1. Introduction

1.1 "Shaping a healthier future" is NHS North West London's proposed programme of change for both out of hospital and hospital services and this is Hammersmith & Fulham Council's response to the proposals. They represent a radical reconfiguration of local health services, including a reduction in the scope and breadth of services provided at Charing Cross Hospital and, to a lesser extent, at Hammersmith Hospital. Given that they will have a profound and lasting impact on local health services, services that are of the utmost importance to local people, the Council is committed to responding fully to the consultation.

1.2 The Council considers that there are several key flaws in the proposals. Broadly, these can be categorised as fundamental problems with the consultation process and methodology, failure to take account of current relative clinical outcomes, and a lack of due regard for the impact on the people who live and work in Hammersmith & Fulham. The proposals are consequently seen as unsafe from the Council's perspective.

1.3 The Council, through its Scrutiny committee, will therefore decide whether to refer the process to the Secretary of State based on the criticisms set out in this document. Further, if the final decision is taken to close the A&E departments at Charing Cross and Hammersmith Hospitals, then the Council, again through its Scrutiny committee, will decide whether to refer this to the Secretary of State as it will represent a significant detrimental impact on health services for local residents. Irrespective of any decision or outcome the Council also expects to see, and be consulted on, detailed plans for the future of the Charing Cross site.

2. Context

2.1 "Shaping a healthier future" is NHS North West London's proposed programme of change for both out of hospital and hospital services. The proposals are now subject to formal consultation, closing on 8 October 2012. This document forms Hammersmith & Fulham Council's response to this consultation. It is presented in this form to encapsulate the whole range of issues that the Council wishes to cover in its response, which would not be possible using the standard consultation response form provided.

2.2 The proposals represent NHS North West London's response to the significant challenges facing the NHS, namely the need to improve the quality of care and reduce unwarranted variation; the need to improve the health of local people and reduce health inequality; and the need to address substantial financial challenges to ensure that services and organisations are sustainable for the long term.

2.3 The proposals represent a radical reconfiguration of local health services, with an increased emphasis on out of hospital care and a reconfiguration of NW London's hospitals. For Hammersmith & Fulham, this means a reduction in the scope and breadth of services provided at Charing Cross Hospital (most notably including a downgrading of the Hospital's A&E and the removal of complex

medicine and surgery services) and, to a significantly lesser extent, at Hammersmith Hospital (both hospitals are currently managed by Imperial College Healthcare NHS Trust).

2.4 Hammersmith & Fulham Council (hereinafter "the Council") is determined to champion the interests of residents by playing a full and positive role in ensuring that the people living and working in Hammersmith & Fulham have access to the best possible healthcare and enjoy the best possible health. Given that NHS North West London's proposals will have a profound and lasting impact on local health services, services that are of the utmost importance to local people, the Council is committed to responding fully and positively to the consultation.

2.5 In this context the Council recognises the need for local health services to improve and develop to meet the changing and growing demands of local people, against a backdrop of the increasing financial challenges that have resulted from the overall pressure on public sector expenditure. Indeed, the Council faces exactly the same challenges in relation to its own services and statutory responsibilities.

3. The Council's position

3.1 In order to inform, inter alia, this consultation response, the Council commissioned an independent review into the proposals. This has identified a number of fundamental flaws in the approach taken by NHS North West London to determine the changes that should be made to local health services. Broadly the key flaws can be categorised as:

- Fundamental problems with the consultation process and methodology;
- Failure to take account of current relative clinical outcomes; and
- Lack of due regard for the impact on the people who live and work in Hammersmith & Fulham.

3.2 Taken together, these flaws mean that in effect NHS North West London's proposals have not been developed in a sufficiently robust way and are consequently seen as unsafe from the Council's perspective.

3.3 The review final report, which should be read in conjunction with this consultation response, is attached as Annex A. Its principal conclusions, which are endorsed by the Council, are as follows:

- The objectives of "Shaping a healthier future" are appropriate (i.e. of improving service quality and reducing unwarranted variation, improving the health of local people through the provision of better care, and ensuring that organisations are financially viable for the long term);
- The current provision of local healthcare is not acceptable, as it is too often characterised by unacceptable levels of quality and service and unwarranted variation, substantial health inequalities, and an unsustainable financial position;

- The adequacy of the pre-consultation engagement of key stakeholders, notably patients, public, clinicians and the Council itself is open to challenge;
- The extent to which the requirements of the 2010 Equality Act have been met in determining the impact of proposals on protected groups at a borough level is open to challenge;
- The timing of the consultation is open to challenge. Consideration should be given to amending the current timetable to allow for further consultation with the affected parties, detailed impact assessment work to be undertaken and revisions to be made to the decision making arrangements;
- The decision making arrangements are inappropriate. Consideration should be given to amending the arrangements to ensure that any decisions are made by the new NHS and local government arrangements that come in to effect on 1 April 2013, rather than key decisions being made by organisations on the eve of their abolition;
- The programme's objectives are appropriate (i.e. of preventing ill health; providing easy access to high quality GPs; and supporting patients with long term conditions and to enable older people to live more independently).
- The assumption that NW London has an over-provision of acute hospitals is open to challenge. If the preferred option for restructuring is adopted, adult acute bed provision in NW London will be reduced to just over half of that required;
- The underlying financial model used to establish the "base financial position" has not been subject to independent verification and cannot necessarily be relied upon to support true comparisons between hospitals. In some cases it is also at odds with organisations' own views of their underlying financial position;
- The proposed clinical standards and visions are appropriate;
- The proposed improvement of Out of Hospital care is appropriate. Given the current shortcomings in primary care, detailed plans should now be developed for urgent implementation;
- The Out of Hospital improvements should be fully implemented before irrevocable decisions and changes are made concerning hospital reconfiguration;
- The methodology used to identify and choose between the various reconfiguration options is open to challenge as it contains a number of fundamental flaws;
- The options appraisal and the resultant preferred option (and secondary options) are open to challenge, on the grounds of the sequential approach (which potentially distorts conclusions), the selective choice of indicators, the absence of an assessment of actual quality and performance, the lack of sufficiently detailed assessment in critical areas (e.g. travel times) and the practical application of the indicators (including a high level of double counting);
- The proposal to designate Charing Cross Hospital a "Local Hospital" and the proposed service reductions at Charing Cross Hospital and Hammersmith Hospital is not based upon a sound premise given the flaws in the methodology;
- The readiness of the local health system to cope with the scale of change proposed has not been demonstrated;

- The scale of change proposed, and in particular the significant and potentially adverse impact on the people of Hammersmith & Fulham, has not been adequately explained or addressed;
- Further significant work should be done to understand, in substantially more detail, the impact on local people; and
- There should be a more transparent articulation by the NHS of the motivations behind the proposals, most notably the need to reduce expenditure.

3.4 The Council, through Scrutiny, will therefore seek to refer the process to the Secretary of State based on the criticisms set out in paragraph 3.3 and in more detail below.

3.5 If the final decision is taken to close the A&E departments at Charing Cross and Hammersmith Hospitals, then the Council, again through Scrutiny, will seek to refer this to the Secretary of State as it will represent a significant detrimental impact on health services for local residents.

3.6 This consultation response now explores these issues, concerns and conclusions in more detail.

4. The pre-consultation and consultation process

- **Engagement**

4.1 In light of the significance of the proposals, the pre-consultation engagement should have been extensive and comprehensive. It should have involved all key stakeholders and should have set out very clearly the emerging implications of the proposals, particularly for those most affected and for those most vulnerable. In the view of the Council some aspects of the engagement process are open to challenge.

4.2 Inadequate public consultation took place during the development of the proposals. Public participation was largely confined to three pre-consultation engagement events that were attended by in total approximately 360 members of the public (about one in five thousand of the NW London population). Crucially, given the large scale impact on the people of Hammersmith & Fulham, there were no specific attempts to engage with local people during the pre-consultation period.

4.3 In particular, the work done to engage with hard-to-reach and vulnerable groups is open to challenge. The business case makes reference to section 149 of the Equality Act 2010 and briefly references work to engage and consult vulnerable groups. However detail is not explicitly provided on the nature of engagement, the issues and concerns raised by those groups, and the programme's response. This is an important and unfortunate omission, given the legal requirements and the diverse nature of Hammersmith & Fulham's population.

4.4 The business case states that the programme has been clinically led and supported by GP commissioners and hospital clinicians. However the extent to

which this work has been influenced by the management consultants engaged to produce the report and their own views and models is not clear. The extent to which the programme is genuinely supported by front-line clinicians across NW London and in particular Hammersmith & Fulham is not clear. Local anecdotal evidence indicates that there are a significant number of local clinicians (GPs and hospital clinicians) that have serious concerns about the proposals and that consequently do not support them.

4.5 Furthermore, the business case equates support from the leaders of the "shadow" clinical commissioning groups (CCGs) with support from GPs in general. Simply because the proposals are supported by the chairs of the "shadow" CCGs and their boards this does not automatically equate with the support of local GPs. There is anecdotal evidence that a number of local GPs have significant concerns about the proposals and their implications for Hammersmith & Fulham.

4.6 The summary of clinical engagement meetings attended by programme representatives has no specific mention of Imperial College Healthcare NHS Trust clinicians. Given the implications for Imperial, local clinicians in particular should have been actively targeted for engagement and their responses explicitly used to shape the proposals.

4.7 It appears that public health clinicians and professionals have had only limited engagement in the development of the proposals. Public health directors have not had a formal connection with the programme, have not been engaged in the modelling and options appraisal, and have not been given an opportunity to assess the impact of the proposals on the health of local people. This is a significant omission. It is clearly essential to understand the impact of the proposals on each borough's population. The Directors of Public Health, given their statutory roles and responsibilities, should have played a key role in this.

4.8 The statements made in the business case relating to wider engagement and involvement in shaping the proposals are also open to challenge. While sound, the stakeholder engagement principles do not address the apparent democratic deficit in the process. It is difficult to see how such proposals can be legitimised democratically without both the active engagement and support of local government. Currently, significant aspects of the proposals do not have the support of the Council.

4.9 The stakeholder mapping makes reference to the "political" stakeholder grouping including various local government representatives (Health Overview & Scrutiny, Councillors and Cabinet Members). Explicitly the chapter states that "there has been significant engagement with political stakeholders throughout the pre-consultation period". Contrary to this statement senior members and officers within the Council have not been engaged effectively in the development of the proposals.

4.10 While it is intended that more work will be done to engage the public and that "this will include work with local authority colleagues who support voluntary and

community sector networks… who are able to access a large number of community members through the work they undertake", this engagement activity should have taken place before the development of the pre-consultation business case.

4.11 The NHS, in pursuing such service changes, is legally required to engage with Health Overview & Scrutiny Committees. For this programme a Joint HOSC has been set up but this operated in shadow form until July 2012 and so has not been given sufficient time to be established before being asked to make crucial decisions. The adequacy of engagement with scrutiny is open to challenge.

4.12 The extent to which the views expressed by stakeholders have been taken into account in shaping the proposals is open to challenge. In a number of cases themes arising from engagement activities do not appear to have been explicitly addressed (e.g. the impact on protected groups; further explicit consideration given to mental health and the elderly). The business case does not but should have set out how each issue raised has been addressed.

- **The "Four Tests"**

4.13 The business case asserts that the current NHS "Four Tests", required to be met by all reconfiguration proposals before they can proceed, have been met. This is open to challenge. Support from GP commissioners has not been demonstrated conclusively, as engagement with the newly developing CCGs is often given as evidence of engagement with GPs but CCGs are not yet statutory bodies and their leaders are not necessarily representative of the individual member practices.

4.14 The business case references a wide range of engagement activities but this is insufficiently evidenced. The substance of the discussions is not included. The response of the various groups to the proposals is not provided. The impact that those responses had on the proposals is not clear.

4.15 The core argument for reconfiguration is restated, namely that there are currently unacceptable variations in the quality of services across NW London and that "there are significantly improved outcomes for patients and improved patient experience when certain specialist services are centralised". However this theoretical hypothesis has not been tested against the actual outcomes and current patient experience in NW London.

4.16 It is also stated that the clinically led nature of the development of the proposals has "ensured that the clinical vision and standards lead the reconfiguration proposals". This is open to challenge. The achievement of the clinical vision and standards can be decoupled from the reconfiguration proposals. The business case states that "all London providers will be held to account against [the clinical] standards over the next three years and local GPs in their clinical commissioning groups are putting in place processes to ensure they are delivered". This is open to challenge. It suggests that plans are

proceeding prior to consultation. It also potentially reinforces the point that the clinical standards can be delivered without the need for radical reconfiguration.

4.17 The business case states that "'Shaping a healthier future' has maintained the balance between providing integrated, localised care and safe, high quality services, centralising services where to do so would significantly improve service provision". This is open to challenge, particularly from a Hammersmith & Fulham perspective. There is no assessment of how local people really feel about the proposed reduction in service at Charing Cross Hospital and Hammersmith Hospital. There is no evidence that this will enhance their choice of care.

- **Equalities Impact Analysis**

4.18 The equalities impact analysis carried out in July 2012 looked at the impacts of the proposed options on populations with protected characteristics within NW London and does not provide a detailed disaggregation of data at borough level. However, the high level identification of potential equality "hotspots" notes that, for major hospital services, Hammersmith & Fulham has the second most numerous critical equality areas in NW London and for maternity services the most numerous (joint with Brent).

4.19 The business case states that "overall the difference between the three options for consultation was found to be minimal with Option 6 likely to give rise to a higher level of adverse effects to the protected groups". However, from a Hammersmith & Fulham perspective, the equality impact analysis highlights that the preferred option has a disproportionate effect on younger people (aged 16 to 25) and older people (aged over 64).

4.20 The business case states that the July 2012 analysis was seen as the first piece of work in the analysis of the proposed configuration on protected groups and that further work will be undertaken during the consultation period. Given the risks of change to vulnerable groups, such detailed work should have been completed before consultation.

- **Timing and decision-making**

4.21 The timing of the consultation, decision-making and implementation processes are open to challenge. Decision making is due to take place from October 2012 to January 2013, with implementation from January. Notwithstanding the fact that the consultation period runs for fourteen weeks (just two more than the statutory minimum) it is not good practice to consult over the summer when stakeholders are not able to give the consultation their full attention.

4.22 Further, the proposals have been developed during a time of major organisational change within the NHS. The 2012 Health Act abolishes Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) from 1 April 2013, replacing them with local CCGs and the NHS Commissioning Board. The business case states that all NW London CCGs have been established. This is

not strictly true. The current PCT and SHA structures are still in place (albeit on a clustered basis) and are still statutorily responsible for local health services until 31 March 2013. "Shadow" CCGs have been set up as sub-committees of PCTs and are currently participating in a formal assessment process to support their eventual establishment and authorisation by early 2013 for them to "go live" on 1 April 2013.

4.23 Crucially, PCTs and SHAs will still be in place at the conclusion of the consultation and will formally make the decisions on "Shaping a healthier future", shortly before their abolition. The JCPCT (Joint Committee) of the eight PCTs has taken the decision to proceed to consultation on the proposals and will "ultimately, take the final decision on whether to proceed with proposed service changes".

4.24 Given the significance of the proposals, it is far more appropriate for any decision to be considered and made by the eight CCGs, once established and authorised, after 1 April 2013. It will clearly be impossible to hold PCTs (and their officers) to account for these decisions once they have been abolished. The new CCGs should clearly take responsibility for such matters, once they are statutorily able to do so. They have a stake in the future and can subsequently be held to account for those decisions.

4.25 In addition the 2012 Health Act also establishes Health & Wellbeing Boards (HWBs) from 1 April 2013. HWBs will be hosted by local authorities and will have responsibility for the strategic oversight of health and healthcare in their area. Their membership will comprise senior representation from local authorities, CCGs and the NHS Commissioning Board. They will be responsible for their area's Joint Strategic Needs Assessment (JSNA) and, in response to their JSNA, will lead the development of Joint Health & Wellbeing Strategies (JHWS). CCGs, in developing their own commissioning plans, are statutorily required to have regard for their local JHWS and they will account to HWBs for their decisions and actions, and for the performance of local health services.

4.26 It would therefore seem highly inappropriate for significant decisions to be made about local health services just before HWBs are established. HWBs should be given an opportunity to properly consider the implications of "Shaping a healthier future" for their local people and they should be clearly involved in the governance and decision making arrangements.

- **Programme assurance**

4.27 A review of the programme was undertaken by the National Clinical Advisory Team (NCAT), which highlighted, amongst other points, the importance of "[ensuring] capacity and capability exists within the Out of Hospital services to operate 24/7". Similarly, in looking at the proposals for maternity and paediatrics, NCAT stated "the need to ensure that community services are in place before closing acute services". Currently this capacity and capability is not in place.

4.28 The Office of Government Commerce (OGC) also undertook a Health Gateway review in April 2012. They gave the overall programme an amber/green assessment. In their summary of recommendations they highlighted the following:

- "Identify clearly the benefits to patients proposed for each Borough, together with who owns them and how they will be measured;
- Develop and agree the future vision for the Charing Cross site, with the engagement of local clinicians, prior to consultation".

4.29 To date it appears that neither recommendation has been fully complied with. In particular the Council has not been engaged in the relevant discussions.

5. Methodology

5.1 There are key aspects of the methodology used by NHS North West London in drawing up 'Shaping a healthier future' that are open to challenge.

5.2 The general flaws with the underpinning principles and analysis can be summarised as follows:

- Insufficient exploration of alternatives to hospital reconfiguration;
- The absence of any detailed independent verification of the baseline financial model provided by local NHS Trusts to support the proposals; and
- The unnecessary combining of much needed proposals to strengthen primary and community services with proposals to reconfigure local hospitals.

5.3 In terms of the methodology used to identify the initial "long-list" of eight potential options, the key issues can be summarised as follows:

- The absence of detail regarding the difference between the patient case-mix of traditional A&Es and the newly proposed Urgent Care Centres;
- The sequential nature of the methodology does not provide the opportunity for all of the options to be tested on a truly comparable basis;
- The exclusive focus on organisations and institutions, rather than the needs and preferences of local people;
- The use of "location" as the primary driver for the development of options, rather than other factors including the needs of local people and the relative quality of local hospital services;
- The lack of supporting detail for the decision to propose the reduction to five "major" hospitals; and
- The use high of level rather than detailed travel times and other measures of access to determine the location of the eight options;

5.4 In terms of the methodology then used to differentiate between the eight options, the key issues can be summarised as:

- The explicit absence of consideration of the potential to integrate services and impact on health inequalities from the options appraisal;

- The explicit disregarding of the current relative quality of service provided by NW London's hospitals;
- The use of Trust level, rather than hospital level, data;
- The inappropriate use of estates data as a proxy for measures of patient experience (contrary to local evidence);
- The explicit disregarding of real patient experience data;
- The absence of any measure of access and travel times to differentiate between the options;
- The use of a spurious argument concerning the correlation between the number of NHS trusts, rather than individual hospitals, offering services and patient choice;
- The absence of sufficient detail in the assessment of the relative capital costs and transition costs of each option;
- The use of marginal differences in estimated financial viability of NHS Trusts;
- The use of a Net Present Value calculation that double counts all of the financial indicators;
- The inappropriate use of staff survey results and the baseline financial model as a proxy for readiness to deliver; and
- The inconsistent assessment of co-dependencies with other strategies.

5.5 In light of the cumulative impact of the above, the Council considers that the methodology is fundamentally unsafe and the conclusions reached are consequently open to challenge.

5.6 Specifically this brings into question NHS North West London's preferred option, which includes downgrading Charing Cross Hospital and Hammersmith Hospital, and transfers key services, including A&E, to Chelsea & Westminster Hospital. The differences between the hospitals reached using the methodology are confined to:

- The patient experience assessment, driven by an inappropriate use of estates indicators;
- The patient choice assessment, driven by a spurious argument about the number of NHS Trusts managing Major Hospitals;
- The financial surplus assessment, that has not been subject to verification and the materiality of which is subject to challenge;
- The Net Present Value calculation, that double counts previous measures and is subject to challenge; and
- The workforce assessment that inappropriately underrates Imperial Trust compared with Chelsea & Westminster.

5.7 In more detail:

- **The case for change**

5.8 The proposals are predicated on the need for substantial change that must start now. Included is an assessment of the changing demands on the NHS in NW London but it is not clear if the business case takes account of the fact that more

than 20,000 extra homes are planned for Hammersmith & Fulham in the next 10 to 15 years.

5.9 The business case states that services also need to be redesigned to be more affordable and to ensure that money is spent in the best way. However, the business case does not explore any real alternatives to service reconfiguration that could be pursued in order to achieve the savings required.

5.10 In addition, the proposals are based on a number of academic studies, which provide the core evidential sources for supporting the need for centralisation of specialised services and specialist teams. However it is not clear what alternative models and concepts were considered. It is also not clear how these fundamental concepts were evaluated, considered and agreed.

5.11 Reference is made to a number of changes recently made in NW London and the moves to already centralise critical services in order to deliver high quality (e.g. in Major Trauma and Stroke services) and the improvements in integrating care. However, the business case states that more change is needed.

- **Principles and objectives**

5.12 The principles and objectives - to prevent ill health in the first place; to provide easy access to high quality GPs and their teams; and to support patients with long term conditions and to enable older people to live more independently - are appropriate. However the key enabler identified in the business case is securing much needed improvements in primary and community care, not hospital reconfiguration. No evidence is provided that demonstrates that the improvements required in GP services are dependent on hospital reconfiguration. Given the current low levels of patient confidence in GP services, improvements need to be made before the burden on those services is further increased as a consequence of reductions in hospital services.

5.13 There is also clear evidence of the need for local hospitals to improve the quality of care, given the relatively low levels of patient satisfaction and staff confidence and the marked variation against clinical indicators as evidence. Clearly, again, the intention to improve the quality of care should be supported. However this does not in itself alone automatically lead to a need to reconfigure hospital services. In the first instance the focus should be on improving performance within the current configuration. The options for this are not sufficiently addressed in the business case.

5.14 One of the key arguments for hospital reconfiguration and rationalisation is that the limited availability of senior medical personnel (particularly at weekends) has a detrimental impact on clinical outcomes. There are clear indications in fact that many of the current outcomes are satisfactory, notwithstanding the limited availability of senior medical personnel and specialist teams. The business case does not explore other ways of securing sufficient cover that are not dependent on service rationalisation.

5.15 The business case also states that "with NW London's growing population it is increasingly hard to provide a broad range of services around the clock at the existing nine acute hospital sites to the standards…patients should expect". This is open to challenge. It is not clear what alternatives to service rationalisation have been explored in order to address this issue. The argument is made for rationalising A&E departments that "we have more A&E departments per head of population than other parts of the country and this makes it harder to ensure enough senior staff are available", but this statement is not supported by quoted evidence. It is not clear whether the pattern in NW London has been compared with truly comparable populations. It is also not clear that local outcomes in A&E departments support this theoretical proposition.

5.16 In light of the above, the business case concludes that the area has an overprovision of acute hospitals for the size of the local population when compared with the average for England. This is open to challenge. Comparisons should not just look at the size of population but also relative complexity and need. It is not clear if this assessment is based on a comparison with similarly complex and growing populations.

- **The financial model**

5.17 Financial analysis is a key element of the underpinning rationale for the proposed changes but there are aspects of the financial model that are open to challenge.

5.18 It is again asserted that there are "extreme financial pressures" facing the NHS in NW London leading to the need for unprecedented levels of efficiency savings (4% per annum). Consequently, the business case states that "a major part of any future configuration of health services in NW London is the degree to which it can help address the financial challenge and create a sustainable health economy". This drive to ensure financial sustainability is clearly appropriate but the link between financial sustainability and reconfiguration is not unequivocally made.

5.19 The baseline financial modelling has been completed, using the respective organisations' own actual and forecast information for the financial year 2011/12. It appears that this information has been not been independently verified. Indeed, there is recognition that further work will be required to complete a "Generic Economic Model" to support any capital business cases. This is necessary analysis that should have been completed before consultation began.

5.20 Current savings plans are already assumed within the financial baseline position. These represent a reduction in acute hospital income of between 9% and 15% based on current levels of patient activity, mainly focused on reductions in outpatients and non-elective activity. This differentially affects the NHS Trusts in NW London. The variation in savings figures between Trusts increases the difficulty in making genuine comparisons. In addition there is no assessment of the realism of these assumptions.

5.21 High level financial forecasts for 2014/15 are set out by Trust. In total this indicates a forecast overall deficit of £8m (0.44% of total budgets), with Chelsea & Westminster the only Trust in what is deemed to be a viable position with a forecast surplus of £8m or 2.61% of turnover (Charing Cross Hospital has a forecast surplus of £1m or 0.44% and Hammersmith £2m or 0.63%). The forecast figures are directly informed by the assumptions around savings. Were Imperial to deliver savings equivalent to Chelsea & Westminster, the forecast position for Charing Cross and Hammersmith would be deemed to be viable. Equally, were Chelsea & Westminster to plan to deliver savings only at Imperial's level, it would not be deemed to be viable. The differences between Trusts are in reality marginal and subject to significant change depending on changes in the underlying assumptions and actual delivery.

- **Clinical model**

5.22 The business case sets out the proposed models of healthcare to be implemented across NW London and the clinical standards that have been designed to improve overall quality. The three core principles all appear sound. However, in applying them, it is also important to take into account the actual quality of care (and outcomes), other factors and constraints (e.g. the specific needs of local populations), and to allow sufficient time for each phase of development to be established before moving to the next phase.

5.23 A significant part of the business case is devoted to setting out proposals to change and improve Out of Hospital care, including the individual high level strategies developed by the shadow CCGs. While the proposals are sound, a great deal more work is required before implementation. It is stated that the developments planned for Out of Hospital care will take the pressure off local hospitals but the proposals to reconfigure hospital services are due to begin implementation before the Out of Hospital developments have been fully implemented. The two programmes of development should be decoupled. The Out of Hospital strategies should be fully implemented and evaluated before any final decision is made on hospital reconfiguration, let alone before reconfiguration actually starts.

5.24 Locally, there is much that is sound in the Out of Hospital strategy developed for Hammersmith & Fulham. However these proposed improvements are not dependent on hospital reconfiguration and in many instances simply reflect good practice in delivering high quality GP and community services. In light of the substantial investment enjoyed by the NHS over the last ten years, the longstanding evidence of relatively poor quality in primary care and the health challenges facing local people, it could be argued that these improvements should already have been secured. These improvements should now be further developed and implemented as a matter of urgency.

5.25 The principles and standards proposed for Out of Hospital care are sound. However, the practical development of this model for Hammersmith & Fulham should be developed with the full involvement of all parties, including the Council, and should be developed to specifically meet the needs of local people. Currently

the eight CCG level strategies appear somewhat generic and lack sufficient detail to support implementation.

5.26 The business case also provides helpful illustrative patient "journeys" to describe the impact of the proposed improvements in care. However, again the improved journeys do not appear to require reconfiguration per se, rather the improved management and delivery of care in line with the proposed clinical standards. Again, it can be argued that there is a case for "decoupling" the delivery of the standards from the proposals for reconfiguration of hospitals.

5.27 Having proposed a number of clinical principles and standards, the business case sets out the proposed service models for delivering the proposed principles and standards. At the heart of the proposals is a model comprising eight settings of care, ranging from "home" to "specialist hospital". In particular it proposes a distinction between "local hospitals" and "major hospitals", with fewer services provided at the former (e.g. an urgent care centre rather than a full A&E department).

5.28 In support of this model, it is stated that "primary care [is] at the heart of the change" It states that "at the moment variable quality of primary care services and poor coordination between services mean that more people end up in hospital than need to", although this isn't quantified in the business case. This should be tested further. Again, given current capability in primary care it could be argued that these services need to demonstrably improve before reducing hospital capacity. A common framework has been developed for improving primary care. This does not require formal consultation and should be decoupled from the case for reconfiguration and implemented as a matter of urgency.

5.29 Within the framework proposed for hospital care, there is a proposed model for "local hospitals" as defined in the model. It states that over 75% of care that would be delivered in a District General Hospital (DGH) can be delivered from a "local hospital". The implication is that up to a quarter of activity would be transferred to another hospital.

5.30 The business case describes the "local hospital" as "a seamless part of the landscape of care delivery…networked with local A&Es". However the implication is that a percentage of patients attending the urgent care centre of a "local hospital" in the first instance will then have to be transferred to the A&E department of a "major hospital" with the consequent increase in inconvenience and risk. Insufficient information is provided on the detailed implications of this assumption. It is not clear from the business case how many patients will require escalation to A&E from Urgent Care Centres or how many current A&E patients will be treated at Urgent Care Centres.

5.31 The conclusion reached in the business case is that "none of the current existing nine acute hospital sites in NW London is able to deliver the desired level of service quality that will be sustainable in the future". However this is not supported by empirical evidence.

- **Options appraisal**

5.32 At the core of the business case is a sequential options appraisal model (described as a "funnel" in the business case) that is used to identify a small number of options. The sequential nature of the option identification process does not provide the opportunity for all options to be tested on a truly comparable basis, as some options will (or may) have been discounted before a specific element of appraisal is applied, and therefore options that may well have scored well in terms of later elements of the appraisal are dismissed before an assessment can be undertaken.

5.33 The other fundamental challenge to the methodology relates to its almost exclusive focus on organisations and institutions, rather than the needs and preferences of local populations. Hammersmith & Fulham in particular is home to a highly diverse population. Ultimately any proposals to substantially reshape health services need to be developed, at least in part, on a sufficiently detailed needs basis. This is a major omission in the current methodology.

5.34 A number of key principles were established to inform the options development process, although it is not clear what alternatives were considered. The business case states that the principles were then used by clinicians to agree "that the options development process would be driven by the location of the major hospitals in NW London to ensure the appropriate delivery of urgent and complex secondary care across London". This decision to give primacy to "location" as the primary decision making driver should be challenged. Other factors should have been used, including the current quality and performance of services, the differential needs of local people, and the current and potential interdependencies (i.e. the impact of the proposed changes to urgent and complex secondary care on other services).

5.35 The business case states that a number of "hurdle criteria" were used to establish the right number of major hospitals (and thereby determine the proposed reduction from the current nine). The objectives of delivering acute clinical standards, deliverability and affordability are not in themselves contentious. However the criteria developed to meet the objectives are restrictive and do preclude consideration of other options for meeting the objectives.

5.36 For example, clinicians concluded that "their desired clinical standards could not be met if all nine current NW London acute sites … were to become major hospital sites". The business case does not provide the evidence for this conclusion. Given its importance in underpinning the proposal to reduce services provided at four of the nine sites, including Charing Cross and Hammersmith Hospitals, this is a significant omission.

5.37 The clinicians considered evidence about factors that were judged to contribute to high quality clinical care. The business case states that as a result of this consideration clinicians "identified that there should be between three to five major hospitals in NW London to support the projected population of 2 million", with a view that more than five major hospitals leading to sub-optimal

care. The proposals centred on five as the proposed number, primarily in light of current capacity constraints. The detailed evidence base for this decision to propose five major hospitals is not provided with the business case and is therefore open to challenge.

5.38 The identification of the options for location of the five major hospitals is entirely predicated on an analysis of the impact of changes to travel times. This is open to challenge. It is clearly appropriate for other factors to be considered, including relative clinical performance, population need and the interdependencies of other services.

5.39 The analysis in the business case demonstrates that the majority of the options would have an impact on Hammersmith & Fulham. The loss of a major hospital at Chelsea & Westminster or Charing Cross would see an increase in journey times of 48-57% and similarly the loss of a major hospital at St Mary's or Hammersmith would see an increase in 13-39%. This needs to be related to the actual numbers of people affected, as population density, and levels of deprivation, are generally higher in Hammersmith & Fulham than in the outer London boroughs. In addition it is not clear that the business case takes sufficient account of the fact that Hammersmith & Fulham is the second most congested borough in London.

5.40 However, the analysis concludes that because of the reported disproportionate impact on local people should Northwick Park or Hillingdon no longer provide major hospital services, it is proposed that they should both be major hospitals in the new configuration. This is open to challenge on two counts.

5.41 Firstly, the travel times analysis is insufficiently detailed. As the predicted routes have not been included in the analysis, it is not clear whether the assumed routes have sufficient capacity for the additional patients/visitors to the major hospitals or what impact (in terms of delays) this could have on the network as whole. It is also not clear whether the delays calculated consider any future growth on the network. A more detailed analysis of the impact on travel times is due to be completed by the NHS by the end of the consultation but this should have been available at the start. Secondly, no other factors beyond an analysis of travel times have been used at this stage to determine the location of the proposed "Major Hospitals".

5.42 The conclusion of the analysis of travel times is that in addition to Northwick Park and Hillingdon, the remaining three major hospital sites should be at i) either Charing Cross or Chelsea & Westminster, ii) either Ealing or West Middlesex, and iii) either Hammersmith or St Mary's. This is articulated by the eight options that are subject to further evaluation in the business case.

5.43 In order to evaluate the options, a number of criteria were developed. Some suggested by clinicians and patients were not accommodated, including integration of services, health equality across NW London, and support for preventative care and help for patients to manage their own conditions. These

exclusions are open to challenge. Their inclusion would go some way to addressing the inadequate population focus of the current proposals.

5.44 On the clinical quality criterion (the highest ranked by clinicians and patients), the position has been adopted that "current clinical quality at Trust level was not a useable proxy for future clinical quality at site level after reconfiguration was complete". This is a contentious statement and is open to challenge. It was proposed because the assessment used current mortality rates at Trust rather than site level. Given the importance of the quality aspect of the option appraisal, site level information should have been secured in order to allow for appropriate and necessary comparisons. The management teams of a number of the respective trusts have indicated that this information is available at site level. Regarding distance and time to access the service (again a highly important criterion for patients and the public), the business case places much less emphasis on this issue given that the criterion was a fundamental part of the basis for identifying the eight options. This is open to challenge. A much more detailed analysis on a more granular individual population and group basis should have been used to inform the options appraisal.

5.45 The subsequent option appraisal assesses the eight options against: quality of care; access to services; value for money; deliverability; and impact on research and education. Key aspects of the actual application of the evaluation criteria are open to challenge.

5.46 Regarding clinical quality, the business case sets out mortality rates by Trust for 2010/11. It would have been appropriate for the scores to have been disaggregated and examined in more detail on a site basis to give a much clearer view of relative respective clinical quality. However this has not been done. Instead, the business case states that "the reconfiguration is being pursued to achieve the clinical standards and the improved clinical quality through the reshaped clinical service models…After reviewing the data available on clinical quality, local clinicians agreed that all eight options…had been designed to achieve the highest levels of clinical quality and that the additional data reviewed at this stage of the evaluation did not provide any significant information that allowed them to differentiate between options on this basis". This is highly contentious and is open to challenge. Relative clinical quality is clearly of the utmost importance to patients, the public and clinicians. Should the current data really be inadequate for the purposes of site level comparisons, steps should have been taken to secure adequate data and for a detailed assessment to have been undertaken to inform the options appraisal. This issue alone undermines the credibility of the options appraisal.

5.47 The patient experience element of the quality criteria includes an assessment of the quality of the respective estates across the nine sites, based on the assumption that there is a correlation between the quality of the hospital or clinic where a patient is treated and their experience (although only very limited theoretical evidence is explicitly quoted to support this statement and it is contrary to local evidence). In order to use this as a comparative measure of patient experience the business case uses nationally collected site level

information (from ERIC returns) in terms of the proportion of space deemed to be not functionally suitable as NHS space and the age of the estate. This makes a large assumption that there is direct correlation between the age and the quality of the estate and it does not take into account in any way current patients' views of the respective sites. Therefore the information's use in this way is open to challenge.

5.48 More appropriately, the patient experience criteria also incorporate recent patient experience data. It should be noted that Imperial College Healthcare NHS Trust has the highest score in respect of the rating of the care received by patients and their assessment of the respect with which they were treated and the second best score in relation to patients' desire level of involvement in their care. However, the business case states that "the difference between all the scores is minimal and indeed the national scores have a very small range. Local clinicians did not feel that using this data in isolation gave them sufficient basis to differentiate between the options". This is open to challenge. Given its source and focus, this is a much better indicator of respective patient experience than the "proxy" estate indicator.

5.49 In terms of the quality criteria, the options appraisal affords the highest rating to the options that retain both Chelsea and Westminster or West Middlesex. In light of the previous comments, this conclusion is open to challenge as it is not based upon a genuinely robust assessment of quality between the nine sites.

5.50 In terms of distance and time to access services, all of the options have been rated the same "in recognition that this analysis has been used in the development of the options and that the analysis has not enabled any differentiation between the options". This is open to challenge. Access was rated as a highly important issue by patients and the public and it is not credible to suggest that there is no difference at all between the options

5.51 In terms of patient choice (included within the access criteria), emphasis is placed on patient choice benefitting from a greater number of Trusts (not sites) offering services. Specifically the business case states that "those options that locate a major hospital at Chelsea and Westminster rather than at Charing Cross result in five Trusts having a major hospital. Where Charing Cross is designated a major hospital then only four Trusts have major hospitals, and Imperial Trust would contain two major hospitals instead of one". This argument is open to challenge on two counts. Firstly, no evidence is provided to support the proposition that patient choice is enhanced by the number of Trusts as opposed to sites offering services to patients. Secondly, the distribution of sites between NHS organisations is not fixed and can be changed. Were it deemed beneficial, the management of the Charing Cross site could transfer from Imperial Trust to Chelsea & Westminster Trust. In summary, again, the conclusions of this element of the evaluation are open to challenge.

5.52 In terms of value for money, the evaluation uses a number of criteria. In terms of the estimated capital cost of the additional capacity required by the reconfiguration the only real difference highlighted is between those options that

include Hammersmith Hospital as a Major Hospital (Options 1 to 4) and those that don't (Options 5 to 8). In terms of relocating maternity and other services, this has a significant impact on any option where Charing Cross Hospital is designated as a Major Hospital, as it currently has no maternity services at present. If the capital cost of such a relocation is truly prohibitive, this element of the model could be looked at again.

5.53 Estimates are also included of the value of capital receipts to be generated by the disposal of land associated with each option. This calculation is based on the same average value per hectare for all sites, and therefore is not really a credible assessment of the likely capital receipts associated with each option. Therefore these assumptions are open to challenge.

5.54 Finally in terms of capital costs, an estimate has been made of the cost associated with establishing the new "Local Hospital" model within each of the relevant options. The same value has been used for each of the relevant options, limiting the value of this as an evaluation criterion between options.

5.55 The overall conclusion reached in the business case is that Options 1 to 4 have a much higher capital cost than Options 5 to 8 (which are ranked equally for this criteria). The capital cost element of the value for money criteria is open to challenge. It is based on very high level figures (often crude averages) and is not a properly assessed estimate of the true capital costs impact of each option.

5.56 The value for money criteria also includes an assessment of the likely transition costs associated with each of the options. This assessment uses an average cost assumption of "12 months disruption at £250 cost per bed-day". The basis for this calculation is not provided. On this basis, there is a difference of approximately £30m (or 50%) between each of Options 1 to 4 compared with Options 5 to 8. There is no significant difference between Options 5 to 8 and they have consequently all been ranked equally. This is open to challenge, as further more detailed work should be done to secure a better estimate of likely transition costs.

5.57 The value for money element also looks at the financial viability of the hospital sites and NHS Trusts in NW London, and the impact on this of reconfiguration. Clearly this is a key motivation underlying the proposals. This uses the financial base case information referred to in the financial model section above, so the issues identified with the model also directly impact on this assessment. Compared with the "do nothing" assumption that forecasts an £8m deficit across the acute sector, all of the reconfiguration estimates improve the position, ranging from a forecast total surplus of £12m (Option 8) to £47m (Option 5). These values equate to 0.66% and 2.58% of total revenue respectively. This is arguably a marginal difference and the actual outcome will be influenced by many other factors, most notably the effectiveness of financial management and control within the hospitals and the effectiveness of GP commissioners in managing patient demand. However this information is used to differentially rank the options. This is open to challenge.

5.58 Finally in terms of value for money, a Net Present Value (NPV) calculation is included, bringing "together all of the financial evaluation issues through a discounted payment profile, calculated over 20 years". The values are reported relative to the financial base case "do nothing" assessment. In effect, because this calculation uses the previous elements of the value for money calculation, it double counts the impact of each element.

5.59 The overall value for money assessment in the business case gives the highest rating to Option 5 and the second highest rating to Options 6 and 7. However this is open to challenge. The differentiation between Options 1 to 4 and Options 5 to 8 is primarily a function of the capital costs estimate. As suggested above, the capital estimates work needs to be significantly strengthened to arrive at the true capital cost of each of the estimates. The differentiation between Options 5 to 8 is entirely a function of the impact on site and Trust viability and the NPV calculation. Both the methodology and the application are open to challenge, as this does not give a sufficiently accurate differential value for money assessment between the options.

5.60 The deliverability criteria include an assessment of the workforce using recent national staff survey results. The business case states that "Chelsea and Westminster can be seen to have scores that are statistically better than the scores achieved by other Trusts". This is open to challenge. Imperial's scores are not significantly different from Chelsea and Westminster's scores, and yet options that include Chelsea and Westminster as a Major Hospital are rated higher.

5.61 The deliverability criteria also include an assessment of the expected time to deliver each option. This assessment should be challenged. It includes again (double counting) information from the financial base case based on the premise that "it is very difficult for Trusts facing such financial difficulties to make the changes in services as part of the reconfiguration". No evidence is provided in support of this statement. The assessment also uses again the assessment of new capacity required (a double count). Finally, it incorporates an assessment of the movement of adult and maternity beds. Again the potential relocation of maternity services has a big impact on the assessment, weighting the overall assessment in favour of the options that designate Chelsea and Westminster a major hospital. Were the maternity element to be decoupled from the consideration of A&E and complex medicine and surgery different results would be likely. Currently, in overall terms this assessment of expected time to deliver ranks options 5 and 6 as equal highest.

5.62 Finally, in terms of deliverability, the assessment includes a consideration of co-dependencies with other strategies, to take account of other work and initiatives going on within NW London and beyond. The issues taken into consideration were:

- Changes to the designation of the Major Trauma Centre at St Mary's;
- Current location of stroke units;

- Changes to the location of the Hyper Acute Stroke Unit (HASU) at Charing Cross.

5.63 Options requiring the relocation of the Major Trauma Centre from St Mary's were ranked the lowest and the options that designated St Mary's a Major Hospital were ranked relatively high. However, the same logic was not applied to the HASU at Charing Cross. The potential relocation of this unit was not used to differentiate between options. This is open to challenge. The assessment gave Options 5 and 6 the highest rating.

5.64 The last element of the option appraisal was an assessment of the impact on research and education. In terms of potential disruption, no differentiation was made between the options beyond seeking to protect the position at Hammersmith and St Mary's (as they scored particularly well in the 2011 National Training Survey). The ultimate conclusion of this element is that it is critical for research to be co-located with clinical delivery and therefore Options 5 to 8 were ranked the highest.

5.65 The summary evaluation ranked Options 5, 6 and 7 the highest, with Option 5 ranked the highest, stating that Option 5 "was significantly better than the other options"64. As stated above this is open to challenge. The options appraisal is open to challenge in terms of the sequential approach, the selective choice of indicators, the absence of an assessment of actual quality and performance (a key weakness), the lack of sufficiently detailed assessment in critical areas and the practical application of the indicators (including a high level of double counting).

5.66 Significantly, the only differences between the assessment of Option 5 (which has Charing Cross Hospital designated a "Local Hospital") and that of Option 6 (which has Charing Cross designated a "Major Hospital") are:

- The patient experience assessment, driven by an inappropriate use of estates indicators;
- The patient choice assessment, driven by a spurious argument about the number of NHS trusts managing Major Hospitals;
- The financial surplus assessment, the accuracy and materiality of which is subject to challenge;
- The Net Present Value calculation, that double counts previous measures and is subject to challenge; and
- The workforce assessment, that inappropriately under rates Imperial Trust compared with Chelsea and Westminster.

5.67 It should be noted that the business case does include a sensitivity analysis, testing the robustness of the options appraisal. The sensitivity analysis itself is reasonably sound. However, it is entirely predicated on the core assumptions and principles that underpin the option appraisal and consequently exhibits the same flaws.

- **Readiness**

5.68 The proposals assume that the various parts of the NHS in NW London have (or will have) the capability and capacity to implement the proposals but there is currently insufficient capacity and capability in primary and community services to support the proposed changes, which include the removal of 1,000 adult beds from the acute sector.

5.69 In percentage terms, Chelsea & Westminster is estimated to have the largest number of excess beds of all nine hospitals in the analysis and it is stated that "having this number of beds without reducing the number of sites in an inefficient and expensive use of buildings". However, there is no evidence that alternatives have been explored that could deliver the necessary efficiencies. In particular, given that over a third of the adult bed capacity at Chelsea & Westminster is estimated to not be required in the medium term, it is notable that the business case does not explore other ways of ensuring that Chelsea & Westminster is viable, other than the transfer of activity from Charing Cross Hospital.

5.70 While the proposals include plans to strengthen "Out of Hospital" care, these developments are currently not planned to be fully implemented until some time after the hospital reconfigurations have commenced. No decisions should be finally made about hospital reconfiguration until the Out of Hospital strategies have been implemented and performance assessed as successful against a number of appropriate metrics.

6. Clinical outcomes

6.1 The proposals do not take adequate account of the respective quality of services currently provided.

6.2 Current clinical quality is insufficiently analysed and reflected within NHS North West London's proposals. However, even in light of the restricted information used, Imperial College Healthcare NHS Trust scores relatively well in terms of quality. This can be summarised as follows:

- Imperial has the lowest (best) rating in NW London in terms of hospital standardised mortality rates (HSMR), significantly below the other trusts in the area;
- Imperial has the lowest (best) rating in NW London in terms of the summary hospital-level mortality indicator (SHMI);
- Imperial is statistically better than could be expected in terms of the number of deaths in low risk conditions;
- The assessment of Imperial's quality of services using the NHS aggregated quality dashboard indicates that the Trust has 50 of 62 measures where it performs above the national average;
- Imperial has the highest score in NW London in respect of the rating by patients of the care they have received and patients' assessment of the respect with which they were treated.

6.3 In light of the above, it is highly inappropriate to seek to transfer services away from Charing Cross and Hammersmith Hospitals. This would put at risk that current quality and potentially expose local people to:

- The adverse effects of increased travel time and delayed access to emergency services, and the impact on the population of the other proposed changes (e.g. to maternity services);
- The impact of primary and community services not being improved as proposed, whilst hospitals proceed to reduce their capacity; and
- The heightened impact on the most vulnerable groups of people in Hammersmith & Fulham's diverse population.

7. Impact

7.1 Insufficient account has been taken of the adverse impact on people who live and work in Hammersmith & Fulham.

7.2 Analysis of the preferred option indicates that currently each A&E in NW London serves an average population 5% less than the national average. If the preferred option is implemented the cuts will result in each remaining A&E serving an average population that is 52% larger than the national average.

7.3 The analysis supporting the preferred option indicates that 91% of current patient activity will be unaffected by the reconfiguration proposals.

7.4 However, the 91% calculation relates to NW London as a whole, from an NHS provider perspective. The significant impact of reconfiguration on patient activity will be the movement of activity from Charing Cross and Ealing. Consequently the specific impact on the population of Hammersmith & Fulham is much more significant. The business case estimates that for the preferred Option the percentage of Hammersmith & Fulham activity impacted by the reconfiguration is as follows:

- 40.0% of inpatient admissions
- 11.5% of outpatient attendances
- 23.0% of A&E attendances

7.5 After Ealing, Hammersmith & Fulham's residents face the most disruption and change as a result of the proposals. Indeed the impact on Hammersmith & Fulham and Ealing is significantly greater than for any of the other boroughs. For both boroughs, it is essential that before any decisions are made, the impact of these changes is tested on a needs based population basis, rather than being primarily driven by the need to ensure NHS Trust organisational sustainability. For Hammersmith & Fulham, this should be undertaken by the new CCG in partnership with the Council (and its new public health directorate) and the new Health and Wellbeing Board.

7.6 Furthermore, these changes would have a detrimental impact on the new Hammersmith & Fulham CCG's ability to influence the care commissioned for

local people. Effectively the proposals fragment Hammersmith & Fulham's health care across many different providers. It is unlikely in consequence that Hammersmith & Fulham will be a major commissioner of any of the receiving NHS Trusts.

8. Additional issues

- **Implementation**

8.1 A key issue in terms of implementation is the relationship between the implementation of the Out of Hospital strategies and the acute hospital reconfiguration. The business case states that the "Out of Hospital transformation should begin immediately and that this critical improvement work needs to be complete by the end of March 2015. Subject to decision making and having the necessary capacity and efficiency improvements in place, implementation of changes to acute provision could then be complete in full by March 2016".

8.2 The outline plan set out in the business case shows the out of hospital improvements being in place by the end of March 2015, but crucially it shows the hospital transition work commencing in the first half of 2013. This is open to challenge. The business case itself refers to the "challenging schedule" to deliver the improvements in Out of Hospital care. These improvements should be in place demonstrably (with performance measured against robust metrics) before the hospital transition work is started. Although the business case refers to a number of risks associated with delaying the hospital transition, the risks of reducing hospital capacity before the alternatives are in place are greater.

- **Benefits and disbenefits**

8.3 The business case is proposed on the basis that implementation of the changes will result in benefits for local people, patient, staff and the NHS organisations themselves. The benefits (improved outcomes, patient experience etc) would clearly be welcomed, and most are largely the result of meeting the proposed clinical standards. However the business case does not consider alternative options for delivering the clinical standards other than reconfiguration. The Council does not consider this approach to be robust or satisfactory.

8.4 Beyond stating the risks associated with the transition period, the business case does not provide an assessment of the likely disbenefits that could result from the proposals. These should be tested further via an assessment of the impact on Hammersmith & Fulham's population, with particular reference to:

- Clinical outcomes: the potential for these to be adversely affected by increased travel time and delayed access to emergency services, and the impact on the population of the other proposed changes (e.g. to maternity services);
- Primary care development: the impact of services not being improved as proposed, whilst hospitals proceed to reduce their capacity;

- Equality and human rights: the impact on the most vulnerable groups of people (particularly children and older people) in Hammersmith & Fulham's diverse population;
- Increased complexity: the establishment of a new "tiered" system of local healthcare (including "local" and "major" hospitals) has the potential to significantly confuse patients and the public; and
- Loss of expertise: the potential significant loss of clinical expertise and excellence at Charing Cross Hospital which has established a world-class reputation

- **Motivation**

8.5 The business case and consultation set out a number of clear reasons for the proposals, including a "case for change" predicated on the need to improve the quality and sustainability of local health services. However, there are arguably other drivers influencing NHS North West London that have not been fully articulated in the business case.

8.6 Such a key driver will be the national imperative to ensure that all NHS provider trusts become Foundation Trusts in the next few years. It should be noted that of the thirteen NHS organisations in NW London, five (38.5%) are Foundation Trusts and eight (61.5%) are NHS Trusts. There are relatively fewer Foundation Trusts in NW London than on average nationally. It is Government policy to eventually move all NHS trusts to Foundation Trust status once they have been confirmed as viable in service and financial terms. Imperial College Healthcare NHS Trust is not yet a Foundation Trust. A significant motive underlying the business case will be the desire to ensure that all local organisations are "fit" to become Foundation Trusts. However, this is not explicitly stated in the business case. This motivation, and its implications, should be clearly articulated.

8.7 In addition, the need to ensure the viability of current NHS organisations and structures should be balanced against the need to meet the needs of local people. The latter should be given primacy, and the organisational arrangements should be tested and shaped to meet those needs.

8.8 However, the primary driver is clearly the need to reduce costs in light of the growing demands on health services, the current exposed financial position of a number of local NHS Trusts and the low level of additional funding that the NHS will receive in light of the current macro-economic position. This is the main driver for change and yet it is somewhat underplayed in the business case. This is open to challenge. The primary motivations behind the changes should be clearly and transparently set out for patients, the public and staff.

9. Next steps

9.1 Taken together, the flaws in the process and methodology underpinning 'Shaping a healthier future' mean that in effect NHS North West London's proposals have not been developed in a sufficiently robust way and are consequently seen as unsafe from the Council's perspective.

9.2 The Council, through its Scrutiny committee, will therefore decide whether to refer the process to the Secretary of State based on the criticisms set out in this document. Further, the proposal to take a final decision on hospital and service reconfiguration before new health management arrangements are properly instituted requires consideration at the highest level.

9.3 If the final decision is taken to close the A&E departments at Charing Cross and Hammersmith Hospitals, then the Council, again through its Scrutiny committee, will decide whether to refer this to the Secretary of State as it will represent a significant detrimental impact on health services for local residents.

9.4 However services and hospitals are reconfigured, the Council will expect clear and comprehensive out of hospital provision to be put in place before any other changes are made. Irrespective of any decision or outcome, the Council also expects to see, and be consulted on, detailed plans for the future of the Charing Cross site including, for example, the implications for the teaching hospital, the effects on local employment and plans to dispose of or redevelop any part of the site.

ENDS –
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