

Health and social care in
North West London

A review of
Shaping a Healthier Future and
the North West London STP

Final report

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SUMMARY

1 Introduction

- 1.1 This is a review of the latest available information on health care changes in North West London, incorporating both information on the new Sustainability and Transformation Planning process and the latest on Shaping a Healthier Future (SaHF).
- 1.2 It is based on the most recent versions available to us (Sustainability & Transformation Plan (STP) V1.0 dated 30 June 2016).

2 Description of the STP process and its implementation in North West London

- 2.1 STP is a new approach to promote collaboration rather than competition between commissioners and NHS providers in local health economies (“footprints”). Since January 2016 England has been divided into 44 Footprints, with each area required to draw up STP plans, working to a strict and rapid timetable which initially stipulated drafts for 5-year plans had to be submitted to NHS England by the end of June.
- 2.2 STPs are now the instrument through which NHS England is attempting to achieve sustainability, to “reset” the finances of the NHS, to tackle the deficits that have already developed at provider level, and to drive reconfiguration and transformation in a more direct way than hitherto.
- 2.3 As part of the STP process London has been divided into five sub-regional areas, North West, North Central, North East, South East and South West: each Footprint has been required to draw up 5-year plans to restore local health systems to financial balance, while at the same time delivering improvements in performance, and integrating health services with social care – which remains the responsibility of local boroughs.
- 2.4 The North West London STP (v1.0) contains many of the same elements as the SaHF proposals that have been highly contentious over the last five years.
- 2.5 At a time when NHS trusts are being asked to make every possible saving and efficiency they can in their effort to deal with the continued shortage of funding in the NHS, the extra cost pressures associated with implementation of the STP will make life more difficult for trust boards, and inevitably divert management time from the organisation of front line services.
- 2.6 The STP has been developed with little reference to the views of residents in North West London. There has been a minimum of (often inaccurate) information on the content, implications and direction of the developing plans. Council leaders and others have been expected to sign up in support of complex and detailed documents they have had little chance to study or critique.

- 2.7 Local authorities have been offered an incentive of “transformation fund” money that might be used towards the future development of social care services.
- 2.8 The position in North West London is no local exception. Elsewhere most STP plans have been kept confidential, and there has been little public consultation on the controversial issues that underlie many of them.
- 2.9 The Nuffield Trust in September 2016 reported on the ambitious nature of the STP process, saying “the speed with which plans are being pulled together is astonishing”, that it “will require skilful implementation of a large number of complex, intra-organizational change management projects in areas that are likely to be controversial”, and “there are significant risks embodied in what needs to be done”. The report questioned what it described as plans based on “plausible hypotheses with little real-time evidence”, and noted that “STP leaders are acutely aware of optimism bias and even of magical thinking”.

3 The assumptions behind STP proposals: how far are they supported by evidence?

- 3.1 The STP presents a “Case for Change” arguing that the NHS and local government together must find ways of providing care for an ageing population and managing increasing demand with fewer resources.
- 3.2 The STP presents what it terms “the Overall Financial Challenge” suggesting that with no change, by 2020/21, providers will be in deficit to £659 million, there will be a fivefold increase in CCG deficits, and a ninefold increase in total NHS deficits. No supporting evidence is offered for these figures.
- 3.3 The STP identifies five “Delivery Areas” where investment will take place to improve quality while helping to bring about financial stability: prevention and wellbeing; unwarranted variation in long-term conditions; better outcomes and experiences for older people; better mental health outcomes; and, safe, high quality sustainable acute services. Little detail is provided, other than a list of enablers, of how these investments will work or what returns are likely to be achieved.
- 3.4 The STP states that it is necessary to reduce the number of acute hospital sites to five, which would result in the closure of Ealing and Charing Cross hospitals as acute sites. No argument or supporting evidence is provided for this view, although we believe it is driven by the need to reduce expenditure.
- 3.5 The STP focuses on the need to make “savings” of £1.3 billion by 2020. This is said to be necessary to address the gap between available resources and levels of need for services that is projected to open up by 2020 as a result of the continued under-funding of the NHS and cuts in social care.
- 3.6 The STP identifies a social care financial “gap” of £145 million by 2020/21. This is intended to be met by boroughs using their power to increase the

precept for social care in the council tax by up to 2% (£63 million); STP local government savings (£25.5 million); savings through joint commissioning (£22 million); savings share of health savings (£15 million); and, a residual gap of £19.5 million to be met from the Sustainability and Transformation Fund. There is no detail on any of the projects that will enable these savings to be made, or what will happen if they are not.

- 3.7 NHS England may make available £147 million of the Sustainability and Transformation Fund to North West London by 2020/21. North West London allocations for health and social care are set to increase from £3.64 billion to £4.09 billion. The additional STP money – which would only be available if a satisfactory STP plan is submitted – would increase that total to £4.24 billion.
- 3.8 The evidence supporting the STP proposals lacks substance and is often flawed. The plans for downsizing and downgrading hospitals and reconfiguration of services rest on largely unproven assumptions that large numbers of seriously ill people can be kept out of hospital by services in the community or from primary care – and that such provision can save money compared to existing services.
- 3.9 The STP does not take account of a growing body of important independent evidence that questions its core assumptions; this comes from bodies like the King’s Fund, the Nuffield Trust, the Policy Innovation Research Unit as well as parliamentary committees and learned academic papers.
- 3.10 Although the STP appears to offer references to external sources, none of these is a reference to a working example or to experience of any of the STP ideas being applied in practice.
- 3.11 We are not convinced that this STP can deliver anything like the large-scale financial savings that the plans project.
- 3.12 If the objective is to transform and integrate services, it is clear that capital is required, along with a process that establishes and tests out the alternative provision of services before busy acute beds are closed and hospitals downgraded. In other words a serious proposal along these lines would require investment up front to cover double-running costs and the eventual phased closure of redundant beds: any savings could only be generated in the long term, not immediately.

4 Current financial position in North West London

- 4.1 The context for assessing the current financial position in the NHS as a whole is one of reduced funding, high demand for services and reductions of 25% in numbers of people receiving social care. The NHS is in a position of prolonged relative financial pressure compared to the past.
- 4.2 However, despite a slight deterioration recently, the NHS in North West London has a record of achieving targets and maintaining good overall financial control.

- 4.3 Funding for public provision for adult social care in cash terms fell by over 10% between 2010/11 and 2014/15 from £14.9 billion to £13.3 billion; in real terms it fell by an average of 2.2% per year between 2009/10 and 2014/15, leading to a 25% reduction in the number of people receiving publicly-funded social care.
- 4.4 Reductions in social care funding are having an impact on the NHS; the recent report in the DH Annual accounts for 2015/16 drew attention to the 11.4% increase in bed days lost caused by delayed discharges because social care was not available.
- 4.5 The financial situation does not justify a high-risk strategy attempting an unprecedented “transformation”, including reductions of almost 600 beds and further cuts in A&E capacity, at a time of increasing population, and increased demand, some of which is due to government cuts in social care. Certainly bed reductions should not be attempted before there is more concrete evidence that demand is reducing and capacity is not required.
- 4.6 The continued inability to present an agreed Business Case providing proof that SaHF plans are affordable, economic and deliverable, reinforces our view that more affordable “Do Minimum” options should be developed.
- 4.7 It will be 2017 before the Strategic Outline Case (SOC) is available for SaHF. One of the criteria used in assessing the Business Case will be the level of engagement and commitment of stakeholders. It will be very difficult to demonstrate these have been established if the business case and its supporting evidence have not been shared.
- 4.8 Given further pressure on capital budgets in the NHS, with land receipts being earmarked nationally to deal with revenue pressures it would be very unwise for the STP to be based on a presumption that full approval for large capital sums will be given.

5 System performance in North West London

- 5.1 The latest estimate of the population in North West London (mid-year 2015 estimates) suggests there are already 2.06 million people, outstripping already the population estimates upon which SaHF was based. The population is projected to continue to grow more quickly than the rest of England, with an increase by 2024 of over 11% across all of North West London, rising to 26% by 2041.
- 5.2 The North West London emergency system already operates an effective split between those people needing urgent care and those in need of emergency care; this has resulted in just one-third of so-called A&E attendances being to acute A&E departments. This in itself is probably a good thing but the abysmal failures of the emergency system in recent months imply there is a significant issue with delivery in the North West London and one that would only be exacerbated by further closures of acute sites.

- 5.3 North West London residents do not over-use acute A&E services when compared with residents of the other London boroughs, or indeed with the rest of England. Utilisation was falling before the closure of Central Middlesex and Hammersmith A&Es, and has continued to fall since. On the other hand, North West London residents make considerably more use of UCCs and the like, over three times as much usage as England in 2015/16.
- 5.4 Type 1 A&E performance in North West London, when measured against the 4-hour target, in the first quarter of 2011/12, was better than the rest of England and the rest of London, and with breaches of the 4-hour target running at just over 3% was well within the margin of the target of 5% set by the government. However the position has worsened, particularly since the closure of two A&E units in North West London (on 10 September 2014).
- 5.5 In 2014/15 we find North West London is much worse than the rest of country and the rest of London: in the third quarter of 2014/15 the figures were 18.3%, 10.9% and 11.1% respectively breaching the target. However, in 2015/16, while the position in North West London got slightly worse, the position in the rest of London and the rest of England deteriorated significantly. Thus by March 2015/16, the comparable figures for North West London, the rest of London and the rest of England were 20.6%, 17.2% and 18.1% in breach respectively. This indicates a rapid failure in the North West London system moving it from being one of the best in the country to now one of the worst.
- 5.6 This suggests that the closure of acute services at Charing Cross and at Ealing should be halted and sufficient resources made available to retain existing services and staff. There should also be an appraisal of the reintroduction of A&E services at Hammersmith with joint staffing across the three Imperial sites.

6 Conclusions

- 6.1 The STP is merely a re-iteration and an elaboration of the SaHF plans, but with a limited five-year time horizon, and within that a tighter focus on eliminating provider deficits within two years. It is therefore no substitute for the SaHF business planning process which of necessity has a much longer planning horizon. This discrepancy runs the risk of promoting short-term cutbacks at the expense of meeting long-term needs.
- 6.2 The STP is not adequately rooted in a needs analysis. There is no discussion of recent population increases and the increased population projected. The STP appears to have ignored the latest population projections and so we have no confidence in the level of services being planned for.
- 6.3 There is no reflection on the action that has been taken in North West London in recent years both to manage the finances in the short term (successful) and to progress the SaHF plans via various closures and experiments in primary, social and community care (unsuccessful).

- 6.4 We estimate some £200 million may have been spent already on taking SaHF forward over the past five years, and there is little to show for it.
- 6.5 At this stage we would have expected to see some progress in reducing demand for acute beds. Instead we have seen reductions in social care funding, a crisis in care homes and increasing demand and activity in acute beds. Operationally there has been a worsening in quality and a drain on local resources. All of these are the opposite of the intended consequences.
- 6.6 The STP plan relies upon a fundamentally naïve options appraisal: it offers only a choice between “Do Nothing” or “Do Something”. This is contrary to Treasury guidance on investment appraisal which regards a “Do Minimum” option as vital in avoiding the presentation of ostentatious and costly options, involving greater capital investment and risk than more modest proposals.
- 6.7 The figures quoted in the STP’s financial and economic analysis follow the previous path of quoting indicative, unsubstantiated figures, presented to inappropriate levels of detail, at an unpublished cost base, and which have proven in the past to be misleading as an estimate of the eventual costs. From the analysis presented it is not clear whether the investments are economic, realistic or deliverable. By ‘economic’ we mean whether the benefits proposed could not be delivered more cheaply by other means. By ‘realistic’, we mean whether the business case and evidence supporting savings proposals are compelling and sound. And by ‘deliverable’ we mean that assumptions on capital availability, including capital receipts, management expertise and staffing can support the magnitude of the ambitious plans put forward.
- 6.8 There is a lack of compelling evidence to support these far-reaching plans. No one would oppose plans to prevent illness or to direct care to less intensive settings – if there was UK evidence that such strategies are working and are deliverable. But at a time of rapidly expanding population, an even more rapidly expanding elderly population, and manifest problems in primary, community, social and mental health services it is foolish to gamble heavily on the success of an unproven strategy. The material cited as evidence by the STP lacks working examples of the new models the commissioners wish to establish, and therefore practical evidence on whether it is possible to deliver either the services required or the savings which are the key current objective.
- 6.9 The risk analysis in the STP is very weak. It fails to cost the consequences of risk events occurring and to assign a probability factor to such events. Based on the evidence before us, we see the risks at this stage – high avoidable costs and deterioration in the volume and quantity of services that are needed – as too high to be acceptable. There appears to be very little in the way of contingency planning to ensure that a failure of one or more parts of the plan do not endanger the longer term continuity of services to patients.

7 Recommendations

- 7.1 The SaHF programme should be abolished / suspended, thereby saving a considerable sum of money at one fell swoop.
- 7.2 There should be an independent review of the North West London health system undertaken under the auspices of a joint health and local authority initiative that builds its case on a thorough assessment of the needs for health and social care of local populations, at local levels.
- 7.3 There must be no presumption that so-called ‘reconfiguration’ of acute services is the solution to what may not be a problem at all.
- 7.4 A “Do Minimum” option should be worked up that seeks to replace speculative and unproven investment in service changes, that require very high levels of up-front investment, with more modest proposals designed to improve quality in the areas most exposed.
- 7.5 In addition there must be no presumption that the solution will involve a top-down approach across the whole area as SaHF assumed; there should be an openness to consideration of local solutions, possibly at the borough level, where these can be shown to work.
- 7.6 The NHS and local authorities must agree to work together to achieve a joint aim to provide good accessible health and social care to all local populations within a sustainable financial model.
- 7.7 The attempt to close Ealing and Charing Cross hospitals must be immediately stopped; there should be a guarantee to sustain acute health services on these sites – with no more double talk from NHS leaders – until the above review is complete and any associated business cases are taken through to Full Business Case level, which is likely to be at least five years.
- 7.8 In light of current failures in the system in North West London there should be an independent review of the emergency system under the auspices of the above joint health and local authority initiative; and this as a matter of urgency should examine the closure of Hammersmith and Central Middlesex A&E departments with a view to opening these, if that is what the review suggests is needed, and what local people want. Local people must be given honest and genuine choices; the opportunity cost of retaining these sites as A&Es must be made apparent.
- 7.9 There should be a review of primary care services in the region, and following this review, immediate steps should be taken to rectify any issues. However any investment must be based on a clear business case that relates costs and benefits to changes across the whole system.
- 7.10 Similarly there should be a review of out-of-hospital services in the region, to establish a clear case if it exists for out-of-hospital services acting as a way of reducing demand for acute services, and also as a way of reducing total system costs. Following this review, any investment in out-of-hospital

services must be based on a clear business case that relates costs and benefits to changes across the whole system.

- 7.11 In the case of changes that take place in primary care and out-of-hospital services as a result of the reviews outlined above, there must be a business case presented that makes a clear case for system-wide improvement arising out of these changes, and this should be consulted on with the relevant local populations; there should be no assumption that this is the population of the whole of North West London.

1 Introduction

This report is a review of the latest available information on health and social care changes in North West London, incorporating both information on the new Sustainability and Transformation Planning process, which has prompted this report, but also the latest on Shaping a Healthier Future (Appendix 1).

Our critique of the Sustainability & Transformation Plan (STP) is based on the most recent version available to us (V1.0 dated 30 June 2016), which was published by NHS England on its Healthier North West London website¹.

This report gives more details of the plans of the NHS, incorporated in the “Sustainability and Transformation Plan” (STP) process as it is known and includes some commentary on the progress of STP plans in other parts of the country (section 2); provides commentary on the evidence base available (section 3) and shows how this will affect the processes around taking forward the SaHF plans, which have been to a considerable extent subsumed in the STP process (Appendix 1). The STP reasserts the wish expressed in “Shaping a Healthier Future” (SaHF) to accelerate the downgrade of Ealing hospital², in this context as a contribution to the financial savings NHS commissioners are seeking to achieve.

Section 4 gives up-to-date information on the background financial position of the NHS, and concludes that the available figures do not justify panic measures overturning established processes.

Section 5 looks at recent trends in population growth and provides an update on performance issues in North West London. This reinforces the case for plans to be soundly based on actual population projections, and to be very closely scrutinised before approval can be given.

Some concluding remarks about the STP are provided in section 6. Finally, Appendix 3 provides some more detail on STP savings plans while Appendix 2 and 4 tabulate and discuss some of the evidence used to support the STP.

¹ <https://www.healthiernorthwestlondon.nhs.uk/news/2016/08/05/north-west-london-sustainability-transformation-plan>

² See the p8 & p46 of the draft V1.0, which explicitly call for a more rapid process at Ealing Hospital, which has elsewhere (p7) been portrayed as non-viable:
“The financial modelling shows a forecast residual financial gap in outer NWL providers at 20/21, attributable to the period forecast for completing the reconfiguration changes that will ensure a sustainable end state for the providers. **This could be resolved by bringing forward the acute configuration changes described in DA5c relating to Ealing.**” – p8 [our emphasis]

2 Description of the STP process and its implementation in North West London

On 22 December 2015, in a circular to NHS chief executives, NHS England announced a new organisational restructuring to respond in a more centralised and coordinated way to the intensifying financial pressures on the NHS and social care³. The new approach is to promote collaboration rather than competition between commissioners and NHS providers in local health economies (“footprints”). Since January England has accordingly been divided into 44 Footprints⁴, with each area required to draw up STP plans, working to a strict and rapid timetable that initially stipulated drafts for 5-year plans had to be submitted to NHS England by the end of June 2016.

As a result STPs are now arguably the instrument through which NHS England is attempting to achieve sustainability, to “reset” the finances of the NHS⁵, to tackle the deficits that have already developed at provider level, and to drive reconfiguration and transformation in a more direct way than hitherto⁶.

NHS England Chief Executive Simon Stevens has made clear he wants the new “combined authorities”⁷ to “pool sovereignty” which will make it easier to push through highly contentious cutbacks and closures which impact on specific communities. STPs are making use of delegated powers to establish Health & Care Executive committees which will help to drive through what may be unpopular decisions, and bind constituent bodies to these “collective” decisions.

As part of the STP process London has once again been divided into five sub-regional areas, North West, North Central, North East, South East and South West: each Footprint has been required to draw up 5-year plans to restore local health systems to financial balance, while at the same time delivering improvements in performance, and integrating health services with social care – which remains the responsibility of local boroughs.

³ <https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf>

⁴ <http://www.healthcampaignstogether.com/pdf/stp-footprints-march-2016.pdf>

⁵ <https://www.theguardian.com/society/2016/jul/21/nhs-england-bosses-launch-reset-plan-tackle-deficit-financial-special-measures>

⁶ https://improvement.nhs.uk/uploads/documents/Strengthening_financial_performance_and_accountability_in_2016-17_-_Final_2.pdf

⁷ <http://www.hsj.co.uk/sectors/commissioning/exclusive-stevens-floats-combined-authorities-for-the-nhs/7004897.article>

2.1 The North West London STP

The North West London STP (v1.0) contains many of the same elements as the SaHF proposals that have been highly contentious over the last five years. The STP v1.0⁸ makes clear that the establishment of a new structure for decision-making is central to implementing the proposals:

“NHS and Local Government partners are working together to develop a joint governance structure with the intention of establishing a joint board which would oversee delivery of the North West London implementation plans for the five delivery areas with joint accountability across partners for the successful delivery and the allocation of transformation resources.” (p47)

It is important to recognise that when cutbacks and downgrading of services primarily affect two or three boroughs, “joint accountability” can mean the views of these two or three boroughs may well be superseded by the views of the others. The larger planning areas may act as a device to minimise local accountability for specific communities.

Lack of consultation

The development of the STP has left the two million residents in North West London almost completely in the dark, with no possibility to respond or influence decisions until after they have been taken. Their services, paid for through their taxes, and on which many of them depend, are being reshaped, quite possibly permanently, by a series of rapid decisions by a small, remote and unaccountable group, driven by the threats of potential financial crisis.

While being offered a minimum of (often inaccurate) information on the content, implications and direction of the developing plans, council leaders and others have been expected to sign up in support of complex and detailed documents they have had little chance to study or critique.

It is clear that once a body’s signature and logo have been appended to a document, the expectation is that each body is then jointly responsible for it – and therefore willing in effect to surrender control and accept the plans that eventually emerge. Although the NHS is of the view this is legal we believe the legal aspects of this are at least questionable and we recommend that the “Vires” or legal power to overthrow the clear intention of Parliament to introduce a form of “localism” in the Health & Social Care Act of 2012 should be firmly established.

⁸ Available as Version 1.0 at <https://www.healthiernorthwestlondon.nhs.uk/news/2016/08/05/north-west-london-sustainability-transformation-plan>. However we know that it is at least Version 40, and that most of the drafting has been done with little if any engagement with local authorities – and none with the wider public whose services face major changes if the plan is implemented.

For local authorities there is the additional incentive of “transformation fund” money that might be offered towards the future development of social care services – or the threat that this money might be withheld in the event of the borough voicing any criticism or withholding its endorsement from the “joint” policy.

Although we question this process with its implicit and explicit threats, some stakeholders take a more benign view. They see the STP as little more than an extension of the long-standing joint planning arrangements contained currently within the Health and Wellbeing Board and within SaHF governance arrangements, and are satisfied that local government’s own institutional governance arrangements preclude circumnavigation by the STP governance arrangements, which in any case, it has been suggested, are not yet agreed.

2.2 The national picture

The position in North West London is no local exception. Elsewhere it seems clear that NHS England has been urging local CCGs to keep STP plans confidential⁹, and not to commit to any public consultation on controversial issues until after plans have been vetted by NHS England. For many this process appears conspiratorial rather than democratic.

The whole process has now been called into question by a former NHS England director, Julie Simon, who was until recently the head of NHS England’s commissioning unit and director of co-commissioning. She is reported by *GPonline* as saying that the timescale imposed on health and care organisations to draw up STPs was ‘shameful’, ‘unrealistic’ and ‘an unfair ask’. The magazine reports her saying:

“Everyone will submit a plan, because they have to. But it means there is a lot of blue sky thinking and then you have a lot of lies in the system about the financial position, benefits that will be delivered – it’s just a construct, not a reality.”

She went on to argue that hastily drawn-up plans would lead to financial problems: “Ultimately it means bankruptcy in some areas.” She also expressed concern over the lack of any public involvement:

“I haven’t seen any genuine patient and public engagement yet. I think it is entirely driven by the speed that NHS England has imposed on this process which is, frankly, kind of mad. It’s mad. I think we will see a lot of catching up

⁹ <https://www.england.nhs.uk/wp-content/uploads/2016/05/stp-submission-guidance-june.pdf> states (p3) “Your submissions will therefore be work in progress, and as such we do not anticipate the requirement for formal approval from your boards and/or consultation at this early stage.” In all but seven of the 44 STP areas this has been interpreted as keeping the plans out of any public scrutiny.

¹⁰ The secrecy has been criticised as unhelpful in a comment piece by a senior *Health Service Journal* reporter: <https://www.hsj.co.uk/sectors/commissioning/the-commissioner-its-time-to-publish-the-stps/7010171.article>

on that end, but to do that right, to do a statutory consultation – it's three months. They don't have three months.”¹¹

In a recent report (September 2016), the Nuffield Trust provided a commentary on the STP process calling it “large and ambitious”, saying “the speed with which plans are being pulled together is astonishing”, that it “will require skilful implementation of a large number of complex, intra-organisational change management projects in areas that are likely to be controversial”, and “there are significant risks embodied in what needs to be done”. The Nuffield Trust goes on to question items in plans that “have proved difficult to bring about real change”, and that “Others are still best described as plausible hypotheses with little real-time evidence”, and notes that “STP leaders are acutely aware of optimism bias and even of magical thinking”.

This supports our long-held concerns on both the form and content of STP and SaHF plans and although we respect the views of stakeholders who are more optimistic we continue to counsel caution. This failure to consult would be worrying enough in conditions where the policy was sound and a genuine outcome of collaboration and engagement between the various “partners”. This is not the case, as we argue below.

¹¹ <http://www.gponline.com/shameful-pace-stp-rollout-risks-financial-meltdown-warns-former-nhs-commissioning-chief/article/1410546>

3 The assumptions behind STP proposals: how far are they supported by evidence?

This section looks at the evidence behind claims of potential financial savings to be made in North West London, as the SaHF process is overtaken and subsumed by the requirement to draw up and implement a Sustainability and Transformation Plan to balance the books of the North West London health economy¹².

The process has been accelerated in North West London by the fact that the SaHF project, extensively and expensively supported by management consultants, has developed a series of proposals, and arguments to justify them, over the past five years. This has enabled the STP simply to adopt many of these concepts, ready-made.

This section examines these arguments, after first exploring some of the financial projections outlined in the STP, with specific reference to the proposals for social care, as well as the reasserted plans to “consolidate” acute services in just five major hospitals, effectively reviving the controversial SaHF plans to downgrade and close beds and services at Ealing and Charing Cross Hospitals.

As the Mansfield Commission report pointed out, the SaHF proposals for reconfiguration and reduction in acute hospital services, to be compensated by expanded provision of care from GPs, community health services and social care, rested on assumptions which either lack evidence or run directly counter to the findings of recent research and experience.

3.1 Describing the document: the draft STP Version 1.0

The STP begins with a “Case for Change” section, much of which will be familiar to anyone who has read any of the arguments for the SaHF proposals. It insists that “Both the NHS and local government need to find ways of providing care for an ageing population and managing increasing demand with fewer resources”.

Graphics and diagrams are used to underline the public health issues that help to explain the levels of need for health care in North West London, although the level of hospital resources and the extent to which they are adequate are not discussed even to the level they were in the SaHF.

The Draft goes on to discuss the North West London Vision “helping people to be well and live well”, which clearly nobody in principle would object to. The authors of the STP Draft appear convinced that effective ways to prevent unhealthy lifestyles have been devised, which can reliably deliver significant and tangible cash savings to the NHS – beginning almost immediately. This is once again a central assertion throughout the STP, as indeed it is in NHS England’s 5-Year Forward View, and as it

¹² NHS England (2015) [NHS planning guidance 2016/17 – 2020/21](#)

was in SaHF. However such wishful thinking is not backed by any credible evidence¹³. Nevertheless it appears to be a common assumption in many if not all STPs, and has recently been criticised in a Nuffield Trust report that we referred to earlier¹⁴.

The case for change also offers a map of the North West London boroughs (p16), with an apparently random and varying list of bullet points for each, making it impossible to make any comparisons or draw any overall picture.

The financial challenge

The “Overall Financial Challenge” section paints a Domesday “Do nothing” scenario¹⁵ in which:

- the financial deficits of providers appear to rise more than threefold from £190 million in 2015-16 to £659 million in 2020-21;
- there is a fivefold increase in CCG deficits; and,
- a near ninefold increase in total NHS deficits.

¹³ Instead we have projections of how much might be saved if heavy smokers were persuaded to quit: it is claimed that if 100 smokers gave up it could save the NHS £73,000 after five years – although the STP Draft does not give the reference for this (p14). There is a much more ambitious claim (p21) that “targeted interventions to support people living healthier lives could prevent ‘lifestyle’ diseases”. The STP declares “an Optimity study” (for which no reference is supplied) claims “intervention to reduce smoking could realise savings over 5 years of £20m to £200m for North West London.” There is no explanation of what this intervention may consist of, or how much it would cost to intervene in this way with smokers across North West London. Two pages on “radically upgrading prevention and wellbeing” (p21-22) include a claim that “targeting people at risk of developing long term conditions” would “also prevent people from developing cancer” – for which the STP cite Cancer Research UK, without offering any actual reference. The fact that such interventions appear to involve offering services to people who are not ill and may well not have sought NHS support is not discussed, and neither are the practicalities of organising such a large-scale project.

¹⁴ As Nuffield Trust Chief Executive Nigel Edwards has pointed out in respect of STPs: “Prevention receives a lot of attention although there is concern in some areas about the level of disinvestment from public health by local authorities. Making the case for a return on investment is proving difficult but there are a lot of ideas building on previous work with a strong focus on obesity, exercise, alcohol and early years.

“There are no magic bullets, and while there may be opportunities to undertake more radical redesign of some services, most of the work is a detailed slog across a wide range of different activities. Some of the ideas being proposed are best described as ‘plausible hypotheses’ and there are some areas where the level of optimism about what can be achieved and the scale of effect is dubious.” <http://www.nuffieldtrust.org.uk/blog/how-are-sustainability-and-transformation-plans-coming-together>

¹⁵ Quite obviously whatever is decided on the STP, “Do nothing” is not a realistic scenario: the NHS has constantly adapted and sought efficiency savings – which according to the Health Foundation (Hospital Finances and Productivity, 2015) were averaging just 0.4% a year from 2010 to 2015. By contrast estimates by Monitor and NHS England, analysing the rate of efficiency improvement up to 2012/13, found an annual improvement of around 1.2% a year. Now the Five Year Forward View and NHS leaders are seeking to deliver a further £22bn of efficiency savings by 2020-21, which will require productivity improvements of 2-3% a year.

None of the working assumptions on which these figures are produced are explained or cited as references. Nor is there any exploration of a “Do minimum” option to make the system more efficient and work to contain demand for services.

It is not clear if the steadily rising figures are based on increasing population, projected demographic changes or other issues. This leaves no clarity on what action might be taken to stem the increase.

Delivery Areas

The Draft then takes two to three pages (in extremely small print) to cover each of five Delivery Areas. Although some of the relevant numbers have been inserted, plans for investment and “Gross savings” for some proposals are still “TBC” ie to be confirmed. The Delivery Areas are defined as:

- Radically upgrading prevention and wellbeing;
- Eliminating unwarranted variation and improving long-term care management;
- Achieving better outcomes and experiences for older people;
- Improving outcomes for children and adults with mental health needs; and,
- Ensuring we have safe, high quality, sustainable acute services.

Under this last heading (Delivery Area 5), the Draft STP (p29) once again argues for reconfiguring acute services, specifically “Consolidating acute services onto 5 sites” – thereby committing to the SaHF plan to run down services at Ealing Hospital (already well advanced) and Charing Cross, all while noting formally that this is not accepted by Ealing or Hammersmith & Fulham councils.

This is followed two lines later in the STP by text that seems to contradict it, inserted at the insistence of LB Hammersmith & Fulham and LB Ealing: this sets out criteria for any future downgrading of the two hospitals. This wording is repeated in the summary (p31), although the same section also commits to closing the paediatric unit at Ealing – another step towards dismantling the hospital in its current form.

Enablers

The following section of the draft STP discusses “Enablers” which are expected to make the Delivery projects deliverable. Sub-sections address:

- **Estates** which sets out proposals for “local hubs” equivalent to Lord Darzi’s idea of “polyclinics”. One problem with this idea is the lack of any capital for new sites and buildings, along with a lack of clarity on whether the Treasury will agree to the retention of the proceeds of any land sales.

The Estates section (p34) also re-states the contested SaHF plan for “consolidation” of services on “fewer major acute sites”, while again noting that this is not accepted by LB Ealing or LB Hammersmith & Fulham. Thus:

“Consolidate services on fewer major acute sites, delivering more comprehensive, better staffed hospitals able to provide the best 7-day quality care.

Develop hospitals that integrate primary and acute care and meet the needs of the local population.

Trusts are currently developing their site proposals, which will feed into an overall North West London request for capital from the Treasury, contained in the strategic outline case to be submitted this summer once agreed by all partners¹⁶.” (p34)

- **Workforce**, with the document offering a striking contradiction in a single sentence – a large reduction in resources combined with a ringing statement of how important the workforce is to the future NHS:

“There will be a 50% **reduction in workforce development funding** for staff in Trusts, **however workforce development and transformation including the embedding of new roles will be pivotal in supporting new ways of working and new models of care**. To meet our growing and changing population needs, training in specialist and enhanced skills (such as care of the elderly expertise) will be required.” (p35) [our emphasis]

A recent King’s Fund blog by Professor Chris Ham has questioned whether the “funding and workforce” can be found to invest in community services on the scale required, arguing that “STPs should be read with a degree of healthy scepticism”¹⁷. In our view the lack of adequate numbers of staff to deliver the proposed new models of services could well prove to be an even more difficult problem to solve than the lack of funding or capital, both of which could be addressed by a change of government policy. Without a sufficient supply of appropriately trained staff, and with the possibility of recruiting from the European Union uncertain, following the Brexit vote, this issue could be a gamestopper and one for which the STP contains no clear proposals.

- The **Digital** section is strongly centred on the notion of using digital technology, apps and other ways to get patients to look after themselves and monitor their own long-term conditions. Many of these ideas seem to come from the USA, and there is no real evidence of their applicability to the North West London context and the NHS. Indeed the STP has no coherent answer to the point it raises itself on page 37:

¹⁶ It is not clear that this could be achieved if it is opposed by LB Ealing and LB Hammersmith & Fulham.

¹⁷ <http://www.kingsfund.org.uk/blog/2016/09/stp-leaders-challenges-care-budgets>

“There is a lack digital awareness and enthusiasm generally among citizens and professionals, requiring a greater push for communication around the benefits of digital solutions and education on how best to use it.”

Primary care

Although referred to in earlier sections, the development of primary care is not addressed until page 39 of the STP, which offers figures charting the expected increase in the elderly population, along with the fact that North West London has “the lowest GP and nurse workforce supply baseline in London”. In addition, 7.4% of GPs are over 65 years old themselves: replacing them runs into “recruitment and retention challenges”.

For all the additional tasks and responsibilities GPs are expected to take on as part of the STP it is perhaps surprising to find that the additional investment in GP services is just £58 million across all eight boroughs over four years – just over 20% of the current primary care budget. This is barely more than the projected cost pressures on the NHS each year, and well short of the kind of investment that could create a full-scale transformation of services.

The limited discussion of GP services and primary care in the North West London STP Draft suggests a correspondingly limited level of engagement between those drawing up the proposals and the GPs themselves, who have often been presented as leading the CCGs and the planning process since the 2012 reforms. This is confirmed at a national level by Dr Mark Spencer of the New NHS Alliance who recently criticised STPs as not having involved GPs sufficiently in the process, showing little consideration for the issues posed for primary care, and lacking in the depth and detail of how and who will bring about change. He writes:

“ ‘GPs will do it’ would seem to be a much-repeated mantra. Really? STPs should be closely examined to determine the extent to which primary care was included. [...]

“New Models of Care require integrated provision across primary and community services [...] Where are they going to come from? Where is the leadership? Where is the local ownership? Where is the buy-in from practices and frontline clinicians? A failure to take the local workforce along this journey will result in stagnation at best and a complete collapse at worst.¹⁸”

Concluding sections of the STP look at how it will be financed, how it will be delivered, and review the risk management strategy. We look at these in turn in the next sub-sections.

¹⁸ Lancashire GP Dr Mark Spencer of the New NHS Alliance, quoted in National Health Executive magazine <http://www.nationalhealthexecutive.com/Comment/stps-a-mile-wide-and-an-inch-deep>

Financing the STP: savings targets are at the centre of the proposal

The STP proposals focus on the need to make “savings” of £1.3 billion¹⁹ by 2020. This is said to be necessary to address the gap between available resources and levels of need for services that is projected to open up by 2020 as a result of the continued under-funding of the NHS and cuts in social care.

However the cash allocations to 2020 are known and published, while the assumptions on which the increased demand has been calculated and translated into deficits for commissioners and providers are not revealed.

It is clear that if the government continues to underfund the NHS and fails to keep up with increased demographic and cost pressures, inevitably problems will emerge. This has been expressed in a most forthright way in a series of articles and public statements by Chris Hopson, Chief Executive of NHS Providers, representing NHS trusts and foundation trusts. In a letter to Dr Sarah Wollaston, Chair of the House of Commons Health Committee²⁰, he spells out grim choices that must be made if no additional funding is forthcoming. But it is a misplaced analysis that portrays the consequences as the emergence of deficits. The most likely result will be deterioration in the quality and accessibility of services, as NHS managers are obliged to prioritise the achievement of financial targets.

The reality, as will be discussed in section 4 of this report, is that the NHS is prevented from entering into large deficit positions and has had a good record locally and nationally in achieving net balanced positions, despite near identical deficits being projected when SaHF was first presented. This is not to deny pressures exist but merely to emphasise that the measures and powers lie with government and the Department of Health to manage finances.

The fundamental weakness of the STP document is that it offers almost no concrete, practical proposals on how the enormous savings targets are to be delivered. At no point do any of the proposals set out clearly who would do what, in what premises, with what funding, how many staff would be required, or how they would be managed. In this respect it is more of a wish list than a plan.

The detail as to how proposed savings will be realised is lacking. For example, NHS England Specialist Commissioning is assumed to make a saving of £188 million. The narrative blandly tells us:

“NHSE spec comm have not yet developed the ‘solution’ for closing the gap, **however it is assumed that this gap will be closed**” [our emphasis]

¹⁹ Or maybe £1.2 billion, or £1.1 billion (depending on which figures are used, from which page in which Draft of the STP or the SaHF).

²⁰ <http://www.parliament.uk/documents/commons-committees/Health/Correspondence/2016-17/NHS-providers-to-Sarah-Wollaston-05-09-16.pdf>

There is a similar evasion over the **“Balance to be addressed”**: [our emphasis]

“Remaining gap of £31m to be addressed – post 2021”

Not only do the target savings fall well short of the projected gap, but on closer inspection almost a quarter of the £1.3 billion projected gap between needs and resources is apparently to be bridged through a (very precise) saving of £303 million from the various proposals in “Delivery Areas 1-5”.²¹ See Appendix 3 for a list of these “savings” as provided on page 42 of the Draft STP V1.0.

Half of the money to bridge the gap is supposed to come from “Business as Usual savings” – in other words more efficiency savings from the acute hospital trusts, mental health, community services, and the CCGs. It could be argued that if this is “Business as Usual” then the “Do Nothing” projections should include the anticipated £570 million savings – thereby drastically reducing the gap. The effect of not including these savings in the “Do Nothing” option is to make the funding crisis appear worse. As section 4 of this report makes clear, the financial problem has never been as acute as the NHS presents it.

More importantly it is not clear whether there is clarity within the NHS between the various savings programmes. Each will only make savings if staffing can be safely reduced but how will it be possible to determine whether staff cutbacks are business as usual or fall within the delivery areas identified? This raises the risk of “double-counting” of savings and financial crises further down the road.

Plans for social care savings

From a local government perspective boroughs are understandably keen to work with the NHS on proposals that can lead to health and social care integration – both to improve resident experience and outcomes, and manage financial pressure. Clearly there are significant challenges to this but there are also areas where plans have delivered some local success. Ealing and Hammersmith and Fulham councils are supportive of proposals in Delivery Areas 1-4 but these will require investment. It has not helped that government funding for social care has been reduced, while nursing homes are under even more pressure.

The single page on Social Care Finances is identical in the Executive Summary (p9) and main text (p44), indicating that there is much more development required to put flesh on the bones of this outline, and set out clearly what measures are expected from local government, and what contribution can be made towards this from the NHS.

The argument for changes in social care follows a familiar pattern. The social care “gap” by 2020/21 is projected at £145 million: but the largest contribution towards

²¹ See Draft STP Ver 1.0, page 43.

that – £63 million – is expected to come from the boroughs using their power to increase the precept for social care in the council tax by up to 2%. This at least is a real possibility, although it requires the councils to raise the money from local residents, with no NHS contribution. It is not clear from the Draft STP how much this would actually raise, or how far this would represent a real increase on existing plans.

From there onwards the proposals become increasingly vague. We have checked with the Director of Adult Social Services and Health for Hammersmith and Fulham, Kensington and Chelsea, and Westminster, Liz Bruce, who confirmed that no additional explanatory narrative has been produced so far. Thus we find:

- £25.5 million is sought from “STP local government savings,” which are not explained or defined;
- £22 million is expected from “savings through joint commissioning” – although this is accompanied by a confusing table, in which general headings (such as “demand management²² and resilience”) appear to be allocated random targets with no explanation, and it is not clear at all which sums are supposed to add up to £22 million; and,
- In addition there is another £15 million from “savings share of health savings” (the meaning of which is unfathomable).

At the bottom of the page the STP Draft makes clear that the savings projected can only be achieved through investment of £21 million a year in 2017/18 “rising to £34 million by 2020/21”.

To complete the £145 million target, there is once again a “residual gap” of £19.5 million – which is expected to come from the additional £148 million Sustainability and Transformation Fund (p44) of which £147 million is available for investment (p45).

It appears that the savings as listed could be worth £30 million to the NHS, and £25.5 million to local government. All of these figures appear to be totals covering all eight boroughs. There is no detail on any of the projects that allows us to deduce which boroughs are supposed to deliver how much, or how. There is no way these proposals can be seen as a clear plan of action.

²² Demand management most commonly refers to ways of restricting access to services. The extent to which demand for social care for some of North West London’s most vulnerable patients could be managed downwards is not really explained, or what alternatives might be open to them and their carers if existing social care spending is indeed held down in this way. How it relates to the STP or to local government is not explained – the phrase only occurs in this one table, as indeed does “resilience”.

Risks and action to be taken

The section of the STP on risks is wholly inadequate as a summary of the risks and risk management strategy required. It fails to quantify the risks, to attribute probabilities of risk events occurring or to describe an adequate response to avoid risks and to manage risks. The elephant in the room: what would happen if after closing acute capacity more capacity was required to cope with increased demand and failures in demand management strategies is hardly discussed; the response – to develop a dashboard, monitoring progress – is of little practical value.

This section seems more an article of faith than based on any practical plans to deal with the risks identified: the risks are great and are certainly not commensurate with the actions proposed to deal with them.

To summarise

There are limited extra funds available through the STP. The only figure that appears to have any objective source is the assumption that NHS England may make available £147 million of the Sustainability and Transformation Fund to North West London by 2020/21. This figure is published by NHS England, in a list of current and eventual allocations to each of the 44 STP Footprint areas²³: this shows that North West London allocations for health and social care are in any case set to increase from £3.64 billion to £4.09 billion. The Draft STP states that the additional money – which would only be available if a satisfactory STP plan is submitted – would increase that total to £4.24 billion. However it should be remembered that the total extra available (£148 million) is to be shared among eight boroughs, eight CCGs, ten acute and specialist trusts, two mental health trusts and two community health trusts as well as the 392 GP practices.

In other words, while there is the promise of some extra money in the pot, it would only come later on, and with extensive strings attached, the most important of which is the ability of providers to eliminate deficits when faced with double the level of targeted efficiency savings that has previously been achieved (see the discussion on p33-34 of this report).

The extra money is small in proportion to the scale of changes being considered and is purely revenue to fund day to day services. There is no significant capital available for the STP process, and according to a recent Simon Stevens speech to the NHS Confederation²⁴, there is little chance of capital being available to fund any projects in the next five years.

²³ NHS England (2016) Indicative 2020/21 STP funding including transformation
<https://www.england.nhs.uk/wp-content/uploads/2016/05/STP-indic-allocs.pdf>

²⁴ <http://www.nhsconfed.org/news/2016/07/nhs-issued-seven-point-plan-to-reset-finances>

This raises serious doubts over the viability of much of the SaHF plan (which lay the foundations for the STP), which requires extensive capital investment. Thus, the successful delivery of the STP proposals would require significant capital investment by the NHS and the Treasury.

3.2 An examination of the evidence available on the assumptions of the STP

The evidence supporting the STP proposals lacks substance and is often flawed. Despite the inclusion at the end of the STP of 78 endnotes, some of which offer references to external sources, not one of these is a reference to a working example or even to experience of any of these ideas being applied in practice.

No matter how worthy the aspirations that inform the STP and SaHF proposals, there is little there to convince us that they can deliver anything like the large-scale financial savings that the plans project. We are not alone in that view. Our doubts over the evidence base for many of the new models of care outlined in the STP and our concerns that they do not offer certainty of delivering the required level of savings within the tight timescale required by NHS England appear to be shared by NHS Providers Chief Executive Chris Hopson, who told a Westminster Health Forum event that STPs are “not going to be the answer” to the NHS funding gap, and will take much longer than five years to implement. Hopson said: “There is little evidence that moving to new care models will release rapid or sufficient savings”.^{25,26}

For more detailed arguments at least seeking to justify some of the projections and the proposals themselves we need to look not at the STP itself, but at the Local Services Transformation document, drawn up for the North West London Collaboration of CCGs by Shona Fearn, principal consultant at PA Consulting²⁷.

This important document, which has only so far been made publicly available by campaigners online, unfortunately breaks down the same basic proposals as the STP into different headings. But it clearly spells out (p20-27) the widely-reported ambition to enable a reduction of over 500 beds (in fact the total is 591 beds).

According to the plans set out, this is to be done through “demand management”. The document breaks down how the target figure for bed cuts and the associated financial savings, estimated at almost £150 million, have been derived: once again all

²⁵ <http://www.gponline.com/new-care-models-promised-five-year-forward-view-may-15-years-away/article/1408975>.

²⁶ An recent impact assessment suggests the Government’s flagship diabetes prevention programme will only start saving the NHS money by around 2030. <http://www.pulsetoday.co.uk/clinical/more-clinical-areas/diabetes/gp-led-diabetes-prevention-scheme-will-start-saving-nhs-money-after-14-years/20032793.article>.

²⁷ ²⁷ Fearn S., Scott A. (2016), Paper 3.1. *NWL Local Services Transformation*, NW London Collaboration of CCGs, May 27, revealed in papers to Brent Healthwatch, June 2016. Now available at: <http://www.healthcampaignstogether.com/pdf/Paper%203-1%20NWL%20Local%20Services%20Transformation.pdf>

of the aspirations are laudable in themselves, but not necessarily achievable or affordable in the way envisaged²⁸.

The key proposals in this document and the cited evidence are summarised in Appendix 4, together with our note showing what further elements would be required to allow them to be implemented. It is also clear from our analysis in Appendix 4 that the evidence to support these hugely ambitious savings and closures of hundreds of currently busy hospital beds is flimsy, lacking or simply inappropriate.

The STP process and SaHF have also avoided taking into account a growing body of important evidence that questions their core assumptions. We turn now to look at recent evidence from independent bodies showing how the assumptions underlying the STP lack any foundation in reality.

Independent evidence on models of change

The lack of any coherent or convincing national-level plan for integrated care, to take account of the levels of need of older people and support them in their own homes was highlighted by a highly critical report from the Commons Public Accounts Committee on Adult Social Care in England in July 2014²⁹. Having taken evidence from the Department of Health and the Department for Communities and Local Government, the all-party committee noted:

“The Departments **do not know** whether the care system can become more efficient and spend less while continuing to absorb the increasing need for care. [...] Local authorities’ cost savings have been achieved by paying lower fees to providers, which has led to very low pay for the care workforce, low skill levels within the workforce, and inevitably poorer levels of service to users. [...] [our emphasis]

“We are concerned that the Departments **have not fully** addressed the long-term sustainability of the adult social care system, and that its policies to drive change (the Care Act and the Better Care Fund) are **not supported with new money** and do not acknowledge the scale of the problem. [...] The Departments acknowledge that they **do not know** how local authorities will achieve the required efficiencies, but still believe the ambitious objectives of implementing the Care Act and integrating services are achievable.” (p6) [our emphasis]

²⁸ As Siva Anandaciva of NHS Providers notes in a guest blog for the Nuffield Trust: “the early indications are that these demand management initiatives take longer than we think to deliver concrete changes; are harder to implement than we think; cost more money in the early years than we think; and are effective on a smaller scale and patient population than we think. These new ways of working also seem focused on delivering greater *value* for the same level of NHS funding, rather than aggressively taking costs out of the NHS in the same way that closing hospital beds and reducing the size of the NHS workforce do.”

<http://www.nuffieldtrust.org.uk/blog/we-might-need-magic-carpet-cross-financial-bridge>

²⁹ <http://www.publications.parliament.uk/pa/cm201415/cmselect/cmpublicacc/518/518.pdf>

“The Department of Health acknowledges that it **does not know** whether some preventative services and lower level interventions are making a difference.” (p 7) [our emphasis]

“The Department for Communities and Local Government told us that they **did not know** how local authorities would be able to maintain spending on care for adults and improve outcomes in a situation where needs were increasing but overall public funding was falling.” (p12) [our emphasis]

To complete the picture of central government ignorance and indifference to the viability of adult social care services, the Public Accounts Committee found: “The Department of Health recognised the need for greater research in these areas, and it acknowledged that the lack of evidence on what works and how changes should be implemented was a barrier to integration of health and social care.” (p13)

A further fundamental problem with implementation of the Care Act, according to the ADASS (Association of Directors of Adult Social Services) report at the end of 2014, is that according to an LGA poll of 54 councillors leading adult social services, not one was very confident that its provisions could be implemented in 2015-16, only six declared themselves “very confident”, while 46 were either “not very confident” or “not at all confident” that the funds would be there.

The Nuffield Trust has carried out further appraisals of the experiments in integrated care undertaken so far in North West London³⁰. The Trust reported:

“The costs of the programme to date are not insignificant: £24.9m over the three years 2013/14 to 2015/16, of which £7.9m was spent during the first two years on management consultancy to provide specialist expertise and support.

“Unsurprisingly in the current financial climate, the evaluation reported findings that questioned the value of such levels of investment in both management consultancy, and the programme team, as well as evidence that their support had been positively appreciated.

“It is likely that the programme will need to account more explicitly for the cost-effectiveness of its current and past spending, **especially in the absence of evidence, to date, that it has secured significant levels of service change on the ground**”. (P5 “Key Findings”) [our emphasis]

A Nuffield Trust seminar in 2015 to review the evidence on Out of Hospital services and other demand management tactics confirmed that there was some evidence that facilitating rapid discharge from hospital would enable reductions in acute capacity. But it also found that **the success of all other demand management**

³⁰ “Putting integrated care into practice: the North West London experience” Nuffield Trust, October 2015.

experiments was very limited, with experiments proving small scale, not reproducing significant impacts or significant savings³¹. [our emphasis]

A report in April 2016 from the Policy Innovation Research Unit³² concludes:

“Embedding large-scale cultural change is not a short-term process. So far, as we have seen, the extent to which the Pioneers have delivered actual changes to service patterns and service delivery is modest. We do not have the data to quantify this precisely, and would face the usual difficulties of attributing causation even if we did.” (p120)

“In addition to the inherent difficulties of large-scale transformative change, the environment in which the Pioneers are operating is getting harsher and, in many respects, increasingly unsupportive of whole systems transformation.” (p121)

Evidence on the impact of integrated care on demand for acute services

A large part of the underlying thinking that informs the SaHF and the STP relies on a greater role for social care and primary health care to reduce the workload on hospitals. An increase in out-of-hospital provision is supported by all North West London local authorities, including LB Ealing and LB Hammersmith and Fulham, but to ensure adequate levels of patient care are maintained, this must be seen to be delivered and effective before any reduction in acute services can be considered.

The more detailed breakdown in the “Local Services Transformation document “ (Paper 3.1) of how integrated care is supposed to reduce pressure on A&E and avoid almost 3,000 hospital admissions cites as “Evidence for these assertions”³³:

“Evidence on the impact of case management is promising but mixed. It is usually difficult to attribute any system changes explicitly to case management as there are often multiple factors at play, and as case management isn't a standard intervention - it can be implemented in a variety of different ways. Case management works best when it is part of a wider programme where the cumulative impact of multiple strategies can be successful in improving patient experiences and outcomes.

“In the US, when compared with a control group, older people enrolled in the PACE programme (case management) showed a 50% reduction in hospital use and were 20% less likely to be admitted to a nursing home. They did,

³¹ This has been followed up with a recent phone appointment with Nigel Edwards, Chief Executive of the Nuffield Trust, who reaffirmed these findings as representing the up to date evidence.

³² Erens B (2016), “Early evaluation of the Integrated Care and Support Pioneers Programme”, PIRU, www.piru.ac.uk/assets/files/Early_evaluation_of_IC_Pioneers_Final_Report.pdf

³³ Local Services Transformation document (p21), available: <http://www.healthcampaignstogether.com/pdf/Paper%203-1%20NWL%20Local%20Services%20Transformation.pdf>

however, use more ambulatory care services. Evaluations of Guided Care have found similar results.

“Evercare was trialled in the UK after success in the US, but unfortunately only showed negligible results. In Wales, an evaluation of case management showed a reduction in non-elective admissions of 9.1% compared to a control group (and preintervention years) and a reduction in length of stay of 10.41%. Despite mixed evidence on the impact of case management on capacity in the system, there is strong evidence that case management results in an increase in patient satisfaction.”

In our view such reliance on US evidence is flawed. It is not surprising that trials of US-developed systems such as Evercare showed negligible results. The US health care system spends close to twice the UK share of GDP on health care, and arguably suffers from over-diagnosis and excessive interventionism in contrast to the NHS; it spends 50% less on social care and much less on primary care, leading to stories of dumping of sick patients on the street after early discharge from hospital when funding runs out. So of course it may be possible to make the US system appear to work better by spending a little more on social care, especially where – unlike the English situation – the system is run as an integrated whole. The same increased efficiency from an integrated system can also be seen in the better-resourced systems run through local government in Scandinavia.

In England however the financial situation for social care remains extremely challenging, with planned savings for adult social care in 2016/17 of £941 million (7% of net adult social care budgets). Funding for public provision for adult social care fell by over 10% in cash terms between 2010/11 and 2014/15 from £14.9 billion to £13.3 billion; in real terms it fell by an average of 2.2% per year between 2009/10 and 2014/15, leading to a 25% reduction in the number of people receiving publicly-funded social care. This is leading to increases in bed days lost caused by delayed discharges because social care was not available (see page 38 of this report).

A survey of all English social service departments by the Association of Directors of Adult Social Services found that fewer savings are proportionately being made from efficiencies and more from reducing frontline services. There are also now next to no further efficiencies to be made from squeezing provider fees paid, or raising income from fees and charges to customers.

In cash terms, where a breakdown was specified, Directors said that 51% of the identified cuts will directly affect services for older people and 31% will affect people

with a learning disability; 18% of the cut will be to personal budgets, meaning reduced levels of care for those receiving it and care for fewer people overall.³⁴

Assumptions behind cuts in hospital services

All of the published plans for downsizing and downgrading hospitals and reconfiguration of acute services in London – and elsewhere in England – rest on the same largely unproven assumptions that large numbers of seriously ill people can be kept out of hospital by services in the community or from primary care – and that such provision can save money compared to existing services.

In South East London the once-threatened Lewisham Hospital has been merged with Queen Elizabeth Hospital in Greenwich, formerly a component of the now-dismembered South London Healthcare Trust. This put the deeply flawed plans of the Trust Special Administrator – who initially called for the closure of most acute services at Lewisham as part of a costly “rescue” package for South London Healthcare – to the test. The failure was spectacular. Dr Tony O’Sullivan, a consultant paediatrician at Lewisham & Greenwich Trust told the People’s Inquiry of a CQC inspection in February 2014:

“One of the major CQC findings was that the Queen Elizabeth emergency department’s acute pathway was not fit for purpose: and the subsidiary finding was that the QE had far too few beds. I think they quoted 75 or 80 beds were needed in order to unjam the log jam of patients pouring into the A&E not being able to be admitted to wards, backing up into the ambulances in the car park, and then fines being imposed for those.”

“So, far from the TSA proposal that 450 beds could be lost from the local South East London health economy, the CQC said that as of that moment the local health economy didn’t have enough beds.”³⁵

The evidence for cost savings from developing GP and community out-of-hospital initiatives is also very limited. Research published in 2012³⁶ surveying all out-of-hospital initiatives failed to demonstrate savings.

Similar findings were highlighted by the Commission on Hospital Care for Frail Older People, set up by the *Health Service Journal* and conducted by a group of experts led by the respected University Hospital Birmingham Chief Executive Dame Julie Moore. After surveying the evidence, the Commission concluded it was a “myth” that measures such as the “integration” of health and social care, and improved services in the community would reduce the need for hospitals or bring cash savings for the

³⁴ ADASS (2016) Budget survey 2016, Association of Directors of Adult Social Services, available <https://www.adass.org.uk/adass-budget-survey-2016-full-report>

³⁵ <http://www.peoplesinquiry.org/pdf/Tony%20Sullivan%2011%20Dec%20TS%20draft.pdf>

³⁶ Purdy S et al. (2012). Interventions to reduce unplanned hospital admission: a series of systematic reviews: final report. Bristol: University of Bristol, available <http://www.bristol.ac.uk/media-library/sites/primaryhealthcare/migrated/documents/unplannedadmissions.pdf>

hospital sector. While better community services were desirable, the report argues that this would only delay rather than avoid the need for hospital stays:

“The commonly made assertion that better community and social care will lead to less need for acute hospital beds is probably wrong.”³⁷

Candace Imison’s report from the King’s Fund makes similar points:

“There have been very few studies to assess the impact of centralising A&E services. The limited evidence available suggests that if services are centralised, there are risks to the quality of care where the centralised service does not have the necessary A&E capacity and acute medical support for the additional workload. A proportion of A&E attenders can safely be seen in community settings, but there is little evidence that developing these services in addition to A&E will reduce demand.”³⁸

Her report concludes:

“The reconfiguration of clinical services represents a significant organisational distraction and carries with it both clinical and financial risk. Yet those who are taking forward major clinical service reconfiguration do so in the absence of a clear evidence base or robust methodology with which to plan and make judgements about service change.”

Another Nuffield Trust report, designed to show that better integration of social care and hospital care would reduce demand for acute care, concluded:

“Our research did not detect lower use of hospitals for the British Red Cross group compared with a matched control group over the longer term. In fact, the evidence suggested that emergency admissions may have been slightly higher in the British Red Cross group.

“The results reinforce the challenges around reducing rates of emergency hospital admission. This is a common concern across health services, and one that has proved difficult to convincingly address. In the absence of well-accepted, evidence-based solutions to reducing emergency admissions, there is a need to subject promising new interventions and models of service provision of this type to thorough evaluation.”³⁹

³⁷ Barnes, S. (2014) Integration will not save money, HSJ commission concludes, *Health Service Journal*, 19 November, 2014 available <http://www.hsj.co.uk/news/acute-care/integration-will-not-save-money-hsj-commission-concludes/5076808.article?blocktitle=News&contentID=8805#.VG41vo1ybxk>

³⁸ Imison C, Sonola L, Honeyman M, Ross S (2014) *The reconfiguration of clinical services What is the evidence?* http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_summary/Reconfiguration-of-clinical-services-kings-fund-nov-2014.pdf

³⁹ Georghiou T., Steventon A (2014) *Effect of the British Red Cross ‘Support at Home’ service on hospital utilisation* http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/red_cross_research_report_final.pdf

A 2012 analytical paper in the *BMJ* by Professor Martin Roland and Gary Abel⁴⁰ went further, to question the received wisdom that hospital admissions could be reduced and costs cut by improving primary care interventions, especially aimed at those of high risk (whose chronic health problems often lead to them being pejoratively dismissed by NHS bureaucrats as “frequent flyers”).

Among the bevy of myths dispelled by this study is the illusion that high-risk patients account for most admissions, or that case management of such patients could save money:

“most admissions come from low risk patients, and the greatest effect on admissions will be made by reducing risk factors in the whole population. [...]

[...] even with the high risk group, the numbers start to cause a problem for any form of case management intervention – 5% of an average general practitioner’s list is 85 patients. To manage this caseload would require 1 to 1.5 case managers per GP. This would require a huge investment of NHS resources in an intervention for which there is no strong evidence that it reduces emergency admissions.”

Roland also points out the difficulties of assessing the effectiveness of those interventions that have taken place because of fluctuations in numbers of admissions even among those at high risk. Some of the interventions that have been piloted, providing case management for high-risk groups of patients, have proved not only ineffective, but to result in increased numbers of emergency admissions – possibly because the increased level of care resulted in additional problems being identified. Indeed three trials of interventions have had to be abandoned because of increased deaths among the patients involved. Roland warns that an additional unintended negative consequence could result from GPs feeling under “excessive” pressure not to refer sick patients to hospital. Roland criticises the failure of many plans aimed at reducing hospital admissions to consider the role of secondary care, and improved collaboration between GPs and hospital colleagues.

⁴⁰ Roland, M. Abel, G. (2012) Reducing emergency admissions: are we on the right track? *BMJ* 2012;345:e6017, 16 September, <http://www.bmj.com/content/345/bmj.e6017>

Subsequent research involving Roland raised even more questions over the value of case management as a means to deliver cost savings or reduce emergency admissions:

“Evidence shows that case management improves patient satisfaction with care, promoting high levels of professional satisfaction and reducing caregiver strain, but its impact on reducing future emergency admissions has not been demonstrated in systematic reviews of randomised controlled trials (RCTs). [...] Current evidence does not support case management as an effective intervention for reducing emergency admissions, despite the effort it requires from the primary care team”.⁴¹

Hope over experience: experiments with Accountable Care Partnerships

The STP in North West London also sets the goal of establishing ‘Accountable Care Partnerships’ across the whole of North West London by 2020/21 as one of the key ways to deliver the new system⁴². Accountable Care Organisations, which Simon Stevens agrees are an American-style system,⁴³ are proposed in the 5-Year Forward View.

In an ACO the provider organisation receives a fixed budget based on the population to be covered, and takes on the risk of being able to deliver the services and retain a surplus. If the costs overrun, the provider takes the hit.

The circumstances however are different in the NHS. In the US the source of funding is through insurance companies rather than the public money of the NHS, and of course many of the providers are in the private sector: but here in the UK the prospect of private health corporations coming in to take up ACO contracts would be controversial.

Establishing an ACO in a locality would also effectively outsource the commissioning role of the CCG. An ACO is unlikely to work without substantial investment in community-based health care, enhanced primary care and the establishment of social care to minimise demand for hospital care and support people living at home, requiring additional investment. And in England, even with an ACO in place continued bureaucracy would also be needed to “monitor” the service: it is not a cheap option if done properly.

Moreover it appears to be little understood that the effect of ACOs would be to overturn the intent of the legislation enshrined in NHS law since 1990: that of the purchaser-provider split with its role for competition to improve performance and

⁴¹ Wallace E., Smith S.M., Fahey T., Roland M. (2016) *Reducing emergency admissions through community based interventions*, British Medical Journal, January 28, *BMJ* 2016;352:h6817

⁴² See Draft STP Ver 1.0, pages 10,11, 26, 47, 48.

⁴³ Stevens will be familiar with the concept from his years in the US as a senior executive of the leading health insurer, UnitedHealth.

remove perverse financial incentives for providers not to provide health care. This is also likely to generate controversy and potential legal challenges may emerge.

Both of Stevens' main suggestions of new models of health care – Multi-Specialty Community Providers, to be led by GPs, and Primary and Acute Care Systems to be led by acute trusts – could potentially be delivered as ACOs.

The STP process has not replaced, but been added on to the machinery of NHS administration established by the 2012 Health & Social Care Act, which entrenched the divide between commissioners and providers, and still obliges CCGs to put an ever-increasing range of services out to tender, or open up to “any qualified provider”.

Any attempt to roll out ACOs in the NHS should also take account of some of the problems they are causing in the USA, where providers are effectively required to operate as insurers, and many are finding the profits non-existent, and going out of business.

The NHS – unless it is substantially and very visibly reorganised – offers only limited options to exclude high risk, and potentially costly patients. This makes capitation-based funding an unattractive gamble for private insurers, who would end up with any deficit.

Attempts to launch ACOs in England have been limited so far, although fresh moves to open up contracts and the lure of a share of the £1.8 billion “Transformation Fund” no doubt means more will be tempted.

Some local ACOs are already happening, with the most high-profile one in Northumbria, where NHS England has provided £8.3 million over two years to kick-start an ACO covering 320,000 people and led by Northumbria Healthcare Trust, starting in April 2017.

Recently Dudley CCG has been first to propose a new type of contract, announcing it will be opening up a competitive tendering process for an ambitious 10-15 year £240 million per year contract for a ‘Multispecialty Community Provider’ to take on an ACO role, as advocated by NHS England. The contracting process means that it could be an early test of the enthusiasm of the private sector to compete for this large but risky element of the NHS budget.

3.3 Summary

This section has set out an extended analysis of the STP proposals as published so far, the assumptions behind them and the evidence that supports them. It makes clear that the STP is based on the plans and assumptions drawn up by the SaHF programme, which have already been examined by the independent Mansfield Commission.

Developing drafts of the STP have not been adequately shared with the boroughs or with the wider public. The confidential process of development has also meant that council leaders have been pressed to sign incomplete documents without the opportunity for proper examination or scrutiny, even though it is now clear that the full document includes obligations on each borough.

Despite ostensible stress on service improvement and integration, the main focus of the STP, even more so than the SaHF, is on financial savings. However the assumptions on which the financial effects of changes are calculated is not transparent, making full scrutiny of the proposals impossible.

The section of the STP setting out proposals for social care remains incomplete and lacks any clear explanation of the details of the general proposals. It is clear that the additional funding that might be available to boroughs as part of the STP process is very limited.

As noted above, the full implications of the STP proposals are only set out in a separate document,⁴⁴ the Local Services Transformation document. This sets out proposals mapped against projected financial savings and reductions in beds required, together with the evidence that has been used. We have summarised these in tabular form in Appendix 4 with notes identifying key missing elements and weaknesses in the evidence. It is clear from this breakdown that the planned savings will be largely achieved by closing 500-600 beds in Ealing and Charing Cross.

We have also provided an update on and reminder of the substantial independent evidence now published which questions the underpinning assumptions and financial projections of SaHF and the STP. This section concludes with a brief critique of the STP proposals to establish “Accountable Care Partnerships”, following a US model that is proving to be problematic even in the US.

In summary, there is little if any evidence available to support the proposals advanced in the SaHF and now the wider STP in North West London, but there exists a large body of evidence that would raise serious questions about whether it can deliver the promised benefits. If the objective is to transform and integrate services, it is clear that capital is required, along with a process that establishes and tests out the alternative provision of services before busy acute beds are closed and hospitals downgraded. In other words a serious proposal along these lines would require investment up front to cover double-running costs and the eventual phased closure of redundant beds: any savings could only be generated in the long term, not immediately.

⁴⁴ Paper 3.1. NWL Local Services Transformation (May 27 2016), a 27-page report produced by management consultants for the North West London Collaboration of CCGs, and now available at: <http://www.healthcampaignstogether.com/pdf/Paper%203-1%20NWL%20Local%20Services%20Transformation.pdf>.

4 Current financial position in North West London: no basis for panic measures

This section sets out the NHS financial position in North West London, and places it in a national context. It goes on to examine the finances behind the STP before drawing some brief conclusions.

4.1 NHS finances in North West London

The context for assessing the current financial position in the NHS as a whole is well summarised by the Health Foundation⁴⁵ as one of reduced funding, high demand for services and reductions of 25% in the people receiving social care.

In this context of financial stringency we assess the recently reported position within North West London. Table 4.1 shows the total financial position for North West London NHS budgets for 2015-16. It is based on our analysis of year-end accounts, where possible, or final year figures as reported in year-end financial reports to Boards. The figures are however not without ambiguity and require some commentary. For example technical adjustments have been made to balance sheets at Imperial College Healthcare that affect the published year-end deficit in the annual accounts but will not affect the operating deficit. This has been excluded. Other non-recurring factors that may have affected year-end performance will have been incorporated in year-end figures.

⁴⁵ “The NHS in England is currently halfway through the most austere decade in its history. In the 2015 comprehensive spending review, the government committed to additional real terms (adjusted for inflation) funding for health of £4.5bn by 2020/21. This means that NHS funding in England will have risen by an average of 0.9% per year in real terms between 2009/10 and 2020/21. This is well below the average real terms increase of 3.7% per year since its creation in 1948, and a far cry from an average increase of 8.6% per year between 2001/02 and 2004/05. It will be the lowest ever rate of funding growth over a 10-year period.

“Pressures on NHS providers grow by around 4% every year, due to a growing and aging population as well as rising costs, expectations and prevalence of long-term conditions. At the levels of funding provided, the NHS is struggling to meet these demands and cost pressures.

“Funding for public provision for adult social care fell in real terms by an average of 2.2% per year between 2009/10 and 2014/15, leading to a 25% reduction in the number of people receiving publicly funded social care. It is hard to identify the additional burden this has placed on NHS services, but due to the strong interdependency between health and social care services, it is likely to have had an impact on the demand for, and cost of providing services.

“Following the comprehensive spending review in 2015, public funding for adult social care is planned to rise by an average of 0.6% per year in real terms between 2015/16 and 2019/20. This increase in funding is welcome, but still below the projected rate of increase for demand pressures of 4% per year. It is therefore likely that the level of unmet need for adult social care will rise in the near future.” Lafond S., Charlesworth A., Roberts A. (2016) *A perfect storm: an impossible climate for NHS providers' finances? An analysis of NHS finances and factors associated with financial performance*, Health Foundation 2016.

However the figures are revealing. All CCGs are showing a surplus, with a net surplus of over £88 million. There is also a significant underspend figure for NHS London locally commissioned expenditure (£26.5 million) – as there is for NHS England as a whole (£599 million).

The commissioners' surpluses act to offset deficits in North West London providers⁴⁶. The recently reported aggregate Department of Health Annual Accounts 2015/16 showed a relatively trivial £0.1 billion deficit on a £110 billion-plus budget, and thus reflected a well-managed outturn.

Table 4.1: North West London NHS financial outturn, 2015/16

Providers	Year-end outturn 2013/14 (£m)	Year-end outturn 2014/15 (£m)	Year-end outturn 2015/16 (£m)
Imperial College Healthcare	15.1	15.4	-30
London North West Healthcare		-24.9	-88.3
North West London Hospitals	-23.3	-21.9	
Ealing	17	-9	
West Middlesex	-5	-7.9	
Chelsea and Westminster Hospital	6.2	2.4	-8.9
Hillingdon Hospital	-0.7	-1.6	-6
Central & North West London	4.6	-2.3	2.9
West London Mental Health	-15.4	9.4	5
Total provider financial position	-1.5	-40.4	-125.2
CCGs			
Hillingdon	-5	3.3	7.5
Ealing	6.9	10.5	7.6
Harrow	-10	0.1	2
Hounslow	1.9	6.9	6.3
Hammersmith & Fulham	12.3	13.2	9.2
Brent	33.6	32.6	21.9
Central London	16.9	13.4	8.6
West London	29.6	31.5	25.7
Total CCG financial position	86.2	111.5	88.8
Net North West London position	84.7	71.1	-36
NHS London (locally commissioned expenditure)	189	N/a	26.5
NHS England surplus	790	372	538.7

Notes: 1 Figures extracted from Board reports submitted by Trusts and CCGs or published annual accounts; 2 The reporting of figures for London North West Hospitals comprises the former North West London Hospital trust and Ealing Hospital trust, which merged mid-way through 2014-15; 3 West Middlesex and Chelsea and Westminster hospital merger for 2015-16; 4 Technical adjustments to figures not impinging on future performance are excluded eg Imperial operating deficit was £30.1m but was £47.9m after adjustment for change in property values; 5. This overall position differs slightly from the 2015/16 position cited in the STP (see p19). It is not possible to reconcile the differences owing to the lack of detail provided in the STP but it is likely these are caused by the differing treatment of non-recurring factors or the inclusion of the performance of nationally important specialist trusts not previously included in SaHF planning.

⁴⁶ Consolidated 2015/16 Year-end Financial Report: Paul Bauman NHS England May 2016.

Of course it is true that figures summarised for the past three years demonstrate deterioration in the net financial position: but they also show good overall levels of control. The problems are concentrated within the acute trusts, London North West Healthcare (LNWH) and Imperial Healthcare. We have attempted to meet with both trusts to explore further the reasons for this deterioration although to date neither trust has been available. It is of concern that both organisations have already begun implementation of the SaHF programme before a full Business Case has been completed.

The SaHF plan declares the aim of making improvements to quality of services and on the sustainability of finances: however the immediate results are deterioration in both. Further details will be available in section 5 of this report (on System Performance). As far as LNWH is concerned, an examination of the M12 finance report for LNWH⁴⁷ and the Confidential Report⁴⁸ into the closure of A&E services in North West London suggest the following factors may be playing a part:

- A&E activity was 14% higher than planned but was not fully funded; and,
- Fines and penalties due to failure to meet contract KPIs and metrics, and relevant block / threshold deductions, totalled £25.1 million, of which £5.6 million was reinvested as part of the year-end settlement with local commissioners.

Planned savings from the merger with Ealing were not fully achieved, because additional capacity had to be commissioned to meet demand and a shortage of beds.

Despite this, the overall position is at odds with alarmist reports suggesting runaway “deficits” within the NHS and the implication that urgent action, bypassing normal governance arrangements, must be taken to correct this. The deficits are also at odds with projections of a £1 billion deficit in North West London that were made as the SaHF programme was put together five years ago.

NHS England has responded to renewed claims of financial problems emerging within providers in 2016/17:

“NHS England will be taking action to address its very marginal forecast overspend (less than 0.1% of allocation) as at month three, so that despite the significant risks, we achieve a balanced year end position. We are working with NHS Improvement to stabilise finances this year and to kick-start the wider changes needed to improve services, as set out in last week’s financial ‘reset’ document”.

⁴⁷ LNWH Integrated Performance and Finance Report: Month 12 - March 2016 Version: Final

⁴⁸ *Retrospective review of impact in NWL of A&E changes at CMH and HH*, NHS England 20th March 2015, <https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2015/11/ae-diagnostic.pdf>

This appears to suggest there was no need for undue concern. However that is not the attitude that has been shaping NHS England initiatives to reorganise the NHS into 44 local “footprint” areas, and impose much tighter, centralised discipline over budgets. The NHS is being told to prioritise financial control to achieve unprecedented levels of increased efficiency. If this is not achieved there will be no money for “Transformation”.

In July 2016 the NHS announced a Financial “Reset”⁴⁹, outlining how NHS finances will be brought back into balance nationally. The main components of the plan are:

1. to distribute £1.8 billion of additional resources;
2. to set financial control totals for every provider and CCG;
3. rigorous implementation of tighter agency staff controls;
4. accelerated deployment of RightCare (“a new programme promoting Value”) to all health economies during 2016/17;
5. national action to implement Lord Carter’s recommendations on operational efficiency;
6. creation of efficiency improvement and intervention capability within NHS Improvement; and
7. transformational efficiency programmes being developed through STPs.

The Financial “Reset” (p3-4) makes it clear that provider trusts and CCGs will be expected to live within the public resources made available by Government in 2016/17. NHS Improvement has set a target to cut the combined provider deficit to around £250 million in 2016/17 and to be in recurring balance (excluding one-off factors) by the commencement of 2017/18. A two-year NHS planning and contracting round for 2017/18 and 2018/19 has been launched, to be completed by December 2016, and linked to agreed STPs. Any commitments for future years are subject to this planning round being completed.

A recent report by Sally Gainsbury for the Nuffield Trust “Feeling the Crunch: NHS finances” (August 2016) summarises the extent of the challenge being placed on services. This report notes that what is required is:

“level of recurrent, sustained efficiency saving [that] **has never been achieved to date and would still require funds to be taken from the Sustainability and Transformation Fund (S&TF) to balance provider deficits in the meantime.**” [our emphasis]

⁴⁹ “Strengthening Financial Performance & Accountability in 2016/17” published jointly by NHS England and NHS Improvement dated 21 July 2016

“The S&TF can only be spent once. **If most of the funds are used to plug the deficit, there will be little money for the transformative service change** that is required to modernise and reshape NHS services for long-term financial sustainability.” (p4) [our emphasis]

Put plainly, Gainsbury reports that NHS provider income has been reduced by the simple expedient of reducing tariffs by 4%. Unless providers make savings of this order there will be no money for investment in “Service Transformation”.

But she goes on to say:

“The NHS is relying on service change and new models of care to curb the growth in activity and treat patients more cheaply. This is highly unlikely without access to the S&TF for transformation. As such the two tasks of **huge provider efficiencies and successful commissioner investment in reducing demand growth** need to happen in a **timely and coordinated fashion.**”

“**If commissioners fail** in their attempts **to reduce the rate at which demand is growing**, or if additional funding cannot be secured, the **NHS will face some unpalatable decisions in order to curb the growth in activity** and bring the books into balance. These could include extending waiting times for treatment, raising the threshold at which patients become eligible for treatment, cutting some services altogether, or closing whole sites or hospitals”. (p4) [our emphasis]

The Financial “Reset” and Gainsbury’s recent report only confirm our view that, for all the lip service to “Transformational Efficiency”, the heavy lifting to bring NHS finances into balance by 2017/18 will be achieved by the simple expedients of providing extra resources, squeezing down on prices paid to suppliers and the tariff paid to acute sector providers, and establishing tighter staffing controls.

This is the problem frankly admitted by Sir Richard Sykes, former Chair of NHS London and now chair of Imperial College Healthcare, which runs Charing Cross Hospital and is one of the key organisations involved in drawing up the STP.

He was filmed speaking to campaigners ahead of the trust's annual meeting on 14 September 2016, when he said:

"The NHS is suffering today very badly. If you go back to 1948, it's gone through these periods when it's been cash-strapped. Today it's really cash-strapped...

The capacity just isn't there at the moment. The A&E is a big problem. Waiting times are a big problem. Referral to treatment is a problem...

This is happening not just here but throughout the country. The finances are very, very strained...

The problem is funding. There is no money. I can't get it."⁵⁰

We are not against experiments in new practices and working methods, or against making changes, but before this is attempted we want to see not only coherent plans but also proof that these will be both clinically effective and represent value for money. The jury is still out on many such experiments.

Our assessment therefore of the current financial situation is that it is more accurate to say that the NHS overall is prevented from entering into financial deficits by law, and action would be taken and is taken to manage emerging financial problems so that overall control of finances remains in place.

The latest national figures demonstrate that this action has so far been successful. Within the overall figure there is scope for flexibility so that hospital providers with particular problems eg Imperial College Healthcare and London North West Hospitals, as was the case in 2015/16 and will be the case in 2016/17, are granted more time and resources to rebalance.

An unprecedented funding squeeze

This is not to deny that the NHS has encountered a second five years of reduced funding at a level unprecedented in its history. In an earlier report (Boyle and Steer 2015) we argued that this should not be used as a pretext for expensive, risky and speculative "transformation" experiments. In fact our recommendation was for "Do Minimum" options to be further developed as more likely to deliver sustainability and quality improvements in the short to medium term. In the longer term a reappraisal of the long-term needs of London to provide health care to a rapidly expanding population would require additional capacity, and would not support a shrinking of either the estate, or a reduction in the ability to meet pressures in A&E and in GP surgeries.

The failure to appraise a 'Do Minimum' option is in breach of the guidance in the Treasury's Green Book (HM Treasury 2003); without a 'Do Minimum' option, it

⁵⁰ <http://www.londonnewsonline.co.uk/6011/health-chiefs-fire-cuts-closures-plan/> and the filmed extracts are available at: https://www.youtube.com/watch?v=IhYva5_0API

would be unlikely the SaHF proposals would gain Treasury approval. Treasury guidance specifically states that a 'Do Minimum' acts as a check against interventionist options. It is not the same as 'do nothing' or the status quo. It requires a conscientious examination of how the investment objectives (in this case quality improvements and financial savings) could be achieved with the minimum of capital investment.

Instead the objective of SaHF, and now the STP, seems to have been to pursue reconfiguration as the answer: a preconceived solution leading to an options appraisal that merely chooses between a limited number of ways of doing the same thing, ie reducing the number of acute hospital sites. In our view there is no way to escape the requirement for a 'Do Minimum' option if the business case is to proceed. The sooner this is addressed the sooner the project can advance and local stakeholders can see the real options.

We believe this stance is vindicated by the independent evaluation reports that have emerged of the Pioneer, Integration and other OOH initiatives taking place in North West London and around the country (see section 3); and the latest population projections (see section 5) showing ONS population projections running at almost double that planned for by SaHF. The limited referencing of sources in the STP makes it difficult to judge if more up to date figures have been used in the new plans: see Appendix 2.

Moreover, we are concerned that the timeframe of the STP is purely to 2020/21 whereas the implications of reducing hospital beds and A&E capacity will extend beyond that date⁵¹. The most recent projections by the GLA in 2016 suggest an average population growth in North West London between 2011 and 2041 of 25-26%⁵² depending on which migration projections are used. This only adds to our fears that the STP is not based on a rigorous analysis of the future needs of the population.

In addition the continued financial pressures have limited the availability of capital: the latest indications are that even if approved there would be at best extremely limited availability of capital to fund the SaHF programme until after 2021, with further news suggesting tight Treasury regulation of even small capital sums, as we complete this report⁵³.

It is classically short-term thinking that is driving spending cuts and capacity reductions when it is universally recognised that population and clinical demands are rising significantly. It may be possible to take a different view of the speed of the

⁵¹ The GLA plan for London for example extends to 2041.

⁵² see <http://data.london.gov.uk/dataset/2015-round-population-projections>

⁵³ <https://www.hsj.co.uk/topics/finance-and-efficiency/exclusive-treasury-could-tighten-grip-on-nhs-capital-spending/7010899.article?blocktitle=Finance-and-efficiency&contentID=20097>

upward trend in demand but as it stands the STP is currently only focussed on balancing the books over two years. This is incompatible with clinical capacity planning which should be focussed on the long-term needs of the population.

Crucial to the planning assumptions justifying closures of acute facilities in North West London were the assumptions that improvements in primary care and out-of-hospital care would act to prevent and reduce demand for acute services.

In practice there seem to be ongoing and persistent problems with the programme. Only four of the 27 Primary care hubs planned are operational, with 19 not even yet having presented their business cases. There is no systematic reporting to indicate if there has been any success at all in achieving significant North West London-wide reductions in demand for NHS care or financial savings attributable to the SaHF programme. The reports to JHOSC are inadequate as they do not allow for proper scrutiny or to ascertain whether plans are on track.

In order to be assured that plans are sound there needs to be much more engagement, involvement and scrutiny of NHS plans, an ability to monitor progress against plans, and more accountability to stakeholders than the NHS has been able to provide hitherto.

Moreover, the early closure of A&E services at Central Middlesex and Hammersmith hospitals has led to a continued reduction in standards of service in North West London (see section 5 below).

The Confidential Review by NHS England of the A&E closures in North West London in 2014 found:

- the change in activity flows associated with the CMH/HH changes were largely as expected, **but underlying increases in local demand were not planned for by Trusts or the SAHF programme;** [our emphasis]
- the increase in admissions at Northwick Park (NPH) and The Hillingdon Hospital (THH) **led to capacity constraints;** *and,* [our emphasis]
- admissions at THH and NPH increasing by 8 and 16 per day vs a plan of 0 and 12 respectively⁵⁴.

These are significant findings and suggest the need for more careful scrutiny of planning assumptions before consent can be given to future major changes in NHS services for local people. An early sight of plans, assumptions and detailed modelling would help that process; something that until now has not been forthcoming.

⁵⁴ Retrospective review of impact in NWL of A&E changes at CMH and HH NHS England 20th March 2015: p 4

4.2 The STP: ambitious or foolhardy

The STP in North West London is extremely ambitious. Myriad business plans are (still) being developed: for SaHF; for various hospital provider sites; for 16 Primary care centres. The draft STP makes clear (p46) that over £2.2 billion of capital will be required to deliver the plans in North West London.

As Table 4.2 shows, the STP assumes that £959.2 million will be available from land receipts and disposals, £330 million of which is before 2020/21. This is netted off to show some consistency with previously reported figures of the cost of the SaHF programme of £1.2 billion to £1.3 billion, but the total investment requirement is about £2.2 billion.

Table 4.2: Capital implications of STP

	Outer NWL	Inner NWL	OOH	Additional Capital	Total
	£m	£m	£m	£m	£m
Pre 2020/21					
Gross Capital Expenditure	75.2	247.4	219.2	206.1	747.9
Disposals and Contingency		-330			-330
Total Net Capital requirements	75.2	-82.6	219.2	206.1	417.9
Post 2020/21					
Gross Capital Expenditure	252.5	1,116	4.5	97.1	1,470.1
Disposals and Contingency	29	-681.2	23		-629.2
Total Net Capital requirements	281.5	434.8	27.5	97.1	840.9
Total Gross Capital Expenditure	327.7	1,363.4	223.7	303.2	2,218
Total Disposals and Contingency	29	-1,011.2	23		-959.2
Total Net Capital requirements	356.7	352.2	246.7	303.2	1,258.8

This is extracted from Table 1 of the STP (p46). Projected costs, land sale receipts and affordability, particularly in the second five-year period, are indicative and subject to detailed business case processes.

It is unwise to assume an investment of over £2.2 billion of capital, £750 million before 2020/21, will be provided in North West London at a time when the NHS is starved of capital and seeking to earmark funds from sales to help meet revenue targets. And all this on the basis of flimsy and, so far, failed plans to reduce and control patient demand for services.

There are two clear risks. The Treasury could:

- earmark the land receipts to use to bridge past and anticipated revenue pressures; and,
- hold the local NHS strictly to account to deliver half-baked promises on delivery that it is in no position to fulfil.

Either way the plan represents a higher risk to the future delivery of local services than more modest proposals based on a so far unidentified “Do Minimum” option.

4.3 Summary

The NHS is in a position of prolonged relative financial pressure compared to the past. Recent headlines suggest this is causing problems across the country. The NHS in North West London is not exempt from those pressures but despite a slight deterioration recently its record of achieving targets and its maintenance of overall financial control is a good one.

In addition reductions in social care funding are feeding through to the NHS; the recent report in the DH Annual accounts for 2015/16 drew attention to the 11.4% increase in bed days lost caused by delayed discharges because social care was not available.

The financial situation certainly does not justify a high-risk strategy attempting an unprecedented “transformation”, including reductions of almost 600 beds and further cuts in A&E capacity, at a time of increasing population, and increased demand, some of which is due to government cuts in social care. Certainly bed reductions should not be attempted before there is more concrete evidence that demand is reducing and capacity is not required.

This, coupled with a continued inability to present an agreed Business Case providing proof that SaHF plans are affordable, economic and deliverable, reinforces our previous view that more affordable “Do Minimum” options should be developed.

Dr Anne Rainsberry, Regional Director (London) NHS England, provided a timetable to the Mansfield Commission in September 2015 claiming that a Business Case would be available in early 2016. This had still not appeared as of the end of September.

One of the criteria used in assessing the Business Case will be the level of engagement and commitment of stakeholders. It will be very difficult to demonstrate these have been established if the business case and its supporting evidence have not been shared.

Moreover, the SOC is still just the first stage of the formal planning process and even if agreed would require Outline Business Case (OBC) and Full Business Case (FBC) approval. Given further pressure on capital budgets in the NHS, with land receipts being earmarked nationally to deal with revenue pressures it would be very unwise to presume full approval will be given.

Evidence summarised in Appendix 1 on various aspects of the SaHF programme and its progress supports this view.

5 System performance in North West London

An earlier report (Boyle and Steer 2015) showed that access to care was not a fundamental consideration in the decisions to close acute hospitals taken by the SaHF team. We presented evidence showing the detrimental effect that closures of Central Middlesex and Hammersmith A&E departments had on the quality of services across North West London.

Once SaHF decided there could only be five acute hospitals in North West London the issue became which to close as acute sites; access for patients did not figure as a major deciding factor. Since then the maternity service in Ealing hospital has closed, followed by inpatient and A&E services for children at the end of June 2016. There is a clear intention to close the A&E departments at Ealing and Charing Cross hospitals. It is just a question of when.

This section provides a further analysis of the impact of proposed changes, and those that have already taken place, on access to care for the population of North West London, and how the health care system is performing. Our focus is on A&E services as these are pivotal to the viability of the hospital site and a good indicator of the quality of service, and are vital as a life and death service for local people

5.1 The context of increasing population growth

The North West London health economy covers eight of the 33 London boroughs, and eight CCGs, each contiguous with a London borough. It comprises a population that was estimated in SaHF's Case for Change (NHS North West London 2012) to be 1.9 million people, with growth 'in the next ten years', which we interpret as until 2022, of 5.9% to 2 million people. In fact the latest estimate (ONS 2016a) of the population in North West London (mid-year 2015 estimates) suggests there are already 2.06 million people, and that this grew by almost 62,000 (3.1%) between 2012 and 2015: already SaHF's population estimates are looking outdated.

Table 5.1: Projected growth in population, eight North West London boroughs, between 2014 and 2024

Borough	Projected growth
Hillingdon	16.1%
Westminster	15.6%
Hounslow	13.9%
Brent	11.4%
Harrow	10.7%
Ealing	7.9%
Hammersmith and Fulham	6.5%
Kensington and Chelsea	2.8%
North West London	11.1%

Source: ONS 2016a.

London is projected to continue to grow more quickly than the rest of England. Thus, the latest ONS population projections, for 2024, suggest growth between 2014 and 2024 of 13.7% for London as a whole; for England the projected growth over the same period is just 7.5% (ONS 2016b). Table 5.1 shows the projected population growth in the eight North West London boroughs, between 2014 and 2024: it is significant and comes to an average of over 11% across all of North West London. More recent population projections produced by the GLA confirm these findings and, moreover, indicate a projected increase in population of up to 26% by 2041⁵⁵.

These figures bear out the testimony and concerns expressed at hearings of the Mansfield Commission that SaHF is failing to plan adequately for such demographic changes.

SaHF also claimed that North West London is overprovided with A&E units relative to the rest of England. In our previous report we drew attention to the inaccuracies in SaHF’s calculations that lie behind this claim. In fact the catchment population of North West London A&Es was close to the national average and, with the closure of Central Middlesex and Hammersmith A&Es, the catchment has increased, and will increase further as the remaining two of what were nine units are closed.

5.2 Total beds in North West London

It appears that bed availability has increased in North West London, in the case of maternity and mental health, at a time when it is falling across England⁵⁶ and also in the rest of London (see Tables 5.2 and 5.3); and has fallen much less in the case of general and acute beds.

Table 5.2: Bed availability, 2009/10

	General & Acute	Mental Illness	Maternity
London North West	4,302	1,371	361
London	17,926	5,373	1,526
Rest of London	13,624	4,002	1,165
England	121,756	25,503	8,392

Source: Analysis based on NHS England 2015a.

Table 5.3: Bed availability, 4th quarter, 2015/16

	General & Acute	Mental Illness	Maternity
London North West	4,272	1,562	423
London	15,971	4,254	1,569
Rest of London	11,698	2,692	1,146
England	103,441	19,086	7,746

Source: Analysis based on NHS England 2015b.

⁵⁵ see <http://data.london.gov.uk/dataset/2015-round-population-projections>

⁵⁶ This is from a low base: England already has less acute beds per capita than comparable countries.

Table 5.4 shows there are more beds per head of population in North West London than in England as a whole – looking in more detail, there are 10% more general & acute beds; and there are 45% more maternity beds. The rest of London has about the same number of general & acute beds as England as a whole.

Table 5.4: Bed availability per 1,000 resident population, 4th quarter, 2015/16

	General & Acute	Mental Illness	Maternity
London North West	2.07	0.76	0.21
London	1.84	0.49	0.18
Rest of London	1.77	0.41	0.17
England	1.89	0.35	0.14

1 Based on above bed figures plus 2015 mid-year estimate of populations (ONS 2016a).

The issue is how North West London compares with the rest of the country. Two key questions remain unanswered: whether the growth in population has been sufficiently factored into the calculations of beds required; and, whether areas where North West London is in excess of average requirements merely reflect their different status as centres for specialist care and for training and research, or whether it does indicate overprovision of local services for local people.

It is well known that London hospitals provide specialist services to patients from all over England. Previous reports have shown that this can amount to as much as 15% of beds used (Boyle and Hamblin 1997). There are three specialist hospitals in North West London: the Royal Brompton, the Royal Marsden and the RNOH, which between them have 770 beds: this is over 18% of the total in NW London. If we remove these hospitals from our bed calculation above we find that North West London is much like any other part of the country.

5.3 Impact of changes on access to services

We consider now the impact of acute capacity closures on access to services. We focus on A&E services particularly since the closure of Central Middlesex and Hammersmith A&Es. We consider the performance of North West London on one or two key indicators of emergency performance, and how this performance may have been affected by the changes taking place under SaHF.

We differentiate between three types of immediate emergency response: that provided by acute A&E departments and designated as Type 1 in Department of Health terminology; that provided by specialist A&E departments and designated as Type 2; and that designated as Type 3 which is provided by a range of centres that are characterised by having more limited access to testing facilities, tend to be run by nurses or GPs, and often are not open 24 hours a day. This last category encompasses Urgent Care Centres (UCC), Minor Injury Units (MIU) and Walk-in Centres (WiC), as well as services provided directly by some GP practices.

Facilities in this last category were designed to deal with less serious health issues; there was a considerable expansion in their numbers after 2004 when UCCs were introduced in an effort to divert activity away from acute A&Es, but there has recently been a reduction in their numbers. Our analysis is based on our understanding of the structure of emergency care provision in North West London as described in our earlier report (Boyle and Steer 2015).

Use of emergency services

In the *Case for Change* (p15, NHS North West London 2012), SaHF claimed that the rate of A&E use is high across outer North West London; in particular it was claimed emergency admissions are much higher in Ealing and Hounslow (595 and 495 per 100,000 population against a national average of 410 per 100,000).

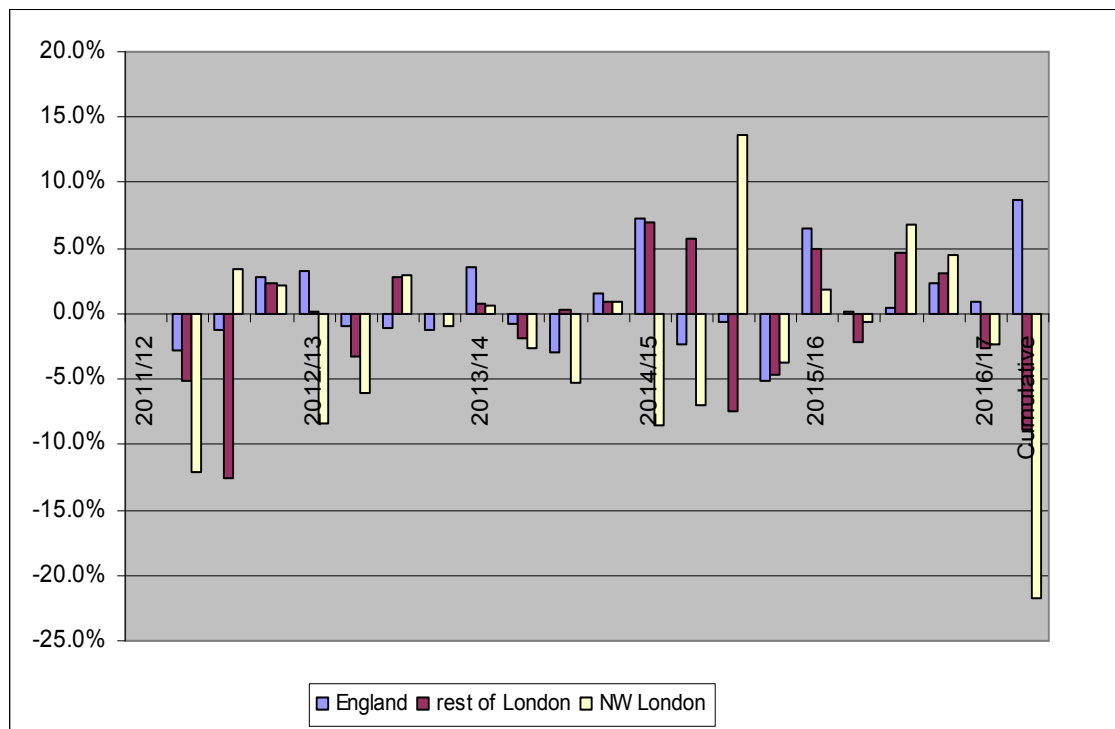
We examine this proposition. First we look at the number of A&E attendances in North West London, how many of these become admissions as emergencies, and how this profile has changed in the recent past. We then look at performance as measured by the NHS in terms of numbers of people attending A&E who are dealt with in less than four hours. For each of these indicators, we consider performance in North West London compared with the rest of London, and the rest of England.

North West London has a very different pattern of use of A&E services compared to the rest of the country and to the rest of London. There is a much larger proportion of attendance at non-acute centres (Type 3) and this has been growing in recent years. So we find that in 2011/12 some 68% of A&E activity in England was Type 1 whereas in North West London the figure was just 51%; by the third quarter of 2014/15 the England figure remained at 68% whereas in North West London just 38% of attendances were at acute A&E centres. For the rest of London the figure remained at 73%⁵⁷.

So patients in North West London appear to be able to distinguish very clearly their need for urgent care with now just over a third of them attending A&E departments when they perceive they have an urgent need for care. Patients in the rest of England, as in London, are being encouraged to behave like this, but there is no evidence of changes in patterns of demand. There has been no change in behaviour elsewhere over the last three years whereas North West London has witnessed a significant change.

⁵⁷ We have excluded Type 2 attendances from these figures.

Figure 5.1: Percentage quarterly changes in Type 1 A&E attendances, April 2011 – June 2016



Source: Analysis based on NHS England 2016

The question is what does this mean for the retention of A&E services in North West London. Figure 5.1 presents percentage change in Type 1 A&E attendances comparing England (excluding North West London), London (excluding North West London), and North West London. Data are provided on a quarterly basis and the final bar on the right-hand side is the cumulative change over this period.

These data reflect the position up to the end of June 2016, and hence include almost two years since September 2014 when Central Middlesex and Hammersmith A&Es were closed. Data are presented for all quarters from 2011/12 to 2015/16 plus one quarter of 2016/17, and the cumulative effect over the whole period.

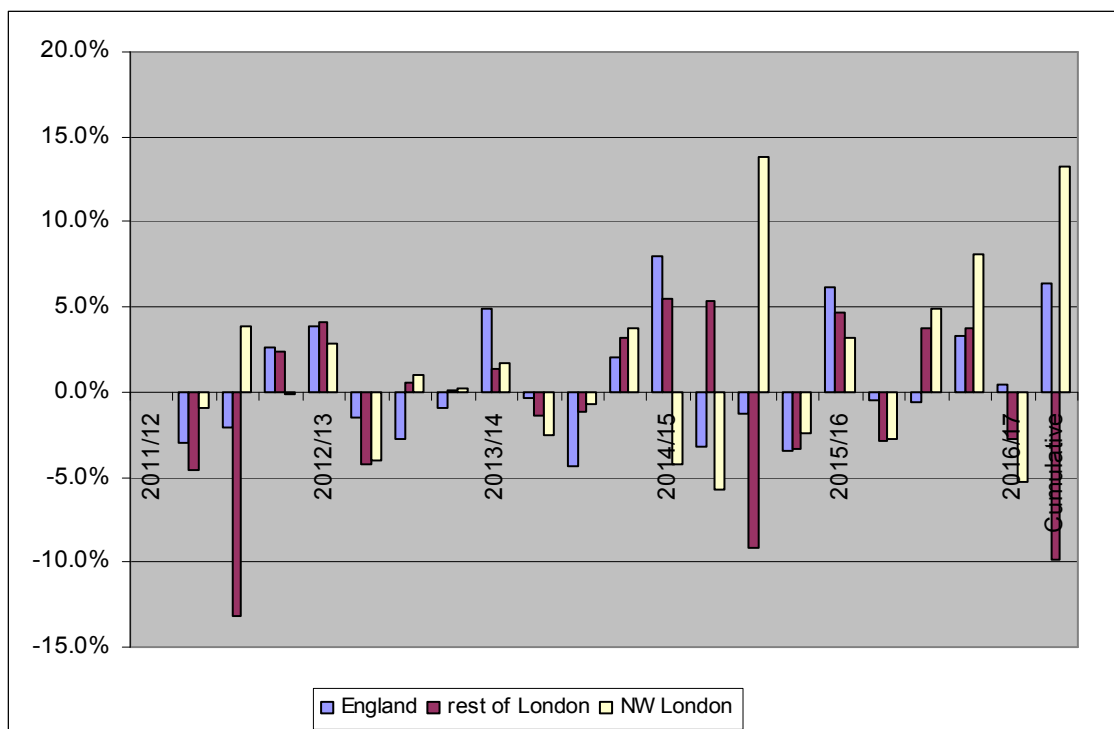
There has been a cumulative increase in A&E attendances in the rest of England over this period of 7.3%. However the picture seems very different in London where there has been a cumulative fall of 8.9% and in North West London where the reduction is even larger at almost 21.7%. This represents a fall of over 35,000 attendances in North West London hospitals over this period.

However, the growth in the use of urgent care centres in North West London would seem to provide most of the explanation for this fall in Type 1 attendances. Thus we find that in April 2011, Type 1 attendances were 55% of total Type 1 and Type 3 taken together, but by the end of June 2016, this proportion had fallen to 38%. The

position in the rest of England is very different: the proportion has remained at around 69% throughout this time; and in the rest of London it has been around 73%.

If we look instead at total A&E attendances including UCCs and specialist units we find a different picture, as Figure 5.2 shows. Attendances in North West London have increased by 13.2%, and in England by 6.4%, whereas those in the rest of London have actually fallen by 9.9%.

Figure 5.2: Percentage quarterly change in all A&E attendances, April 2011 –June 2016



Source: Analysis based on NHS England 2016.

Taking a population view, we compare use per 1,000 population⁵⁸. We find that in England, utilisation of Type 1 services has gone up marginally between 2011/12 and 2015/16, from 264 to 273 per 1,000 resident population; in North West London on the other hand utilisation has fallen from 304 (when it was above the England average) to 242 (now well below the England average). The rest of London exhibits greater use of Type 1 A&E services and although this has fallen marginally, from 375 in 2011/12 to 361 in 2015/16, it remains above both England and North West London figures.

On the other hand we find that North West London residents make considerably more use of UCCs and WiCs, between two and three times as much as England or the rest of London, and this has increased over these five years, from 295 to 400

⁵⁸ We use the 2012, 2013 and 2014 ONS mid-year population estimate for ease of comparison.

attendances per 1,000 population: the equivalent figures for England are 129 and 134, and for the rest of London, 143 and 134.

This provides a fascinating insight into the use of services in North West London. Certainly North West London residents are not over-using acute A&E services when compared with residents of the other London boroughs, or indeed with the rest of England. So this cannot be used as an argument for removing services or closing down A&E units. Utilisation was falling before the closure of Central Middlesex and Hammersmith A&Es, and has continued to fall since.

On the other hand, North West London residents are making considerably more use of UCCs and the like, over three times as much usage as England in 2015/16. This could be a sign that the message has got through to North West London residents in a way that it has not in other parts of the country, that A&E departments should only be used in an emergency. It may also indicate a paucity of GP services, or poor quality services that cause residents to go to UCCs as an alternative to primary care. As one medical director in North West London said in an interview, for a younger more mobile population, UCCs may be a sensible alternative to the traditional GP practice.

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

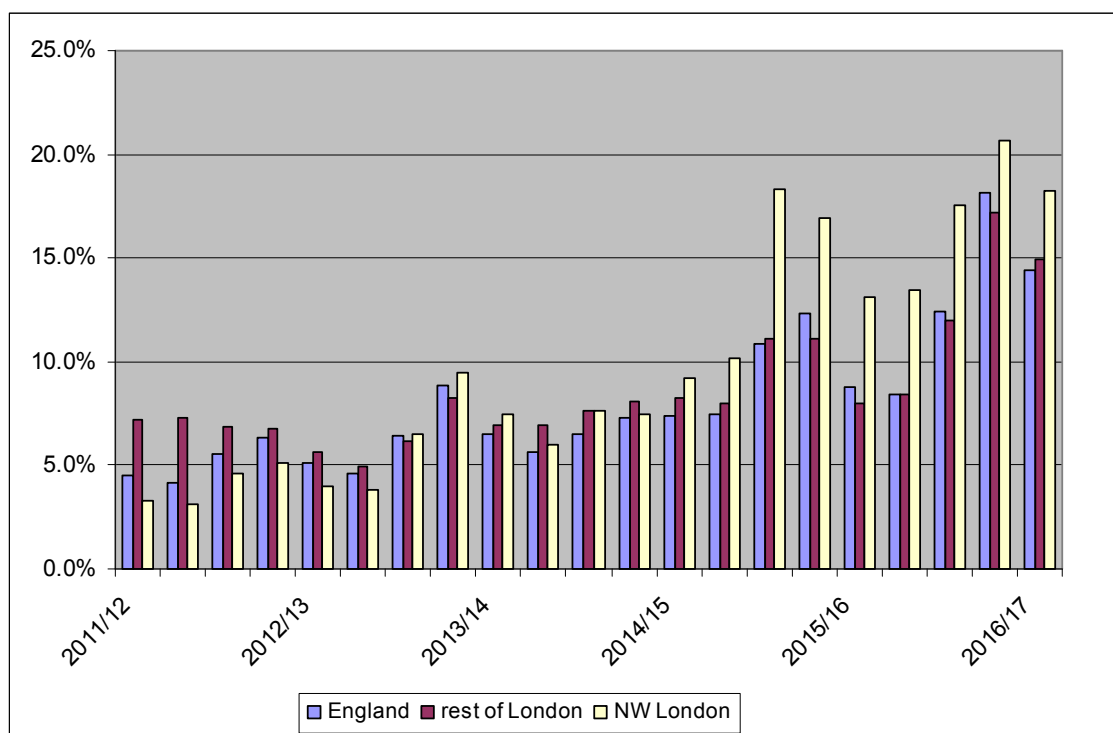
A&E performance

Several indicators are used to measure A&E performance. In an earlier report (Boyle and Steer 2015) our focus was on the proportion of people attending A&E who are not dealt with within four hours, and we found that there had been a considerable deterioration in performance on this measure. North West London, in the first quarter of 2011/12, was better than the rest of England and the rest of London, and at just over 3% was well within the margin of the target of 5% set by the government⁵⁹. However the position gradually worsened during this period – a period when attendances were in fact falling – so that by the last quarter of 2013/14, North West London was worse than the rest of England and almost as bad as the rest of London: in the final quarter 7.4% of people were not seen within four hours.

However when we look at more recent performance and in particular since the closure of two A&E units in North West London (on 10 September 2014) there is a considerable deterioration in performance. Figure 5.3 compares the position in North West London with the rest of London and the rest of England for Type 1 attendances.

⁵⁹ This refers to attendances at Type 1 facilities.

Figure 5.3: Proportion of patients not seen at Type 1 A&E within 4 hours, April 2011 – June 2016



Source: Analysis based on NHS England 2016.

The situation continued to get worse in 2014/15 so that we find North West London much worse than the rest of country and the rest of London: in the third quarter of 2014/15 the figures were 18.3%, 10.9% and 11.1% respectively. This is a dramatic deterioration in performance with the biggest change coming between October and December 2014 (just after the closure of two A&Es) when the proportion failing to meet the target increased from 10.2% to 18.3%.

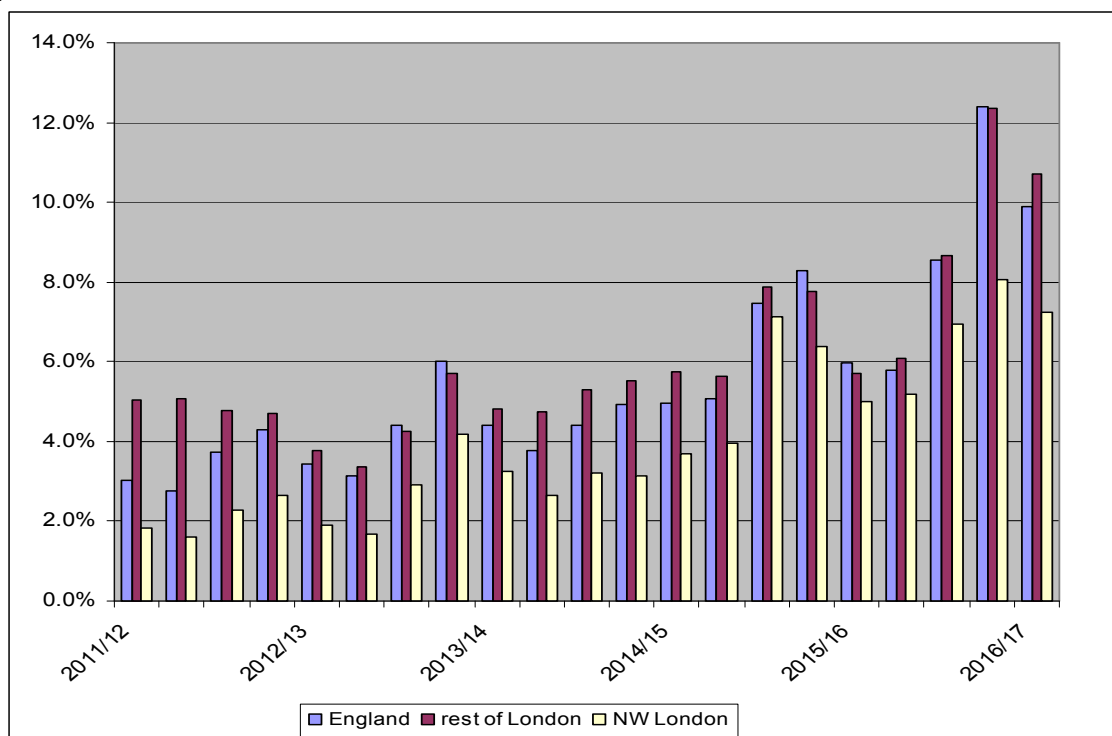
However, in 2015/16, while the position in North West London got slightly worse, the position in the rest of London and the rest of England deteriorated significantly. Thus by March 2015/16, the comparable figures for North West London, the rest of London and the rest of England were 20.6%, 17.2% and 18.1% respectively. By the end of June 2016 this had fallen slightly to 18.3%, 14.9% and 14.4% respectively, although this is for a quarter when we would normally observe a much lower level of failure.

However it is scant consolation to residents of North West London that the rest of country is catching up in terms of poor A&E performance. Moreover, as noted earlier, A&E attendances are less in North West London with much greater use being made of Type 3 sites. Those people attending Type 1 A&Es in North West London are therefore likely to have greater needs than elsewhere in the country.

If we include all A&E attendances (Types 1, 2 and 3), we find North West London performs better than the rest of London and the rest of England, and has done so

throughout this period, although performance has deteriorated across the country. In the last seven quarters, even on this measure North West London failed to achieve the 95% target.

Figure 5.4: Proportion of patients not seen at all types of A&E within 4 hours, April 2011 – June 2016



Source: Analysis based on NHS England 2016.

Confusion has been introduced by the way in which Type 3 services are often referred to as A&E services, both in national and in local documents, and in the press. This can sometimes lead to apparently contradictory statements if a system is able to meet targets across all types of service but fails on the key service, Type 1, which is what most clinicians and members of the public would regard as key to a well-functioning emergency service. It is the inability to meet the target for Type 1 A&E services that is of most concern.

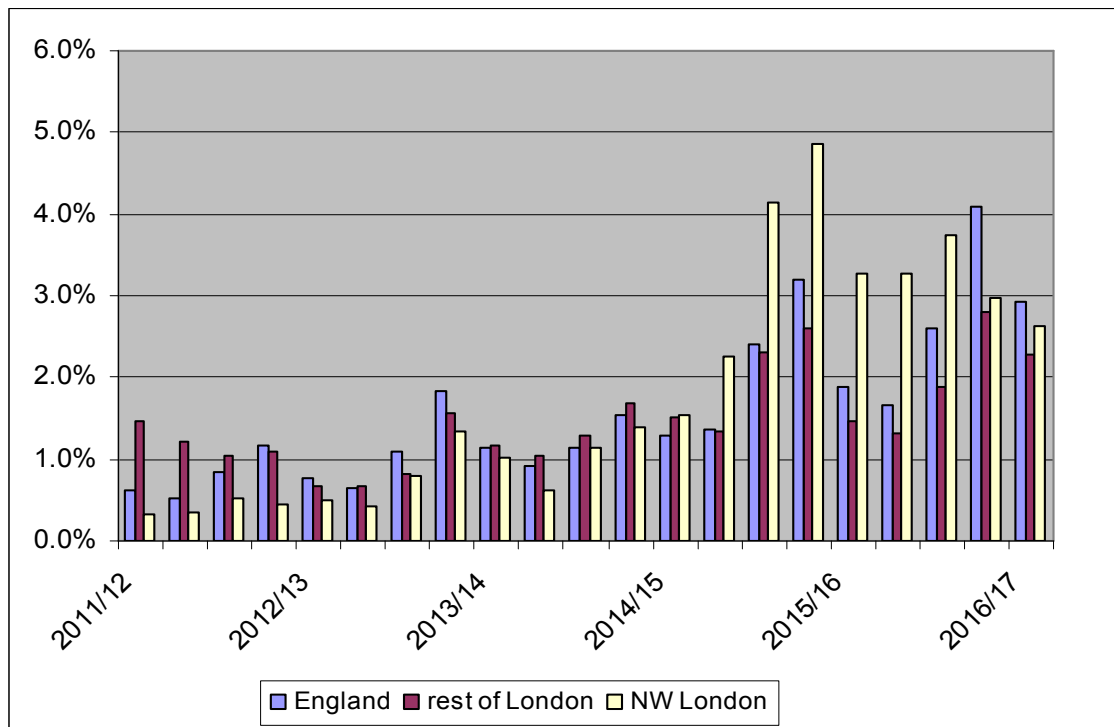
Time from decision to admit to admission

Another measure of quality in the A&E department is how long it takes a patient to be admitted to a bed once the decision has been made to do so. In many cases this can take up to 12 hours, and in rare cases over 12 hours. These incidents are also recorded in the 4-hour target breaches but provide a further indication of poor overall performance.

Again we find that performance in North West London has deteriorated sharply since the closure of two A&Es in September 2014. Nationally and in the rest of London the picture is also poor. As Figure 5.5 shows, in the first quarter of 2016/17, 2.6% of

patients in North West London A&Es waited up to 12 hours for admission, 2.3% in other parts of London, and 2.9% in the rest of England.

Figure 5.5: Proportion of patients who spent >4 hours but <12 hours from decision to admit until admission, April 2011 – June 2016



Source: Analysis based on NHS England 2016.

Conversion from A&E to emergency admission

An indicator of the potential pressure on emergency capacity is the conversion rate between A&E attendances and emergency admissions to hospital ie the proportion of patients who attend A&E who have a condition that is serious enough to warrant admission to an acute bed.

The rate in North West London hospitals has changed considerably over the last five years, most probably due to the shift between attendance at Type 1 and Type 3 A&Es. Looking first at England we find the conversion rate increased from 25% to 27% considering just A&E Type 1 attendances. But if we look at North West London we find that this rate has increased from 24% to 33%, and at times has been as high as 35%. In absolute terms the number of emergency admissions each year from this source increased from 162,370 to 164,690 even though the number of A&E Type 1 attendances had fallen by over 115,000, between 2011/12 and 2015/16. We can only speculate as to what is happening but given the observed shift from Type 1 attendances to Type 3 (UCCs), it would appear that those patients attending Type 1 A&E are more acutely ill as a group than was the case previously.

This would seem to be confirmed by the fact that taking all attendances at all types of A&E we find the proportion in North West London admitted has remained at around 12-14% throughout this period whereas in England it has increased from 16% to 18%. In London (not including North West London) the conversion rate for Type 1 A&E has varied between 22% and 24% during this period while the rate for all A&E attendances has remained around 15-16%.

Our results suggest that poor performance and closure of A&E units are linked.

5.4 Summary

The SaHF analysis failed to take adequate account of likely increases in population over time, as the latest ONS population projections indicate. SaHF's assumption of 5.9% growth over ten years in North West London considerably understates the trend that is projected to be almost twice that. Moreover recent population projections indicate even more significant growth over the period to 2041, of 26% when compared with the position in 2011.

North West London has a different pattern of use of emergency services with greater use of UCCs than other parts of London, and the rest of England.

There is no evidence that North West London uses more A&E emergency services than other parts of England, or London.

Partial implementation of a programme of closures of acute services before an adequate business case has been produced, has had a detrimental effect on the delivery of services in North West London. The deterioration in A&E services raises questions as to whether further closures of services should be allowed prior to the agreement of a final business case.

This suggests that the closure of acute services at Charing Cross and at Ealing should be halted and sufficient resources made available to retain existing services and staff. There should also be an appraisal of the reintroduction of A&E services at Hammersmith with joint staffing across the three Imperial sites.

6 Concluding comments on the STP

6.1 The STP is merely a re-iteration and an elaboration of the SaHF plans, but with a limited five-year time horizon, and within that a tighter focus on eliminating provider deficits within two years. It is therefore no substitute for the SaHF business planning process which of necessity has a much longer planning horizon. This discrepancy runs the risk of promoting short-term cutbacks at the expense of meeting long-term needs.

6.2 The STP is not adequately rooted in a needs analysis. There is no discussion of recent population increases and the increased population projected. The STP appears to have ignored the latest projections and so we have no confidence in the level of services being planned for.

6.3 There is no reflection on the action that has been taken in North West London in recent years both to manage the finances in the short term (successful) and to progress the SaHF plans via various closures and experiments in primary, social and community care (unsuccessful).

6.4 We estimate some £200 million may have been spent already on taking SaHF forward over the past five years, and there is little to show for it.

6.5 At this stage we would have expected to see some progress in reducing demand for acute beds. Instead we have seen reductions in social care funding, a crisis in care homes and increasing demand and activity in acute beds. Operationally there has been a worsening in quality and a drain on local resources. All of these are the opposite of the intended consequences.

6.6 The STP plan relies upon a fundamentally naïve options appraisal: it offers only a choice between 'doing nothing' or 'doing something'. This is contrary to Treasury guidance on Investment appraisal which regards a "Do Minimum" option as vital in avoiding the presentation of ostentatious and costly options, involving greater capital investment and risk than more modest proposals.

6.7 The figures quoted in the STP's financial and economic analysis follow the previous path of quoting indicative, unsubstantiated figures, presented to inappropriate levels of detail, at an unpublished cost base, and which have proven in the past to be misleading as an estimate of the eventual costs. From the analysis presented it is not clear whether the investments are economic, realistic or deliverable. By 'economic' we mean whether the benefits proposed could not be delivered more cheaply by other means. By 'realistic', we mean whether the business case and evidence supporting savings proposals are compelling and sound. And by 'deliverable' we mean that assumptions on capital availability, including capital receipts, management expertise and staffing can support the magnitude of the ambitious plans put forward.

6.8 There is a lack of compelling evidence to support these far-reaching plans. No one would oppose plans to prevent illness or to direct care to less intensive settings – if there was UK evidence that such strategies are working and are deliverable. But at a time of rapidly expanding population, an even more rapidly expanding elderly population, and manifest problems in primary, community, social and mental health services it is foolish to gamble heavily on the success of an unproven strategy. The material cited as evidence in references to the STP lacks working examples of the new models which the commissioners wish to establish, and therefore practical evidence on whether it is possible to deliver either the services required or the savings which are the key current objective⁶⁰.

Independent appraisals of experiments in the UK and in North West London have all applauded good intentions and improvements in patient satisfaction: but it is not clear whether new ways of working are economic or sustainable.

Experiments have been being kept going by non-recurring sources of funding and support nationally but independent reviews are questioning whether the funding is value for money or likely to be successful in the longer term as the background situation deteriorates (with less availability of capital, nursing homes closing, and continuing restrictions to social care funding).

6.9 The risk analysis in the STP is very weak. It fails to cost the consequences of risk events occurring and to assign a probability factor to such events. Based on the evidence before us, we see the risks at this stage – high avoidable costs and deterioration in the volume and quantity of services that are needed – as too high to be acceptable. There appears to be very little in the way of contingency planning to ensure that a failure of one or more parts of the plan do not endanger the longer term continuity of services to patients.

⁶⁰ We note also the extremely poor quality of the referencing, which would be rejected as inadequate if submitted by a student in any first-degree level essay. More than half of the references are either not valid references to identify the data or document used, not published, or sources internal to the NHS. Several refer to the 2,678-page SaHF Decision-making Business Case, and one to papers for the long-awaited but still unpublished SaHF Implementation Business Case. Of the remainder many are general references to statistical sources, one of which shows different results from the argument in the STP. There is a vague link to a 274-page study from 2007 without any specific details, another to the middle of a 2006 debate in the House of Commons on a Labour government Green Paper on welfare reform, one to Lord Carter of Coles' recent study which does not seem to support the argument of the STP, another to a 2010 analysis of 148 research studies, just seven of which were from the UK, and another a fascinating if irrelevant study by a team of unmistakably Swedish authors on diabetes in Sweden. We are appending a summary of the evidence presented so far as Appendix 2.

Appendix 1: Outline of current position in respect of SaHF

We draw on a number of sources to describe the current position with respect to the SaHF programme, which has to a large extent now been sidelined by the STP project, which has taken on some of the system transformation tasks set in the SaHF proposals. Our sources include:

- North West London Implementation Business Case (ImBC) briefing for North West London Joint Health Overview and Scrutiny Committee 14 October 2015
- NWL JHOSC April 2016 report on “Shaping a healthier future - transforming care in North West London
- Summary and Analysis of Documentation from Dr Anne Rainsberry – Briefing From Peter Smith LBHF –Oct 2015
- SaHF Month 2 Budget Update SaHF & NWL Strategy and Transformation Programmes June 2016

We begin by emphasising the unusual and unprecedented complexity of presenting a business case encompassing nine hospitals and eight CCGs for over £1.3 billion of projected capital expenditure “transforming” health care for 2 million people. It is over four years ago that a “Case for Change “was drafted and presented for public consultation. As we reported in our earlier report (Boyle and Steer 2015) we believe that the public consultation grossly underestimated the capital costs, misrepresented the case for reducing acute capacity required to meet the needs of an expanding population and seriously underestimated the problems of delivering and implementing the plans being discussed.

Since then there have been continuing false dawns as promises to deliver business cases by particular dates have been unfulfilled. Not only that, despite it being an established Nolan principle that there should be openness and transparency, and despite the NHS Constitution stating “The NHS also commits to provide you with the information and support you need to influence and scrutinise the planning and delivery of NHS services”, it has been extraordinarily difficult for local government to influence and scrutinise the SaHF plans.

Despite Government seeming to encourage integrated working between local government and the NHS, the reality on the ground is that local government has felt excluded, not involved and lacking information on the detail of plans being developed and the evidence on how such plans were progressing.

It was a result of these anxieties that the Mansfield Independent Commission was asked to examine the SaHF process. The Mansfield Report was published in

December 2015 and presented a number of recommendations regarding the SaHF process including that the programme be halted.

This has not happened; there have been increasing concerns that plans are being implemented prior to the publication and approval of a business case. In particular closures of A&E units (for safety reasons) at Central Middlesex and Hammersmith Hospitals and closures of maternity and paediatric services at Ealing Hospital (again citing safety concerns and inability to recruit staff) have taken place prior to the presentation of a business case, even to Strategic Outline Case (SOC) –the first stage standard.

This is plainly an unsatisfactory situation. In the meantime the SaHF programme is well resourced and is set to continue albeit at a reduced rate as the latest position as reported in the SAHF Report of June 2016 suggests:

- The funds committed to the SaHF process totalled £67.7 million in 2015/16 and a further £41.7 million is budgeted in 2016/17;
- ImBC (the Implementation Business Case) has been forecast as a six-month project expected to end in September 2016. According to the report to JHOSC there is no further funding available within the current budget to extend this work, either within the S&T (Sustainability and Transformation) directorate or from further support to providers.

However, this is at odds with reports that the programme to support transformation is likely to be even more prolonged as capital availability is reducing with no significant investment capital available before 2021.

Previously we estimated the cumulative costs of the SaHF process (Boyle and Steer 2015) as follows in Table A.1.

Table A.1: Estimated costs of the SaHF programme, 2010/11 to 2017/18

	Identified programme costs/budgets £ m	Of which, identified consultancy costs £m
2010/11	0.50	0.50
2011/12	2.55	2.55
2012/13	8.60	8.60
2013/14	27.30	10.34
2014/15	62.90	13.44
2015/16	53.70	
2016/17	40.00	
2017/18	40.00	
TOTAL	235.55	35.43

Sources: SaHF reports to JHOSC, CCG reports and Colin Stansfield. Figures for 2016/17 and 2017/18 are estimates.

It would appear that these costs may have been underestimated; it was reported in May 2016 to the JHOSC that consultancy expenditure in 2014/15 was £20 million and in 2015/16 a further £5.17 million.

The response of SaHF officers when our figures were presented in 2015 was that they did not recognise these figures. However, they have failed to provide their own public account of the costs of the SaHF programme since its inception. There is therefore an unacceptable lack of a clear audit trail providing the ability to monitor and hold accountable the costs of the SaHF process.

It is clear however that the vast majority of this expenditure has come from local commissioning budgets and this alone will have contributed significantly to the financial pressures felt in North West London.

Who can understand the SaHF business case approval process?

At this stage it is helpful to clarify the approval process that SaHF faces: who and what organisation will approve the business cases presented by SaHF so as to provide the basis for resources to be allocated and investment to take place. Since we first reported there has been a clarification of the process; the precise meaning of an Implementation Business Case (ImBC) in relation to the normal planning process has been defined in an unsigned report to North West London Joint Health Overview and Scrutiny Committee on 14 October 2015 from the Accountable Officer, CWHHE Collaborative⁶¹.

This was how the SaHF process was described:

“The standard development process for a capital case is firstly that a SOC is produced, followed by an Outline Business Case (OBC) and then a Full Business Case (FBC). Approval for the DMBC (Decision making Business Case) allowed the development of the ImBC, incorporating the agreed clinical model and identifying the level of capital investment required for implementation of the site-based service changes agreed in the DMBC. The ImBC therefore goes beyond the level of a conventional SOC but is not strictly an OBC in the conventional sense.”

It should be emphasised that such categories as the DMBC and ImBC only came into existence very recently to provide a justification for claiming decisions had been made to continue with projects such as SaHF, which had been given ministerial approval prior to the obligation to provide and secured approval for a SOC, OBC and FBC, as was always the model previously. Thus we hear the SaHF business case has

⁶¹ <http://www.harrow.gov.uk/www2/documents/s130337/151014%20NWL%20JHOSC%20-%20paper%203%20-%20Implementation%20Business%20Case%20briefing.pdf>

already been approved by the minister, even though it has not been presented even to the SOC level hitherto.

The report to JHOSC continued,

“For assurance purposes, the ImBC is a ‘SOC plus’. Because NWL NHS Trusts have worked on and agreed the specifics of the site-based service changes and costs in the ImBC, there is no requirement for trusts to produce a SOC of their own. The NHS Trust Development Authority (NTDA) has agreed to treat the ImBC as an ‘umbrella’ SOC for trusts and will be agreeing the ImBC through its governance process, as will NHS England. Individual scheme OBCs will then be developed from the ImBC and they will identify the best procurement route. At this point, high level financial estimates will exist for the preferred approach, but considerably more detailed than for a SOC.”

The latest expectation therefore is that after approval of the umbrella commissioner SOC, provider OBCs will be compiled and presented for individual approval. The report to JHOSC continued,

“The FBC, developed from the OBC, should be sufficiently detailed to support a procurement decision and commit actual funding, as well as providing the basis for the necessary project management, monitoring, evaluation and benefits realisation.

There are two Foundation Trusts in NWL – Chelsea and Westminster and the Hillingdon. Monitor does not approve or agree Foundation Trust OBCs, as this is effectively a commercial and value-based decision for the Trust Board. However, Monitor will need to agree the FBCs within the terms of the FT licence.

Classing the ImBC as an ‘umbrella’ SOC, allows trusts to submit their OBCs for approval as soon as the ImBC is approved. This should significantly speed up the process of producing the business cases – which has a direct impact on the timings for actual development works to commence. It will also allow Commissioners to submit their OBCs for the Primary Care and Out of Hospital (OoH) developments included in the ImBC rapidly and in sequence.”

The expectation is then that the following list of separate business cases will be presented and individual approval sought:

1. 19 CCG Commissioner out-of-hospital ‘hub’ business cases. In total there expected to be 27 hubs, four of which are already operational. The remaining four are sited within NHS Trusts and are included in the relevant Trust OBCs. The 27 ‘hubs’ are the cornerstone of the NWL CCG out-of-hospital clinical service model.
2. a number of relatively smaller CCG Commissioner primary care estate scheme business cases.

3. two Local Hospital business cases (Ealing and Charing Cross) – these are acute trusts.
4. one Elective Hospital business case (Central Middlesex Hospital) – this is an acute trust.
5. five Major Hospital business cases (St Mary’s, Northwick Park, West Middlesex, Hillingdon and Chelsea and Westminster) – these are acute trusts.
6. one Specialist Hospital business case (Hammersmith Hospital) – this is an acute trust.

In the words of the report to JHOSC,

“The programme is currently finalising the complex sequence of approvals which ensures, as far as possible, that business cases transit rapidly through their governance stages and that the ‘slower’ business cases do not hold up the ‘fastest’ or most able to rapidly deploy. Given the complex interrelationships and inter-dependencies of the various service movements, the programme is taking care to fully work this up”.

The ImBC will go through the NHS approval processes after approval by NWL CCG and Trust boards. Assuming approval from NHSE, the ImBC will go to DH (Department of Health) and HMT (Her Majesty’s Treasury). The NTDA has agreed to accept the ImBC as an umbrella SOC and it will also go to the NTDA approvals process”.

“The DH scheme of delegation sets out that NHS Trust and CCG business cases above £50m require approval by the Department of Health and Treasury. NHSE will be engaging both to discuss assurance and capital availability.

The NHSE scheme of delegation sets out that business cases with a financial value up to £15m will require Chair, Chief Executive Officer or Chief Financial Officer approval; between £15m - £35m will require investment committee approval and above £35m require Board approval.

NTDA’s scheme of delegation sets out that business cases with a financial value up to £15m will require Director of Finance approval; between £15m - £35m will require investment committee approval and above £35m will require Board approval

CCG primary care and out-of-hospital business cases will be processed through the normal NHSE capital planning and approval processes”.

We reproduce this – undigested for the lay reader – to demonstrate using the NHS’s own language what a hugely complex process it is. The fact that it still has not yet got

beyond first base and that the bodies set to approve the business cases (the NHS Trust Development agency and Monitor) have both since been abolished and put under the new leadership of NHS Improvement with a brief to control and 'get a grip' on NHS finances only serves to underline this complexity.

Will the process ever be completed?

This was reported in May 2016 to the JHOSC in North West London,

"We plan to provide a draft ImBC to NHS England in July 2016 as part of the review and assurance process

We plan to submit the ImBC to the NHSE Investment Committee on 13 September 2016. It is also expected to reference two 'business as usual' bids for Northwick Park Hospital and Central Middlesex Hospital for essential maintenance and modernisation (examples include boilers and pharmacy – updating and expanding both to meet current need and be more efficient in future)"

But even reports dated May 2016 have been subject to slippage and at the time of writing (end of September 2016) no ImBC had been received by NHS England and the proposals are unlikely to be presented to the NHS England Investment Committee earlier than the end of 2016. It is further understood that proposals would require minimal capital in the period to 2021 implying a slowing of the SaHF timetable as first envisaged.

Again in May 2016, the report to JHOSC continued,

"NWL CCGs and hospital trusts are currently working together to finalise the level of capital that will be needed.

Clearly it has taken longer than we would have liked to produce the ImBC a major factor has been changes in trust finances across the country in last 12-18 months which has meant a reworking of the financial case. SaHF has always been driven by the need to improve the quality of care and patient experience, but we must equally ensure that financial sustainability is achieved.

The capital needed must be credible in the current financial context and it must be available and it must be affordable. This means the ImBC will not be made public before it has been assured by NHS England and NHS Improvement and recommended by the NHS England Investment Committee".

We are concerned by this last statement as it will be impossible for NHS England to provide assurance that the business case has the involvement, engagement and commitment of local stakeholders (as is required) if the business case has not been

shared, understood, scrutinised, and subject to independent review, so that informed consent can be meaningful. Sufficient time must be allowed for this.

Further, given the alarmist publicity regarding the extent of NHS provider deficits and the requirement to cope with the likely further adverse financial consequences of Brexit, it would be unwise in our view to assume that this path will lead to rapid and full approval. Already we understand consultancy budgets used to support the SaHF process have been cut back after concerns over costs and value for money.

In particular the use of land receipts is likely to be a thorny issue: the past Chancellor had earmarked these as a contribution to the NHS revenue budget and so these receipts would not be available to fund further capital expenditure. Given the sacking of the Chancellor this may be reviewed but it is likely to result in delays to the onward development of the SaHF programme.

In June 2016 it was reported by the SaHF team that 130 people were working on the SaHF process including 75 interim executives. Although it was stated that numbers would reduce by 16 in October, almost a hundred staff would be in post in March 2017.

It becomes clear elsewhere in this report however that SaHF is being transformed into part of a larger Sustainability and Transformation Planning (STP) process: as such SaHF will become a subset of STP and any pretence of formal accountability may be lost.

We believe that the SaHF programme should continue to be held accountable and subject to continual review. We are concerned that the STP process represents a way to inject new life into a programme struggling to maintain credibility. Our concerns with the governance and other aspects of the STP process are discussed elsewhere in this report (See section 6).

Summary

Given the strategic context and continuing delays in the development of an evidence base supporting the assumptions in draft SaHF business cases we remain sceptical that NHS England can assure the plan – as is required before it can be presented for approval to the NHS England Investment committee in October and then it will need to go before the DH and Treasury.

It is inappropriate and undermines trust and confidence in the claims for integrated working if local government cannot be trusted by the NHS to review business cases in advance of presentation and agreement. We recommend that boroughs ensure sufficient time and resources are available to review what emerges. This is likely to be significantly different to the original proposals presented to the public in 2012.

Whatever is presented should be submitted to detailed scrutiny, including access to the detail of financial and bed modelling assumptions. Significant errors were made in the modelling of bed numbers arising from the closures of Central Middlesex and Hammersmith hospitals that the Independent Review concluded could have been prevented if there had been better review of the planning assumptions. Without access to such details any review is worthless and the potential risks attached to future plans and modelling are unacceptable.

In our earlier report we recommended far more attention be given to “Do minimum” options. However, SaHF and other NHS officers do not appear to have taken this recommendation seriously and instead have put the onus on others to identify alternatives to the SaHF proposals.

This could lead to further delays in the approval process for plans being presented although it is understood that the latest drafts of business cases have cited very large increases in the value of clinical benefits, and from the multiplier effect of large investments in hospital capacity which may act to downgrade the impact of a “do minimum” in an economic appraisal.

Without sight of the documentation it is difficult to say whether this is credible, although the reality on the ground is that the programme is being denied any significant capital for at least five years and that each further business case will be required to demonstrate its viability as the programme proceeds. The threat remains however, particularly to Ealing hospital.

It is likely that the time lags between finally presenting business cases, implementing the changes in primary and community care, and demonstrating that acute capacity can be successfully reduced are likely to be at least five years, if ever. In these circumstances no further changes to acute capacity should be implemented and more measures should be taken to bolster short- to medium-term confidence at Central Middlesex, Hammersmith, Charing Cross and Ealing hospitals.

Appendix 2: An examination of the quality of evidence and appropriateness of sources cited in support of the Draft STP Version 1.0

The table below provides an examination of the quality of evidence and appropriateness of sources cited in support of the Draft STP Version 1.0.

Reference given	Comment
Executive Summary	
1 Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team.	Not an adequate reference. Not published
2 ONS 2011 population figures 65+ accessed at https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/lowersuperoutputareamidyearpopulationestimates = 159,617.	ONS Lower Super Output Area Mid-Year Population Estimates – latest year 2014 This is not an accurate reference to check the source used.
2 Living alone 2011 public health % of households occupied by a single person aged 65 or over accessed at http://fingertips.phe.org.uk/search/older%20people%20living%20alone#page/3/gid/1/pat/6/par/E12000007/ati/102/are/E09000002/iid/91406/age/27/sex/4	Public Health England figures from 2011
3 https://www.gov.uk/government/publications/child-poverty-basket-of-local-indicators	Department for Education 2014 figures
4 http://www.phoutcomes.info/search/overweight#pat/6/ati/102/par/E12000007	Public Health England Outcomes Framework
5 System-wide activity and bed forecasts for ImBC	Not published – frequently postponed
6 Chin-Kuo Chang et al (2011), Life Expectancy at Birth for People with Serious Mental Illness and Other Major Disorders from a Secondary Mental Health Case Register in London. PLoS One. 2011; 6(5): e19590 cited in https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/05/serious-mental-hlth-toolkit-may16.pdf	May 2011 article available online. Cited in Public health England 2016 pamphlet on improving physical health of people with mental illness
7 National Survey of Bereaved People (VOICES 2014)	http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystems/bulletins/nationalsurveyofbereavedpeoplevoices/2015-07-09 Statistical survey – England. No specific reference to London
8 Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team. Serious and Long Term Mental Health needs figure comes from GP QOF register for Serious Mental Health Issues.	As above, not published
9 NW London high level analysis of discharging rates within/across borough boundaries.	Not an adequate reference. Not published?

10 Initial target for LPOl project	Not an adequate reference. Not published?
11 Estimate based on numbers of emergency referrals responded to by Single Point of Access in first six months of activity; extrapolated to cover both CNWL and WLMHT SPAs for full year	Not an adequate reference. Not published?
12 Initial activity analysis following service launch at West Middlesex University Hospital	Not an adequate reference. Not published?
13 London Quality Standard	https://www.england.nhs.uk/wp-content/uploads/2013/08/lon-qual-stands.pdf
14 Shaping NW London High Level Analysis of Inpatient Radiology Diagnostic Imaging and Reporting. Data extracts from Trust RIS systems for all inpatient radiology imaging	Not an adequate reference. Not published?
Case for Change	
1 Public Health Outcomes Framework data - Slope Index of inequality in life expectancy at birth using 2012-2014. 16.04 years relates to figures for Kensington & Chelsea.	Not an adequate reference
2 NOMIS profiles, data from Office for National Statistics	Not an adequate reference
3 Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team. Serious and Long Term Mental Health needs figure comes from GP QOF register for Serious Mental Health Issues.	Not an adequate reference. Not published?
4 Health & HSCIC, Shaping a Healthier Future Decision Making Business Case and local JSNAs	Not an adequate reference: DMBC is 2,678 pages long.
Delivery Area 1: radically upgrade prevention & wellbeing	
1 Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014)	Not an adequate reference
2 TBC – requested from Public Health	Not a reference
3 Commissioning for Prevention: NW London SPG: Optimity Advisors Report	Commissioning for Prevention is at https://www.england.nhs.uk/wp-content/uploads/2013/11/call-to-action-com-prev.pdf Optimity report is at http://optimityadvisors.com/sites/default/files/research-papers/Optimity-Matrix-Report-Cost-effectiveness-review-of-blood-pressure-interventions.pdf or alternatively a different report at www.yhpho.org.uk/resource/view.aspx?RID=213721 It's not clear which, if either, and which data is being used.

4 Health First: an evidence-based alcohol strategy for the UK, Royal College of Physicians, 2013	http://www.stir.ac.uk/media/schools/management/documents/health-first.pdf
5 Siegler, V. Measuring National Well-being - An Analysis of Social Capital in the UK, Office for National Statistics (2015) http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/dcp171766_393380.pdf	Accurate reference, but data very general, no specific analysis of geographical areas (no mention of London).
6 Westminster Joint Health and Wellbeing Strategy (2016). http://www.centrallondonccg.nhs.uk/media/45071/120-clccg-gb-part-i-westminster-joint-health-and-wellbeing-strategy-and-sign-off-processes-v2.pdf	40-page report: no accurate reference, but presumably to page 8.
7 DWP - Nomis data published by NOS	As in previous use, not an adequate reference.
8 IPS: https://www.centreformentalhealth.org.uk/individual-placement-and-support	Working web link but imprecise location for reference: page cited online does not give the figure used in the STP.
9 Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014)	Second time of citing. Not an adequate reference
10 Commissioning for Prevention: NW London SPG: Optimity Advisors Report	Same as 3 above
11 Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014)	Same as 1 and 9 above: Not an adequate reference
12 Cancer Research UK	Not an adequate reference; no specific location cited.
13 http://www.phoutcomes.info/search/overweight#pat/6/ati/102/par/E12000007	Childhood obesity is a serious problem, and especially bad in London, but the figures cited do not show North West London worse on 4-5 year olds, although the same or worse on 10-11 year olds.
14 Public Health England (2014)	Not an adequate reference
15 Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014)	4th time of citing. Not an adequate reference
16 Holt-Lunstad, J, Smith TB, Layton JB. (2010) "Social Relationships and Mortality Risk: A Meta-Analytic Review" PLoS Med 7(7)	Located at: http://journals.plos.org/plosmedicine/article/asset?id=10.1371%2Fjournal.pmed.1000316.PDF However interesting of the research may be of doubtful relevance to NW London: just 7 of the 148 studies analysed relate to the UK; most are

	US-based.
17 Commissioning for Prevention: NW London SPG: Optimity Advisors Report	Third time of citation: same as 3 above.
18 http://www.phoutcomes.info/search/overweight#pat/6/ati/102/par/E12000007 , Public Health Outcome Framework	Second time of citation, same as 13 above
19 Westminster Joint Health and Wellbeing Strategy (2016). http://www.centrlondonccg.nhs.uk/media/45071/120-clccg-gb-part-i-westminster-joint-health-and-wellbeing-strategy-and-sign-off-processes-v2.pdf	Second time of citation, same as 6 above
Delivery Area 2: Eliminate unwarranted variation and improving LTC management	
1 Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014)	5th time of citing. Not an adequate reference
2 Cancer Research UK	Not an adequate reference: no document or page identified
3 http://www.hscic.gov.uk/catalogue/PUB02931/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf	This is a 274-page document giving data from 2007. The information referenced and its relevance to this STP is not clear.
4 Naylor C, Parsonage M, McDaid D et al (2012). Long-term conditions and mental health: the cost of co-morbidities. London: The Kings Fund	Incorrectly referenced, but available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf
5 Pan-London Atrial Fibrillation Programme	No precise reference given, but Google search for this highlights this report: http://imperialcollegehealthpartners.com/wp-content/uploads/2016/07/Medicines-Optimisation-PoP.pdf on the NW London programme, which gives a very different figure from that in the STP.
6 NHS London Health Programmes, NHS Commission Board, JSNA Ealing	We assume this must relate to file:///C:/Users/John/Downloads/JSNA_2014_-_Chapter_7.1_-_Strengthen_the_role_and_impact_of_ill-health_prevention_-_COPD_and_Asthma.pdf page 5: but the figures are from Ealing: is this typical for NW London?
7 Kings Fund, 2010	This is not a valid reference. No document or page identified.
8 Initial analysis following review of self-care literature	Not a valid reference: is this review published?
9 http://dvr.sagepub.com/content/13/4/268	Swedish study by Katarina Eeg-Olofsson, Björn Zethelius, Soffia Gudbjörnsdottir, Björn Eliasson, Ann-Marie Svensson and Jan Cederholm. Title: <i>Considerably decreased risk of</i>

	<i>cardiovascular disease with combined reductions in HbA1c, blood pressure and blood lipids in type 2 diabetes: Report from the Swedish National Diabetes Register</i> Relevance to NW London population not explained.
Delivery Area 3: Achieve better outcomes for older people	
1 Office for National Statistics (ONS) population estimates	Not an adequate reference
2 Source: Index of Multiple Deprivation 2015 Income Deprivation Affecting Older People (IDAOP); Greater London Authority 2015 Round of Demographic projections, Local authority population projections - SHLAA-based population projections, Capped Household Size model	Not an adequate reference
3 https://www.england.nhs.uk/mentalhealth/wp-content/.../dementia-diagnosis-jan16.xlsx	Web link does not work: data to be found via http://tinyurl.com/hscpkra
4 SUS data - aggregated as at June 2016	This is not an adequate reference, but it appears this data is not published
Delivery Area 4: Improve outcomes for children & adults with mental health needs	
1 Tulloch et al., 2008	<i>The Costs, Outcomes and Satisfaction for Inpatient Child and Adolescent Psychiatric Services (COSI-CAPS) study</i> , a 229-page study, available at: http://www.rcpsych.ac.uk/pdf/COSI%20CAPS.pdf
2 Royal College of Psychiatrists, 2012	Not an adequate reference. Not found in text
3 http://www.publications.parliament.uk/pa/cm200506/cmhansrd/vo060124/debtext/60124-06.htm#60124-06_spm1	Not found in text. Relevance not clear: this link takes us to an extract from a Commons debate in January 2006 on a Green Paper on Welfare Reform from the then Labour government.
Delivery Area 5: Safe high quality and sustainable acute services	
1 Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team	Not an adequate reference. Not published. Used 4 times.
2 SUS Data. Oct 14-Sep15	As above: not a proper reference, data not published.
4 Shaping a Healthier Future Decision Making Business Case	Not an adequate reference: DMBC is 2,678 pages long
5 Shaping a Healthier Future Decision Making Business Case	Not an adequate reference: DMBC is 2,678 pages long
6 Shaping a Healthier Future Decision Making Business Case	Not an adequate reference: DMBC is 2,678 pages long
7 Shaping NW London High Level Analysis of Inpatient Radiology Diagnostic Imaging and Reporting. Data extracts from Trust RIS systems for all inpatient radiology imaging.	Not an adequate reference: data not published
7 <i>Review of Operational Productivity in NHS providers – June 2015</i> . An independent report for the Department of Health by Lord Carter of Coles.	Lord Carter's report makes many interesting points, but the claim made by the STP is not one of them.

Enablers: Estates	
1 ERIC Returns 2014/15	This can be found via http://digital.nhs.uk/catalogue/PUB18726
2 NHSE London Estate Database Version 5	Not a valid reference: is data published?
3 NW London CCGs condition surveys	Not a valid reference. Is this published?
4 Oxford University's School of Primary Care Research of general practices across England, published in <i>The Lancet</i> in April 2016	Reference is at: http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(16)00620-6.pdf The report also argues that: <i>"Our findings show a substantial increase in practice consultation rates, average consultation duration, and total patient-facing clinical workload in English general practice. These results suggest that English primary care as currently delivered could be reaching saturation point. Notably, our data only explore direct clinical workload and not indirect activities and professional duties, which have probably also increased."</i> It appears that both the STP and SaHF would further increase this pressure.
5 Lord Carter Report: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2016-02-05/HCWS515/http://qna.files.parliament.uk/ws-attachments/450921/original/Operational%20productivity%20and%20performance%20in%20English%20NHS%20acute%20hospitals%20-%20Unwarranted%20variations.pdf	2 nd time of citation: as above (7): however this link does not work. Should be https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2016-02-05/HCWS515/
Enablers: Workforce	
1 Trust workforce: HEE NWL, eWorkforce data, 2015. Not published a) Social Care Workforce: Skills for Care, MDS-SC, 2015 b) GP Workforce: HSCIC, General and Personal Medical Services, England - 2004-2014, As at 30 September, 2015 c) Unpaid Carers: ONS, 2011 Census analysis: Unpaid care in England and Wales, 2011 and comparison with 2001, 2013 d) Pharmacy Data: Royal Pharmaceutical Society of Great Britain, Pharmacy Workforce Census 2008, 2009 Maternity Staff: Trust Plans, 2015. Not Published Paediatric Staff: Trust Plans, 2015. Not Published	a) General, national figures: no London or borough breakdown b) http://digital.nhs.uk/catalogue/PUB16934 c) http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/articles/2011censusanalysisunpaidcareinenglandandwales2011andcomparisonwith2001/2013-02-15 d) Old figures
2 Conlon & Mansfield, 2015	Not an adequate reference to identify any study

	or data
3 Turnover Rates: HSCIC, iView, retrieved 23-05-2016	Access restricted to NHS
4 Vacancy Rates – NHS Trusts: HEE NWL, eWorkforce data, 2015. Not published Vacancy Rates – Social Care: Skills for Care, NMDS-SC, 2015	http://www.skillsforcare.org.uk/Document-library/NMDS-SC,-workforce-intelligence-and-innovation/NMDS-SC/State-of-2014-ENGLAND-WEB-FINAL.pdf
5 GP Ages: HSCIC, General and Personal Medical Services, England 2005-2015, as at 30 September, Provisional Experimental statistics, 2016	http://digital.nhs.uk/catalogue/PUB20503
6 GP Appointments: Nuffield Trust, Fact or fiction? <i>Demand for GP appointments is driving the 'crisis' in General Practice</i> , 2015 GP Practices: HSCIC, GPs, GP Practices, Nurses and Pharmacies, 2016 Providers: HSCIC, GPs, GP Practices, Nurses and Pharmacies, 2016 Skills for Care, nmds-sc online, retrieved 17-06-2016	http://www.nuffieldtrust.org.uk/node/3996 References very general: no connection established with STP draft
7 McKinsey, Optimising Bank and Agency Spend across NW London , 2015. Not published	
Enablers: Digital	
1 Local Digital Roadmap - NHS NW London (2016)	"A number of sessions have been held locally and through discussion collaboratively, to develop the detail of the draft Local Digital Roadmap for submission to NHS England by 30 June 2016." (NW London CCG Collaboration July 2016 http://tinyurl.com/hz9sfqq) Is it published?

Appendix 3: Savings plans in the Draft STP V1.0

Delivery Area		Projected Gross saving (£m)	Investment (£m)	General description
DA1	A	2.5	0.2	Enabling and supporting healthier living
	B	6.5	3.3	Wider determinants of health interventions
	C	6.6	0.5	Addressing social isolation
	D	TBC	TBC	Helping children to get the best start in life
Total		15.6	4	
DA2	A	TBC	TBC	Improve cancer screening to increase early diagnosis and faster treatment
	B	TBC	TBC	Better outcomes and support for people with common mental health needs (with an initial focus on people with long term physical health conditions)
	C	12.4	2.0	Reduce variation by focusing on 'Right Care' priority areas
	D	6.1	3.4	Improve self-management and 'patient activation'
Total		18.5	5.4	
DA3	A	0.0	2.0	Improve market management and take a whole systems approach to commissioning
	B	25.3	0.0	Implement accountable care partnerships
	C	26.3	18.0	Implement new models of local services integrated care to consistent outcomes and standards
	D	64.9	20.0	Upgrade rapid response and intermediate care services
	E	9.6	7.4	Create a single discharge approach and process across NW London
	F	7.0	4.9	Improve care in the last phase of life
Total		133.1	52.3	
DA4	A	16.0	11.0	Implement the new model of care for people with serious and long term mental health needs, to improve physical, mental health and increase life expectancy
	B	5.0	TBC	Addressing wider determinants of health, e.g. employment, housing
	C	TBC	TBC	Crisis support services, including delivering the 'Crisis Care Concordat'
	D	1.8	TBC	Implementing 'Future in Mind' to improve children's mental health and wellbeing
Total		22.8	11.0	
DA5	A	TBC	TBC	Specialised Commissioning
	B	21.5	7.9	Deliver the 7 day services standards
	C	89.6	33.6	Configuring acute services
	D	143.4	4.1	NW London Productivity Programme
Total		254.5	45.6	
Grand total		444.5	118.3	
Total net saving		326.2		

Appendix 4: An examination of the evidence base for models of care cited in the 'Local Services Transformation document' (Paper 3.1), companion paper to Draft STP Version 1.0

Proposal	Claimed impact	Benefit (£m)	Benefit (beds equivalent)	Evidence	What is missing: requirements for implementation
New model of primary care to divert potential caseload from hospital	17,000 fewer A&E attendances; 2,979 fewer non-elective admissions	21.2	Close 117 beds	RCGP report 2014 on impact of improved GP access. JAMA study, USA, although relevance to British/North West London context not established.	Business plan for new model of primary care – and the resources to carry it out.
Case management for older patients	Increased patient satisfaction	no data on cash savings	no data on bed use	"Promising but mixed" evidence, primarily from USA. Relevance to British/North West London context not established. Kaiser Permanente/ EverCare experiment failed in UK 10 years ago.	Resources and funding to deliver individual case management to large and growing numbers of older people, led by Advanced Primary Nurses
Illness prevention scheme with drastic change to focus on patient engagement, prevention and integration of services	Ambitious claims of cash savings "if just 20% of the eligible population were affected by prevention programmes targeting diabetes and smoking"	as much as 38-41	no data on bed use	Report apparently commissioned by Healthy London Partnerships in 2016: could not be identified in web search (no reference given)	Key requirement is a proven and effective method of engaging with 'patients' who are not ill and convincing them to stop smoking for example. No methodology outlined, or costings for necessary resources or staff
Promote "self-management, self efficacy and behaviour change". Self care "thought to save an hour per day of GP time". A report on 5,000 GP consultations found 6% (300) could have been dealt with through self-care	17,568 fewer A&E attendances	2.4	0	"Evidence" cited by the Health Foundation 2011 (no reference given). Other evidence is claimed to come from the King's Fund 2010, Robinson et al 2001, Kennedy et al 2003, a Canadian trial reported by Bourbeau et al 2003, and the Primary Care Foundation (2003), None of the actual references is cited, making it impossible to check. Relevance of Canadian example to British/North West London context not established.	In our view it is likely that more patients will resort to A&E as result of not seeing GPs when needed. What possible argument is there for less? Issuing 400,000 patients with commercial version of software developed in US, to be used as an "activation tool" to "support tailoring and evaluation of self-care". Culture change for 400,000 patients to ensure they use it, and use it correctly. No costings available.

Integrated shared delivery model with Local Authorities and 3rd sector to tackle the social determinants of health: early priorities to include social isolation, housing and employment	1,021 fewer non-elective admissions	4.4	3	King's Fund estimate poor housing costs NHS £2.5bn/year. NHS Alliance 'Housing for Health' website. Mansfield (Notts) experiment, but relevance to London property prices and availability not proven. Other data mentioned from US, DWP, Rotherham Social Prescribing Pilot, Cornwall, Victor et al (2003), Buffel et al (no date). Again no references supplied, so could not be checked.	Capital, revenue and sufficient appropriate housing accommodation available to avert homelessness in context of North West London property prices, staff to manage discharge support. Resources required to address social isolation are not identified – task for social care? Employment is mentioned but there are no actual proposals for action to create jobs.
Agree the definition, scope and offer of Intermediate Care Services (both step up/rapid response and step down/discharge): review availability of home based care. Scale up to provide care that is cheaper but better.	38,165 fewer non-elective admissions	64.9	408	ImBC (still awaited) but evidence for this projection unclear. National Audit of Intermediate Care 2015 found 72% of people maintain their dependency level in intermediate care. 2014 report calculated costs. No references supplied.	Funding to cover a minimum of £1045 and a maximum of £5549 per episode of care for levels of services required. Sufficient suitable premises, appropriately qualified staff, management structure.
Roll out use of single needs-based discharge form and process to refer into community health care services provided in patients' homes. Expand this to include referrals to bedded community health services.	3,848 fewer non-elective admissions.	8.5	31	No external evidence cited. Apparently activity data from 2015/16 shows 35% of North West London non-elective admissions were to a cross-border hospital, with average length of stay 2.9 days longer than those within a CCG boundary.	No clear explanation offered for increased length of stay, or obvious action to avert it. But SaHF and STP plans to concentrate acute services in 5 hospitals will increase cross boundary admissions, and therefore increase costs.
Improve end of life care by better identification of patients in the Last Phase of Life, to avoid unnecessary admissions and treatment	2,300 fewer non-elective admissions	7	32	National End of Life Strategy, Gold Standard Framework and Nuffield Trust report Sept 2014. No full references supplied.	Additional services required have not been costed: Nuffield Trust estimate £653 per person. Difference between this and hospital treatment is expected to yield £7m cash savings.
Totals	34,568 fewer A&E attendances, 48,313 fewer non elective admissions	146.4-149.4	591		