SUMMARY
A Critique of ‘Shaping a Healthier Future’

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For the North West London Commission on Health

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Introduction

1. SaHF is an NHS centrally-run programme the stated aim of which is to improve the quality and safety of care in North West London while putting the financial status of the NHS in that region on a sustainable footing in the long run.
2. SaHF has laid out a programme to achieve this that would result in the closure of four out of the nine acute hospital sites in the area. While some NHS activity will be retained on these sites, they will no longer deliver acute health care; A&E, maternity and paediatric care will not be available on these sites; and much of the buildings and land will be sold off.
3. The SaHF programme in our view was a preconceived solution that was imposed on the North West London health system without there being any clear problem that it was designed to solve.
4. In particular there was no proper assessment of the needs of the whole area to which the health and social care system would respond.
5. The financial position in the region is relatively stable, and could be regarded as sustainable in the near future, particularly if the NHS as a whole begins to see a non-zero growth in resources.

The evidence

6. We have examined the arguments put forward by SaHF and we find these deficient in almost all aspects:

    - The evidence supporting the reduction from nine to five sites based as it is on an association between numbers of sites, numbers of staff, and quality and safety of care is deeply flawed and certainly has no basis in the literature.
    - Instead SaHF has relied on a set of clinical standards developed by the London NHS, and although North West London might aspire to these standards, there is no basis in evidence for insisting upon them, and no basis to the claim that a failure to adhere to them has or will result in additional deaths or poorer outcomes for patients. We would expect to see these arguments balanced by mortality and quality considerations associated with poorer access to emergency services, but SaHF has not taken account of these.
    - The evidence behind assumed reductions in demand for acute capacity that would allow the closure of sites and replacement by less capacity on the remaining sites is deeply flawed, failing as it does to take proper account of population growth, increased acuity of illness within that population, and being dependent on ill-founded assumptions about the impact OOH services would have on acute demand, and on the LOS of acute patients in the remaining hospitals.
    - Moreover, based on our limited access to the models behind the SaHF recommendations, and without independent scrutiny of the activity and cost assumptions underlying the business case, we

have no confidence that the capacity and cost projections presented in published business cases can be relied upon. The modelling of activity and finances needs to be submitted to independent scrutiny so that local people can be reassured they are accurate and reasonable.

- OOH services are intended to play a key role in reducing acute demand but this takes no account of the substantial literature in this area that suggests this is unlikely to be the case, and moreover that it is unlikely to be cost-saving; the SaHF analysis fails to draw out the connections in a detailed way that would give any credibility to claims that demand will fall and hence acute capacity can be reduced.
- Similarly, the evidence on the impact of better primary care and OOH services on demand for A&E services is flawed.
- The financial case relied on projections of a £1 billion deficit emerging by 2015 if something urgent was not done. In fact the financial pressures have been managed without recourse to massive reconfiguration and options other than reconfiguration existed, and still exist, that would balance budgets.

7. The business case was incomplete at the time of consultation with the public, incomplete when it was reviewed by other 'independent bodies', eg IRP, OGC, and incomplete when it was agreed by the Secretary of State: it remains incomplete.
8. The capital costs associated with the programme were underestimated and have continued to increase with each iteration of the business case process with the current estimated cost of the programme at £1 billion; it is unlikely that the SaHF programme as a whole would be affordable or deliverable: the revenue impact of the extra capital costs are likely to have eliminated any financial savings, which were estimated at £42 million.

The process

9. The governance and legitimacy of the SaHF programme is flawed. SaHF has continued to operate in a top-down style as if it were a central planning body with the ability to make decisions with little recourse to the community it serves, and seemingly on behalf of other NHS bodies.
10. The closure of Central Middlesex A&E was agreed prior to the overall programme being put to the public in 2012; making this decision without public consultation flies in the face of legislation and should have been challenged vigorously at the time.
11. The reduction from nine to five acute sites was presented as a fait accompli with no evidence for this change, nor any detailed model to indicate what the impact would be, and the assumptions underlying this analysis.
12. No attention was paid to solutions other than the closure of acute services to attain the programme's aims of improved quality at a lower

cost; in clear breach of Treasury guidance, a ‘do minimum’ solution has been discounted without being examined.

13. SaHF failed to give adequate weight to access to care for local populations especially those from disadvantaged groups; the effect of the proposed closures of services on the safety and quality of care and on the health of these local populations has been ignored in the SaHF process and therefore invalidates the whole process.

14. The SaHF programme has been taken forward in a piecemeal manner with no regard for the fact that if any agreement was reached it was for the overall architecture of change not just parts of it; this has resulted in the closure of A&E departments at Central Middlesex and Hammersmith hospitals without the changes in OOH services or improvements in primary care that might have justified those closures.

15. In addition, SaHF closed Central Middlesex and Hammersmith A&Es without giving due consideration to the views of local people; this unseemly haste was attributed to an urgent need for closure because it was claimed that these sites were unsafe and unable to recruit senior staff but no evidence was given of safety issues, nor of poorer outcomes; the closure is a result of the clinical standards adopted by SaHF. Clinical opinion should be supported by evidence: in this case it is not.

16. The recommendations – on what should be in place before any change was made – of two independent bodies (IRP and OGC) and of the Secretary of State, have not been followed by SaHF; nor it would seem by the Secretary of State who ignored his own recommendations and was instrumental in the closure of Central Middlesex and Hammersmith A&Es.

17. Although no formal decision to close Ealing maternity unit has been taken, SaHF has encouraged the transfer of staff and activity from that site which will eventually make it unsustainable.

18. The process applied by SaHF in producing an agreement to these closures failed to involve local people and organisations including local authorities; it was deeply flawed in the way in which critical content was presented. This continues to be the case as decisions are made behind closed doors, without due regard for the wishes of local people, and before business cases have been agreed.

Impact of closures so far

19. Finally we draw attention to the impact of the closures of the A&E units at Central Middlesex and Hammersmith hospitals.

20. There has been a significant deterioration in the performance of A&E services in North West London over the last three years; this has culminated in a rapid failure over the last six months so that from being one of the best in the country, this region is now one of the worst.

21. For local people this situation is made worse by the fact that SaHF leaders have continued to claim that there is nothing wrong with

performance, and that the system is performing well. These leaders should be held to account for this.

22. The North West London emergency system already operates an effective split between those people needing urgent care and those in need of emergency care; this has resulted in just one-third of so-called A&E attendances being to A&E departments. This in itself is probably a good thing but the abysmal failures of the emergency system in recent months imply there is a significant issue with delivery in the North West London and one that would only be exacerbated by further closures of acute sites.

23. In addition it has become clear that the development of OOH services is behind schedule, and moreover, there is no evidence that what is there is delivering reductions in demand for acute care of the level that is needed to justify the plans of the SaHF leaders. There is a need to develop OOH services but the evidence that this will be a more cost-effective way of delivering care than at acute sites is not supported by national studies – there are no local studies or analyses available – nor is there even evidence it will reduce acute demand.

24. There is universal agreement that primary care in the region is in desperate need of improvement but this still remains an issue. Now is the time to bring about these improvements, not to demolish the acute services that are meeting the needs of the population in the face of poor primary care responses, and certainly not before such improvements – independently audited – take place.

Recommendations

1. We recommend that the SaHF programme is abolished / suspended, thereby saving a considerable sum of money at one fell swoop.
2. We recommend that an independent review of the North West London health system is undertaken under the auspices of a joint health and local authority initiative that builds its case on a thorough assessment of the needs for health and social care of local populations, at local levels.
3. There must be no presumption that so-called ‘reconfiguration’ of acute services is the solution to what may not be a problem at all.
4. In addition there must be no presumption that the solution will involve a top-down approach across the whole area as SaHF assumed; there should be an openness to consideration of local solutions possibly at the borough level where these can be shown to work.
5. The NHS and local authorities must agree to work together to achieve a joint aim to provide good accessible health and social care to all local populations within a sustainable financial model.
6. We recommend that the attempt to close Ealing and Charing Cross hospitals is immediately stopped; that a guarantee is given to sustain acute health services on these sites – with no more double talk from NHS leaders – until the above review is complete and any associated

business cases are taken through to Full Business Case level, which is likely to be at least five years.

7. We recommend that in the light of current failures in the system in North West London there is an independent review of the emergency system under the auspices of the above joint health and local authority initiative; and that this as a matter of urgency examines the closure of Hammersmith and Central Middlesex A&E departments with a view to opening these, if that is what the review suggests is needed, and what local people want. Local people must be given honest and genuine choices; the opportunity cost of retaining these sites as A&Es must be made apparent.
8. We recommend that there is a review of primary care services in the region, and that following this review, immediate steps are taken to rectify any issues. However any investment must be based on a clear business case that relates costs and benefits to changes across the whole system.
9. Likewise we recommend that there is a review of OOH services in the region, to establish a clear case if it exists for OOH acting as a way of reducing demand for acute services, and also as a way of reducing total system costs. Following this review, any investment in OOH services must be based on a clear business case that relates costs and benefits to changes across the whole system.
10. In the case of changes that take place in primary care and OOH services as a result of the reviews outlined above, there must be a business case presented that makes a clear case for system-wide improvement arising out of these changes, and this should be consulted on with the relevant local populations; there should be no assumption that this is the population of the whole of North West London.