a clinical initiative designed to improve the quality of care available to residents of North West London. At the same time, it is clear from the documentation made available so far, and discussion around this, that there are key financial issues that SHF purports to address. In fact, in determining the preferred option, the financial issue was the key consideration for SHF as illustrated by its use of financial criteria as the hurdle that must be satisfied if more than five major hospitals are to be provided. But so far SHF has failed to provide evidence that it will achieve either better quality or robust financial plans. Moreover while quality is an issue for patients, access to care is also a significant concern. Although it was used as one of the criteria in assessing options the funnelling process of establishing ever more restrictive hurdle criteria to arrive at options for reconfiguration effectively ruled out the most desirable options as far as patients were concerned.

It is apparently true that GP commissioners (the CCGs) are in favour of the SHF proposals as confirmed in a letter of support for the programme proposals by the Chairs of CCGs North West London Collaboration of Clinical Commissioning Groups (2013). But this support should be tested across the GP populations in the main areas affected. Ealing CCG did conduct a ballot of their GPs, and only 11% were in favour of Option A which includes the closure of Ealing Hospital (NHS North West London 2012e). Even the letter from the Chair of Ealing CCG has a somewhat critical tone raising the following concerns of Ealing GPs:

- there are implications for travel times for both car and public transport users. Public transport routes must be designed to accommodate reconfigured health services;
- the scale and proposed timing of the reconfiguration; in particular the pace of acute bed reductions and whether this is achievable given the increasing complexity of managing patients with multiple long term conditions;
- it will be essential for the Ealing Out of Hospital Strategy to be fully implemented before changes are made to acute services. There needs to be clarity about what is expected of primary care and of the investment needed to deliver this over the next 3-5 years;
- further clarity is needed about the requirement for capital investment in suitable buildings and facilities

The hospital doctors at Ealing specifically claimed '*we have clear emerging evidence that many local GPs whose patients actually use the hospital do not support these plans. It's clear from our evidence that these views were not taken account of at the time and that the majority view is being ignored*' (NHS North West London 2012e).

The difference in stance between the views expressed by the Chairman of the CCG in his joint letter of support for SHF and the views of some local doctors reinforces the view that, at the very least, there should be a secret ballot of GPs in each local authority area. The Lewisham Judicial Review weighted heavily local GP commissioner opinion. If it can be shown that GPs in Ealing, or Hammersmith & Fulham, for example, are not in support of SHF, then this can only enhance the case for opposing the closure of services, even those closures that have already taken place.

It is likely that if the problem was framed differently, if a genuine search for 'do minimum' options was undertaken and if a better appraisal of the true costs and benefits was provided that gave more weight to patient preferences and to local GP views, the population of North West London would have been faced with different choices.

4 Changes that have taken place since the SHF consultation

Section 4 highlighted two key aspects of the SHF programme: the reduction of acute hospital beds as a result of planned reductions in workload; and the reduction in the number of sites providing A&E, maternity and paediatric services: the SHF documentation argued that these would be achieved by the development of OOH services alongside a pressure to reduce the Average Length Of Stay (LOS) of hospital inpatient cases.

This section attempts to examine the actual developments that have taken place alongside what was planned and how plans have changed; and also considers some measures of activity and performance that may be associated with these changes. In all of this we are hindered by incomplete information (more information may become available as the Commission's work unfolds) and the imprecision of the SHF programme itself, at least in its public form, and the reporting back by SHF officers to the NHS and to their local authority colleagues.

4.1 Hospital developments

The SHF proposals entail a major reconfiguration of hospital services affecting almost every hospital in North West London. While there has been little in the way of developments or investment on the acute sites (see the discussion of delays in production of OBCs), the NHS has already moved to close A&E services at Central Middlesex and Hammersmith hospitals (in September 2014), which seems to run

counter to the often stated intention to develop OOH services before any changes to acute services.

At this stage it is worth being explicit about the scale of changes and the investment required at each site. It should also be noted that the degree of sophistication in the costing of the business cases presented so far is less than required under OBC requirements. This is one of the reasons for the future likely delay in completing the OBC for developments in North West London until the summer of 2015. This casts a shadow of uncertainty in both quoting the capital costs and claims of affordability and deliverability of the scheme.

Nonetheless the DMBC lists the estimated investment costs required on hospital sites (NHS North West London 2013a, P50) as shown in Table 5 below. A considerable sum is required on a hugely complex and extensive set of developments across a large number of separate institutions.

Table 5: Estimated investment in acute hospital sites

Hospital	Estimated gross new investment (£ million)
St Mary's	132
West Middlesex	22
Northwick Park	20
Charing Cross	15
Chelsea & Westminster	26
Hillingdon	17
Ealing	19
Central Middlesex	9
Hammersmith	25
Contribution to Imperial College[1]	35
Total	**320**

1 this is compensation to Imperial College Medical School for helping clear the sites by moving some of buildings and services.

It is acknowledged that land receipts may eventually meet some of these costs (£167 million is assumed) but timing and the final amounts could yet be subject to considerable variation (the downside of buoyancy in land receipts is the rising cost of building in London). Already it has been reported to the JHOSC that 143 extra beds will have to be provided mainly at Chelsea & Westminster and West Middlesex hospitals without it having been made clear what the capital and revenue implications are.

4.2 Out of hospital developments

The general thrust towards the development of OOH services in SHF was rather vague about the pace and specific implications of changes to services and how these would impact on outcomes.

The DMBC described the various improvements and enabling strategies each CCG is planning to implement. Although the level of detail in the documentation, and the implied impact on quality and demand for acute services is wanting, we would expect in a change of this scale that it would eventually be possible to calculate the additional monies spent on implementation, extra staff employed, the numbers of new GP and community care premises opened, and for reports of improved performance to be presented quantitatively and qualitatively. The impression from reviewing the progress reports provided to the JHOSC Boards however is that slippage is occurring.

This is an issue that was also addressed in the IRP report (Independent Reconfiguration Panel 2013) which recommended OOH service development plans should be built up from the individual practice and locality level. At present these plans read as aspirational rather than based on agreed local changes.

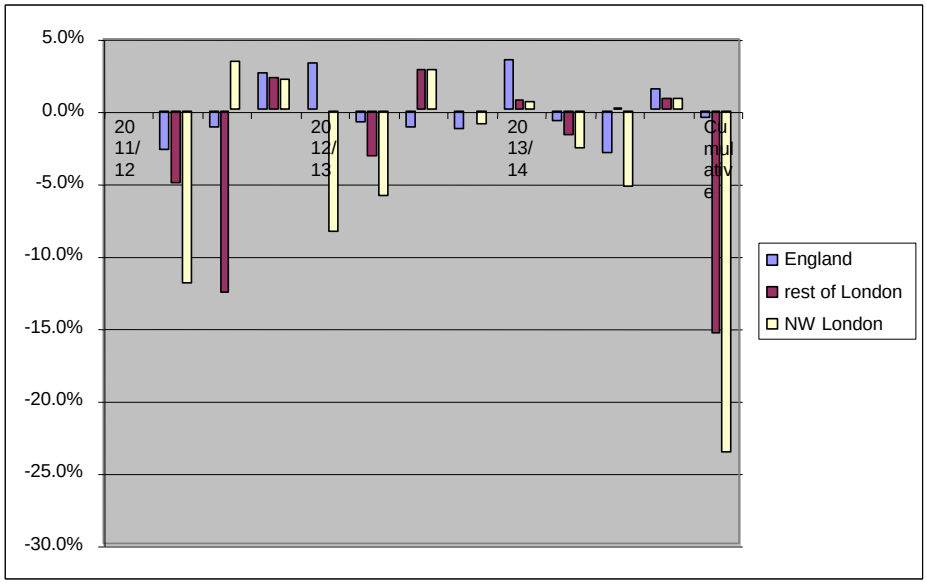
4.3 Activity and performance

This section considers the performance of North West London on one or two key indicators, and how this performance may have been affected by the changes taking place under SHF.

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 inside of four hours. For both of these indicators, we consider performance in North West London compared with the rest of London, and the rest of England.

Finally we intend to look at 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 SHF programme is supposed to bring. This will be completed when more data becomes available from the CCGs.

Figure 1: Percentage change in Type 1 A&E attendances, April 2011 – March 2014



This figure shows 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.

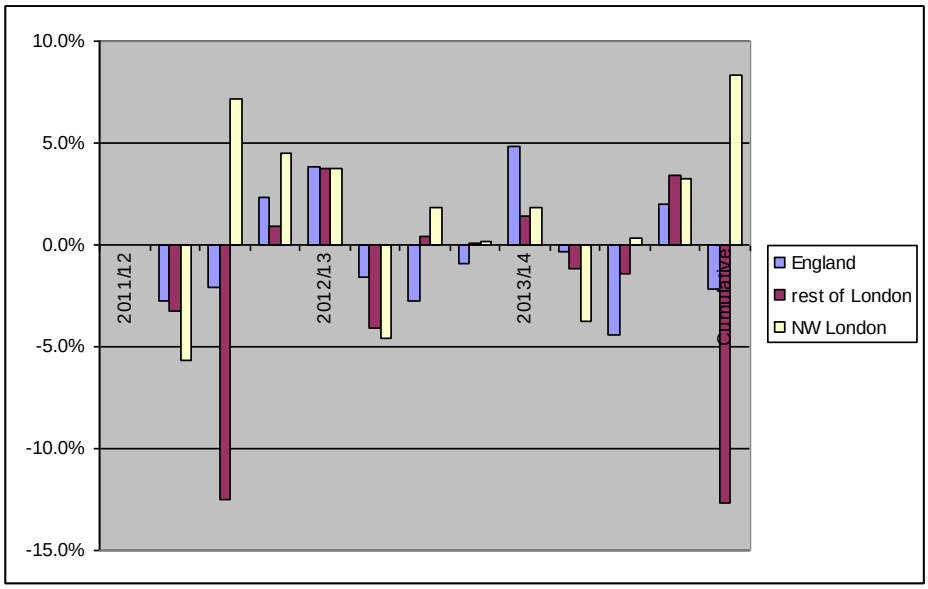
These data reflects the position before the closure in September 2014 of Central Middlesex and Hammersmith A&Es.

We observe that there has been a very small reduction in A&E attendances in England over this period of three years. However the picture seems very different in London where there has been a cumulative fall of over 15% and in North West London where the reduction is even larger at almost 24%. This represents a fall of almost 100,000 in attendances in North West London hospitals over this period.

However, the growth of the use of urgent care centres in North West London provides most of the explanation for this fall in Type 1 attendances. Thus we find that in April 2011 Type 1 attendances were 71% of total Type 1 and Type 3 taken together, but by the end of March 2014, this proportion had fallen to 52%. This compares to the very different position in the rest of England where the proportion has remained at around 67% during this time, and in the rest of London where it has been between 68% and 65%.

If we look instead at total A&E attendances including UCCs and specialist units we find a different picture as Figure 2 shows. Attendances in North West London have increased by 8.4% whereas those in the rest of London and in the rest of England have actually fallen, in London by over 12% and England by just over 2%.

Figure 2: Percentage change in all A&E attendances, April 2011 – March 2014

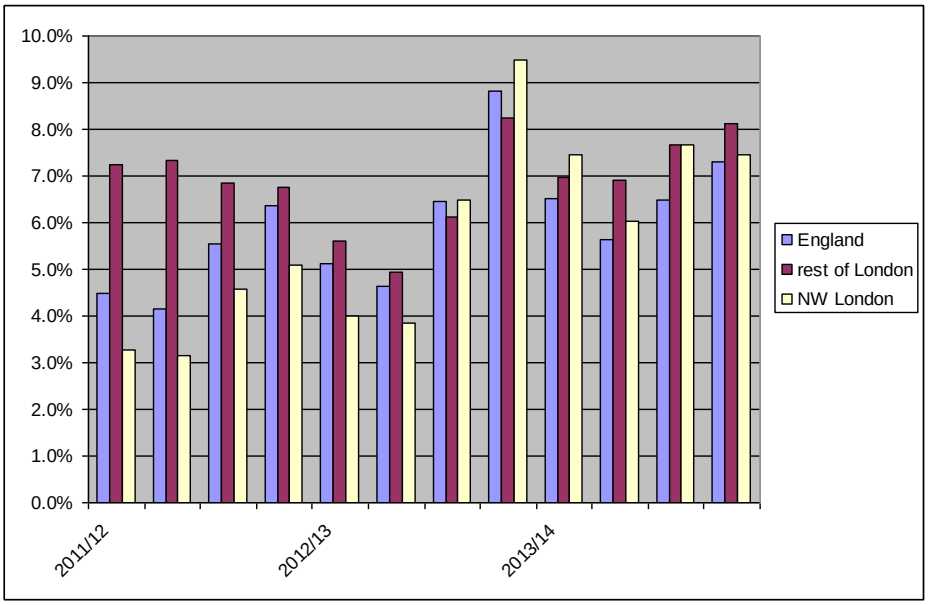


So we have a situation in North West London where total attendances have been increasing but Type 1 A&E attendances have fallen in recent years. What has been the impact of this on performance?

A&E performance

The measure normally used to measure performance is the proportion of people attending A&E who are not dealt with within four hours. Figure 3 compares the position in North West London with the rest of London and the rest of England for Type 1 attendances.

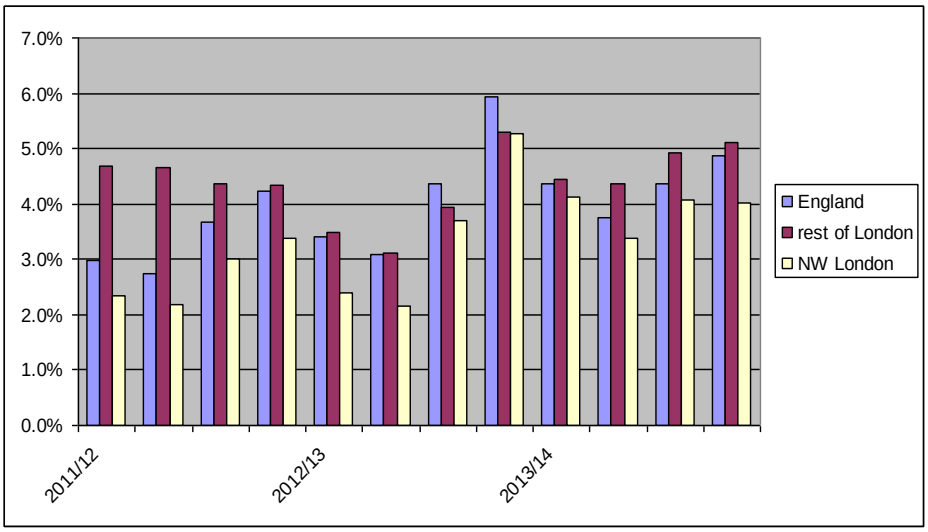
Figure 3: Proportion of patients not seen at Type 1 A&E within 4 hours, April 2011 – March 2014



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 has 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.

Figure 4 includes all A&E attendances (Types 1,2 and 3). 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.

Figure 4: Proportion of patients seen at all types of A&E within 4 hours, April 2011 – March 2014



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.

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.

For the first 11 weeks of quarter 3 (until 14 December), the position in North West London has got even worse, with the proportion not seen within four hours increasing to 13.4%, compared with 10.6% in the rest of London and in England.

There was a steady deterioration over this period: in the final week, 22% of Type 1 A&E patients were not being seen within four hours in North West London hospitals.

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 35%. 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%.

4.4 Delivering the business cases

The Secretary of State in accepting the broad thrust of SHF had announced that its approval was '*the start of a five year implementation programme – nothing will be rushed and we will now work closely with local residents, hospitals, GPs, local authorities, carers and patients to identify the best range of services in the local hospitals at Ealing and Charing Cross which will best serve the needs of that community*' (Statement from The Shaping a Healthier Future website 30 October 2013). Therefore it might be expected that the detail would take time to develop. However an examination of the reports provided by SHF leads to the JHOSC gives a different impression.

In September 2013 programme timetables stated that major and local hospital OBCs would be completed by the end of 2013/14; hub and GP premises development would be taking place between the end of 2013/14 and 2015/16 and

workforce planning would have been completed by the end of 2013/14 as would the specification and commissioning of new OOH services.

Plans for Ealing and Charing Cross hospitals referred to enhanced services being taken forward with local stakeholders and it was said options for the future of Central Middlesex hospital were being studied. The equivalent reports to the JHOSC in December 2013 maintained the timetables for completing business cases for major and local hospitals but specification and commissioning of new OOH services would now not be completed until the end of 2014/15. It was reported that the changes to Central Middlesex and Hammersmith A&E would occur in Summer 2014, and that Central Middlesex would become an elective hospital with no A&E services.

Each CCG has reported 'successes' in developing various aspects of the OOH strategy. From the papers however there is no quantification of the targets within periods for reducing activity although some comfort was drawn from the very good performance data for A&E services and the general reduction in A&E attendances of 1-5% (apart from at North West London Hospitals (+2%). It was also reported that 7-day GP access had begun.

In February 2014 however the overview of the programme was omitted from the report. It was clear that progress on the OBCs was slower than expected and it was reported that reviews of individual business cases may be necessary throughout 2014. Reports on OOH initiatives and enabling strategies were at a high level. However, the reporting of the closures and transitions at Hammersmith, Central Middlesex and Ealing maternity unit were much more explicit.

The next report in August 2014 was rather bullish in its assessment of progress made by the SHF programme in its first year although a comparable overview with previous reports was omitted again. Nonetheless it was clear that OBCs for major and local hospitals had still not been agreed; nor was it possible to tell from the method of reporting of progress with OOH strategies, what the impact would be on the demand for acute services. It seemed that an application to receive money from the 'Challenge Fund' might expedite progress within primary care. Detailed planning for the early closure of maternity services at Ealing were revealed at this point.

It was also reported that recent modelling showed the need for 143 extra beds mainly in Chelsea & Westminster and West Middlesex hospitals. This increase is bound to have a significant impact on the financial savings and on the viability of the whole project, although this fact was not reported.

It was also reported that the DMBC, plus the more recent Implementation Business Case would act as the SOC (strategic outline case) for NHS England (and Department of Health) approval. Thus it is clear the SHF plans have still not overcome the first hurdle toward obtaining approval and funding.

The SHF report mentioned almost as an aside that there had been progress in the merger of Ealing Hospital and North West London Hospitals Trusts, and West Middlesex and Chelsea & Westminster Trusts. These transactions were to be completed by April 2015. Neither had been mentioned previously in SHF reports and both would have profound implications on choice and competition, the supposed drivers of health policy.

In addition, capital estimates have increased significantly for both West Middlesex and Chelsea & Westminster trusts, and access to Public Dividend Capital (PDC) is a critical planning assumption. These issues appear as little more than a footnote on page 66 of the August SHF report to JHOSC and yet both issues could pose large difficulties and delays, at very least in implementation. Increases in capital costs increase the already high cost of the proposals and extra PDC is not granted automatically. The presumption is that capital is funded privately through the PFI route in normal circumstances, for larger schemes.

Further reports from August 2014 provided more details of the assurance measures surrounding the closures of Central Middlesex and Hammersmith A&Es detailing the readiness of St Mary's, Charing Cross and Hammersmith and arrangements at North West London Hospitals Trust and the Ambulance Service.

The SHF reports from October 2014 focus on the issues around the transition of services at Ealing hospital. They also reveal that A&E performance had been good right up to the closures in September and highlighted how a range of system indicators would monitor changes in performance. In the absence of a comprehensive and comparable programme overview report, partial information of successes still did not indicate how performance was expected to change as a result of these initiatives.

The only conclusion we can draw therefore from all this activity and reporting is that there has been significant slippage in plans particularly surrounding the presentation of business cases; the requirement for 143 extra beds has been identified and is likely to change fundamentally the economics of the SHF programme; and, the lack of clarity in the OOH plans in terms of the targets and the performance implications of various components of such plans only undermines confidence that they will deliver the reductions in demand for acute services predicted.

4.5 Financial background

The financial projections behind the SHF case for change suggested there would be a £1 billion shortfall by 2014/15 if radical action was not forthcoming. What is the position now in North West London?

We present the position in North West London based on the latest available documentation. For the NHS as a whole there have been surpluses since 2010/11, of £305 million in 2013/14, £1,527 million in 2012/13, £826 million in 2011/12, and £1,098 million in 2010/11 (Department of Health 2014, p30). The same is also true of NHS London where there was an overall surplus in 2013/14 and is expected to be so again at the end of 2014/15. (see Report from Paul Bauman Chief Financial Officer NHS England Paper 1505143 Board Paper, NHS England 2014).

Table 6 is based on an extract from the year-end audited accounts of the CCGs and provider organisations in North West London for 2013/14. Taken together there was a surplus of just over £100 million.

Table 6: Summary of latest financial information for North West London commissioners and providers, 2013/14

Commissioners in North West London	**£ million**	**£ million**
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	86.2
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	
Central & North West London	4.6	13.9
Total Surplus		100.1

NHS England reported that London had a £189 million surplus in 2013/14; this suggests North West London contributed more than its fair share to the overall London surplus.

In 2014/15 the reported financial picture is more difficult to collate and interpret, but what is known is shown in Table 7.

Table 7: Summary of latest financial information for North West London commissioners and providers, 2014/15

Commissioners in North West London	Latest 2014/15 £ million	Month	Projected year-end £ million
Brent	0	4	0
Harrow	0.853	5	0
Hammersmith & Fulham	6.8	6	11.85
Ealing	4.2	6	9.1
Hounslow	4	6	17
Central London	8.3	6	17.3
West London	0.23	6	0
Hillingdon	0	7	0
Providers in North West London			
Hillingdon	-1.3	8	-2.8
North West London	-21.9	6	0
Ealing	-9.07	6	0
Imperial	0.8	7	11.2
Chelsea & Westminster	0.8	6	1.2-3.4
West Middlesex	-0.94	1	-7.9
Central & North West London	-3.4	6	-2.54
Total Surplus	-10.627		53.21

The table shows that North West London Hospitals and Ealing hospital have large deficits that have been resolved by a rapid merger and short-term support from the NHS centrally. This route is also being taken for West Middlesex and Chelsea & Westminster hospitals, with a merger planned for 2015.

While the business case for SHF has yet to be agreed, and has been outstanding for some time, implementation of closures of acute capacity and mergers of trusts have proceeded at a rapid pace.

It is not clear whether the savings programmes (QIPP) of providers and commissioners have succeeded in making the necessary savings even without recourse to the closures that have been proposed by the SHF programme. As the information becomes available, we intend to present the current position and will attempt to identify how much of the supposed savings from reconfiguration will add to those already achieved through QIPP efficiency savings.

Finally, the inability of the SHF programme to present a business case that can fulfil the function of a Strategic Outline Case of sufficient quality and integrity to be assured of being passed is of concern. While a certain amount of slippage is expected it is not surprising that both NHS England and local councils have organised reviews at this stage. In our view the DMBC and the subsequent reports of progress to the JHOSC suggest that substantial progress should have been achieved by now; both in developing and securing agreement to Investment Business Cases to develop acute services, and, to achieve change in OOH services designed to achieve real reductions in demand and expenditure in the acute sector.

To assess actual progress against these plans is difficult without access to the latest information from the SHF team, but it should be noted that as of early December 2014 there have been no investment-making OBCs presented or approved for the major hospitals (although Northwick Park proceeded with a £21 million scheme for its A&E department); nor is it clear whether the necessary investments or progress in implementing and achieving better outcomes in OOH care have been made.

The Board papers of Imperial Hospitals NHS Trust make the following reference to progress on presenting business cases (Report of Chief Executive, Imperial Trust 26 November 2014),

> *The Investment Making Business Case (IMBC) is the sector wide response of healthcare organisations in North West London to the delivery of the Shaping a Healthier Future (SaHF) programme. North West London CCGs are in the process of considering the overall IMBC for all capital developments under SaHF. The IMBC is then due to go to NHS England and Trust Development Authority for consideration in December. Some more detailed building design work is now underway with clinical leads on St Mary's estate proposals, but more clarity needs to be established on the Charing Cross clinical vision. The majority of building design and development work for all sites will need to wait until a decision is made on our outline business case.*

Key documents required to assess the progress of SHF have yet to be produced although their publication is said to be imminent –the release of the business cases for hospital reconfigurations and the latest success in implementing plans for achieving change in OOH services impacting on acute demand.

We are concerned that there is no local involvement or engagement of local authority, community or patient representatives in any of this. All of the decision-making process is held in secret with the public reduced to consumers of propaganda surrounding the programme.

5 CRITIQUE

We are developing a separate section providing our own critique but feel we should hold back on giving any views until the Commission is underway.

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Seán Boyle & Roger Steer
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