Michael Mansfield QC

Independent Healthcare Commission

for North West London

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London Borough of Hounslow

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Foreword

At the very core of any decent civil society is the imperative to ensure that the individuals and communities who make up that society have sustainable access to good quality healthcare.

The issue faced by those tasked with delivering this objective is, put at its simplest: "how can this be done?".

The response in North West London (seemingly flowing top down from government) came in the form of the "Shaping a Healthier Future" (SaHF) programme, a project of unprecedented size and scope, aimed at achieving a root and branch reconfiguration of all health services across eight diverse, densely populated London boroughs.

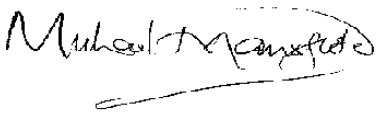
This Commission was set up, some two years into the implementation of that programme, to examine whether or not SaHF was, is,or can be, fit for purpose.

The findings of the Commission, set out in this report, demonstrate that the reforms, both proposed and implemented thus far, are deeply flawed. As a consequence there is no realistic prospect of achieving good quality accessible healthcare for all. Therefore, any further implementation is likely to exacerbate a deteriorating situation and should be halted immediately until the measures we recommend are carried out.

The impact of fragmentation through privatisation is slowly eroding what was a 'national health service '.

These questions are raised, not to decry the efforts of those who have undoubted commitment to the provision of healthcare across the region, but out of a desire to ensure that, through robust and evidence-based challenge, only those plans and initiatives that are genuinely able to meet the needs of this rapidly growing and changing area are pursued.

As Chair, It has been my privilege not only to read a wealth of information and evidence but to hear from a wide range of professional and lay interested parties. Their commitment to "getting this right" has been palpable throughout. I wish to express my sincere thanks to all those who have contributed to the work of the Commission, especially my fellow Commissioners, Peter Smith (Head of Policy and Strategy for LBHF), Katy Rensten (counsel to the Commission), and Marcia Willis Stewart (Birnberg Peirce, solicitors to the Commission).



Michael Mansfield QC
Chair of the Commission

Key Findings and Main Recommendations

Key Findings:

There is no completed, up-to-date business plan in place that sets out the case for delivering the Shaping a Healthier Future (SaHF) programme, demonstrating that the programme is affordable and deliverable.

There was limited and inadequate public consultation on the SaHF proposals and those proposals themselves did not provide an accurate view of the costs and risks to the people affected.

The escalating cost of the programme does not represent value for money and is a waste of precious public resources.

NHS facilities, delivering important public healthcare services, have been closed without adequate alternative provision being put in place.

The original business case seriously underestimated the increasing size of the population in North West London and fails to address the increasing need for services.

Main Recommendations:

The SaHF programme needs to be halted.

Local authorities should consider seeking a judicial review of the decision to implement the programme if it is not halted.

Executive Summary

Section 1: Current and future healthcare needs

It is clear to the Commission, from the evidence received, that there have been significant increases in actual population and in future population projections across the North West London region since the SaHF programme's Pre-consultation and Decision Making Business Cases were laid down in 2012 and early 2013. What is not clear, because we have not been given access to the documentation, is whether these changes have been accounted for in the current Business Case and what impact this has had on plans for the future of healthcare services in the region, especially where major new housing developments are being planned. Crucially, the SaHF proposals are not based on any robust needs assessment of the population that would give confidence in the proposed reduction in services.

Recommendation

1. The Commission recommends that the current Business Case is immediately made available for proper public scrutiny. This is the only way to ensure that the SaHF programme has taken full account of the current and projected population changes in North West London since 2012 and is soundly based on an up-to-date assessment of needs. The need for this is reinforced by the observations in the next section.

Section 2: Finance and economics

The SaHF programme is to cost the NHS £1billion to implement and the likely return on this investment is insufficient, based on the strength of the existing evidence. Although it is understood that the NHS must plan to ensure resources are used most economically, the expensive reconfiguration proposed is not the best way to make savings or to improve quality. The planned centralisation of hospital services does not appear to have been formulated on the basis of patient need. The evidence points to financial factors playing a significant, if not decisive, role in the SaHF programme's selection of major and local hospitals, to the detriment of the more deprived communities in North West London, which are also the communities with the most acute healthcare needs. Contrary to the tacit assurances of the SaHF consultation document (e.g. pages 8, 14, 18 and elsewhere), which profess a concern to address inequalities, cutbacks are being targeted on the most deprived communities as part of a plan for additional investment in central London.

If the information collated by the consultants acting for the Commission is borne out, it reveals that the much vaunted plans to create a sustainable health economy will actually cost far more than will be saved and reduce the quality of access and the delivery of services to local people.

The Commission is most disappointed and deeply concerned at the failure of the NHS witnesses to produce the Business Case. The lack of this document leaves a gaping hole in

the evidence. Without a published Business Case there can be no meaningful external scrutiny of the SaHF programme plans. The exclusion of local government from the development of this document is also of concern.

Recommendation

2. The Commission recommends that the National Audit Office undertakes a review of the value for money of the SaHF programme.

Section 3: Public consultation

There is clearly widespread concern and continuing criticism as to the public consultation exercise conducted in 2012. Witnesses representing a range of different interests and from a variety of backgrounds – clinicians, politicians, patients and residents – have all raised similar criticisms about the process and structure of the exercise, as well as how the results have been analysed and interpreted. We have heard from a Healthwatch body how the Independent Reconfiguration Panel's call for closer engagement with the public does not appear to be happening and yet the key NHS witness describes an extensive consultation process having occurred, with an outcome demonstrating resounding support for the programme. There is clearly a mismatch between the perception of the NHS as to how consultation has been managed and that of the many witnesses that have presented to the Commission on this issue over the four days of public hearings.

On a more fundamental point, the consultation that did take place in 2012 was on the basis of a Business Case that has now been very substantially changed, not least in the huge increase in the costs of implementing the scheme. With the plan not yet finalised, our consultants have been advised that the eventual cost is likely to be more than five times the original projection, questioning its affordability and viability. It seems from this that the case for a fresh, genuine consultation on what's now planned as part of SaHF is essential to secure public confidence.

Recommendation

3. The Commission calls for a fresh consultation on the latest version of the Business Case (referred to as the Investment Business Case in official guidance but as the Implementation Business Case by SaHF programme leads) as the programme has changed significantly since the Pre-consultation and Decision Making Business Cases were published. There should be extensive and uniform publicity across the region and a clear consultation document with appropriate translations of the full text as well as summaries made available in areas of high concentrations of BME communities.

Section 4: A&E closures and other reconfiguration plans

The evidence presented to the Commission, regarding A&E performance on waiting times over the course of the past year and more, clearly indicates the impact that the early closures of Hammersmith and Central Middlesex A&E departments have had on waiting times at other A&E departments across the region and, in particular, on Northwick Park Hospital. The fact that performance was poor elsewhere does not escape the fact that it was worst in North West London, particularly after September 2014 when the closures took place.

The NHS witnesses' denials, in the face of this evidence, that this is the case, is of concern to the Commission as it suggests a reluctance to accept that the modelling on expected patient movements, that was employed to inform the closure plans, was inaccurate. From the evidence heard, it is the Commission's view that this modelling failed to take account of service failures across the various levels of healthcare provision in the region, especially GP services, that has resulted in an increasing reliance on A&E services and an inability of those services to cope with the increased demand.

The selection of hospitals on which SaHF service closure plans are focussed, i.e. Hammersmith, Central Middlesex, Ealing and Charing Cross, whether by accident or design, are in areas of comparative deprivation when looked at next to the selected major hospitals, i.e. St. Marys, Chelsea and Westminster, West Middlesex, Northwick Park and Hillingdon. The residents that will be having to travel further for acute healthcare services are those who are most vulnerable and least able to afford travel costs. Invariably they are also the communities that exhibit the most acute healthcare needs.

The evidence heard by the Commission reveals widespread confusion among GPs, consultants and patients as to what an urgent care centre (UCC) can deliver in the way of services and who should be referred there. As a result of this confusion there is no consistency in referrals to UCCs, either self-referrals or clinical referrals. This confusion can lead to fatal consequences. The Commission concurs with the view of many expert witnesses that A&Es and UCCs, especially in London, should be co-located. In areas where this is no longer the case, i.e. the catchment for Hammersmith and Central Middlesex hospitals at present, there should be a co-ordinated and intensive education campaign to raise both public and professional awareness of which services can be provided at these UCCs, and which cannot safely be dealt with, so as to clarify what injuries or symptoms are appropriate for people to be referred or self refer to these centres. The guidance on A&E and UCCs due to be published by the Chief Medical Officer, Sir Bruce Keogh, remains outstanding amid continuing evidence of the breakdown of the existing system. This is not a stable environment for planning major change.

The Commission has been impressed by the evidence of the exemplary services provided at Ealing maternity unit. The specialist care that the unit clearly offered to a vulnerable and deprived client group has, from the

evidence of service users, immeasurable community benefits. In the view of the Commission, the costs on this community of the loss of the unit has not been adequately considered by the SaHF programme medical directors nor Ealing CCG.

Recommendations

4. In the light of these factors, and recommendations 1-3, it is imperative that there be no further implementation of SaHF in the following two principal respects:

    i) The Commission demands that there must be no further closures of any A&E departments in North West London. Ealing and Charing Cross hospitals must retain full 'blue light' A&E services for the foreseeable future;

    ii) The Commission calls for an equalities impact assessment to be carried out into the whole SaHF programme, with a particular focus on the communities that will be deprived of services at Ealing and Charing Cross hospitals, as it is clear to the Commission that the selection of these hospitals for service closures will adversely affect the more deprived BME communities in the region.

5. The Commission recommends that all UCCs in North West London should be co-located with A&E departments. Where this is no longer the case there should be an immediate and extensive publicity campaign mounted to raise awareness as to what such centres can provide and who should refer there.

6. The Commission recommends that the decision to close Ealing maternity unit should be reversed with immediate effect.

7. The Commission recommends that the A&E department at Central Middlesex Hospital should be re-opened to alleviate the burden on other A&Es, especially Northwick Park.

Section 5: Out-of-hospital provision

The evidence suggests that out-of-hospital provision is developing in a piecemeal fashion and at a very slow pace, largely due to the lack of any fixed or detailed plans, together with the complex procurement processes that GP commissioners are having to deal with. It is not yet clear how performance will be monitored and, therefore, how decisions about closing acute services will be made. The lack of any published outline business cases or any update on progress towards the promised new provision of services makes scrutiny of the out-of-hospital strategies impossible at this point in time.

The continuing absence of any business cases is particularly worrying in this case. Without this information it has been impossible to scrutinise plans across North West London. The Commission would like to see performance monitoring both at a local and North West London level. At present it

is not clear how success will be measured and, therefore, at what point it would be considered safe to close acute provision and rely on out-of-hospital provision.

As part of evidence gathering, each CCG provided the Commission with their Out-of-Hospital Strategy but these are CCG specific and there seems to be little in the way of a sub-regional strategy. There is also concern that there is little understanding of how performance of out-of-hospital services will be measured, either locally or sub-regionally, and, therefore, how they will be judged effective enough to support patients in the absence of services that are being closed as part of the SaHF reconfiguration. The success of hospital reconfiguration is dependent on a safe and reliable out-of-hospital strategy.

The evidence also reveals a developing crisis in the delivery of GP services, that are clearly failing to meet demand across the region, contributing to the crisis in A&E performance. Without adequate GP services, none of the SaHF proposals are capable of implementation.

The cuts in social care provision, imposed as a result of central government spending cuts since 2010, have compounded the problems of excess demand on the acute services, with patient discharge being affected by a lack of bedspaces in care homes and/or a lack of domiciliary care. Various witnesses have referred to significant reductions in social workers in post over recent years. This reduction in social care creates bed-blocking and a resulting logjam in patient intake.

Recommendations

8. The Commission calls for a substantial investment in GP and out-of-hospital services, which are clearly overwhelmed and inconsistent, to meet the additional demands of more vulnerable patients, and a recruitment drive for additional GPs and primary care staff.

9. The Commission calls for a sub-regional out-of-hospital strategy to be produced with clear metrics and targets setting out at what level such services will be considered sufficiently successful to allow for further reconfiguration.

10. The Commission notes that levels of spending on social care in North West London and elsewhere have been hit by ill-conceived central government policies, but recommends that social care budgets are increased and protected to maintain patient flows from hospital to domiciliary and residential care.

Section 6: Governance and scrutiny

There is a lack of transparency in the governance arrangements for the SaHF programme. There needs to be clearer accountability for decision-making across the whole programme. There has been no direct engagement of local authorities in their wider community leadership role, nor sufficient engagement with adult social care departments about the sub-regional agenda,

beyond the borough level mechanisms, despite the impact of these changes on adult social care practices.

The scrutiny role of Healthwatch bodies needs to be clarified as the organisations are, themselves, unclear as to exactly what their role is in challenging the programme.

The role of Patient Participation Groups (PPGs) might also be clarified as there appears to be some uncertainty around confidentiality issues, especially when patient representatives are involved in procurement processes.

Recommendations

11. The Commission recommends that elected local authority representatives be invited to attend SaHF Programme Board meetings to give greater public accountability and transparency.

12. The Commission recommends that NHS England issues up to date guidance to CCGs and Healthwatch England as to the exact scrutiny role of Healthwatch bodies and Patient Participation Groups in all matters of commissioning and service reconfiguration.

Postscript:

The Commission delayed publication of this report, on the promise of additional information from NHS England's London office, but were disappointed to find that the documentation provided did not answer any of the outstanding questions raised in this report. The Commission has still not been given sight of a completed final Business Plan for a project which, according to current NHS estimates, has now ballooned in cost to £1.3 billion.

Introduction

In 2012 the NHS consulted on proposals to make significant changes to the healthcare economy of North West London, set out under the heading "Shaping a Healthier Future". This involved the downgrading of several hospitals across North West London to "local" hospitals without A&E provision, closure of acute provision and reduction or downgrading of specific services. It also promised commitments to investment in capacity of out-of-hospital, GP and community services in order to offset reductions in acute provision.

Two years into the implementation of "Shaping a Healthier Future", Brent, Ealing, Hammersmith & Fulham and Hounslow Councils (later joined by Harrow Council) set up an independent commission of inquiry to review the programme, in particular: the impact of reductions to acute provision on the North West London population; the extent of progress with investment in capacity and capability of community and out-of-hospital services to meet local needs, and; the extent to which demand for acute services has changed as a result of those investments. The Independent Healthcare Commission for North West London was launched on 1st December 2014.

The Commission's brief

The Commission's terms of reference were agreed at its first meeting on 10 January 2015. It was recognised that, given the speed with which widespread far reaching Government proposals were being implemented, there was a clear and urgent requirement to focus and identify basic principles. Within these it was imperative to prioritise those areas of significance where change was either underway or imminent.

First principles of analysis entail the identification of the constituents of healthcare which are then developed on a firm evidence base.

The specific terms of reference set for the Commission were to identify:

1. The nature of each of the boroughs with particular regard to the citizens who form the contemporary patient constituency;

2. The current principal medical needs of this community;

3. The means by which these needs are presently being met;

4. Whether these are the best attainable means;

5. What resources are required to sustain the best attainable means;

6. The extent to which the government's 2012 plan,

   (a) in inception,

   (b) subsequent implementation, and

   (c) intended development in 2015,satisfies the 'best attainable means' test.

Over the course of the first six months of 2015, the Commission conducted an independent, evidence-based evaluation of what was set out under "Shaping a Healthier Future" in terms of commitments to investments in out-of-hospital and community services, as well as proposed changes to acute services, and has investigated the extent to which the proposals on which the public were consulted have been and will be delivered. This report is the result of that evaluation.

Evidence submissions and witness statements

The first call for written evidence was issued on 16th December 2014. By June 2015, a total of almost 150 written evidence submissions had been received by the Commission and these have all been published on the following webpage: www.lbhf.gov.uk/healthcarecommission

Given the sheer number of general practitioners practicing across the region, there was a surprisingly small number of responses received from GPs. Not counting the written evidence submitted from the Clinical Commissioning Group (CCG) chairs, only four other practicing GPs submitted evidence and one of these requested anonymity. This very low level of response may be partly due to the debilitating workload that most GPs are facing at the present time – there are no spare hours in their day to draft witness statements – but anecdotal evidence suggests that many in the field are reluctant to 'rock the boat' and feel intimidated by the all-powerful CCGs. Among the profession there appears to be a reluctance to stick one's head above the parapet.

In addition it seems that few, if any, GPs outside of the limited number holding leading positions in the CCGs were ever made fully aware of the SaHF plans or the role of GPs in the proposed new system – or asked their views. Only in Ealing does the CCG appear to have conducted a (practice-based) poll of GP views – one of which (opposing the closure of services at Ealing Hospital) has been largely ignored.

Anne Drinkell, Secretary of Save Our Hospitals (SOH), submitted anonymous evidence from an emergency nurse practitioner and an employee of Imperial College Healthcare NHS Trust and she told the Commission that they had sought to submit their statements anonymously as they feared for their jobs if their identities were revealed. This anxiety is of concern to the Commission in the aftermath of the Francis Report, which drew particular attention to the need to ensure a safe environment for whistleblowing.

Ms Drinkell, in her evidence to the Commission, talked about a disconnect between the leadership and clinicians on the ground and recounted a discussion she had had with a GP just the day before who had expressed a desire to attend the public hearing but was too worried about the consequences and didn't believe that anything could be changed. We were told that Save Our Hospitals has a mailing list reaching 500 people, of whom about 40 are GPs, hospital doctors and consultants.

Ms Drinkell assured us that those clinicians had been made well aware of the Commission's existence and SOH had tried to get them to submit evidence but that "there is a real culture of nervousness about getting involved."

We are told, by the CCGs, that the SaHF programme is clinically-led and has the support and backing of health professionals but the evidence for that is in very short supply. What we would like to see is an open but anonymous survey of all health professionals across the region to gauge the true perceptions of those who work most closely with patients.

National context: impact of the Health and Social Care Act 2012

Professor Allyson Pollock, from Queen Mary University of London, in her evidence to the Commission, defined two key aspects of the Health and Social Care Act 2012 that she believes are integral to the changes that are taking place in the NHS today: firstly, the abolition of the duty on the Secretary of State to provide listed services throughout England and, secondly, the entrenching of contracting.

CCGs have been left with a duty to promote health services but there is no longer a duty to provide those services, as there had been a duty incumbent on the Secretary of State and area based health services since 1948. That duty has now been totally abolished by the 2012 Act. As Professor Pollock stated in her evidence:

"There is no duty to provide. They (CCGs) have a duty to arrange, which is contracting those services, and an overarching framework duty of a duty to promote."

Further evidence, provided by the Commission's consultants, identified dysfunctional relationships between the intermediate bodies newly created and ineffective tendering arrangements. Our conclusion is that the system newly created is wrong in principle and not working in practice, yet somehow it is no one's responsibility to put the problems right.

Consultants' interim report

At the beginning of the process we commissioned consultants to review the existing evidence, including all available documents pertaining to SaHF, and to interview key decision-makers and members of the SaHF Programme Board and then to report to us on their findings. This they did in March 2015 and both the summary and full report are published online at www.lbhf.gov.uk/healthcarecommission. This report provided a basis of evidence for us in constructing questions for the witness sessions.

Oral evidence hearings

We conducted four full day hearings, held in public, at four town halls across the region. Invited to give oral evidence at those hearings were local politicians, the Royal Colleges and other national bodies, the clinical commissioning groups, NHS trusts, independent experts, clinicians, other health professionals, patients, service users and local residents.

In March we heard from 16 witnesses at Hammersmith Town Hall, 14 witnesses at Ealing and 10 witnesses at Hounslow Civic Centre and, at the final hearing in May, we heard from another 16 witnesses in Brent. Those 56 witnesses included two MPs, 12 local councillors, three Royal Colleges, 10 clinicians, 20 patients/service users but only three CCG representatives and only one NHS trust representative. The lack of NHS engagement with the Commission has been a grave disappointment.

The chairs of the eight CCGs, the chief executives of the four NHS trusts and the chief officer of the SaHF programme were all invited to give oral evidence to the Commission at any of the four hearings but only four of those 13 key witnesses attended a hearing. The Commission got the distinct impression that there is a siege mentality developing across the North West London CCGs.

The proximity of the public hearings to the general election may explain the refusal of the NHS representatives to give evidence at any of the three March hearings and it may also explain the recruitment of a media consultant to act as an intermediary in all communications between the Commission and all NHS bodies from February onwards. What it does not explain, however, is why only a third of the NHS representatives, invited to give evidence at the hearings, were able to attend the final hearing on 9 May, which was post-election.

Full trancripts of the four evidence hearings, along with video recordings of the witnesses giving their evidence, can be found via the following link: www.lbhf.gov.uk/healthcarecommission. Also published there is correspondence between the Commission and the NHS.

Section 1:
Current and Future Healthcare Needs in North West London

1.1 The SaHF programme was drawn up using retrospective figures on population and demographic changes, three years ago, at a time of considerable population growth in London and England as a whole. Subsequently a number of decisions have been taken on new housing developments, changing the reality substantially – yet with no sight of the draft Business Case we have no evidence that these changes have been taken on board and service provision tailored to population needs. Concerns that the SaHF programme is out of touch with demographics are underlined by the haste to close the maternity services at Ealing Hospital.

"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 out-of-hospital services would have on acute demand…"

Consultants' interim report

Population estimates and future projections

1.2 London generally and West London in particular has increased its population since the mid eighties (London from 6.5 million to 8.5 million) and this increase is projected to continue. What has not happened is a commensurate increase in resources to match this increase in demand.

1.3 Evidence from Brent, Ealing and Hammersmith and Fulham Councils reveal a number of planned housing developments that will substantially increase local population figures in those boroughs. The largest known development is planned for Old Oak Common, which both Brent and Hammersmith and Fulham Council have confirmed in written and oral evidence as estimated at 24,000 additional homes, a likely population increase of at least 70,000 people. The Hammersmith and Fulham Council Leader, Cllr Stephen Cowan, also highlighted a planned development in Earls Court that is likely to add a further 10,000 to the population of the area and further developments that may arise from the sinking of the A4 flyover in Hammersmith. Both Brent and H&F council leaders are clear that these developments have not been taken into account by the SaHF plans, as they were not known about in 2012.

1.4 Professor Ursula Gallagher, Director of Quality and Patient Safety for Brent, Harrow and Hillingdon CCGs,

in her evidence to the Commission, accepted that 24,000 new homes at Old Oak Common would have a major impact on the SaHF programme plans. Professor Gallagher stated that the SaHF programme is "quite a long term programme and, therefore, it needs to be constantly refreshed as new information, both about clinical evidence and population, comes on stream which could include population growth linked to developments". She was unsure, however, whether the current draft Business Case has taken account of the latest data on new developments and population projections.

1.5 The Leader of Ealing Council, Cllr Julian Bell, highlighted the apparent existence of a 'shadow' population in Ealing, where the Office for National Statistics (ONS) estimates the population at 350,000 but 405,000 people are registered with GPs. The Chair of Ealing CCG, Dr Mohini Parmar, in her evidence to the Commission, acknowledged the discrepancy between the ONS population data and the numbers appearing on the GP registered list in Ealing.

1.6 Cllr Bell noted that the population projection to 2031 in Ealing is an increase of 9% in total population but an increase of 30% in over 65s. He also alerted the Commission to the plans for 4000 new homes in the Southall Gasworks development alone over the next 15 years. The Leader of Hounslow Council, Cllr Steve Curran, also made reference to "a huge population increase" in Hounslow.

1.7 Tomas Rosenbaum, a consultant urologist at Ealing Hospital, gave further evidence of an apparent underestimation of the population size that is receiving services from Ealing Hospital. Mr Rosenbaum gave evidence of a large peripatetic population in the Southall area that does not appear to have been counted in official population figures.

1.8 Dr Onkar Sahota, Chair of the GLA Health Committee, London Assembly Member for Ealing and Hillingdon and an Ealing GP, with practices in Hanwell and Southall, came to the Commission with a valuable range of both regional and local experience and expertise. On the issue of population projections and healthcare provision in London, Dr Sahota stated:

"I think that the premise that these calculations are based upon may be inaccurate. We were all surprised at how rapidly the population of London is increasing. By 2025 the population of London will be nine million. By 2035 the population of London will be ten million. London is a city growing very rapidly. We are being stretched in terms of our education system, public transport and hospitals."

Changing health needs and deprived communities

1.9 Jonathan Ramsey, of the Royal College of Surgeons, highlighted the "increased demand for level 2 and level 3 care… also known as high dependency HDU and intensive care". His explanation for this was the combination of an ageing population and improved surgical techniques meaning more operations are being performed.

1.10 Dr Onkar Sahota stated:

"I think that patients are getting much more ill, they have more specific needs, and what we need to do is a huge investment in primary care in community services if you ever want to think about closing your hospitals down. On the current model it does not operate at all and you would not be delivering care to the patients."

1.11 Tomas Rosenbaum highlighted the "much higher than average level of cardio-vascular disease and of certain infectious diseases and of metabolic syndrome" of Southall residents using Ealing Hospital.

1.12 The Leader of Brent Council, Cllr Muhammed Butt, referred to Stonebridge, Harlesden and Kensall Green as some of the most economically deprived areas of the borough with, also, some of the most acute healthcare needs. Both Cllr Butt and Cllr Krupesh Hirani, Brent Council's Cabinet Member for Adults, Health and Wellbeing, criticised the closures of Central Middlesex and Hammersmith Hospital A&E departments as having forced deprived communities with greater healthcare needs to travel longer distances to access A&E services at Northwick Park Hospital.

Conclusion

1.13 It is clear to the Commission, from the evidence received, that there have been significant increases in actual population and in future population projections across the North West London region since the SaHF programme's Pre-consultation and Decision Making Business Cases were laid down in 2012 and early 2013. What is not clear, because we have not been given access to the documentation, is whether these changes have been accounted for in the Business Case and what impact this has had on plans for the future of healthcare services in the region, especially where major new housing developments are being planned. Crucially, the SaHF proposals are not based on any robust needs assessment of the population that would give confidence in the proposed reduction in services.

Recommendation 1:

The Commission recommends that the current Business Case is immediately made available for proper public scrutiny. This is the only way to ensure

that the SaHF programme has taken full account of the current and projected population changes in North West London since 2012 and is soundly based on an up-to-date assessment of needs. The need for this is reinforced by the observations in the next section.

Section 2:
Finance and Economics

2.1 SaHF originated in plans led by NHS London, drawn up by McKinsey. Primary Care Trusts (PCTs) in London were grouped into five "clusters" (North West, North Central, North East, South East and South West) with orders to find ways to meet the expected financial pressures on health economies of the 2008-9 banking crash and the likely freeze on spending from 2010, after the ten years of above inflation increases in NHS budgets had come to an end. NHS London declared that the capital's PCTs were expected to deliver savings of £5 billion – and North West London represents 24% of London's health budget. The projections of the "cash gap" these savings were designed to bridge, now appear to have been inaccurate as budgets have been more or less balanced up to 2015.

2.2 The SaHF programme was always intended to be a cost-saving plan. However, it has now gone from a plan aiming to generate £1 billion of savings to one requiring £1 billion of capital investment – only a small proportion of which could be generated from sales of land assets from the closure of services at Ealing and Charing Cross hospitals. This questions the extent to which the proposals have ever been genuinely "clinically-led," rather than attempts by a minority of clinicians, engaged in PCTs and later CCGs (along with McKinsey and other management consultants), to cope with financial problems.

2.3 Various documents from NHS North West London (the cluster of PCTs prior to the creation of CCGs) confirm that the North West London target for "efficiency savings", to meet rising pressures on health services with near zero real terms increases in NHS budgets, was £1 billion over five years (compared with a budget of £3.4bn)[1]. The savings were to come from reductions in staff, closed beds and in hospital care (tacitly assuming that any alternative services would be cheaper and require fewer clinical staff). But the 2012-15 NHS North West London Commissioning Strategy Plan (Part B: page 163) also carried a table setting out the planned reduction in North West London's NHS workforce needed to generate the required savings, with an overall planned reduction of 13.8% of staff (5,630 posts), more than 70% of these posts to be clinical.

2.4 The following table summarises the projected costs, as set out in the Pre-consultation Business Case (PCBC), the Decision Making Business Case (DMBC) and the latest estimates, as reported by the Commission's consultants.

[1] The figure appeared in the **2012-15 NHS NWL Commissioning Strategy Plan** (Part A: page 9), in the 2012-13 NHS NWL Commissioning Intentions (page 5), the **NHS NW London Operating Plan 2012-13** ("Deliver £1bn of financial savings by 2014/15 to achieve financial balance," page 5) and again in the **Decision Making Business Case** (published after the consultation) (Volume 3, Edition 1: p 163). Many of these documents were signed off by the same people leading SaHF and the CCGs now

Summary of costs and benefits of SaHF proposals			
	PCBC £million	DMBC £milllion	Latest estimates £million
Capital investment	112	206	1,000
Revenue cost OOH	84	190	250
Savings NPV (20-yr)	271	114	Not known
Savings per annum over 'Do nothing'	55	42	-38
Cost of quality improvements	17	17	17

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

2.5 Although these are the real underpinning assumptions to the SaHF plan, there has never been any equivalent detailed plan for the scale, location and scope of any services to replace the hospital provision. This is particularly worrying as the success of hospital reconfiguration is directly dependent on stable and safe out-of-hospital services. The financial pressure was presented differently for public consumption in the SaHF consultation document, which argued:

"…keeping up with new technology and better treatments and managing the health needs of a population that is getting older means that the NHS needs to find an extra £20 billion a year by 2015. In NW London we estimated that by 2014/2015 we would need an extra £1 billion a year.

"However, we already know that there isn't anywhere near this amount of money available. We have to find savings of at least 4% a year – something which has never been done by the NHS before…" (SaHF consultation document, p17)

2.6 The SaHF document denied that these financial pressures were the main drivers of change, but could not avoid the issue completely:

"It would be wrong to say the NHS, and these proposed changes, are driven mainly by the need to save money. We are actually first and foremost driven by the challenge of delivering high-quality care. But money is an important consideration." (SaHF consultation document, p17)

2.7 However, far from saving up to £1 billion, the SaHF process will have, by our own consultants' estimate (Interim Report, pp52-53), incurred "programme costs" of over £235 million – including at least £35 million for management consultants, while still having not, as yet, produced a final Business Case. For £235 million it is possible to build a new hospital, or fund several thousand nursing or other clinical staff to improve services. Instead SaHF is driving the closure of hospital services with no clear plans for any replacement health care.

Influence of PFI hospitals on the reconfiguration plans

2.8 Cllr Julian Bell, in his evidence to the Commission, highlighted the impact on the SaHF programme of the existence of hospitals that have been built or redeveloped with investment from a private finance initiative (PFI) arrangement. Both Central Middlesex and West Middlesex hospitals are PFI-funded hospitals but Cllr Bell's evidence pointed to the latter as having had the greatest impact on decisions affecting Ealing Hospital. He stated that once "Ealing was twinned with West Middlesex, that…because the financial problem that West Middlesex had with its PFI was driving the whole process… it was inconceivable for West Middlesex not to be the major hospital and for Ealing to lose out and just be a local hospital."

2.9 Mrs Judy Breens, an Ealing resident, also raised the question of what impact PFI hospitals have had on the selection of major hospitals under the reconfiguration plans. She suggested, in her oral evidence to the Ealing hearing, that Ealing and Charing Cross hospitals, being wholly owned by the hospital trusts, offer better scope and better return on land sales than those hospitals which have private investors involved.

2.10 Our consultants drew attention to the fact that Ealing Hospital is the most efficient hospital site in London (Consultants' Interim Report, p75). Charing Cross is acknowledged to hold the leading specialist stroke unit in the country. It is paradoxical that the most efficient site and most successful service are both to be more or less closed so that new PFI hospitals can be constructed in central London.

Costs of reorganisation and devolved commissioning

2.11 Dr Onkar Sahota, in his evidence to the Commission, was highly critical of the financial aspects of the NHS reorganisation programme arising from the coalition government's Health & Social Care Act. He stated that:

"We certainly do not think that spending £3 billion for a top-down reorganisation that no one wanted and no one needed has helped the NHS at all."

2.12 In a criticism of devolved commissioning arrangements he stated:

"We have got GPs now, and I speak as a GP, sitting across the various CCGs looking at contractual arrangements, they have been taken out of consulting rooms, they are sitting now in CCGs and do you know these poor doctors are so busy with their day job looking after patient care."

2.13 Dr Sahota referred to a query raised by Stephen Dorrell, Chair of the Parliamentary Select Committee on Health, as to the transactional costs of the NHS, i.e. monitoring and setting up contracts, and stated:

"The answer is about 10-11% of the NHS budget is spent on negotiating contracts, monitoring contracts, seeing whether the contracts are being put out. Local GPs in Ealing had to set up a federation because the local CCG is required to tender out contracts…they waste their time."

2.14 As well as GP commissioning taking up a lot of time that might otherwise be spent in clinical practice, the Commission also heard evidence with regard to the experience and expertise of CCG commissioning boards. Phillip Brownley Eldridge is a resident of Isleworth and was a patient representative on the Hounslow CCG. In this role he was invited to participate in a number of procurement panels, including co-commissioning panels with other CCGs. In his evidence to the Commission he was highly critical of the expertise and experience of the CCG panel members in procurement and tendering, giving examples of panels being unfamiliar with TUPE regulations and of failing to examine the past performance of bidding organisations.

2.15 Peter Latham, Chair of Willesden Patient Participation Group, gave evidence to the Commission of a recent failed procurement exercise for out-of-hospital musculoskeletal and gynaecology services in Brent. Mr Latham's evidence, reciting information provided to him by the senior responsible officer, revealed two main reasons why Brent CCG discontinued the Wave 2 musculoskeletal and gynaecology procurement halfway through the bidding process:

"The Mott MacDonald impact assessment was that, of the £9 million for those groups of outpatient consultants, about £4 million was still going to have to go to the secondary hospitals because the draft specifications for both gynaecology and musculoskeletal had a whole list of expected conditions which were going to have to go to the secondary hospital in any event", and;

"On examining the Bedfordshire musculoskeletal project, that has been put in place contracted to Circle Healthcare, they ran into serious difficulties…because of competition with the local hospital (leading to) GPs continuing to refer to the secondary hospital (meaning that) in Bedfordshire the CCG is paying twice over".

2.16 Robin Sharp CB, Chair of Kilburn Patient Participation Group added:

"On the whole we think it is right that the CCG has now abandoned this procurement but it is after huge expenditure of time, money and involvement of outside experts and the patient volunteers."

2.17 These criticisms confirm the findings of our consultants (Consultants Interim Report, p84) of the difficulties the CCGs and various NHS and public bodies have had in managing this process which is now proceeding without a formal approved plan, an agreed budget or confidence that the changes designed to reduce acute demand are deliverable: a recipe for disaster.

Centralisation of hospital services

2.18 We heard a range of views on the pros and cons of centralisation of hospital services. One doctor, Dr K, who had formerly worked at Ealing Hospital and has since been studying health economics, referred to evidence from the US and elsewhere that suggests that the best number of beds that hospitals should run on is 300. She stated that:

"When you merge hospitals that is a bad idea because then you get inefficiency and it is inequitable so you have both problems running side by side."

2.19 An alternative view was expressed by Dr Julian Redhead, Chair of the London Board of the Royal College of Emergency Medicine (RCEM) and an A&E consultant who stated that for a small proportion of the emergency hospital caseload, patients benefit from referral to more specialist hospitals, even at further distance:

"We have a very good evidence base now around services of trauma, hyper-acute stroke and cardiac that you improve outcomes and save patients' lives by ensuring that the patient gets to the correct hospital with the right backup services in the fastest possible time. The previous system of taking patients to the local or the closest hospital did not have the same benefits to patients as taking them to a hospital which has the set-up and ability to deal with the care that they require."

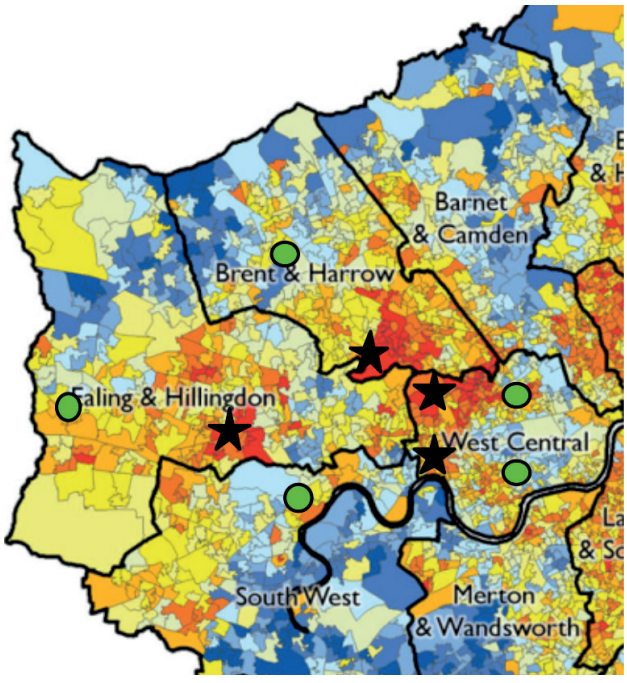
2.20 However, the SAHF team has shown no evidence to prove that similar benefit can be found for the remaining 95% of emergency patients by transporting them further for care.

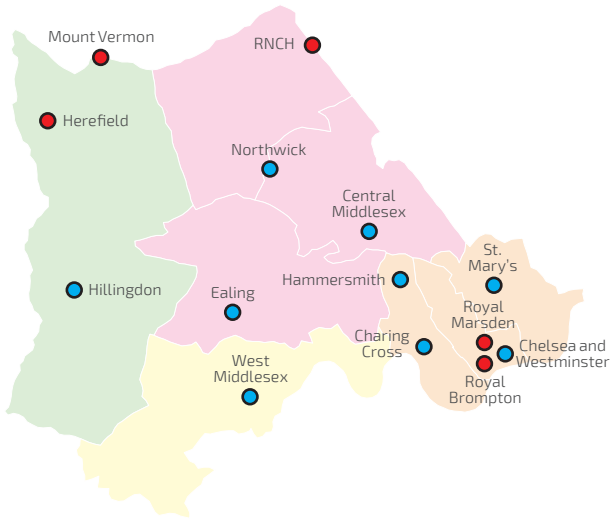
2.21 Professor Clara Lowy, a retired consultant physician from St Thomas's Hospital, was clear in her evidence to the Commission that consultants' private practice is highly influential in where hospital services are centralised, with a focus on central London and wealthier areas.

2.22 Dr Gurjinder Singh Sandhu, a consultant in infectious diseases and acute medicine at Ealing Hospital, provided the Commission with a map, previously submitted to the Independent Reconfiguration Panel, that superimposed SaHF emergency department closure plans over areas of deprivation (see over page). This clearly shows that the hospitals where service closures have occurred or are planned are located in areas of high deprivation.

2.23 Dr Sandhu stated in his oral evidence:

"The emergency departments in Southall, Harlesden and Acton are set to close whilst the emergency departments in Chelsea, Paddington and Harrow are set to stay open. As Dr K has also said earlier on, there is evidence from the US that emergency departments were closed primarily in Medicaid areas, black minority ethnic areas and areas where you needed a safety net for a core of patients."





Impact of land asset sales

2.24 A number of witnesses alluded to NHS trust proposals to sell off land for development purposes where hospitals are to be downgraded, most specifically at Charing Cross and Ealing Hospitals. Cllr Mel Collins, Chair of the Joint Health Overview and Scrutiny Committee for North West London (JHOSC), in his evidence to the Commission, stated:

"The JHOSC is particularly concerned about the loss of estate to the private sector…if the estate is lost to the private sector, it will never, ever come back and we believe that the case for selling off some of the estate on the various sites across the piece has not been properly thought out and whether it is possible to work in conjunction with our social care teams to make greater use of a linking up between health and social care on the same site."

Financing of emergency medicine

2.25 Dr Julian Redhead, Chair of the London Board of the Royal College of Emergency Medicine (RCEM), called for reform of the way in which emergency medicine is financed, arguing that the tariff system is not working:

> "The way that the NHS within secondary care is funded is through a tariff system so…, in a general sense, each patient that comes to your hospital carries a sum of money with them to pay for their care which comes from the CCG. The trouble is that these tariffs were set several years ago…(and) have not changed to reflect (changes to) those services so, therefore, it is very difficult for a trust to invest money in a department which is losing money for them in terms of the tariff that they receive for it."

2.26 Dr Redhead went on to say:

> "There is also the fact that, across the whole board of acute medicine the government set a target that said you should not increase your number of admissions over a threshold that was set about four or five years ago and they basically took a 70% tax away from the hospitals and you are only paid 30% of the tariff when you go over and above those thresholds of admissions. So the whole funding is very, very tricky in order to invest in your systems of emergency medicine."

2.27 This 30% of tariff is known as the marginal cap rate, with the 70% retained by the CCG for investment in out-of-hospital services. Tina Benson, Director of Operations at London North West Healthcare NHS Trust, suggested that this creates a "healthy tension" between hospital trusts and CCGs. Peter Latham, representing the Brent PPGs, however, suggested that this loss of revenue to hospital trusts, without a subsequent drop in attendance, must affect hospital staff morale as performance targets are missed. He also offered up evidence of possible conflicts of interest for GPs in commissioning services through CCGs and GP networks.

Cost of the SaHF programme

2.28 Colin Standfield, an Ealing resident, revealed to the Commission that, over a 10 month period in 2014, the SaHF programme had cost £13 million in consultancy fees alone. A subsequent Freedom of Information request revealed that the consultancy spend in just the past two years, from April 2013 to March 2015, has amounted to over £33 million. This is not the full picture as many millions more was spent on consultants, such as McKinsey, prior to 2013.

2.29 Dr Mark Spencer, Medical Director and clinical lead for the SaHF programme, was asked to explain some of the financial costs but declined to do so on the basis that he was not responsible for the financing of the programme. He stated that we could have invited the Finance Director to answer such questions. For the record, the Commission wishes it to be known that we invited Clare Parker, the SaHF Chief Officer and former Finance Director, to give evidence but the witnesses who attended the May hearing were selected by the NHS and Clare Parker was not put forward.

The Business Case

2.30 The Commission has expressed its concern, throughout the course of the public hearings, that the implementation of the SaHF programme has begun before the Business Case has been completed and made public. In his evidence to the Commission, Dr Mark Spencer stated that the Business Case is "in draft formation being informally discussed with the Department of Health and the Trust Development Agency". He explained the delay in completing this as:

"Because part of the recommendations from the Secretary of State was that further discussions should happen with the local population around Hammersmith and Ealing to help define what a local hospital would be on those sites. … There have been other delays around the merger with Ealing and Northwick Park Hospital as part of a separate process."

2.31 Dr Spencer stated that he has seen an early draft of the Business Case. In response to counsel's questioning, as to why the document can not be shared with the Commission, he stated that:

"It is an implementation plan designed by the CCGs but it is being shared with the Trust Development Agency and the Department of Health and they have given advice at this stage in its early development that it should not be shared."

2.32 Dr Spencer was unable to advise the Commission as to when the overall Business Case, or the outline business cases for the out-of-hospital provision within each CCG area, would be ready and available for scrutiny.

2.33 When asked to explain why the SaHF programme is being implemented before the Business Case is completed, Dr Spencer stated:

"Because that is the nature of planning within the NHS and Department of Health. The consultation was made on a pre-consultation business case where we had the outline financial analysis. Following that there is now a wider, more detailed business case that needs to be developed for each site."

2.34 Cllr Mel Collins, Chair of the JHOSC, in his evidence to the Commission, stated that he was "certainly not" satisfied with the explanations as to why the Business Case has not been provided:

"On Wednesday we go into the third year of this reconfiguration and so all of the financial business cases and the CCG cases ought to have been up and ready for examination and certainly the out-of-hospital services should be in place so that we can then examine what role the acute services are going to play."

2.35 Cllr Robert Freeman, of Kensington and Chelsea Council, when asked by the Chair of the Commission if he believed that the plan for out-of-hospital care was safe, stated:

"It could be safe but it is not safe and it can only be safe if we know how it is going to be implemented. You cannot have a plan unless that plan includes an implementation strategy and I do not believe we have that at the moment."

2.36 Carmel Cahill, Chair of Healthwatch Ealing, revealed in her evidence that she had seen a draft of the Business Case and that:

"The main area that we challenged was around the out-of-hospital developments which we did not feel were given enough prominence in the actual development of the business case when we saw it."

2.37 There is so much political capital invested in the programme that it has become impossible for anyone involved with SaHF to say that the plans don't add up anymore. But in public sector business investment cases, it isn't just a matter of the necessary public consultation having to be completed, it is ensuring the plans add up, are deliverable and will achieve the benefits claimed. That is what business cases are about and that is what is absent here. According to our analysis, in the absence of sight of any further documentation to the contrary, the plans are not compliant with the Treasury's guidance and are not likely to be. Revenue savings outlined in the public consultation have been overtaken by the additional capital costs of new hospital premises planned to replace the ones being demolished.

Conclusions

2.38 The SaHF programme is to cost the NHS £1 billion to implement and the likely return on this investment is insufficient, based on the strength of the existing evidence. Although it is understood that the NHS must plan to ensure resources are used most economically, the expensive reconfiguration proposed is not the best way to make savings or to improve quality. The planned centralisation of hospital services does not appear to have been formulated on the basis of patient need. The evidence points to financial factors playing a significant, if not decisive, role in the SaHF programme's selection of major and local hospitals, to the detriment of the more deprived communities in North West London, which are also the communities with the most acute healthcare needs. Contrary to the tacit assurances of the SaHF consultation document (e.g. pages 8, 14, 18 and elsewhere), which profess a concern to address inequalities, cutbacks are impacting on the most deprived communities as part of a plan for additional investment in central London.

2.39 The SaHF process has been driven by a misguided belief that substantial reductions in the demand for acute services are achievable and this would justify closures of hospital premises and enable large net decreases in costs. The claims for large reductions in demand for acute services are unproven at best, lack support or a clear strategy and do not justify pre-emptive closures in the meantime. The economics of this approach are based on unreliable projections and on, what have turned out to be, massive errors in costing.

2.40 If the information collated by the consultants acting for the Commission is borne out, it reveals that the much vaunted plans to create a sustainable health economy will actually cost far more than will be saved and reduce the quality of access and the delivery of services to local people.

2.41 The Commission is most disappointed and deeply concerned at the failure of the NHS witnesses to produce the Business Case. The lack of this document leaves a gaping hole in the evidence. Without a published Business Case there can be no meaningful external scrutiny of the SaHF programme plans, a point that the Joint Health Overview and Scrutiny Committee (JHOSC) has also made repeatedly to the SaHF programme team. The exclusion of local government from the development of this document is also of concern.

Recommendation 2:

The Commission recommends that the National Audit Office undertakes a review of the value for money of the SaHF programme.

Section 3:
Public Consultation on SaHF

3.1 There had already been criticism of the public consultation on the SaHF programme prior to the Commission's call for evidence. For example, the Ipsos MORI report on the outcome of the consultation, contained in the Decision Making Business Case (Vol 3 pp 270-272) was far from a ringing endorsement of the SaHF plans. Many of the key concerns identified in the written comments (such as travel problems as a barrier to access to services in different hospitals, and scepticism over the level of resources for any alternative services in the community) have never been seriously taken into account or addressed by the SaHF programme since the consultation took place in 2012. The evidence presented to the Commission revealed widespread concern and frustration at the quality of the consultation process and scepticism as to how genuine it had been in seeking the public's views on the proposals.

Levels of engagement

3.2 Andy Slaughter, the Labour MP for Hammersmith, was highly critical of the consultation and described it as "a box ticking exercise which did its best to minimise the opposition." The MP was also critical as to the extent to which the consultation engaged the 2 million people in the North West London region, especially his constituents in Hammersmith. Cllr Robert Freeman, of the Royal Borough of Kensington and Chelsea, also told the Commission that there was very little public awareness of the proposals in his borough.

3.3 Stephen Pound, the Labour MP for Ealing North, also criticised the lack of engagement with his constituents:

"I cannot think of an occasion where there has been less engagement and less sense of ownership. In all honesty, we were actually more engaged with the Heathrow Airport consultancy than we were with this and this is much, much more important."

3.4 Cllr Julian Bell, Leader of Ealing Council, was also highly critical of the level of engagement of Ealing residents in the consultation process. Cllr Bell was also critical of the level of engagement with his authority:

"Again, it was a process where we were very much on the outside. … Over a period of time leading up to the proposals (we) requested meetings, requested information but we were only really brought in when the decisions were made."

3.5 Christine Vigars, Chair of Healthwatch Central West London, told us:

"We have had sight of all the proposals, as they have come forward, but we feel that the process of engagement with the public has been very lacking."

3.6 She also went on to criticise the lack of ongoing engagement with the public since the initial consultation phase:

"When the proposals went to the Independent Reconfiguration Panel they said that there needed to be a shift in emphasis from telling people what was going to happen to an active engagement with the community in order to co-design the services, and that is a shift that we would like to see happening because a lot of what has been happening has really been about telling people who are already very confused."

3.7 The Joint Health Overview and Scrutiny Committee (JHOSC), in its written evidence to the Commission, is also critical of the level of public engagement, concluding that the numbers of people directly engaged was very low in relation to the population that would be affected by the changes. On the other hand, Dr Mark Spencer, in his evidence to the Commission, pointed to JHOSC approval of the planned consultation timetable. In response, the JHOSC submitted further evidence to the Commission which highlights its concerns with the consultation, at the time of the consultation taking place, which contradicts Dr Mark Spencer. This adds to concerns about how the SaHF programme has responded to outside comment, and the inaccuracies in information coming from the programme. Dr Spencer also referred to public information being made available in all local GP surgeries, in libraries and town halls and he pointed to the deployment of a full-time worker seeking to engage with hard-to-reach groups "like the small Somali groups working throughout Southall and other areas."

3.8 In his oral evidence to the Commission, Dr Spencer's explanation as to why there is a strong and widespread perception that the consultation failed to engage people enough, focussed on the timing of the exercise:

"The timing of this whole programme has been difficult because it coincided with wider changes in the NHS that were being imposed by Government which were unpopular amongst a wide range of people. There has been a lot of campaigning to save the NHS and to stop privatisation within the NHS and people have become confused about the various processes in here. I would argue very strongly that what we are doing in North West London is exactly those two things and I would sign up to many of the petitions that have been around to save the NHS because we are exactly having a programme that does that."

Management of the process

3.9 Merril Hammer and Jim Grealy of the Save Our Hospitals campaign were critical of the extent to which consultation meetings were advertised and managed. They both stated that few people heard about the meetings and those that did had little information in advance and little opportunity to have their views heard, as the time was taken up by NHS speakers. Merril Hammer told us:

"It was quite clear they were driving the consultation to get the answers that they wanted, in other words, to support the preferred option."

3.10 Dr Mark Spencer, in his evidence to the Commission, denied that any options were out of scope at the time of the public consultation. He did not agree that there were only three options on the table.

3.11 Dr Onkar Sahota expressed his concern at the inadequacy of consultation in Southall, where about 80% of the population are from BME communities whose first language is not English. He was critical of the extent to which the SaHF consultation document was circulated among local libraries, its complexity and the lack of access to copies in locally spoken languages. Arthur Breens, an Ealing resident, and Robin Sharp, Chair of Kilburn PPG, were also critical of the complexity of the consultation document and the questionnaire.

3.12 Dr Sahota expressed concern at the way in which the consultation divided communities and set one hospital against another:

"The choice was given that if Ealing Hospital was to be a major hospital then West Middlesex could not be a major hospital. If Charing Cross was going to be a major hospital then Chelsea and Westminster could not be a major hospital. … I also think that different trusts responded differently to the consultation process. They were trying to fight for their own survival and different trusts encouraged people to respond in different ways and that was all so apparent in the consultation process."

Interpretation of responses

3.13 Andy Slaughter was critical of the fact that petitions, which may have had thousands or even tens of thousands of signatories, were treated as single submissions, equal to one person submitting a consultation questionnaire.

3.14 Both Dr Mohini Parmar and Dr Onkar Sahota referred to the results of a referendum of Ealing GPs, carried out as part of the consultation process locally, but chose to highlight the responses to different questions. Dr Parmar reported that of those who responded to the survey (41.6%), a total of 68% felt there was a case for change. Dr Sahota, in his evidence to the Commission, pointed to the fact that 54.2% of respondents also

wanted Ealing Hospital to be the major hospital.

3.15 Robin Sharp, Chair of Kilburn PPG, was critical of the official interpretation of the outcome of the consultation:

"The heading was just over three-fifths support option A, but when you look at the numbers that is 3,770 in support and 1,780 opposing so that is only 5,000 responses out of a population of two million. Since there was no stratified sampling, this is not a reliable way of gauging true opinion."

Geographical variations

3.16 Fulham resident, Dede Wilson, highlighted the discrepancies in the way in which the consultation was promoted across different areas. She was very clear as to the lack of promotion in Hammersmith and Fulham, in comparison to the extensive promotion in Chelsea:

"There was no leafletting in Hammersmith and Fulham, whatsoever. The only way that people knew about it was through newspaper reports and advertising in the Fulham Chronicle. Otherwise it was not available unless you went online to Hammersmith and Fulham Council to find out there was something there and that there were going to be meetings."

3.17 Ms Wilson provided the Commission with examples of consultation leaflets that were circulated in Chelsea and Westminster Hospital but not at Charing Cross Hospital, the inference being that the views of staff and patients at proposed major hospitals were sought far more readily than those at hospitals which were targeted for downgrading. She stated that:

"There was open electioneering in all of the favoured hospitals and this was most evident in Chelsea and Westminster. In Chelsea and Westminster, when I went in, it was not just the Trust newspapers that were there, there were actually instructions as to how to vote for Chelsea and Westminster. Not only were there instructions as to how to vote, and I went through the whole hospital into every single department, on every counter in every reception department there were these purply blue cards where people could tick a box and they could submit this."

Conclusion

3.18 There is clearly widespread concern and continuing criticism as to the public consultation exercise conducted in 2012. Witnesses representing a range of different interests and from a variety of backgrounds – clinicians, politicians, patients and residents – have all raised similar criticisms about the process and structure of the exercise, as well as how the results have been analysed and interpreted. We have heard from Healthwatch how the Independent Reconfiguration Panel's call for closer engagement with the public does not appear to be happening and yet the key NHS witness describes an extensive consultation process having occurred with an outcome demonstrating resounding support for the programme. There is clearly a mismatch between the perception of the NHS as to how consultation has been managed and that of the many witnesses that have presented to the Commission on this issue over the four days of public hearings.

Recommendation 3:

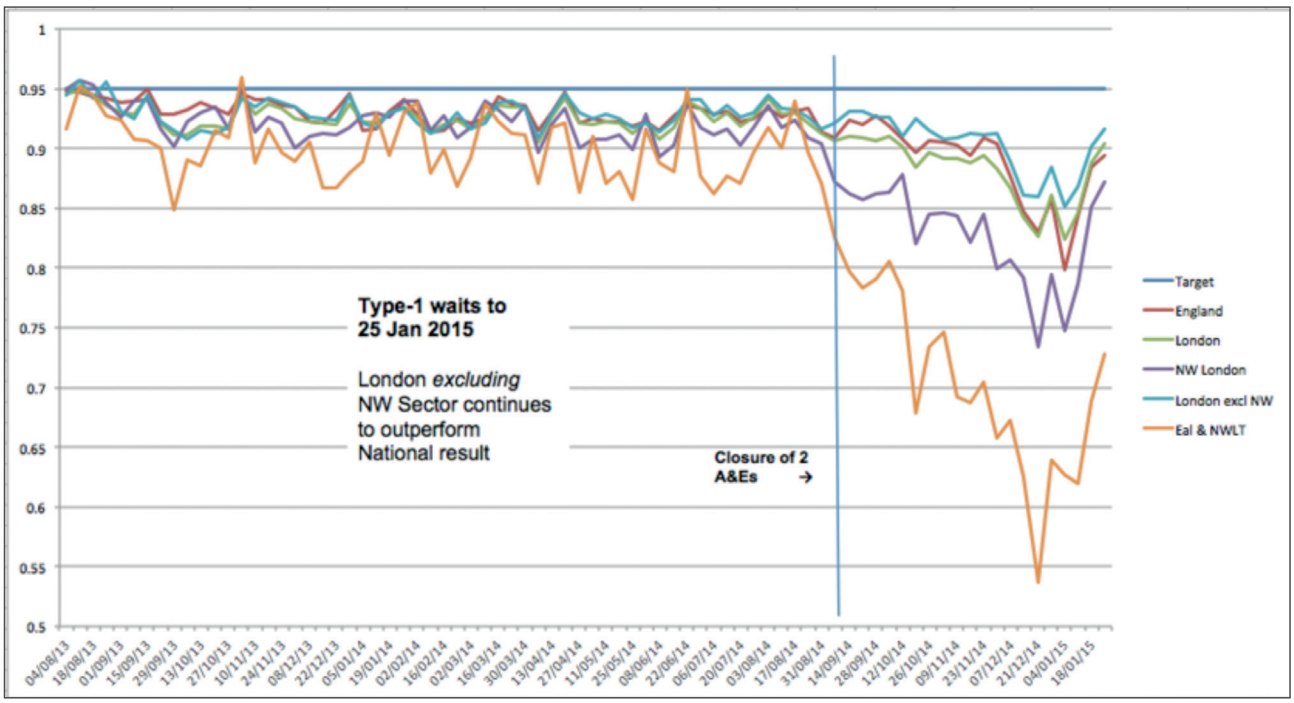
The Commission calls for a fresh consultation on the Business Case (referred to as the Investment Business Case in official guidance but as the Implementation Business Case by SaHF programme leads) as the programme has changed significantly since the Pre-consultation and Decision Making Business Cases were published. There should be extensive and uniform publicity across the region and a clear consultation document with appropriate translations made available in areas of high concentrations of BME communities.

Section 4: A&E Closures and Other Reconfiguration Plans

4.1 Serious questions have repeatedly been raised on these plans by local boroughs, the public in the consultation, and campaigners. Few of these questions have been adequately addressed or answered by the SaHF team. Many of the points were again highlighted as current and unresolved concerns by our witnesses.

Impact of A&E closures at Hammersmith and Central Middlesex Hospitals

4.2 The Commission both received and heard a wealth of evidence with regard to the performance of A&E departments across the region. Colin Standfield, in his written evidence to the Commission, had provided graphical illustrations of the drop in performance of A&Es across North West London that appeared to follow the closure of Central Middlesex and Hammersmith A&Es on 10 September 2014. This data was updated in Dr Gurjinder Singh Sandhu's evidence to the Commission and this graph is reproduced below, where the vertical blue line shows the date of the A&E closures.



4.3 There is no mistaking the sharp decline in performance of Ealing Hospital and North West London Healthcare Trust (now London North West and covering Northwick Park Hospital). These are the two hospitals that would be most likely to take patients that would otherwise have gone to Hammersmith and Central Middlesex A&Es.

4.4 Colin Standfield was critical, in his oral evidence to the Commission, of the decision to close the two A&Es early:

"So everything we were told about replacing A&Es with this wealth of community and out-of-hospital care did not happen when it came to the closures of those two hospitals. I think they were done in haste because it suited their programme and they had this Independent Reconfiguration Panel footnote to say that is something you should do."

4.5 Mr Standfield was asked whether the drop in performance after September last year could be attributed to the closures of Central Middlesex and Hammersmith Hospital A&Es. He stated:

"The drop off happened nationally and across London as a whole but it happened an awful lot worse in North West London and massively worse in Ealing and Northwick Park. Of course Northwick Park bore the brunt of the closure of Central Middlesex."

4.6 Tina Benson, Director of Operations at London North West Healthcare NHS Trust, the Trust which manages Northwick Park Hospital, pointed to detailed modelling that had been carried out prior to the closures of Hammersmith and Central Middlesex Hospital A&Es that led to a decision on closure made on the balance of risk:

"So there was the risk of knowing we had a capacity challenge at Northwick Park versus the potential of the inability to staff Central Middlesex medically over the winter period and having to do an emergency closure. So we had some ongoing concerns but we felt we had planned well enough to maintain safety, which was always the key."

4.7 Professor Ursula Gallagher, Director of Quality and Patient Safety for Brent, Harrow and Hillingdon CCGs also stated in her evidence that the closure of the two A&Es had been well planned for:

"We planned properly for what we expected to occur and even for a degree of unexpected occurrence. We got something that was completely unpredictable."

4.8 Dr Mark Spencer also pointed to A&E performance failures elsewhere to suggest that the problems at Northwick Park were only partly due to the closure of Central Middlesex. He also pointed to delays in putting in place some extra beds at Northwick Park. Our consultants were informed that these delays were in fact due to miscalculations made in the bed numbers required at Northwick Park to cope with closures elsewhere. Errors such as this at an early stage further undermine confidence in the ability of the SaHF programme to deliver.

4.9 Dr Spencer was unable to say when the NHS review of A&E performance failures in North West London, carried out in response to the data from last autumn and winter, would be available. The Commission has been refused access to this report, despite it being promised to our consultants at the beginning of the process and despite the fact that SaHF representatives have quoted from it.

4.10 Peter Latham, of Willesden PPG, was critical of the NHS assertion that the problems at Northwick Park were not primarily due to the closures of Hammersmith and Central Middlesex A&Es:

"Dr Spencer and Professor Gallagher have talked about two components in their difficulty in coping at Northwick Park with the accident and emergency arrivals, number one being the planned excess and, secondly, the unexpected excess due to surge. That surge, on Colin Standfield's chart, is simply inaccurate. The figures have been remarkably consistent and that reveals that what is likely to have gone wrong is that their projections and modelling for Northwick Park and other surviving full accident and emergency departments, after the closure of Central Middlessex Hospital and Hammersmith Hospital, have been inaccurate."

4.11 Dr Onkar Sahota, in his evidence, was quite clear that the performance failure at Northwick Park had been very much affected by the closure of Central Middlesex A&E and he was critical of NHS denials of this:

"When you ask them why did this happen, as I did indeed ask them at the (GLA) Health Committee meeting, we were told that the number of sick patients has increased, but if you look at the data of the Type 1 cases arriving at Northwick Park, that is the people who are very unwell, that has not increased at all. What has increased, of course, is the number of people attending Northwick Park Hospital and they cannot cope with the pressure."

4.12 Dr Sahota's analysis of the pressure on North West London A&Es is that it reveals a wider pressure across the whole of the health service in the region:

"So by closing A&E departments in a community without replacing it with alternative services you put pressure on the A&E, and the A&E departments are

the barometer of the health service in any given area. When GPs cannot cope, when patients cannot get appointments with GP practices, when they do not get the advice they expect from the 111 service, they will attend an A&E department which is trusted, safe and they know they will get some care, and that is what is happening."

4.13 Reduction in A&E provision also means greater demands on the ambulance service as they have longer journey times. Cllr Rory Vaughan, a member of Hammersmith and Fulham Council and a member of the JHOSC, referred to figures that the JHOSC received from the London Ambulance Service showing that average ambulance journey times to hospital are increasing:

"They are clear that they are not meeting their target journey times at the moment even with just two closures having taken place."

4.14 Dr Sahota was just one of a number of witnesses who referred to an existing shortage of paramedics in the ambulance service:

"We are 400 short of paramedics across London."

4.15 Colin Standfield confirmed this in his evidence and also highlighted the increased waiting time for ambulances arriving at Northwick Park.

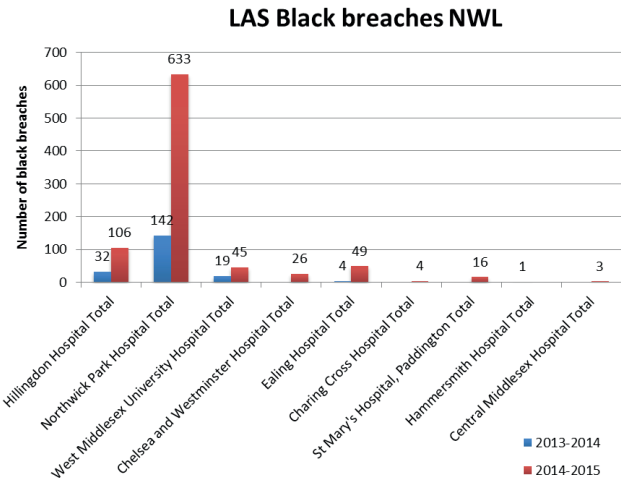
4.16 In its written evidence submission, the Royal College of Nursing highlighted the pressures that A&E departments have been under in North West London and referred to the numerous times that Northwick Park had been on 'divert' over the winter period. Sharon Bissessar, of the RCN, in her oral evidence to the Commission elaborated on this:

"A divert is a request from a receiving trust for ambulances to avoid approaching the trust with a patient, and that is purely on the basis of capacity, whether it be through an emergency situation or not. So a patient has already called for an ambulance and that ambulance is told to go elsewhere. The issue within North West London is we found that the majority of A&E departments are running at full capacity and some of them are over capacity, so there is no real release valve for that ambulance, anywhere for that ambulance to go. What seems to happen now is that ambulances just queue outside with sick patients, vulnerable and very ill patients sometimes, sitting in the back of the vehicle and they are unable to bring that patient into the hospital for proper care and treatment."

4.17 Dr Gurjinder Singh Sandhu, a consultant in infectious diseases and acute medicine at Ealing Hospital, provided data on the huge increases in 'black breaches' of ambulance waiting times:

"A black breach is where an ambulance is taking more than an hour to offload a patient so they can actually be seen by the accident and emergency staff. If we look at the graph of black breaches last year we had possibly 142 in Northwick Park and about 32 in Ealing. This year there have been 633 black breaches in Northwick Park and that is not complete data because the complete data will be ready by April, so that is 633 patients waiting for more than an hour to be offloaded from the ambulance. All hospitals in North West London saw a rise in black breaches after the closure of these emergency departments."

4.18 The graphic below shows the huge increase in black breaches at Northwick Park and across other North West London Hospitals in the past year.



Likely impact of roll out of other proposed A&E closures at Charing Cross and Ealing Hospitals

4.19 Colin Standfield was asked what his view was of the risks of continuing the roll out of SaHF A&E closure plans. He stated:

"Having seen half of it I would say it will be twice as bad as it is now. If Northwick Park can plunge to a level of 51% of Type 1 A&Es seen within four hours on one day, 16 February, then that means that the whole system is under pressure. It may not be only a result of the two closures, but I do not know what else can be responsible for that significant effect, given that certainly in North West London and certainly in Ealing and Northwick Park the number of attendances is not the problem. There is no increase in acuity, which is the latest spin they are putting on it, that people are sicker now. The only ones who are sicker are the ones who have had to wait longer for an ambulance."

4.20 Cllr Robert Freeman expressed his concern as to the ability of St Mary's Hospital to cope with the additional burdens that would flow from any closures at Charing Cross Hospital. Cllr Stephen Cowan, Leader of Hammersmith and Fulham Council said:

"What is absolutely clear in the closure of Charing Cross is if you already have other hospitals operating at capacity then what you will see is what you

currently see in Northwick Park with people waiting up to an hour in ambulances."

4.21 Dr Gurjinder Singh Sandhu, when asked what the result of further A&E closures would be, said:

"Absolutely catastrophic. It will have a huge impact on the morbidity and mortality of this population. We are talking about people who are waiting longer for the ambulance to arrive and then they are waiting longer in the ambulance to get to their destination. Then they are waiting longer for the ambulance to offload them. Then they are waiting longer in the A&E to be seen. Then there would not possibly be the appropriate intensive care unit bed for them at that location. If you look at something like sepsis or you look at something like renal failure or you look at the unconscious patient or respiratory distress, all of that amounts to minutes and hours which would be life-saving where cells are dying; patients are dying."

4.22 Both the Hammersmith and Fulham and Ealing Council submissions also point to the quality of service at the A&E departments targeted for closure, in comparison to the Care Quality Commission (CQC) reports for the A&E departments at those hospitals that will retain a full 'blue light' service. According to the latest CQC reports, Central Middlesex performed better than Northwick Park and Charing Cross is performing better than St Mary's.

4.23 Dr Mohini Parmar, Chair of Ealing CCG, could not say when changes planned for Ealing A&E would be finalised:

"We do not know what the A&E changes are going to be because we are waiting and waiting for Bruce Keogh's report to come through at this point, so some of these things are still to be determined."

4.24 She did state, however, that there will be no changes to the current A&E provision for the next three years.

4.25 Following on from Dr Parmar's evidence, Tina Benson, on behalf of London North West Healthcare NHS Trust, stated:

"I have not got any plans, as being the responsible Director, to close Ealing A&E and in fact I am working with my Ealing team at the moment to expand the footprint (space and capacity) in A&E in Ealing."

4.26 When pressed to clarify this statement, Ms Benson said:

"I am saying at the moment there are not any plans to close Ealing A&E."

4.27 While this will be welcome news to many in Ealing and elsewhere, it is scarcely evidence of coherent planning and common vision among the SaHF commissioners and providers.

Urgent care centres replacing A&E departments

4.28 The Commission heard a lot of evidence as to the level of public confusion that exists with regard to what services an urgent care centre can provide, in contrast to an A&E department. Anne Drinkell, a Brent resident, Secretary of Save Our Hospitals and a former nurse practitioner, referred to the "huge amount of confusion" over the difference between an A&E department and an urgent care centre (UCC). She also referred to a lack of consistency of approach across different UCCs, further adding to the confusion of patients, nurse practitioners and referring GPs. She stated that:

"I think the evidence is that urgent care centres work best when they are co-located with A&Es. That makes perfect sense because you can triage and if you need more back-up then you have got it in the A&E departments."

4.29 Dr Mohini Parmar, however, stated in her evidence that:

"There are examples of urgent care centres up and down the country which are not co-located with A&E. Hemel Hempstead is one of them. … For those areas where urgent care centres are not co-located, there are proper clear pathways in place. Those are networked with major A&Es. There are clear pathways with local ambulance services to ensure that patient safety and quality is not compromised".

4.30 Other witnesses disagreed with this view. Dr Julian Redhead, of the Royal College of Emergency Medicine, felt that London, in particular, requires co-location of UCCs with A&Es:

"The Royal College calls for co-location of urgent care centres together with emergency departments to try and avoid some of these issues (confusion over services and referrals), but we do know that around the country there are well-established urgent care centres which operate very well for their communities. London potentially is different because it is an urban environment."

4.31 Sharin Bissessar, of the RCN, was also critical of the separation of UCCs from A&Es and contradicted Dr Parmar's claim that there are clear pathways in place for transferring patients in London:

"UCCs historically were always meant to be nearby to an A&E department so the patients could walk over or there would be a wheelchair, but at the moment there is no formal system in place to enable patients to transfer directly from the UCC to an A&E. There is no ambulance sitting there waiting to take people. It is on a case-by-case basis."

4.32 Dr Sahota's written evidence submission stated that there are some 28,000 transfers per year between Ealing's UCC and A&E and these are presently co-located.

4.33 Dr Onkar Sahota's evidence also contrasted with Dr Parmar's evidence. When asked what information he had been given about how transfers between the urgent care centre and an A&E will be organised, he said:

"I have not been given any information as a GP at all. They also say they will discuss this with the ambulance people about ambulance times. I do not know what the impact of all this is going to be but there is going to be a huge impact on the ambulance staff because there will be sick patients needing to be transferred to Northwick Park and that will have to be done by the ambulance crews. We already have a shortage of ambulance paramedics in London."

4.34 Two witnesses gave evidence of misdiagnoses at the two UCCs in North West London where the A&E closures have taken place, one of which may have contributed to a fatal outcome. Sebastian Balfour attended Hammersmith UCC soon after the A&E closure and was misdiagnosed by a GP. With the pain considerably worse a week later, he attended Chelsea and Westminster A&E where his condition was correctly diagnosed as diverticulitis. He was hospitalised by the A&E and provided with the urgent attention that his condition required. Ruth Bradshaw recounted the experience of a neighbour who was taken to the Central Middlesex UCC soon after it's A&E had closed. While at the UCC the patient stopped breathing and an ambulance had to be called. Ms Bradshaw stated that he was not resuscitated for 15 minutes, leading to brain damage, and that he died two weeks later in hospital.

4.35 Dr Louise Irvine, a Lewisham GP, stressed the importance of co-location of UCCs and A&Es:

"As a GP referring patients into that situation, I know that the whole point of an emergency department or an A&E is often GPs like myself do not really know if something is serious enough to need admission or not. This is the nature of medicine. There are grey areas. Is this abdominal pain appendicitis or not, is this abdominal pain an ectopic pregnancy or not? … If you know that there is not going to be the level of expertise there, you are not going to send them to an urgent care centre, you are going to send them to another A&E somewhere else."

4.36 Christine Vigars, Chair of Healthwatch Central West London, reported on the outcome of a survey of residents and a series of focus groups that her organisation had conducted, looking at public awareness of the 111 telephone service and urgent care centres. She reported that about half the people surveyed did not know what the 111 service was and 60% did not know what an urgent care centre was. In her evidence, Ms Vigars highlighted the confusion around where to take sick children and whether UCCs are the right place to go:

"Hammersmith UCC deals with children, however, at one of our groups this question was asked of a consultant from St Mary's who said 'If you have a sick child always take it to A&E'."

4.37 From the anecdotal evidence of witnesses, this confusion among clinicians appears widespread. Cllr Hirani, of Brent Council, recited the example of his mother who fell over on her driveway and damaged her hand:

"She went to the GP and rather than being referred to the urgent care centre for an x-ray she was referred to the A&E at Northwick Park. What this tells me is that there is a problem in making sure that people are referred to the right place by professionals. If professionals are struggling to understand where to send people what hope do the general public have?"

Closure of Ealing maternity unit

4.38 The Commission received over 30 written evidence submissions from midwives, nurses and service users, that were dedicated solely to the desired retention of the Ealing maternity unit. The quality of the maternity services provided there was widely praised and many service users expressed fears and concerns at having to travel further from home to access such services when the unit closes[2].

4.39 Stephen Pound MP expressed his deep concerns as to the impact of the impending closure of Ealing maternity unit on the quality of maternity services for residents of the borough:

"Ealing Hospital is a very, very culturally sensitive hospital and the maternity services are a safe, reassuring and comforting place for women to give birth in. ... I do not wish to go into specific areas but there are certain aspects of maternity which really do need to be handled extremely carefully. … Ealing is good at that and all that expertise, all that institutional memory, all of that sensitivity, all of that is going to get thrown out."

4.40 Dr Mohini Parmar was asked by counsel for the Commission why Ealing maternity unit had been targeted for closure. Her response was that:

"Ealing maternity unit, historically, has been a very small maternity unit, one of the smallest in London. The number of births across North West London has been declining and in Ealing it has declined further than in any other unit across North West London."

4.41 Dr Parmar pointed to the level of consultant cover in Ealing (60 hours) compared to West Middlesex (140 hours):

"This will inevitably lead to an unequal service for Ealing women. It is my responsibility as Ealing CCG Chair to ensure all women in Ealing get the same quality of care."

[2] The maternity unit at Ealing Hospital was closed on 1 July 2015.

4.42 Professor Clara Lowy, in her evidence to the Commission stated that:

"I think the maternity unit in Ealing should definitely continue and I think be expanded. We have got an expanding population and not only that but we have also got an expanding population of diabetes, so this is an area that needs to be conserved."

4.43 Sadie Eyles-Slade, a midwife at Ealing Hospital, explained the services on offer at the new birth centre at Ealing maternity unit, including a new triage area that has had great success in making plans for women with complex needs. She explained the sorts of needs that Ealing is used to meeting, particularly those of vulnerable women in Southall, that other hospitals in other areas of North West London may not be familiar with:

"We have a lot of women who do not speak English as a first language and many who do not speak English at all, a lot of immigrants. There is quite a high rate of issues like domestic violence and poverty and very low housing standards among a lot of the women who we serve and, although not all women in the borough of Ealing get their maternity care at Ealing, just about all the women in Southall do. … We offer them antenatal care, choice of place of birth and postnatal care all within the same organisation so there is continuity, which is really important in terms of understanding their social needs and plans."

4.44 Dr Onkar Sahota, in his evidence to the Commission, also stressed the specific needs of vulnerable and deprived communities that use Ealing maternity services:

"You were talking about maternity services and 50% of patients who go to Ealing Hospital for maternity services come from Southall and Hanwell. Lady Margaret ward, Dormers Well ward and Southall Broadway are some of the most deprived wards in the country. These patients have great difficulty using public transport. They have great difficulty in making their way around and Ealing Hospital is so accessible and it understands their problems."

Conclusions

4.45 The evidence presented to the Commission, regarding A&E performance on waiting times over the course of the past year and more, clearly indicates the impact that the early closures of Hammersmith and Central Middlesex A&E departments have had on waiting times at other A&E departments across the region and, in particular, on Northwick Park Hospital. The fact that performance was poor elsewhere does not escape the fact that it was worst in North West London, particularly after September 2014 when the closures took place.

4.46 The NHS witnesses' denials, in the face of this evidence, that this is the case, is of concern to the Commission as it suggests a reluctance to accept that the modelling on expected patient movements, that was employed to inform the closure plans, was inaccurate. From the evidence heard, it is the Commission's view that this modelling failed to take account of service failures across the various levels of healthcare provision in the region, especially GP services, that has resulted in an increasing reliance on A&E services and an inability of those services to cope with the increased demand.

4.47 The selection of hospitals on which SaHF service closure plans are focussed, i.e. Hammersmith, Central Middlesex, Ealing and Charing Cross, whether by accident or design, are in areas of comparative deprivation when looked at next to the selected major hospitals, i.e. St. Marys, Chelsea and Westminster, West Middlesex, Northwick Park and Hillingdon. The residents that will be having to travel further for acute healthcare services are those who are most vulnerable and least able to afford travel costs. Invariably they are also the communities that exhibit the most acute healthcare needs.

4.48 The evidence heard by the Commission reveals widespread confusion among GPs, consultants and patients as to what an urgent care centre can deliver in the way of services and who should be referred there. As a result of this confusion there is no consistency in referrals to UCCs, either self-referrals or clinical referrals. This confusion can lead to fatal consequences. The Commission concurs with the view of many expert witnesses that A&Es and UCCs, especially in London, should be co-located. In areas where this is no longer the case, i.e. the catchment for Hammersmith and Central Middlesex hospitals at present, there should be a co-ordinated and intensive education campaign to raise both public and professional awareness of the services that can be provided at these UCCs and with what injuries or symptoms people should be referred or self refer to these centres. The guidance on A&E and UCCs due to be published by the Chief Medical Officer, Sir Bruce Keogh, remains outstanding amid continuing evidence of the breakdown of the existing system. This is not a stable environment for planning major change.

4.49 The Commission has been impressed by the evidence of the exemplary services provided at Ealing maternity unit. The specialist care that the unit clearly offers to a vulnerable and deprived client group has, from the evidence of service users, immeasurable community benefits. In the view of the Commission, the cost on this community of the loss of the unit have not been adequately considered by the SaHF programme medical directors nor Ealing CCG.

Recommendation 4:

In the light of these factors and recommendations 1-3 it is imperative that there be no further implementation of SaHF in the following two principal respects:

i) The Commission demands that there must be no further closures of any A&E departments in North West London. Ealing and Charing Cross hospitals must retain full 'blue light' A&E services for the foreseeable future;

ii) The Commission calls for an equalities impact assessment to be carried out into the whole SaHF programme, with a particular focus on the communities that will be deprived of services at Ealing and Charing Cross hospitals, as it is clear to the Commission that the selection of these hospitals for service closures will adversely affect the more deprived BME communities in the region.

Recommendation 5:

The Commission recommends that all UCCs in North West London should be co-located with A&E departments. Where this is no longer the case there should be an immediate and extensive publicity campaign mounted to raise awareness as to what such centres can provide and who should be referred or self-refer there.

Recommendation 6:

The Commission recommends that the decision to close Ealing maternity unit should be reversed with immediate effect.

Recommendation 7:

The Commission recommends that the A&E department at Central Middlesex Hospital should be re-opened to alleviate the burden on other A&Es, especially Northwick Park.

Section 5:
Out-of-Hospital Provision

5.1 Three years after the SaHF process started there is still no clarity on what out-of-hospital services will be provided, by whom, where, on what scale, how their success or otherwise will be measured and how they will be funded. We have no more information than the outdated Decision Making Business Case. The most senior SaHF/NHS England spokesperson to attend the Commission (Dr Mark Spencer) declares no knowledge of any of the local plans which may or may not be being drawn up. This is a huge issue of major concern in the consultation which the SaHF project team have simply ignored, while focused on the hospital changes. There are major grounds to question the viability of the plans on a number of counts, and to question whether current evidence supports the plan.

Out-of-hospital strategies

5.2 The written evidence submitted to the Commission by North West London CCGs offered some examples of what is being delivered in the local 'hubs' as part of each CCG's out-of-hospital strategy. In the absence of the Business Case and the outline business cases for each of the hubs that form a part of this, however, the evidence appears piecemeal and does not set out the extent to which these developing services are reducing demand elsewhere. The evidence from elsewhere clearly suggests that the developing out-of-hospital provision is having very limited impact on demand for existing acute healthcare services across the region.

5.3 To inform its written evidence to the Commission, Harrow Council engaged residents in a series of consultation events to examine the implementation of the out-of-hospital strategy across the borough. Harrow residents' views are that there is insufficient joint planning and delivery of care in the community and that planning may not have been sufficiently aspirational.

5.4 Anne Drinkell, Secretary of Save Our Hospitals, was positive about many of the out-of-hospital schemes that are in development:

"I know of lots of out-of-hospital strategies locally that are really useful and good and probably will deliver something and should be supported. I think the issue is that they have not been tried and tested. They need to be properly resourced and unless they are delivered on a much bigger scale for a much longer time on a much wider premise then, although they will be very good and very useful in themselves, they are not going to stop the tide of unplanned admissions and deliver what SaHF wants to deliver."

5.5 Evidence from Brent PPGs suggests that there may be a reluctance among patients and GPs to test out newly procured services. Robin Sharp stated:

"The ophthalmology service has been running since last September and there

is some information in the possession of the CCG about how it is working…I think reports to my Patient Participation Group suggest those people have been reasonably happy and the GPs have been happy with the reports they have been getting. However, low take-up of this service has been cited as one of the key reasons for not proceeding with the Wave 2 procurement…There must always have been an issue as to how many people exercising patient choice or how many doctors exercising GP clinical freedom would send people to this new and untried service as opposed to services that already seem to be reasonably available and not too far away."

GP provision

5.6 Dr Onkar Sahota was critical of the lack of investment that he has seen in expanding GP services:

"I have been a GP for the past 25 years in this part of the borough. No investment has taken place. Certainly nothing happened since SaHF came out. What we have had is a reduction in the budgets spent on general practice. 90% of consultations in this country take place in general practice yet only 8% of the NHS budget goes on general practice. I certainly think we need to put huge investment into our premises and we certainly need to increase the number of doctors and nurses so that they can give the time and care to patients and lift morale up."

5.7 Professor Clara Lowy also raised concerns as to the impact of current demands and pressures on GPs' time on their ability to diagnose cancers:

"About 20% of cancer diagnoses occur at A&E. Why is that? I think the answer is that if a GP has ten minutes in order to see a patient they are never going to get there because there is not enough time, so I think the way to improve it is partly education of the GPs and partly having more time for that kind of activity."

5.8 Cllr Mel Collins, the Chair of the JHOSC, described the roll out of seven day a week GP services as patchy:

"It varies from borough to borough. Some boroughs are stronger placed than others. In some areas it is working and in other areas it is not."

5.9 Cllr Collins also confirmed that the JHOSC had not received the progress report on workforce recruitment that had been requested and stated that this was a cause for concern.

5.10 Some participants in Harrow Council's engagement workshops, suggested that, in the context of the poor performance of out-of-hospital services, it seems that residents may actually be making informed, conscious decisions about how to access healthcare – sooner wait four hours in A&E than four days to see a GP.

5.11 Cllr Hirani, of Brent Council, raised concerns as to the future capacity of GP services across the borough, with many approaching retirement age. He suggested that there may be "massive infrastructure problems in trying to recruit the GPs that we need to meet our population demands."

5.12 Dr Ajaib Kaur Sandhu, an Ealing GP who formerly worked in a Chiswick practice, described the 14 hour day, seven day week that she and her fellow GPs work in her Southall practice. She described a picture of GP burnout and workloads that are dissuading people from staying in general practice or from seeking to become doctors.

Social care

5.13 Dr Sahota, in his evidence to the Commission, was also critical of the lack of community care after discharge:

> "There has been a huge cut in social services. That is what is driving this. Patients cannot be looked after in the community. They go to A&E departments, they get admitted, they cannot be discharged back into the community so I think we need to ring-fence the social services budget and healthcare budget and integrate them and cut out the costs."

5.14 Dr Gurjinder Singh Sandhu, of Ealing Hospital, drew attention to the lack of social care in the community:

> "I am sorry, it really is just frightening, the lack of social care for people in the community. I work with 50% fewer social workers than when I started as a consultant at Ealing Hospital. I feel that we are battling with social services because we heard earlier…about cuts to social care and sometimes it would be very clear that someone needs to go to a residential home or go to a nursing home. If granddad keeps putting the electric kettle on the gas hob then that family cannot wait for the big kaboom before they all come in. When we have identified we need more care space for this person, it almost feels like social services have got a remit from higher above not to send them to a residential home. It is going to cost too much, you have got to get them home…I am sorry but the doctors, the nurses, the occupational therapists and the physiotherapists are not going to do that. They are going to keep that patient in hospital until they know it is safe for them to go somewhere in the community that is safe."

5.15 When asked about out-of-hospital provision in his borough, Cllr Julian Bell stated:

> "Well, I think we actually have a long way to go in terms of our primary and community care in Ealing. As Mr Pound said earlier, we have a lot of single GPs and I think, as he again said, it is a patchy service and we have some way to go. You could argue that with the resources that the NHS have had

in the last ten years, before austerity kicked in, that we probably could have seen improvements to primary care community services in that time, but we have not. … I think our concerns are that with a rising population, a particularly fast-growing elderly population, with the specific health needs of some of the ethnic groups within our borough, that we need to have sufficient acute services to meet those needs and those growing population demands."

5.16 Cllr Bell also explained the increasing pressures on council's social care budgets:

"Obviously, we welcome the monies that we are getting from the Better Care Fund…in Ealing it is about £25-26 million. However, we have £38 million of cuts to our adult social care, so the Better Care Fund is probably a bandage rather than a sticking plaster, but the resources that we have as the Council are significantly reducing and it is what is known as the "Barnet Graph of Doom" where basically by 2018/19 if, as I have said, this 30% increase in the elderly population part of the graph goes up, that is one part of the Graph of Doom, and the financial resources that are coming to councils is the downward path of the Graph of Doom, by 2018-19 when those two parts of the graph cross we as a council, and this is the same for councils all over the country, will only be able provide those statutory care services and I think we might just be able to collect the bins and the rubbish, but any other of our services we will not be able to provide because unless there is a change in national policy in terms of actually ring-fencing social care budgets, in the same way that healthcare budgets are being protected (because at the moment they are not being), frankly, I do not know how we are going to manage as a council to meet those statutory social care responsibilities that we have with a reducing budget. And it is not just me, the National Audit Office says that, in 2018/19, 50% of councils will not be financially solvent if things stay as they are.

5.17 Anne Drinkell, Secretary of Save Our Hospitals and a former nurse practitioner, highlighted the shortage of community nurses:

"If you look, for example, at vacancy rates amongst community nursing, which is massively, massively high, I think the community trust would acknowledge that is a problem. James Reilly, the Chief Executive, said last week there was an overall 17.6% vacancy rate and they have that as a red risk but, actually, if you dig beyond that, the figures for clinical staff are higher so that, for example, in Hammersmith and Fulham amongst trained district nurses there is a 60% vacancy rate. There is only one district nursing place for the whole of Hammersmith and Fulham this year. There are 15 community nursing vacancies."

5.18 Our consultants looked in detail at the recently published national evidence justifying investment in out-of-hospital care and at the plans put forward by SaHF. They highlighted the key role that out-of-hospital developments are assumed to play in reducing demand on acute services (see table below) and the lack of compelling evidence that substantial investment in out-of-hospital services will be effective in reducing demand to the extent planned.

Reduction of activity forecast as a result of investment in out-of-hospital provision					
	Measures of activity (inpatient stays)		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
These are reductions relative to the pre-QIPP baseline as of 2011/12. Source: NHS North West London 2013c, Volume 7, Appendix N, p18.					

Conclusions

5.19 The evidence suggests that out-of-hospital provision is developing in a piecemeal fashion and at a very slow pace, largely due to the complex procurement processes that GP commissioners are having to deal with. It is not yet clear how performance will be monitored and, therefore, how decisions about closing acute services will be made. The lack of any published outline business cases makes detailed scrutiny of the out-of-hospital strategies virtually impossible at this point in time.

5.20 The continuing absence of any business cases is particularly worrying in this case. Without this information it has been impossible to scrutinise plans across North West London. The Commission would like to see performance monitoring both at a local and North West London level. At present it is not clear how success will be measured and, therefore, at what point it would be considered safe to close acute provision and rely on out-of-hospital provision.

5.21 As part of evidence gathering, each CCG provided the Commission with their Out-of-Hospital Strategy but these are CCG specific and there seems to be little in the way of a sub-regional strategy. There is also concern that there is little understanding of how performance of out-of-hospital services will be measured, either locally or sub-regionally, and, therefore, how they will be judged effective enough to support patients in the absence of services that are being closed as part of the SaHF reconfiguration. The success of hospital reconfiguration is dependent on a safe and reliable out-of-hospital strategy.

5.22 The evidence reveals a developing crisis in the delivery of GP services, that are clearly failing to meet demand across the region, contributing to the crisis in A&E performance.

5.23 The cuts in social care provision have compounded the problems of excess demand on the acute services, with patient discharge being affected by a lack of bedspaces in care homes and/or a lack of domiciliary care. This creates bed-blocking and a resulting logjam in patient intake.

Recommendation 8:

The Commission calls for a substantial investment in GP services, which are clearly overwhelmed and inconsistent, to meet the additional demands of more vulnerable patients, and a recruitment drive for additional GPs and primary care staff.

Recommendation 9:

The Commission calls for a sub-regional out-of-hospital strategy to be produced with clear metrics and targets setting out at what level such services will be considered sufficiently successful to allow for further reconfiguration.

Recommendation 10:

The Commission notes that levels of spending on social care in North West London and elsewhere have been hit by ill-conceived central government policies, but recommends that social care budgets are increased and protected to maintain patient flows from hospital to domiciliary and residential care.

Section 6:
Governance and Scrutiny

6.1 Through the course of the public hearings there emerged a widespread confusion as to just who or what is driving the SaHF programme and who is responsible for making major decisions on implementation and delivery. The evidence of NHS witnesses suggests that this responsibility is split across, yet shared by, a coalition of the eight CCGs. This does not explain, however, the role of the NHS trusts, which also seem to be making decisions of their own on closure or expansion plans that may, or may not, be directed by the CCGs.

6.2 The lack of a clear governance structure around the SaHF programme makes it difficult to pinpoint who to talk to about programme change and raises concerns as to the extent to which the programme is being properly co-ordinated at both the strategic and operational level. There is also a lack of clarity about how decisions are signed off. The various roles of NHS London, NHS England, Monitor and Department of Health is unclear.

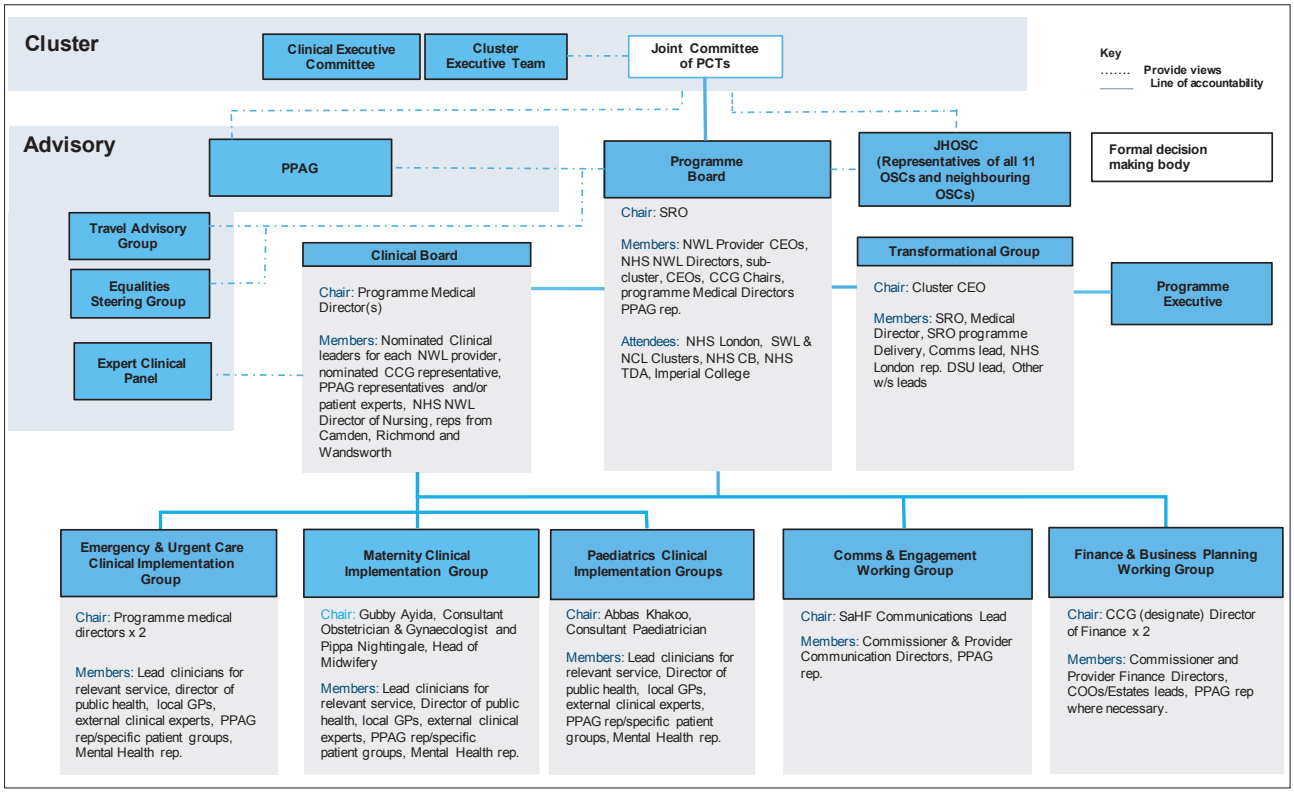
6.3 All of the Commission's questions of NHS witnesses on finance matters were referred on to 'the Finance Director", as the CCG chairs and clinical lead for the programme did not feel able to answer questions on SaHF finance. The Commission had invited Clare Parker, SaHF Chief Officer and former Finance Director, to attend a hearing but she did not appear. This lack of financial scrutiny is a serious worry for the Commission – who is making the financial decisions across the programme? What will they do if insufficient funds are available to implement the increased cost of the full plan which they consulted upon in 2012? We have major questions of these finance managers and they have gone unanswered.

6.4 Directors are jointly and severally responsible for business decisions. In the case of SaHF it is worrying that clinicians disavow responsibility for finance claiming to have no knowledge of financial issues while, on the other hand, the financial analysis seems to accept uncritically the view that huge savings are available from changing clinical patterns of care even though there is no evidence for this.

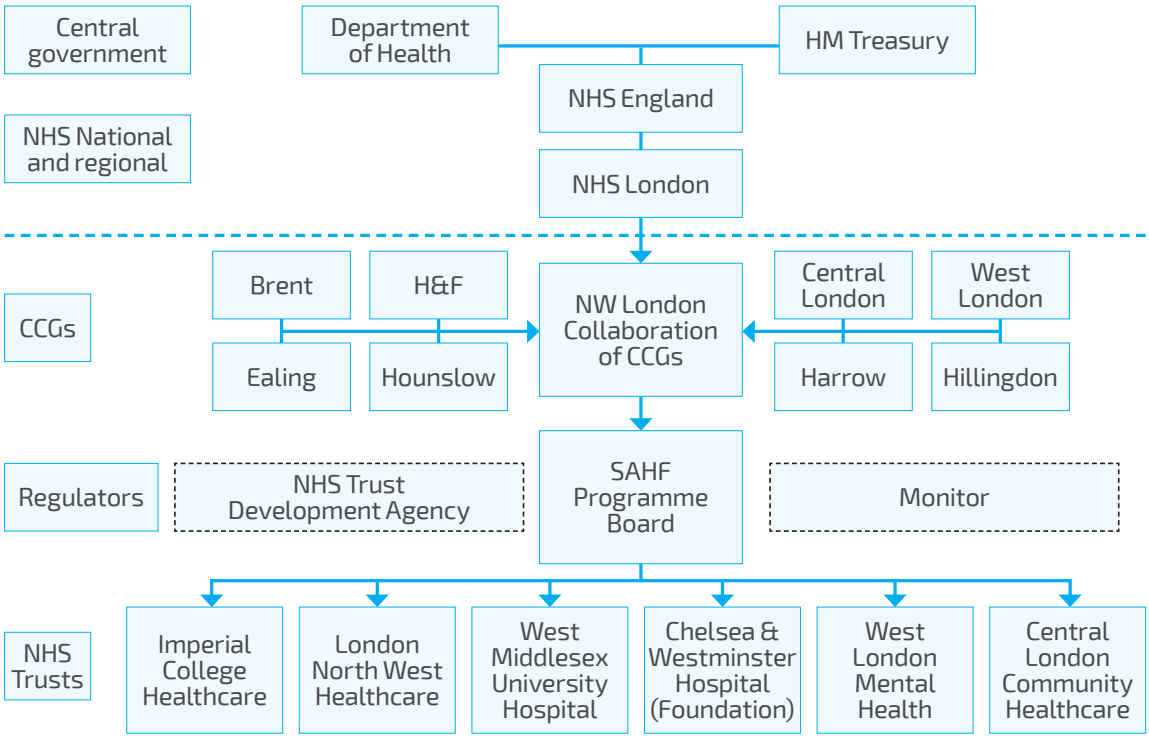
6.5 When asked by the Commission who he sees as the decision-makers in the hierarchy, Colin Standfield stated:

"Well the decision-making authority appears to be an entity known as Shaping a Healthier Future because I keep being told that this has to be done because Shaping a Healthier Future says so. I do not know what Shaping a Healthier Future is. I know some of it is people, Dr Anne Rainsberry, Dr Mark Spencer and somewhere along the line this nexus of Clinical Commissioning Groups who all signed up to the original Pre-consultation Business Case."

6.6 The following graphic illustrates the governance arrangements that the Decision Making Business Case set out for the SaHF programme in 2013.



6.7 The following graphic sets out what the Commission believes to be the current governance arrangements that are responsible for decisions affecting the SaHF programme today.



6.8 The opaque nature of the governance structure for SaHF makes scrutiny of the programme a difficult task for local authorities. The authorities have individual scrutiny powers of their own, pre-dating the Health & Social Care Act, relating to the CCGs and NHS providers in their area, and the JHOSC has been set up for the sole purpose of scrutinising the SaHF programme. As a result of the Act, authorities also lead local Health and Wellbeing Boards, which relate both to public health issues and to CCGs.

6.9 Healthwatch bodies and Patient Participation Groups (PPGs) have a different scrutiny role to that of local authorities. The evidence of the Healthwatch bodies revealed a confusion as to their actual role in relation to scrutiny of and challenge to the SaHF programme. Questioning the programme itself was something that at least one Healthwatch chair felt was beyond her remit.

6.10 PPGs are clearly active in many areas in engaging with the commissioning process but there is a perception, certainly among the PPG witnesses that presented evidence to the Commission, that the CCGs find them a burden and do not want to be challenged over procurement processes and commissioning decisions. The Commission heard evidence of PPG representatives being removed from CCG procurement bodies for being 'awkward'.

Conclusions

6.11 There is a lack of transparency in the governance arrangements for the SaHF programme. There needs to be clearer accountability for decision-making across the whole programme. There has been no direct engagement of local authorities in their wider community leadership role, nor sufficient engagement with adult social care departments about the sub-regional agenda, beyond the borough level mechanisms, despite the impact of these changes on adult social care practices.

6.12 The scrutiny role of Healthwatch bodies needs to be clarified as the organisations are, themselves, unclear as to exactly what their role is in challenging the programme.

6.13 The role of PPGs might also be clarified as there appears to be some uncertainty around confidentiality issues when patient representatives are involved in procurement processes.

Recommendation 11:

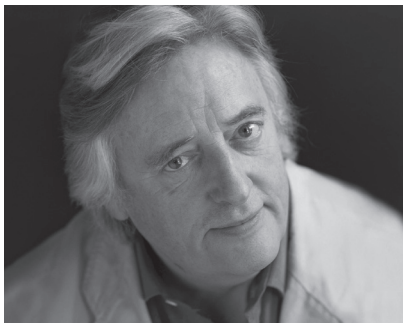
The Commission recommends that elected local authority representatives be invited to attend SaHF Programme Board meetings to give greater public accountability and transparency.

Recommendation 12:

The Commission recommends that NHS England issues up to date guidance to CCGs and Healthwatch England as to the exact scrutiny role of Healthwatch bodies and Patient Participation Groups in all matters of commissioning and service reconfiguration.

Appendices

The Commissioners



Michael Mansfield QC (Chair)

Michael Mansfield has represented defendants in criminal trials, appeals and inquiries in some of the most controversial legal cases the country has seen. He represented the family of Jean Charles de Menezes and the families of victims at the Bloody Sunday Inquiry. He chaired an inquiry into the shoot to kill policy in the North of Ireland and has represented many families at inquests, including the Marchioness disaster and the Lockerbie bombing. He also represents the family of Stephen Lawrence. In 2013 he chaired the Lewisham People's Commission: an inquiry into the proposals to close Lewisham Hospital A&E, Maternity and Childrens Services. In 2015 he has been representing families of victims of the Hillsborough disaster at the Hillsborough Inquiry.

Dr John Lister

John Lister has written and researched extensively on health services and health policy issues for trade union and other organisations for over 28 years. His PhD thesis (2004) was a comparative study of market-style reforms on health care systems around the world, a revised version of which was published in 2005 as 'Health Policy Reform, Driving the Wrong Way?' by Middlesex University Press. In 2008, to mark the 60th anniversary of the National Health Service John researched and wrote a major book: 'The NHS After 60, for Patients or Profits' (Middlesex University Press), which is still the most up to date history of the NHS. John is a joint chair of the Standing Orders Committee of the National Union of Journalists and a member of the Medical Journalist's Union, the Guild of Health Writers, and the Association of Health Care Journalists (US-based) for whom he has helped edit a European web page.

Dr Stephen Hirst

Stephen Hirst is a retired family doctor who worked in Chiswick and Brentford. He was managing and senior partner within a large group practice. Over forty years of professional life he experienced many changes in the NHS and the GP's role. His postgraduate training was at Charing Cross Hospital. He went on to hold several posts associated with the Hospital mostly related to teaching and training. These included working as an academic facilitator, an Honorary Senior Lecturer and also as the Postgraduate Tutor in General Practice. He was recently appointed as a GP Specialist Advisor to the Care Quality Commission and works as a voluntary GP Assessor for the Confidential Enquiry into Maternal Deaths.

Written Evidence Submissions and Witness Statements Received

NHS bodies

Brent Clinical Commissioning Group
Dr Etheldreda Kong, Chair

Central London Clinical Commissioning Group
Dr Ruth O'Hare, Chair

Ealing Clinical Commissioning Group
Dr Mohini Parmar, Chair

Hammersmith & Fulham CCG
Dr Tim Spicer, Chair

Harrow Clinical Commissioning Group
Dr Amol Kelshiker, Chair

Hillingdon Clinical Commissioning Group
Dr Ian Goodman, Chair

Hounslow Clinical Commissioning Group
Dr Nicola Burbidge, Chair

West London Clinical Commissioning Group
Dr Fiona Butler, Chair

North West London Collaboration of CCGs
Medical Directors

Imperial College Healthcare NHS Trust

London North West Healthcare NHS Trust

Royal Colleges and Universities

Royal College of Emergency Medicine
Dr Julian Redhead, Chair, London Board

Royal College of Nursing

Royal College of Surgeons
Jonathan Ramsey, Director of Professional Affairs

Queen Mary University
Professor Allyson Pollock

Clinicians and NHS staff

Anonymous clinician for Imperial NHS Trust

Anonymous medical secretary

Anonymous midwife

Hayley Archer, midwifery student

Sadie Eyles-Slade, midwife

Dr Louise Irvince

Dr K (anonymous GP)

Regina Kincaid, midwife

Professor Clara Lowy

Ranjit Mahal, midwife

Dr Donald McRobbie

Josephine Njogu, midwife

Dr Rakowski

Tomas Rosenbaum FRCS

Dr Ajaib Sandhu

Dr Gurjinder Singh Sandhu

Dr Abraham Teferi

Local authority bodies and councillors

Brent Council

Brent Council Scrutiny Committee
Cllr Mary Daly, Committee Member

Ealing Council
Cllr Hitesh Tailor, Cabinet Member for Adults, Health and Wellbeing

Greater London Authority Health Committee
Dr Onkar Singh Sahota, Chair

Hammersmith and Fulham Council
Cllr Rory Vaughan, Chair, Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Hammersmith and Fulham Conservative Group

Harrow Council

Hounslow Council

Kensington and Chelsea Council
Cllr Robert Freeman, Chairman, Adult Social Care and Health Scrutiny Committee

North West London Joint Health Overview and Scrutiny Committee

Members of Parliament

Angie Bray, MP for Ealing Central and Acton

Stephen Pound, MP for Ealing North

Andy Slaughter, MP for Hammersmith

Healthwatch and Patient Participation Groups

Healthwatch Brent

Healthwatch Central West London

Healthwatch Ealing

Brent Patient Participation Groups Four Locality PPG Chairs

Harrow Patient Participation Group
Rob Sale, Harrow PPG Committee

Other organisations

Brent Fightback

Brent Trade Union Council

Cavendish Staffing Ltd
Maireed Liston

Ealing Save Our NHS Action Group
Eve Acorn, Committee Member

Richmond Park Constituency Labour Party

Save Our Hospitals:
Hammersmith and Charing Cross
Merril Hammer, Chair

Members of the public

Charlotte Abbott

Harry Alvarez

Rebecca Amery

Sebastian Balfour and Grainne Palmer

Katrina Black

Giulia Bove

Ruth Bradshaw

Judy Breens

Lucia Cavalcanti-Vervecken

Annette Chambers
and Desiree Cranenburgh

Mr NFC Coward

Winsa Dai

Philip Day

Stewart Derrick

Anne Drinkell

Kate Fowler

Fiona Gibson

James Grealy

Mohinder Singh Grewall

Jessica Hall

Pam Hughes

Karah

Abi Luffman

Herbai Hirani

Helen Kuttner

John McNeill

Lalita Nagrajan

Sonal Patel

Rosa Suarez Ortiz

M. Robinson

Helen Savery

Jasveer Singh Gill

Gillian Spragg

Colin Standfield

Tamara Walker-Moore

Richard and Theresa Adam

Mr J Ambrosino

Sandeep Bafna

Elizabeth Balsom

Sarah Boston

Rae Bowdler

Arthur Breens

Gen Capazorio

Sapna Chima

Vic Cowan

Ian Cranna

Nikki Daniel

Tamara Dragadze

Cathleen Dittrich

Phillip Brownley Eldridge

Bob Garner

Judith Gordon

John Green and
Dr Bruni de la Motte

Elaine Griffin

Suzanna Harris

Valerie Hull

Marc Loost

Richard Hering

Rizwana Khan

Nick Martin

Christine Merrigan

Carol and Ray Nurse

Julia O'Connell

Keith Perrin and
Elizabeth Gaynor Lloyd

John Ryan

Kate Sinclair

Mary Smith

Linda Stewart

Adrienne Talbot

Dede Wilson

All written evidence and witness statements submitted to the Commission have been published. They can be found via the following link: www.lbhf.gov.uk/healthcarecommission

List of Witnesses

Hammersmith Town Hall, 14 March 2015

Andy Slaughter, MP for Hammersmith

Royal College of Nursing:
Sharon Bissessar, Senior RCN Officer
Nora Flanagan, RCN London Operational Manager

Hammersmith and Fulham Council:
Cllr Stephen Cowan, Leader
Cllr Vivienne Lukey, Cabinet Member for Health and Adult Social Care
Cllr Rory Vaughan, Chair, Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

H&F Conservative Group:
Cllr Andrew Brown

Royal Borough of Kensington and Chelsea:
Cllr Robert Freeman, Chairman, Adult Social Care and Health Scrutiny Committee

Elizabeth Balsom, Putney resident

John McNeill, regular NHS service user and Board member, Healthwatch Ealing

Tomas Rosenbaum FRCS, Consultant Urologist, Ealing Hospital

Save Our Hospitals:
Merril Hammer, Chair
Jim Grealy

Anne Drinkell, Brent resident and Secretary, SOH

John Ryan, H&F resident

Royal College of Surgeons:
Jonathan Ramsey, Director of Professional Affairs

Sebastian Balfour and Grainne Palmer, Hammersmith residents

Ealing Town Hall, 21 March 2015

Stephen Pound, MP for Ealing North

Ealing Council:
Cllr Julian Bell, Leader
Cllr Hitesh Tailor, Cabinet Member for Adults, Health and Well-being

Chair, GLA Health Committee:
Dr Onkar Sahota, Assembly Member for Ealing and Hillingdon and Ealing GP

Clara Lowy MD MSc FRCP, retired Diabetic and Endocrine Physician and Ealing resident

Sadie Eyles-Slade, midwife at Ealing Hospital

Healthwatch Ealing:
Carmel Cahill, Chair

Ealing Save Our NHS Action Group: Eve Acorn, Committee Member

Dr K, anonymous clinician

Colin Standfield, Ealing resident

Dr Gurjinder Singh Sandhu, consultant at Ealing Hospital

Judy and Arthur Breens, Ealing residents

Richard Hering, Ealing resident

**Hounslow Civic Centre,
28 March 2015**

Chair, Joint Health Overview and Scrutiny Committee (JHOSC)
Cllr Mel Collins

Hounslow Council:
Cllr Steve Curran, Leader
Cllr Lily Bath, Cabinet Member for Health and Adult Social Care

Royal College of Emergency Medicine:
Julian Redhead, Chair, London Regional Board

Professor Allyson Pollock,
Queen Mary University

Dr Ajaib Sandhu, Ealing and Hounslow GP

Dr Abraham Teferi, Consultant Virologist

Healthwatch Central West London:
Christine Vigars, Chair,

Phillip Brownley Eldridge, Isleworth resident and patient representative on Hounslow and NWL CCG

Dr Louise Irvine, Lewisham Campaign

**Brent Civic Centre,
9 May 2015**

Dr Mark Spencer, Medical Director, SaHF Programme,
Deputy Regional Medical Director, NHS England (London),
GP at Hillcrest Surgery (Ealing)

Dr Mohini Parmar, Chair, Ealing CCG
GP Partner Barnabas Medical Centre

Ursula Gallagher, Director of Quality and Patient Safety for Brent, Harrow and Hillingdon CCGs.

Tina Benson, Director of Operations, London North West Healthcare NHS Trust

Brent Council:
Cllr Muhammed Butt, Leader
Cllr Krupesh Hirani, Cabinet Member for Adults, Health and Well-being

Brent Patient Participation Groups:
Peter Latham, Chair, Willesden PPG
Robin Sharp CB, Chair, Kilburn PPG

Harrow Patient Participation Network:
Varsha Dhodia and Rob Sale

Healthwatch Brent:
Ann O'Neill, Chief Executive, and Ian Niven, Co-ordinator

Keith Perrin and Elizabeth Gaynor Lloyd, Brent residents

Ruth Bradshaw, Brent resident

Dede Wilson, Save Our Hospitals campaign

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