health care audit

Report for London Borough of Merton on

‘*Improving Health Together*’

Public Consultation

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About the Author

Roger Steer is a senior and experienced healthcare manager and management consultant. He has worked in the NHS in Chief Executive and Director of Finance roles, but has also been a Regional Performance manager of very large capital programmes and is familiar with the issues of gaining Treasury approval for large schemes and planning large scale change.

Since 2003 he has been a Director of Healthcare Audit Consultants which specialises in providing advice to Local Authorities scrutinising NHS Plans, including reviews in 2005 and 2013 of previous reconfiguration proposals in south west London and more recently of very large reconfigurations proposed in north west London, where he is engaged in a monitoring role ensuring he is current with the latest issues and thinking. He co-authored a large review of STPs for South Bank University and has acted as an expert witness in two recent judicial reviews on reconfiguration proposals.

1 Introduction

This briefing has been commissioned by the LB Merton in order to help them discharge their public duty to scrutinise NHS plans, specifically proposals for major changes in local health services in Merton, Sutton and Surrey Downs, contained in public consultation documents and supporting documents for "'Improving Health Together'[1].

The current advice provided to the NHS [2] on scrutiny usefully summarises these duties (page 38):

"Local authority overview and scrutiny committees have a role in reviewing and scrutinising matters relating to the planning, provision and operation of health services in their local area.

• Commissioners must consult the local authority when considering, or a provider is considering, any proposal for a substantial development or variation of the health service in the area. The local authority may scrutinise such proposals and make reports and recommendations to the NHS commissioning body (CCG or NHS England) or referrals to the Secretary of State for Health.

• As part of the overview and scrutiny process, the local authority will invite comment from interested parties and take into account relevant information available, including that from local Healthwatch. The overview and scrutiny process can therefore enhance public involvement in the commissioning process.

• The threshold for reporting proposals to the local authority under the overview and scrutiny process is higher than that for the duty to involve the public under section 14Z2 and 13Q. However, the duties frequently overlap, particularly where significant changes to the configuration of local health services are under consideration.[3]

The advice is further elaborated in the following sections of the 2018 advice in regard to Public Consultation:

7.6 Health scrutiny

NHS bodies have a legal duty to consult the local authority in certain circumstances.

Although it is strongly advised that local authority scrutiny functions are involved throughout development, commissioners should hold a separate formal discussion on the final set of proposals on which they intend to consult.

7.8 Public consultation

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[1] All documents are listed on the Improving Health Together website https://improvinghealthcaretogether.org.uk/important-documents/

[2] *Planning, assuring and delivering service change for patients* NHS England March 2018

[3] For further information, see s.244 NHS Act 2006 and Part 4 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (*http://www.legislation.gov.uk/uksi/2013/218/pdfs/uksi_20130218_en.pdf*

Subject to feedback from local authorities, the proposing body may decide to progress to public consultation on the range of options that will be tested with staff, patients and the public, subject to assurance by NHS England.

NHS England has a role in the assurance of all commissioner-led schemes. This will ensure consistency across the NHS commissioning system and ensure that good practice and lessons learnt are shared.

And in regard to decisions:

8.1 Situations may arise where consensus over service change cannot be agreed between the commissioner and relevant local authority. Wherever possible, decisions about how the NHS is run should be made locally by those directly involved. Local authorities may refer proposals to the Secretary of State, if:

• The consultation has been inadequate in relation to the content or the amount of time allowed.

• The NHS body has given inadequate reasons where it has not consulted for reasons of urgency relating to the safety or welfare of patients or staff.

• A proposal would not be in the interests of the health service in its area.

The NHS is further reminded of what can go wrong:

3. The high costs of getting it wrong

A high profile programme that has been subject to both Judicial Review and referral to the Secretary of State is estimated to have cost >£6m. The proposed changes remain unimplemented. (p23)

I would add this is not the greatest risk: a greater risk is of proposals being inadequately scrutinised leading to uneconomic or risky proposals being implemented which prove more costly than expected, which fail to deliver the benefits and reduce the quality and quality of services delivered to patients.

In NW London following closures of A&E departments as the first stage of its "Shaping a Healthier Future" reconfiguration plan, emergency building of expensive, additional capacity at London North West University Healthcare NHS Trust (LNWH) had to be arranged as remaining capacity could not cope. A Confidential Inquiry[4] organised by NHS England found that there had been errors in calculations, lack of scrutiny in plans and inadequate account taken of the increases in demand and population. The costs of this programme reached £250m before it was eventually scrapped.

There is every reason therefore for the local authority to closely scrutinise plans and for the NHS to pay due regard to the feedback of local authorities.

In section 2 I draw attention to the history and the changing nature of proposals in this part of SW London and highlight issues from the process for making decisions around the

[4] Retrospective review of impact in NWL of A&E changes at CMH and HH NHS England 20thMarch 2015.pdf

proposals being made in the Improving Health Together (IHT) Pre-consultation business case (PCBC)[5]. In particular I draw on the extensive guidance that exists around the subject. I further discuss the key issues that emerge from the IHT process and proposals in terms of the clinical arguments (section 3), the financial and economic arguments (section 4) and the impact on access for local people (section 5). In addition I make suggestions for how the ongoing process can be improved to ensure that as much consensus can be reached in future decision making and that stakeholders can be persuaded that the processes are fair (section 6). Finally I provide some concluding remarks, recommendations and a way forward.

2 Background to the IHT proposals

There is a long history of proposals for radical change to the provision of healthcare in South West London going back to at least the 1990s when the Epsom and St Helier trusts were merged. Each of these plans has presented differing rationales, and not all have involved the creation of a new hospital at Sutton as the solution. At the end of 2000 the “Investing in Excellence” plan proposed downgrading services in Epsom to centralise at St Helier. In the autumn of 2003 a Clinical services Review Team proposed closing Epsom’s A&E and temporary centralisation at St Helier pending the building of a new critical care centre: the plan was abruptly dropped, but not before the Epsom MP had proposed the expansion of Epsom and to downgrade of St Helier as a counter proposal.

This was followed by the consultation on Better Healthcare Closer to Home (BHCH 2003), which involved the closure of both Epsom and St Helier hospitals to be replaced by a new single site 500-bed ‘Critical Care Hospital’ at St Helier, Sutton or Priest Hill, and a group of ten local care centres which were said to facilitate a reduction in activity of up to 50%. These proposals were rejected at the end of 2005 following strong local opposition.

In January 2006 plans for a single site critical care hospital on the Sutton Hospital site collapsed, and the project director resigned.

In 2009 with the future of services secured at Epsom Hospital after Surrey PCT dropped proposals to divert patients elsewhere, plans were approved for the complete

[5] Improving Health Together 2020-2030 Pre-Consultation Business Case Surrey Downs, Sutton and Merton Clinical Commissioning Groups December (2019)

refurbishment of St Helier hospital at a cost of £219m, and it was agreed that this would be government funded, and not paid for through the Private Finance Initiative.

However it came to nothing. After the election of the coalition government in 2010, another reconfiguration proposal, Better Services, Better Value (BSBV), was introduced in May 2011 and in effect killed off the refurbishment plans. BSBV was put forward as a clinical initiative led by local GPs and hospital clinicians, and included some of the original proponents of BHCH. Ostensibly its aim was to improve the quality of services in South West London and to contribute to the need to ensure financial sustainability in the wake of the financial crash and the Government's austerity policies. However, common to both BHCH and BSBV seems to have been an antagonism to the continuation of services on the St Helier site.

Then came proposals to break up the Epsom St Helier Trust, with St Helier to be merged with St George's and Epsom to be merged with Ashford and St Peter's in Surrey. Both of these proposed mergers collapsed in 2012 because of unresolved financial problems. Eventually in 2014 after much controversy BSBV plans were dropped after failure to present a compelling business case and to secure agreement across stakeholders in SW London and in Surrey.

Just 3 months later a new 5-year "strategy" document was published by the South West London CCGs, now working together as "South West London Collaborative Commissioning," effectively cutting the links with Surrey Downs CCG. The Strategy proposed "vacating and disposing of" the Sutton Hospital site, but also called for "service changes … across the provider landscape which will deliver financial savings while also making it easier to deliver the improved services Commissioners want to achieve for their patients." It proposed to expand Kingston Hospital and increase bed numbers at St George's.
By 2016, with much of the "strategy" apparently forgotten or discarded the new Epsom St Helier chief executive began promoting plans for a new 800-bed single site hospital – to replace the 1,162 beds provided in the Epsom and St Helier hospitals.

The most recent IHT proposals, formulated in 2017/18, have sought to overcome past problems by:

- narrowing the scope of proposals to three CCG areas rather than as a pan SW London solution,

- cost shifting the impact of reducing local capacity to other providers, social care providers and community services;
- using the main argument that this is because staff cannot be recruited to support two A&E departments at St Helier and Epsom ,and,
- securing pre-approval from the Secretary of State for up to £500m of resources earmarked now in future capital spending rounds as an incentive to proceed quickly.

These announcements were made in the run up to the last election and thus there is legitimate public expectation that spending pledges will be fulfilled; albeit that the caveat was made that plans would be subject to business case approval. Many may be forgiven for thinking this is a minor technicality but in reality it remains a significant hurdle, not least in that the financial case seems weak and stakeholders are fiercely divided on the legitimacy of the processes for selecting options to be shortlisted, on the adequacy of the analysis presented so far, for the viability of the severely reduced scale of acute bed provision outlined in the preferred option, and for the selection of the preferred option for centralising major services at Sutton.

IHT seek to promote a preferred option of removing all major services (A&E services, maternity and paediatrics, emergency surgery and acute medicine) from both Epsom hospital and St Helier hospital to a site in Sutton. The pre-consultation business case (PCBC) suggests there should be what are termed District hospital services (a novel term) based on the existing sites at Epsom and St Helier. Stakeholders are led to believe this will be cheaper, safer and provide higher quality accommodation on a more sustainable basis, principally by being easier to staff fully – but only as a result of significantly reducing the number of consultants and proportion of qualified nurses required to cover the reduced number of acute beds and downgraded beds at Epsom and St Helier.

In proceeding with public consultation quickly before establishing a broader understanding and agreement across stakeholders the NHS risks taking short cuts in the complicated business of winning the necessary support. I have referred to NHS guidance to planning change earlier but there is further extensive guidance that has been published by government and HM Treasury in particular which is required to be followed or is provided to help proposers in the process.

Thus the Treasury, who approve all capital projects of more than £50m at the moment, issue the Green Book[6] and the Guide to developing the Project Business Case[7]. These lay down clear guidance for on the process involved in investment appraisal, particularly the options appraisal process and the requirement to consider properly lower cost do-minimum options. Further guidance on multi –criteria analysis of the type deployed in the PCBC can be found in a manual issued by central government [8] and the guidance on economic modelling issued in December 2019. [9]

It should be noted that the Secretary of State in making the announcement of the funding for Epsom and St Helier capital development[10] also said that future details of a new capital funding regime would be published before the end of 2019. In his September statement criticisms of the current system were made but at time of writing it is still not clear either what that the future system will be; or the system for future funding of social care, again long promised.

A further complicating factor in the context for decisions on the proposals is that the local CCGs and the ESTH are to be incorporated in 2021 into new Integrated Care systems meant to centralise major commissioning decisions and to plan more formally across SW London and Surrey Heartlands, a separate Integrated Care system for Surrey.
Finally the ESTH trust is in significant financial deficit requiring support from NHS England to continue in operation. This effectively means that NHS England is closely involved in the ongoing management of the Trust.

3 Clinical arguments for IHT

The key clinical argument underlying IHT is the need to reduce the number of sites providing the major acute health services of the three CCGS areas of Merton, Sutton and Surrey Downs so as to improve the quality and sustainability of clinical care. This is intended to stand independent of financial consideration although, as I argue, this clearly cannot be the

[6] The Green Book : central government guidance on appraisal and evaluation –HM Treasury 2018
[7] Guide to developing the project business case- HM Treasury 2018
[8] Multi-criteria analysis: a manual Department of Communities and Local Government 2009 Department for Communities and Local Government: London January 2009
[9] Comprehensive Investment Appraisal (CIA) Model-User Guide DHSC December 2019
[10] Health Infrastructure Plan A new, strategic approach to improving our hospitals and health infrastructure DHSC September 2019

case as questions of affordability set the framework for all decisions and ultimately HM Treasury will approve all plans. Nevertheless if IHT's key argument is accepted, the choice then becomes which acute hospital sites should be closed or downgraded. However the underlying argument for the closure of services on some sites is flawed. In addition, the argument for removing services from the hospital used by many of the residents of Merton – St Helier – is also flawed.

The clinical argument is based on three key claims: first, that increased specialisation improves quality of care; and second, that new models of care reduce the need for hospital beds and that care can be provided by other means in the community and thirdly and most emphatically, it is not possible to offer a full range of services on the existing sites at the existing hospitals due to shortages of clinicians, specifically key consultants in emergency medicine and acute medicine. I examine each of these in turn.

3.1 Specialisation

In our previous report in 2013 we examined the general evidence for specialisation as the key to improved quality. Our references bear repeating before I go onto update the advice we gave at that time.

We referred in 2013 to a report from Tony Harrison in which he concluded (Harrison 2012),

I have argued that volume and outcome studies do not provide, in themselves, an adequate justification for centralizing hospital services.

The same also applies to the association between efficiency and size of unit. Thus, in a Nuffield Trust report, Hurst and Williams (2012, p59) observed,

There is also a large literature on the effect of changes in size on unit costs in hospitals. Reviews suggest that cost per case declines as hospitals increase in size to about 200 beds. There appear to be roughly constant returns to scale between 200 and 600 beds; however, above approximately 600 beds diseconomies of scale seem to set in, possibly because larger hospitals become more difficult to manage[11]*.*

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[11] NB the authors do not consider the economics of a three site solution with transfers between the major acute and district hospital beds across three sites.

On this basis neither St Helier (594 beds) nor Epsom (454 beds) hospitals are small hospitals. It is perfectly feasible to provide high-quality services from the sites, and indeed they have scored well on quality in recent and past assessments. As sites with a significant proportion of older accommodation they should benefit from reduced capital charges and depreciation and be better able to focus on the delivery of services compared to other hospitals burdened by the added costs of new PFI funded schemes. Where they seem exclusively to be marked down is in relation to 'London quality standards'[12] (which seem to have been established purely to promote reconfigurations) and in the quality of accommodation (which can be rectified by investment).

Moreover, in the case of emergency care, centralisation may have a negative impact with mortality increasing the greater distances that have to be travelled. Thus Harrison (2012) has found,

Even if gains in outcomes are achieved by centralization, the longer journey times that it entails for some patients may offset them to some extent. One study of stroke care found that the clinical risks of longer journeys outweighed the benefits of centralization. Nicholl et al. found that for every mile a seriously injured person had to travel to hospital, the risk of death increased by one per cent. Other work has found that the longer journeys discouraged use of health-care services.

These findings were echoed by a more recent report by Shropshire, Telford and Wrekin Defend Our NHS[13] for the West Midlands Clinical Senate on the local reconfiguration plan known as Future Fit. [14] This points out that Nicholl's study in 2007 is one of the more important pieces of UK research on the relationship between journey length and mortality, looking at survival rates for patients with life threatening conditions, relating this to the distance between home and hospital. For patients travelling up to 10 km, the overall mortality rate was 5.8%; for those travelling 11-20 km, 7.7% died; and for those travelling 21 km or more, 8.8% died. Overall, people who travelled more than 20 km to access treatment were 50% more likely to die than those living close to the hospital. Those with

[12] London Quality Standards (2013) https://www.england.nhs.uk/wp-content/uploads/2013/08/lon-qual-stands.pdf

[13] Shropshire, Telford and Wrekin Defend Our NHS (STWDON) (2016). *Future Fit A commentary for the West Midlands Clinical Senate*. Health Campaigns Together, https://nhsfuturefit.org/key-documents/draft-public-consultation-documents/full-consultation-document-1/506-public-consultation-document-english/file

[14] https://nhsfuturefit.org/key-documents/draft-public-consultation-documents/full-consultation-document-1/506-public-consultation-document-english/file

acute respiratory conditions fared even worse, and were around twice as likely to die if they had to travel the longer distance to access A&E. Although distances in South London are less of an issue, travel times, because of congested roads do become an issue and are clearly a local concern.

STWDON reports (p16),

"More recent research confirms the pattern. A 2013 Japanese study looked at distance to hospital for patients with acute heart attacks, strokes and pneumonia – a sub-set of the conditions examined by the Sheffield study. The study found a strong correlation between transport distance and mortality for acute heart attack and for ischaemic stroke; and a moderate correlation between distance and mortality for pneumonia and for subarachnoid haemorrhage".

And goes on (p16) to draw attention to a 2014 York University analysis[15] of Swedish data that,

"… compared survival rates from myocardial infarction for people having to travel different distances to emergency care. The author concluded 'The results show a clear and gradually declining probability of surviving an acute myocardial infarction as residential distance from an emergency room increases'. People travelling 50 to 60 km to emergency care were 15% less likely to survive than those living close to the hospital. Most of the excess deaths were of people dying on the way to hospital. The author noted an inherent bias in much medical research, as studies typically look only at outcomes for people who arrive alive at hospital. Those who die on the way are excluded. Most research also takes place in urban areas, with little research on the impact on survival of rurality and/or long journey distance. The few studies that do exist strongly support the case that longer journeys to A&E result in higher rates of mortality."

Finally STWDON refers (p16) to,

"… evidence from the USA of Emergency Department closure having a strong 'ripple effect', with mortality increasing by 5% for patients at neighbouring Emergency Departments that remained open. Existing facilities can easily be overwhelmed by increased demand. A strong and growing body of anecdotal UK evidence is of severe pressure on A&Es that remain following the closure of a neighbouring unit."

[15] Avdic, D (2014). A matter of life and death? Hospital distance and quality of care: evidence from emergency room closures and myocardial infarctions. HEDG: Health, Econometrics and Data Group. University of York

My own experience in NW London was of major unplanned operational difficulties caused by early closure of two A&E departments as the first stage of reconfiguration plans leaving A&E services in NW London amongst the worst in the country both then and now.

I will go on to consider access issues later in section 5 but it is clear that public transport users face significantly longer journeys of around 20 minutes, with a minority even longer. This is not only dangerous for those accessing emergency and urgent services but discouraging for attendees, when it is known that late presentation still remains a significant risk factor, contributing to relatively poor UK performance in international comparative studies. *"Access, public transport, parking and travel times and their impact for patients , relatives and visitors"* were flagged up as the biggest concern in early consultation around development plans. (PCBC p87)

In this consultation we note that despite previous claims[16], there is now no reference to '*over 500 avoidable deaths in London a year due to different consultant hours at weekends and in evenings at hospitals across the capital*', and no attempt to use this justification for centralisation of services.

In fact subsequent work by Professor Sutton and colleagues[17] debunked this theory and demonstrated the "weekend effect" as almost wholly a result of differing case mixes at the weekend. I would like to see a quantification of the risks associated with additional travelling times and the additional complexities of transferring patients across three sites in any next stage business case.

A&E services are something of a 'Cinderella' service providing care disproportionately to the disadvantaged; it is difficult to attract consultant staff partly because there is little opportunity for private earnings as exist in most other clinical areas. Utilisation of A&E services has increased in recent years as access to GP services has deteriorated and the population has grown older. The size of Emergency department seen as a minimum by the

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[16] BSBV 2012, p5

[17] Meacock, R., Doran, T. & Sutton, M. (2015). What are the Costs and Benefits of Providing Comprehensive Seven-day Services for Emergency Hospital Admissions? Health Economics, 24(8), 907-912. DOI: 10.1002/hec.3207
http://www.manchester.ac.uk/discover/news/new-study-shows-major-omission-in-evidence-of-weekend-effect-on-mortality-rates-in-hospitals/

Royal College of Emergency Medicine would cover a catchment area of 300,000. Given the actual population for the existing three CCG's covers 720,000 people this suggests that two A&E departments are required. By planning for much smaller catchment areas for future A&E departments (PCBC table119 p267)[18] in effect these plans merely cost shift the problem of A&E provision to other providers.

Updating these arguments using more recent information I can now refer to further work by the Kings Fund[19], House of Commons Library[20] , Monitor [21] a, the Nuffield Trust [22] and the Royal College of Emergency Medicine[23].

The Kings Fund concluded in regard to specialisation:

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. In particular:
– Evidence to support the impact of large-scale reconfigurations of hospital services on finance is almost entirely lacking.
– Evidence on the impact on quality is mixed, being much stronger in relation to specialist services than other areas of care.

This latter finding point to a negative aspect of the IHT proposals in that one of the claimed advantages of the proposals for the Royal Marsden hospital is that it provides the necessary infrastructure to establish a new specialist children's cancer centre. However this would detract from existing specialist cancer centres at St Georges and Guys and St Thomas' and represents proliferation of yet more specialist centres when it can be argued there are already too many in London[24]. The existence of a major centre for acute services is also likely to act as a magnet for consultants looking to establish their own unplanned specialist services and is contrary to what seems a more sensible direction for ESTH of becoming part

[18] The table shows the planned emergency catchments for the new proposed major centres as respectively Epsom 312-316,000; St Helier 331-360,000 and Sutton as 404-422,000.
[19] The reconfiguration of clinical services: What is the evidence?, The King's Fund, November 2014, p23
[20] Briefing Paper House of Commons Library Number 8105, 9 October 2017
Reconfiguration of NHS services (England)
researchbriefings.files.parliament.uk/documents/CBP-8105/CBP-8105.pdf
[21]Facing the Future : Smaller Acute Providers Monitor 2014
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/320075/smalleracuteproviders-report.pdf
[22] "Rethinking acute medical care in smaller hospitals" by Dr Louella Vaughan, Nigel Edwards, Candace Imison and Ben Collins . Nuffield Trust 2018
[23] Reconfiguring Emergency Medicine Services Royal College of Emergency Medicine April 2017
https://www.rcem.ac.uk/docs/Policy/Reconfiguration%20guidance%20April%202017.pdf
[24]https://www.hsj.co.uk/specialist-care/inherently-risky-childrens-cancer-service-to-be-overhauled-after-hsj-revelations/7026834.article

of a pre-existing hospital chain , probably with St Georges or possibly Guys and St Thomas'.[25]

The House of Commons Library report (2017) provides a very good summary of the reconfiguration debate and the opposition this created. They point both to the widespread opposition to A&E closures and the "limited evidence linking hospital unit size and quality of outcomes".

The Monitor report (2014) on the other hand points to the need to reach a balance between the conflicting objectives:

We need to better understand the factors that are affecting change, such as workforce issues, clinical specialisation or increased staffing levels, and consider how best to balance competing objectives.[16]

The Nuffield Trust (2018) finds in relation to smaller hospitals, but of relevance in examining the continuation of services at Epsom that:

The tendency for some specialists to opt out of the general medical rota has increased staffing problems and has increased the pressures on the remaining staff. There is limited evidence that the benefits outweigh the problems that this can create, and more imaginative networked solutions have been adopted in some places.

These problems with staffing are further exacerbated by the imposition of minimum staffing levels, specific rota designs and other standards by external regulators. In many cases these rules are based on guidance developed for larger (often urban) centres, and there is limited evidence that these standards translate into improved outcomes. Smaller and remote hospitals need to be free to design the acute medical service in a less rigid way.

What this points to is standards being an obstacle to finding creative solutions that best meet local needs, as these further quotes from the Nuffield report signify.

The benefits of specialist services and staff should be set against the increased costs, fragmentation and threats to viability that can result and that can reduce hospitals' ability to effectively deal with multi-morbid patients whose severity and urgency of need has not yet been determined. Policy and

[25] Dunhill, L. (2020) We've proved hospital chains work, says CEO HSJ 7 February 2020 https://www.hsj.co.uk/pennine-acute-hospitals-nhs-trust/weve-proved-hospital-chains-work-says-ceo/7026875.article

training models need to recognise the importance of generalist skills. Proposals that allow further opting out of acute medical on-call care in small hospitals require very careful thought.

*(*p8) *Regulators and clinical senates should take a more critical and innovative approach to the application of standards. At present many standards have a relatively low level of evidence underpinning them*. (p10)

The Royal College of Emergency Medicine in 2017 stated in the summary of its report specifically addressing reconfiguration:

5. Most EDs are already crowded. Actively deciding to increase attendances into crowded EDs will harm patients. This will be made worse if bed closures are also planned in the same systems.

And ,

7. Emergency Departments can become too big to work effectively.

It is remarkable that the PCBC do not discuss this guidance or refer to it in their references. This reveals a bias in my view to promote reconfiguration. The IHT programme actively promotes many of the things the Royal College specifically warn against. (See later sections for further discussion).

Increasingly it appears that the London quality standards in pursuit of the "Very best healthcare" are creating more problems than they are solving and undue weight to meeting these standards should not be used in any options appraisal evaluation.

3.2 Reductions in demand justify A&E closures

The crucial assumption justifying reduced provision of A&E services in the locality in the future and hence savings in capacity and staffing is that investment in out-of-hospital care will reduce demand. But the evidence for this did not stand up at the time of the BSBV proposals.

Carson *et al.* (2011, p19) found no direct link between A&E attendance and hospital admission, and moreover diversion schemes are generally ineffective. They state,

There is some evidence that when A&E departments become overwhelmed junior staff will admit more people – the primary failure is in the A&E system not the volume presenting.

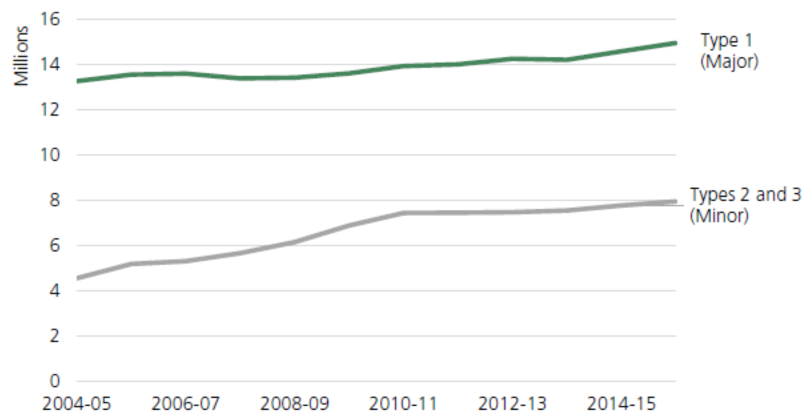
There is little or no evidence for the effectiveness of diversion schemes on admissions; some have had serious safety questions raised; while diversion schemes tend to focus on people who are never likely to be admitted because all they needed was advice or more basic care.

The same study (p22) also examined the use of urgent care centres and walk-in clinics. They found that,

There is a lack of published evidence to support the hypothesis that urgent care centres and walk-in centres will reduce attendances at emergency departments; in contrast, indications suggest they increase total burden on the NHS. Where the vision of the urgent care centre is that it is fully integrated part of the A&E service … it will take time to establish and much longer for the relationships and mutual trust to grow so that the centre functions with full effectiveness.

BSBV in 2012 claimed that there would be a decrease of around 50% in A&E attendances from development of Out of Hospital services. In fact the Trust has seen an increase of 11% in hospital admissions overall, and a 31% increase in emergency admissions, despite the development of these services. This is not to deny that reductions in inappropriate attendances would be desirable but to point to the weight of evidence suggesting it is more difficult to achieve than current plans acknowledge (see below).

The graph below, from another House of Commons report, instead points to stable trends of A&E admissions with large increases in overall attendances as a result of the opening of more urgent care and walk in centres.



More recent trends reported by the latest (2018-19) DHSC Annual report reveals that demand is increasing more rapidly:

The demand for services provided in the health and care system continues to rise above population and demographic growth as better diagnosis and medical advancement means more treatment is possible, 24.8 million people attended an A&E facility in England in 2018-19, an increase of 4.1% compared with 2017-18.

Despite this the plans contained in IHT project 2% per annum (pa) reductions in emergency admissions up to 2025/26 , a 3% pa reduction in activity overall and a 3% pa bed savings by reducing length of stay. Overall a reduction of 80 beds from the grand total of 1014 is planned, but that assumes that the expected increases in demand for community beds and extra activity calculated of 243 beds (PCBC p201) can be accommodated by reducing length of stay and other efficiencies.

Many people including myself are sceptical about the NHS's ability to continue significantly to reduce length of stay [26] (as day case expands for patients with simple requirements and as the complexity and multi-morbidity of remaining patients increases at the same time as availability of social care decreases). IHT risks entering a "counterfactual" world of trying to convey a story to stakeholders which is divorced from reality. This is what eventually sank the "Shaping a Healthier Future" project in NW London in 2019 when it became impossible

[26] Jones R (2017) Growth in NHS admissions and length of stay: a policy based evidence fiasco. British Journal of Healthcare Management 23(12); 603-606

for the project leaders to justify ambitious attempts to reduce NHS capacity further whilst surrounded by evidence on the ground of rapidly rising demand, very high occupancy rates and inefficient bottlenecks in crowded A&E departments.

In addition, demand for healthcare in general is rising for a number of reasons:

- increasing population in London and the South East;
- rising birth rates;
- an ageing population with associated rising morbidity;
- social fragmentation and increased lone living;
- And, reducing social services budgets.

It makes little sense to undermine local successful units that have some capacity to absorb any extra workload that may emerge. It has been little appreciated that London health services are now funded at national average rates as a result of the surge in population in recent years. There is thus no imperative to be seen to be reducing capacity and every reason to ask for more. It is the paradox of the preferred options that while spending £500m key capacity in A&E, intensive care and acute care will be reduced at a time when recent events would suggest the opposite is required.

In relation to planning reductions in activity as a justification for reconfiguration, the Royal College of Emergency Medicine[27] states:

Basing reconfiguration decisions around planned reductions in demand for urgent and emergency care, or around hoped-for effects of redirection strategies, is not recommended.(p3)

Again it is not clear why confidence is placed in major reductions in capacity when such doubts have been expressed.

3.3 Difficulties in recruitment of clinicians

As the arguments above have weakened the greatest emphasis is now placed on the argument that it is impossible to find the staff to support existing services.

The Strategic Outline Case (SOC) presented by ESTH in 2018 puts it clearly:

[27] https://www.rcem.ac.uk/docs/Policy/Reconfiguration%20guidance%20April%202017.pdf

What is clear from all of our work is that we cannot continue to run all our acute services on two sites because we will not have the clinical staff to deliver all of the standards.

The PCBC puts it thus:

ESTH is the only acute trust in South West London that is not clinically sustainable in the emergency department and acute medicine due to a 25 consultant shortage against our standards. Additionally there are shortages in middle grade doctors, junior doctors and nursing staff. The Care Quality Commission has highlighted workforce shortages across its two sites as a critical issue.

This follows the tradition of those that have promoted reconfiguration for many years. The same arguments were raised when BHCH was presented in 2003 and BSBV in 2012. The international evidence is that the UK lags other comparable countries in numbers of doctors and nurses.

	UK	US	France	Germany	Netherlands
Physicians per 1000 popn	2.8	2.6	3.2	4.3	3.6
Nurses per 1000 popn	7.8	11.7	10.5	12.2	10.9

Source : OECD Health at a Glance 2019

This has been the position for many years. It is a general policy, not a local problem. The actual number of students accepted into medical schools has actually declined.[28]

Problems of staffing have been attributed to the European Working Time Directive, but as the Chairman of the Independent Reconfiguration Panel (IRP) in reviewing the Panel's work stated (Barrett 2012, p5),

With the benefit of hindsight, I think it is fair to say that the EWTD did not turn out to be the insurmountable obstacle it was originally perceived to be. Instead, in many cases it forced the NHS to think more imaginatively about how best to utilise its staff.

It is particularly dismaying in this respect to note within the Technical annex to the Consultation exercise (p37) that it is implied that the HEE (Health Education England)

[28]https://www.gmc-uk.org/static/documents/content/SoMEP_2017_chapter_2.pdf
https://infogalactic.com/info/Medical_school_in_the_United_Kingdom

allocate medical trainees on a simple per trust basis rather than taking into account the needs at a particular two centre trust. The HEE have therefore ensured that a shortage of staff has been created by restricting the supply of junior staff on the two sites and cutting off a major source of potential future recruitment. This coupled with the government policy not to increase the numbers of medical students and instead to cut the number of trainees in 2012[29] has manufactured a crisis which was preventable. The College of Emergency Medicine produced a report in 2011 [30] calling for urgent action! Future staff shortages have been predicted for many years. In the 2017 and 2019 elections the RCEM called for a programme to create 2000 more consultants.

The work of the House of Commons Library in summarising problems with the reconfiguration policy (see footnote 15) in general shows it is an example of confused objectives, where it is not clear whether it is a solution to problems of recruitment in certain local services which is being pursued or the objective in itself.

Monitor in its excellent report on small acute hospitals also identified that there are a range of responses to workforce problems:

There are other ways in which providers are responding to the developing challenges. For example, we were told of many different ways in which providers are working around staff shortages and responding to other recruitment needs. This included:

• conducting international recruitment campaigns, particularly for qualified nurses and for junior and middle doctors in some specialties

• developing new roles and re-designing existing roles, eg new roles for advanced practitioners in diagnostic areas, hybrid roles for nurses and therapists that include hospital and community care skills or new roles for physician associates

• employing a pool of trained nurses who may be used to address shortages in staff and skills mix without relying on agency staff

• making joint appointments with neighbouring providers

[29]https://www.telegraph.co.uk/news/health/news/9724532/The-NHS-will-train-fewer-doctors-to-avoid-future-brain-drain-report-warns.html

[30] CEM Emergency Medicine Taskforce Interim Report 2011

The Nuffield Trust[31] note in the first paragraph of their report:

"Too often, the knee-jerk reaction has been to try to close or downgrade these services rather than to develop solutions that better suit the needs of the local community".

They cite various reasons for low staffing levels which I have already referred to (p16) which point to resource allocation issues being at the heart of the issue rather than the need for reconfiguration; but they go on to point to additional problems that may be presented by the complex web of services across three sites rather than two:

• *The fragmented and complex systems that have emerged for EDs, acute medical units (AMUs), frailty units and a variety of other internal systems are often hard for hospitals to coordinate. Moving patients between units, and the handovers of responsibility that accompany this, becomes inefficient. Work is duplicated, reducing the overall resilience of the system and creating potential for delays and even harm.(p4)*

The report goes on to list a number of suggestions for managing problems. It advises, (echoing my own view) that support should be sought from other neighbouring hospitals and those resources from a wider network of sources within the STP footprint. The retort that they have troubles of their own undermines the case for transferring a large portion of the workload to other hospitals and doesn't contradict my point (along with the sources quoted) that greater use of networked solutions, hospital chains and reprioritisation toward generalist services everywhere is a more positive route than increased specialisation at a local level.

Much is made of the importance of integrated working, and it is disappointing that the PCBC specifically rejects any STP-level approach and restricts itself to the smaller footprint of the 3 CCGs. This means it has not fully explored resolving problems across the STP /ICS footprints, particularly as the "solution" of centralisation is unlikely to be realised for a further five years. This period would allow initiatives to train additional doctors, to fast track consultant appointments and to extend the membership of medical rotas as an alternative to expensive and risky centralisation. I say risky because it can only be done under existing financial constraints by restricting the number of beds built to replace those closed. It is again paradoxical that Planning Guidance recently issued by the NHS stresses the need to

[31] "Rethinking acute medical care in smaller hospitals" by Dr Louella Vaughan, Nigel Edwards, Candace Imison and Ben Collins Nuffield Trust October 2018

end the reduction in bed numbers, and maintain or increase numbers from the expanded provision over the winter period 2019-20[32]:

In 2020/21 A&E performance must improve, and all providers should plan to deliver a material improvement against a 2019/20 benchmark. To achieve this, systems and organisations will be expected to reduce general and acute bed occupancy levels to a maximum of 92%. This means that the long period of reducing the number of beds across the NHS should not be expected to continue.

The conclusion I come to is that it is not clear to me that the staffing problems being encountered in ESTH are as a result of an inefficient configuration (the size of the hospitals would suggest not) or that a reconfiguration will in fact resolve these problems. The risk is that, after spending £500m, the new hospital continues to have staffing issues which may be made worse by crowding A&E and centralising services into far fewer acute beds. It is a further paradox that the solution to staffing problems is to decrease the numbers of staff planned in the new configuration: cutting consultants by 69wte and middle ranking and junior staff by 73 wte (PCBC p259) and concentrating the entire consultant workforce in the new hospital. You would have thought that if this were possible it could be planned within the existing facilities as less space would presumably be required.

The following graphic extracted from a Health Foundation report of 2019[33] addressing the staffing problems in England's NHS shows that staff stability, i.e. the ratio of staff in post at the end of the year compared to the beginning of the year has decreased in general since 2010/11 and that South London is not the area of London suffering the worst, although all areas of London suffer more than the rest of the country. The problems of ESTH are not local but general.

There are a range of explanations offered for this but they conclude:

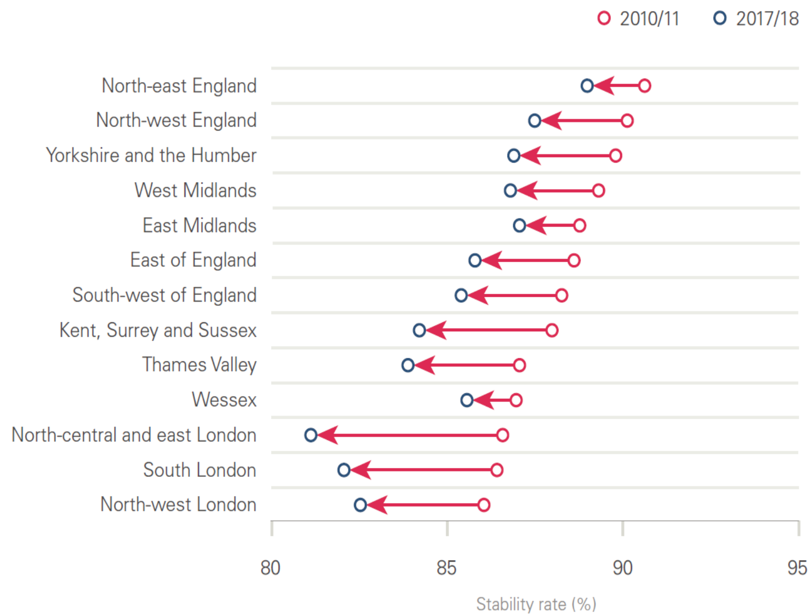
...*that a lack of coherent policy that takes into account both funding and staffing has been a recurring theme. The combined effect has been to undermine any long-term consistency in the NHS's approach to workforce policy and planning*.(p4)

[32]NHS Operational Planning and Contracting Guidance 2020/21:NHS England January 2020 https://www.england.nhs.uk/wp-content/uploads/2020/01/2020-21-NHS-Operational-Planning-Contracting-Guidance.pdf

[33] A critical moment: NHS staffing trends, retention and attrition Health Foundation 2019

NHS staffing issues and NHS funding streams are inextricably linked – staffing challenges cannot be solved without consideration of funding, and funding decisions should not be made without consideration of the impact on NHS staffing. (p32)

Figure 17: Regional-level NHS trust stability-rate, 2010/11 and 2017/18



Source: Health Foundation analysis of NHS Digital data. Excludes doctors in training.

Medical staffing problems are a subset of these general problems but if anything these seem to arise from:

- the high cost of living and housing in London,
- failure of pay policy to keep pace with high London costs of living ,
- failure of the NHS to create enough trainees to keep up with demand,
- policies that have incentivised junior medical staff to pursue careers as specialists rather than generalists,
- allowing specialists to opt out of medical rotas,
- the attractiveness of locum and agency staff working ,
- changes in the gender mix of the workforce and expectations of work life balance.
- barriers to entry for foreign doctors and incentives to work abroad for UK trained doctors,

- the hot house working in London that can be attributed to surging levels of demand not compensated by increased resources (which results in very high occupancy levels in acute hospitals),
- burn out of staff , and staff voting with their feet etc.

It is not clear to me that concentrating major acute services on the one hand, creating a new major acute hospital site requiring its own 24/7 management on the other and an increased number of patient transfers between sites are necessary and sufficient conditions to resolving these problems. In certain respects this approach may make matters worse by creating instability, disrupting other A&E departments and hospitals across South London and Surrey and by taking the focus away from more obvious ways of addressing staffing problems more directly i.e. by increasing numbers of trainees and the incentives for generalists and A&E consultants such as housing.

3.4 The Dis-benefits of centralisation

Any clinical benefits of centralisation and reconfiguration need to be balanced by a better appreciation and an honest appraisal of the clinical dis-benefits and a more thorough appraisal of alternatives to improve clinical quality, other than the removal of key services from some hospital sites.

The new configuration proposed replaces two sites, not by one new integrated hospital, but by three sites separated by distances requiring ambulance transfers between sites of a significant number of patients. This will be more complex, pose additional management problems and costs, and be potentially disruptive for patients and staff. There will also be additional clinical risks of patients presenting to the wrong site, of risks during transfers and of additional travel time for staff who may be required on more than one site.

The new major centre, as the only centre providing front line acute beds, is likely to be working at high levels of occupancy. The pressure of the new configuration will be borne by fewer staff than currently, and this in turn may discourage potential recruits.

The plan also expects one in six (16%) of patients to travel outside the current catchment area to travel further to alternative A&E departments while most people within the area will be required to travel further for longer. The costs, risks and uncertainties associated with planning for this are not addressed sufficiently within the Consultation document or PCBC.

On reading the proposals there is no identification of possible disadvantages, which is necessary to enable patients and staff to make an informed and balanced judgement. Many

will detect therefore a biased presentation, raising suspicions that the scheme is being promoted to satisfy vested interests.

4 Financial and economic arguments for IHT

4.1 Introduction

As mentioned previously there is clear national guidance on how to go about presenting the economic and financial case for local change**.**

The requirement to follow guidance and due process is a clearly understood stipulation in public sector commissioning, investment and expenditure. Guidance has been prompted by a history of problems with large-scale public planning, procurement and implementation which have resulted at times in judicial review, lengthy and costly public inquiries, planning blight, construction of the wrong facilities in the wrong place, and excessive costs.

There is therefore a strong presumption that guidance should be followed wherever possible to help avoid potential pitfalls and risks associated with complex and controversial reconfiguration proposals.

I would add however that it is not just the letter but the spirit of the guidance that needs to be followed.

It is in this respect that I find the presentation in the PCBC lacking.

A naïve reading of the documentation might conclude that for the sake of 25 extra consultants the proposals rush to the conclusion that £500m of capital resources should be committed to a scheme that reduces the numbers of consultants required by 63.

There seems to have been no conscientious attempt either to identify lower cost options or, where alternatives have been identified, subject them to serious consideration.

The rationale for expensive centralisation and the building of an entirely new hospital at substantial additional cost is not firmly established. If a rationale can be inferred from the proposals it is that the costs and difficulties of providing services which are unattractive (for clinicians) can be shifted to other providers. Thus the catchment areas of the new centralised facility are to be significantly reduced leaving St Georges, Kingston, Croydon, St Peters, and Royal Surrey County Hospitals to take the displaced patients (see footnote 13).

Treasury guidance is quite clear that the principles of economic appraisal are those of welfare economics (providing a net improvement in social welfare) and not of calculating a local advantage. Thus the decision not to include the necessary cost of enabling capital in neighboroughing hospitals, which will require additional capital investment, appears to be in error and a potential distortion of the economic appraisal.

The case for change appears over-reliant on compliance with London clinical standards which appear excessively prescriptive and not justifiable, failing to take account of wider issues of both the economy and the wishes of patients for easier access to services. I have examined the current clinical evidence and thinking and I am clear that a more balanced view is required (see Section 3 above).

There appear to be lower cost options that require to be fully evaluated as alternatives to the three centralised options chosen. These would be:

- no change ("Business as Usual"),
- a do–minimum option which fulfils investment objectives (which in the absence of clearly stated objectives I take to be to create sustainable clinical services of high standards serving the local community)
- and other lower cost options (centralisation on one of the existing two sites at Epsom and St Helier and the conversion of the other into a district Hospital –thus foregoing the Sutton site).

The expressed aim of ensuring the very best quality of care available (PCBC p5, 19, 105, 106, 205) appears extravagant in the circumstances of the advice published by NHS Improvement in November 2016.[34]

"2.2 Financial discipline is necessary in a tight spending environment. Resource spending is increasing in real terms but capital expenditure will be more constrained. As a result this is a medium-term challenge for the NHS.

2.3 In this context trusts should be aware that access to Department of Health (DH) capital financing will be more restricted than in previous years and expenditure that scores against the DH capital departmental expenditure limit (CDEL) will be subject to increased control and scrutiny going forward. Trusts should also note that all capital expenditure, however financed (whether through self-generated resources, DH financing or borrowing from financial institutions, local government or other sources), scores against the DH departmental spending limit.

...

4.1 NHS Improvement will require assurance that a capital investment business case has been subject to an appropriate level of scrutiny and governance by the trust proposing the investment, before the case is submitted to NHS Improvement

- *The trust has the resource and capacity to deliver the investment programme within a realistic timeframe. (p14)*

[34] NHSI Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts https://improvement.nhs.uk/resources/capital-regime-investment-and-property-business-case-approval-guidance-nhs-trusts-and-foundation-trusts/

Of course since then there have been changes in the NHS, changes of government ministers and a change in attitude to investment in the NHS, making it a more attractive proposition. However I believe it is still incumbent on the proposers of this programme to be mindful of the limited resources available generally and the need to persuade stakeholders that all options have been properly considered, including lower cost options impacting less on users of services.

This point is made in the NHS England Planning guidance (2018), which goes on to spell out the key requirements of the Pre-consultation Business case: the table below contrasts the requirements with the content of the IHT PCBC and Consultation.

Key requirements from NHS England 2018 Guidance ***Planning, assuring and delivering service change for patients (page 27-28)***	**PCBC and Consultation document approach**
Summary financial statements and supporting financial modelling which shows the impact of each option on commissioners/providers revenue financial position supported by activity, income and cost modelling which is sufficiently robust for both commissioners and providers to be confident that options would be sustainable;	There is no supportive financial modelling provided, making full scrutiny impossible. The explanation for excluding options from evaluation is insufficient and inappropriate, and clearly in breach of the guidance.
Confirmation of assumptions made in the financial modelling for both commissioners and providers e.g. commissioner growth in allocations, provider inflation, levels of efficiency savings;	Assumptions are provided but the levels of efficiency savings assumed appear unrealistic.(see discussion under 4.3 Financial Appraisal)
Reconciliation of the scheme's financial impacts to the STP financial plan	The STP/ICS financial plan has still not been released for to the public to enable the public and stakeholders to give feedback
Credible activity/throughput analysis that translates sustainably to the scale of infrastructure change anticipated;	It is not clear from the analysis when and if the enabling capital investment will be funded and implemented to

	ensure that the displacement of activity planned and the cuts in activity planned can be achieved in practice. The scale of activity changes planned are very large (16% diversion of A&E activity and a reductions of by 452 of beds accessible for major acute patients!! (PCBC p201) This is not only contrary to recent NHS Planning guidance to avoid planning reductions in bed capacity but in the light of recent events foolhardy.
A clear assessment of the financial benefits of the scheme e.g. provider efficiency savings, system reductions in activity levels and the basis of these calculations;	Table 110 p257-8 of the PCBC summarises the benefits of the options compared to Business as Usual. The task is to demonstrate how net benefits compared to the baseline budget can be achieved not how benefits assuming that the medical establishment, incorporating new unfunded standards, can be calculated. Furthermore other major benefits claimed e.g. benefits of using new technology; reductions in recurrent cost pressures seem either to be irrelevant to the consolidation of major acute services or a desperate attempt to shore up the benefits (see further discussion in the next section). The basis of the calculations both for these benefits and assumptions justifying the evidence that capacity can be safely cut and diverted to low dependency settings is inadequate and unconvincing in the light of failures in the past to achieve such targets and given the extent of the supporting evidence to justify the success of

	community care initiatives to reduce demand and divert care into community settings,
A high level source and application of capital funds, to demonstrate capital costs and how these are expected to be funded. It should be noted that every effort should be made to generate local capital funding including land disposals or internally generated capital and initial assessments of this should be included;	I can find no high level source and application of capital funds that. Claims are made on pages 263-267 in the PCBC in section 13.7 discussing Financing options but the level of supporting detail is inadequate and certainly is not a 'source and application of funds'. Further discussion on p308 seeks to provide reassurance but lacks supporting detail.
Indicative capital costs recorded using OB forms and recognisable benchmarks and which assume compliance with all applicable design, technical, building and space standards and known site constraints, and key adjacencies should be identified;	Indicative capital costs are included in the PCBC but it is not clear how reliable they are, what standards have been used, and for example what additional space is being created under the options proposed. We note that recent tenders have demonstrated unexpected cost increases over those estimated in the 50-100% range.
Indicative designs that demonstrably reconcile to up-to-date estates strategies at site, provider and STP levels;	Given the STP/ICS strategy has yet to be made public it is impossible to verify whether the strategy reconciles. The indicative designs made public shows attractive facilities but raises immediate questions as to their affordability.
Confirmation of support from all commissioners proposing the scheme and acknowledgement from all providers who will be significantly affected by the scheme that	The PCBC describes the assurance process in some detail but it is by no means clear that the process was completed prior to the release for public consultation. There is in my view

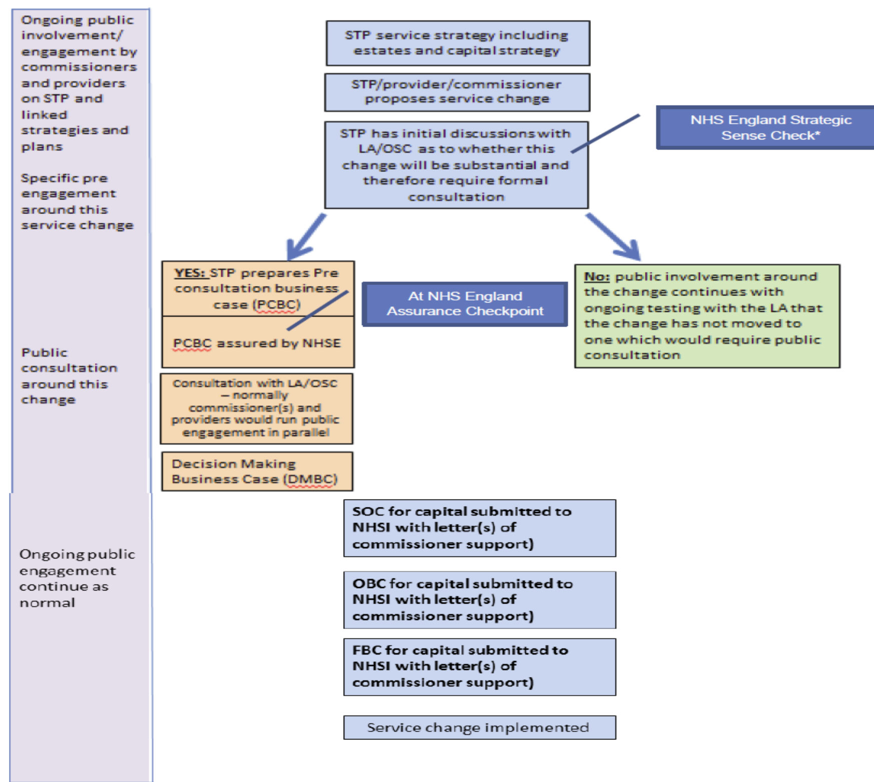
their views on any impact on them have been sought. **All options requiring capital will be assured prior to consultation by NHS Improvement and NHS England, and, where appropriate, through them the Department of Health and Social Care to ensure each option is sustainable in service and revenue and capital affordability terms, that the scheme size is proportionate and that it is capable of meeting applicable VFM and return on investment criteria.** **Schemes requiring larger amounts of capital (i.e. over £100m) will be required to provide more detail and be subject to higher levels of scrutiny prior to going out to consultation.** **Following this assurance the following letters of support will be required prior to consultation being launched:** **... where options require capital above £100m the scheme will be considered by the NHS Improvement Resources Committee and a letter of support from the NHS Improvement Chief Finance Officer provided.**	a serious danger therefore that the public consultation was undertaken too soon and may be potentially misleading to the public who may think the level of assurance is greater than actually seems to be the case.
At this early stage, before pre-consultation business case (PCBC), , if service change options will require capital, it is helpful to take account of the requirements that individual providers' capital investment business cases will need to satisfy if they are to be able to support the formal proposals. These are set out in NHS Improvement's guidance Capital regime, Investment and Property Business Case Approval for NHS Trusts and Foundation Trusts.	The PCBC as it stands does not provide evidence that the NHS Improvement Chief Financial Officer has expressed support. One problem is that there has been a delay in the SW London STP/ICS publishing its plans – which normally signals some disagreements. For my part the level of detail provided in the PCBC itself and indeed in supporting documentation makes it difficult to be sure that the outputs

Therefore in preparing the PCBC advice/input should be sought from NHS Improvement and NHS England (and through them, the Department of Health and Social Care and HM Treasury if appropriate) so that they can as far as possible underpin subsequent provider business case processes and NHS Improvement's subsequent assurance of them.	from modelling are supported by the necessary supporting detail. I sought to secure further detail from the IHT programme director to ensure scrutiny can be completed but at time of writing this was not available to me . Copies of correspondence between NHS Improvement and the IHT Programme Director and Programme Board was also sought to ensure that assurance issues seem to have been appropriately flagged and responded to prior to consultation being triggered. I would have advised if requested that the PCBC be extended to allow for more options to have been evaluated prior to launch of the public consultation and that the claimed system benefits could have been better scrutinised and confirmed pre-consultation.

Nonetheless the benefit of these issues being flagged at this stage is that they can be raised by the Local Authority on behalf of stakeholders so to ensure the Decision Making Business Case could be adjusted prior to the real business planning process being initiated as outlined in the graphic taken from the planning guidance (ibid p51):

Annex 11 - Flowchart for service change for scheme including capital.

If it does not require capital, then those elements in bold will not be required



4.2 The Economic Appraisal

This I believe is fundamentally flawed for two main reasons:

- Options have been too hastily limited and exclude lower cost options risking the choice being variants of three 'gold plated' schemes. It would be better to face up to this now rather than it is pointed out later in the process.
- Benefits claimed for centralisation in Table 110 of the PCBC seem to exclude the likely full additional costs for other providers created from the changes in the patient catchment area. The assumption that capital enabling costs can be excluded and that non A&E flows will remain the same and not follow urgent flows seems overly optimistic. Furthermore benefits are calculated as the avoidance of the costs of higher clinical standards rather than as a saving to the current financial baseline. In addition significant benefits are claimed from use of technology (which does not require centralisation to be realised). The avoidance of recurrent cost pressures is also referred to, in what seems to be a desperate effort to bulk up the benefits. In practice new builds are subject to unplanned price uplifts, transitional problems and in this case additional operational and space costs not seemingly taken into account. Benefits are thus mis-stated and exaggerated.

While it is appreciated that the economic appraisal uses as its baseline the BAU position, rather than a Do minimum position, by artificially raising this to incorporate the full costs of implementation of improved clinical standards it exaggerates the "benefit" and moreover is not a benefit that would improve the overall financial affordability of the scheme as might be understood by readers.

Without wanting to labour the point The Green Book is quite specific that the short-list should include the "preferred way forward" (the combination of choices most likely to deliver the SMART[35] objectives), the Business As Usual benchmark; a viable "do-minimum" option that meets minimum core requirements to achieve the objectives identified and at least one viable alternative option[36]. As described in Section 3 above there is a tendency in reconfiguration proposals to dismiss a "do–minimum" option as impossible to achieve but that is not what the Independent Reconfiguration Panel, Monitor and the Nuffield Trust have said, nor the Treasury. Furthermore it is the flaw in the methodology adopted that options are seen as hard and fast, whereas in reality the BAU and do–minimum options can be subject to behaviour modifications that can render these options viable e.g. making changes to national training policies, allocations of trainees, increasing the numbers of generalists and those on take within medical rotas, networking with other hospitals , altering terms and conditions, targeting recruitment and retention policies , adjusting case flow etc.

Above all it creates suspicion and ill-will amongst the local population who often prefer to retain improved local services (as was indicated in this case in pre-consultation) and cannot see why this option has been dismissed seemingly out of hand. This is not to say that it will be the best option but it should be properly evaluated as a means of moving stakeholders to a position where they can recognise the reasons why the preferred option is the best , for whom and to what extent. Only in this way is consensus likely to be built.

4.3 The Financial Appraisal

The question to be addressed here is:

What is the impact of the proposal on the public sector budget in terms of the total cost of both capital and revenue?

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[35] Specific Measurable Achievable Realistic and Time-limited

[36] Please note I am aware of a recent legal case based on the South Tyneside hospital reconfiguration which ruled that the NHS could rule out unrealistic options but that was in the particular circumstances of that case which did not include the necessity for major capital investment. This is not the circumstance in SW London.

This means that the total costs of the additional capital invested has to be included in financial analysis including the enabling capital seemingly excluded. This includes interest payments, capital charges and additional depreciation. These are known collectively as availability charges and are around 10% per annum, although under PFI they were often more. They play an important part in determining the financial health of a local health economy. Their importance was discussed fully in an important study by Keith Palmer for the Kings Fund in 2011 based on the experience of reconfiguration in SE London.[37]

These need to be understood in terms of the impact on the finances of the Trust and on the wider health economy outside of the three CCGs. There can be a tendency for clinicians and others in the NHS to misunderstand positive statements from ministers on the availability of up to £500m of capital for investment. It is not a free gift: it is conditional on presenting a business case that can at least cover the revenue impact of capital costs (which are not possible to fully identify in the analysis as presented) and so generate surplus benefits to deliver the main investment objectives of the proposals.

This represents a tall order as not only do the additional costs (excluding capital charges) of an extra hospital have to be covered (which is also not possible to identify in the PCBC) but also the loss of income to the Trust as a result of restricting the patient flows by adopting a more limited catchment area for those services where patients will want to opt for the closest hospital rather than the preferred option (£17m PCBC p253); on top of the £69m of CIPS (PCBC p64) and loss of income from changes to the Market Forces Factor used to adjust tariffs paid to the Trust (£11m PCBC p64).

The risks that could threaten these plans, but which do not seem to have been quantified and considered, are:

- that elective patients will follow flows of non-elective patients to the nearest hospital with the consequent loss of income,
- that CIP savings will not be achieved,
- and that it will no longer be possible significantly to reduce length of stay and hence achieve savings in major acute beds

None of this is clearly laid out in the PCBC although elements can be pieced together and some estimated.

In effect the consultation documentation is probably misleading, and the PCBC together with the accompanying documentation of over 1200 pages represents in my view an

[37] Reconfiguring hospital services Lessons from South East London Keith Palmer Kings Fund 2011

obfuscation of the issues and choices facing local stakeholders. The public will either be cowed into accepting the advice of the CCGS or resentful and suspicious of the motives of those who have made the attempt to mislead them.

I recommend that a better summary of the major categories of additional costs for an enlarged range of options is presented, making it easier for stakeholders to better understand the key differences between all the options and whether the plans as they exist are likely to be affordable.

This is supposed to have been assured by the Chief Financial Officer of NHS England. Copies of that assurance have not been made available.

5 Access for Local People

In this section a summary of the implications for increased travel times, reduced accessibility and the disproportionate impact this has on disadvantaged groups is provided plus consideration on the location of services and legal safeguards for the most disadvantaged.

It relies on the work that the IHT programme is obliged to undertake but it presents it differently and identifies further work that could be undertaken to reveal more precisely the impact to the various stakeholders.

The key document examined is the Draft Interim Impact Assessment. Judging from minutes of meetings examined and correspondence seen there has been controversy over whether the impact assessment properly considers all the issues and whether the information contained within it is reliable enough for the purposes of decision making.

The document itself defines Integrated Impact assessments (IIAs) as:

…a continuous process to evaluate the reasons for intervention, to weigh up various scenarios for achieving objectives, and to understand the consequences of a proposed intervention. They are used as a tool to develop policy by assessing and presenting the likely costs and benefits and the associated risks of a proposal that might have an impact on the public, private or third sector, the environment and wider society over the long term.

It is important to note that the purpose of impact assessments is not to determine the decision but act to assist decision-makers by giving them better information on how best they can promote and protect the wellbeing of the local communities in which they serve.

It is not surprising that this has been a focus of controversy as it is one of the grounds to challenge any future decision if the decision is seen not to be in the interest of the health service, particularly those that need it the most.

From the evidence presented it seems to be unequivocal that compared to the current baseline of major services at the two existing sites at Epsom and St Helier the preferred option of centralisation at Sutton represents a deterioration in accessibility of major acute services. By adding further distances to travel it adds to travel times and this disproportionately will affect those in disadvantaged groups and the elderly. This in turn adds risk during longer journeys, discourages utilisation of services, and by necessitating the greater use of patient transfers between sites adds a further tier of risk not otherwise borne. Furthermore it is not clear whether the analysis takes into account that for many people (over 100,000) the additional distances will require them to plan to go to another hospital during the spell , breaking continuity of care, adding problems on accessibility of records and notes, and thus representing an additional clinical risk.

This table drawn from the data supplied by Mott McDonald shows the impact of the increased travel time for public transport users.

Public Transport Tuesday - Morning peak protected characteristic data tables							
	% population within 30 mins travelling time				Worse than Baseline %		
	Baseline	Epsom	Sutton	St Helier	Epsom	Sutton	St Helier
Overall Population	69%	49%	59%	53%	20%	10%	16%
Relatively deprived (quintiles 1&2)	91%	58%	75%	83%	33%	16%	8%
BAME (Black , asian , minorities)	82%	63%	75%	73%	19%	8%	10%
Female population (16-44)	74%	53%	64%	59%	21%	11%	15%
Population 65+	62%	44%	52%	43%	17%	9%	18%
Unpaid carers	70%	49%	60%	55%	21%	11%	15%
Population with LTHD	68%	48%	58%	52%	21%	10%	16%
Male population	69%	49%	59%	53%	20%	10%	16%

This is why it is surprising that the draft Impact assessment summarises the adverse impacts on those in greatest needs (with protected characteristics) as follows:

Table 2: Protected characteristics expected to experience disproportionate adversely impact as a result of change

	Patient provision	Longer journey times to acute services for patients	Longer journey times to acute services for visitors	Transportation costs and accessibility of acute services on a single site	Other providers	Wider sustainability
Children and young people (under 16s and those aged 16-24)					N/A	✓
Older people (65 year and over)		✓(In relation to Option 2 St Helier for blue light ambulance)		✓	N/A	
People with a disability				✓	N/A	
Pregnancy and maternity				✓	N/A	
Race and ethnicity				✓	N/A	
People living in deprived areas		✓(In relation to Option 1 Epsom for car and blue light ambulance)	✓(In relation to Option 1 Epsom car and public transport and Option 3 Sutton, public transport)	✓	N/A	✓

Source: Mott MacDonald

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This appears to present a positive gloss on the fact that a large number of people will feel obliged to travel to other hospitals outside the locality as a result of losing local major acute provision; that travel times for all options will be worse for each of the centralised sites for both patients and visitors; and that the public transport difficulties for many of travelling to Sutton will be significant. In this regard the words of the Impact assessment itself bear repeating:

Public transport options to the Sutton site are predominately via bus. While some bus services do run directly to the hospital site, others stop within a 10 to 15 minute walk of the site. The nearest rail stations are located approximately 10 to 20 minute walk from the site.
Consequently, those who may struggle with walking long distances may experience particular difficulties with accessing this site, such as those with a disability or illness, pregnant women and older people. Further, those travelling from Surrey Downs may also be disproportionately impacted when accessing the site compared with those in Sutton and Merton, due to fewer bus routes travelling within this area which are directly connected to Sutton Hospital. (p27)

This description furthermore undermines the credibility of claims that very high percentages of patients will be able to travel to Sutton within 45-60minutes. It is not clear that waiting and walking times at the beginning and end of journeys have been taken into

account, or the particular difficulties of travelling by public transport at or even before peak traffic to arrive for an early morning appointment, or travelling in either direction during the evening (returning from a late afternoon/early evening appointment, or visiting relatives in hospital). These times are irrelevant for car and ambulance journeys but not public transport journeys. Furthermore the likely consequence is that there will have to be greater use of ambulance services or patient transport services for patients for whom public transport is not a viable option. This is made clear in the interim draft impact assessment (p114):

The proposed service model is likely to have a negative impact on the capacity of the ambulance service through:

- *Increased journey times conveying some patients who require access to major acute services such as the ED or maternity services to the major acute hospital (rather than their nearest local hospital which may now be a district hospital). This is a model which is already in place for emergency general surgery which is provided from a single site.*
- *Increased turnaround times for ambulances at the major acute hospital given the greater number of critically ill patients arriving by ambulance at a single site. Around 20% of all current ED attendances are conveyed by ambulance.130 Ambulance handover delays often occur as a result of a mismatch between ED/hospital capacity and the number of elective or emergency patients arriving.131*
- *Emergency transfers for those patients who inappropriately present at a standalone UTC at a district hospital but require the services of the major acute hospital, or those patients whose conditions unexpectedly deteriorates at the district hospital.*
- *Increased volumes of patients drawing on ambulance services to convey them to acute services. Engagement with equality groups highlighted that a number of participants felt that potential increased journey times, complexity and cost would result in them calling an ambulance to take them to acute services where as previously they would have taken alternative transport modes.*

There is no quantification of the financial or clinical impacts of this in the PCBC.

The draft report is only a draft as further information is expected as a result of engagement with staff. However the report itself identifies that:

…for some staff, the proposed changes may have an adverse personal impact as they become accustomed to:

● A change in their place of employment. This would be particularly evident under the option in which Sutton Hospital is the major acute hospital, as staff (including medical staff and specialist nursing staff) would be required to transfer from Epsom and St Helier Hospitals.

● Potential changes to the rota patterns, positions and teams within which they work.

No quantification is as yet available nor is there any analysis of where staff live, which would enable a picture of the likely impact of additional commuting times, difficulties from using public transport out of normal working hours and paint a picture of which groups might be advantaged by the preferred option.

Nonetheless the draft impact assessment purports to identify a range of additional benefits from centralisation for various groups for whom special regard should be kept (protected characteristics):

Table 1: Protected characteristics expected to experience disproportionate positive impact as a result of change

	Patient outcomes	Accessibility of district health services	Health inequalities	Patient experience	Service delivery	Workforce	The physical accessibility of services
Children and young people (under 16s and those aged 16-24)	✓	✓		✓	✓		
Older people (65 year and over)	✓			✓	✓		✓
People with a disability	✓	✓		✓	✓		✓
Gender reassignment	✓			✓	✓		
Pregnancy and maternity	✓			✓	✓		
Race and ethnicity	✓	✓	✓	✓	✓		
Sexual orientation	✓			✓	✓		
People living in deprived areas	✓	✓	✓	✓	✓		

Source: Mott MacDonald

The criticism I would make of this analysis is that it is neither quantified, nor justified beyond vague assertions:

Across all options for change patients are likely to experience improved outcomes arising from:

- *The achievement of workforce standards which promote consultant delivered care.*
- *Reducing variation through the establishment of seven-day services.*
- *A model which allows for a critical mass of cases to be undertaken and provides opportunities for sub-specialisation.*

- *Timely access to co-dependent services as a result of their co-location, in fit for purpose facilities. (Draft IIA p7)*

As I argue elsewhere it is not clear that staffing problems will be eradicated by simply building a new hospital (it merely exports them elsewhere, or will be imported into the new hospital). Variation will not be reduced to a significant extent by additional A&E coverage at the weekend as the work of Professor Sutton has established (see footnote 17). By incentivising sub-specialisation the local NHS will be promoting further inefficiencies in staffing structures and causing the proliferation of specialist services not in the interests of the NHS; and, separation of district and centralised services across three sites will increase problems of transfers in all weathers and the complexity of co-ordination of services (a problem noted earlier when the size of hospitals exceed 600 beds).

No detailed analyses of these issues appear despite the significance of the assessment.

Rather the focus of the report is to down play the overall impact to patients and key groups of the centralisation process and to support Sutton as the centralised option despite the transport and access issues being worse at Sutton for the deprived communities, who would be forced to undertake either complex bus journeys with long walks to get to the hospital or require greater use of an already overstretched ambulance service.

Insufficient weight seems to have been given to this in the quantification of non-financial factors incorporated in the PCBC options appraisal.

A recommendation will be for the local authority to undertake its own market research on the importance of this issue in any final decision making.

Considerations on the Location of services

The NHS has an obligation to fulfil its Public Sector Equality duty as described in the Draft Interim Impact assessment.(ibid p38):

The PSED is a legal obligation for public sector organisations to consider how they could positively contribute to the advancement of equality and good relations and requires equality considerations to be reflected in the design of policies and delivery of services.

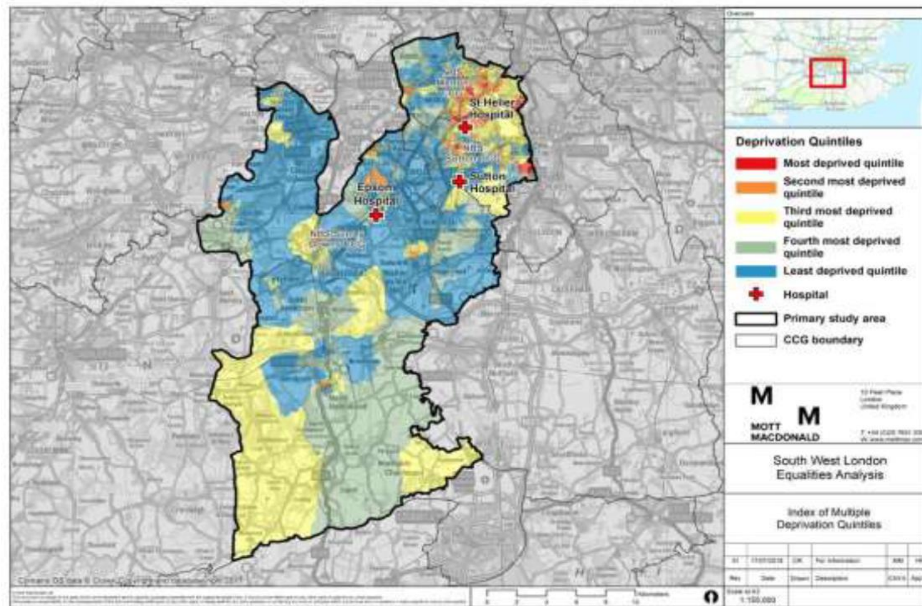
In this respect I find it surprising that the consultation document itself (p36) while acknowledging that health inequalities may be made worse by longer journey times, still

endorses these proposals. The case made is that improving non major services will have a bigger improving effect. My case is that the squeeze likely to be exerted on non-major services as a result of the high costs of centralising major services and any failure to achieve savings targets and to substitute for acute services through the planned expansion of out of hospital care will compound the negative impact of changes to major services.

In the PCBC itself very little coverage is provided to this issue in the light of its importance. It appears obvious to me that the geography dictates that more serious consideration should be given to locating services close to where the services are needed.

The diagram that makes it clearest appears in the initial equalities analysis in 2018 but not in the PCBC or interim draft impact assessment:

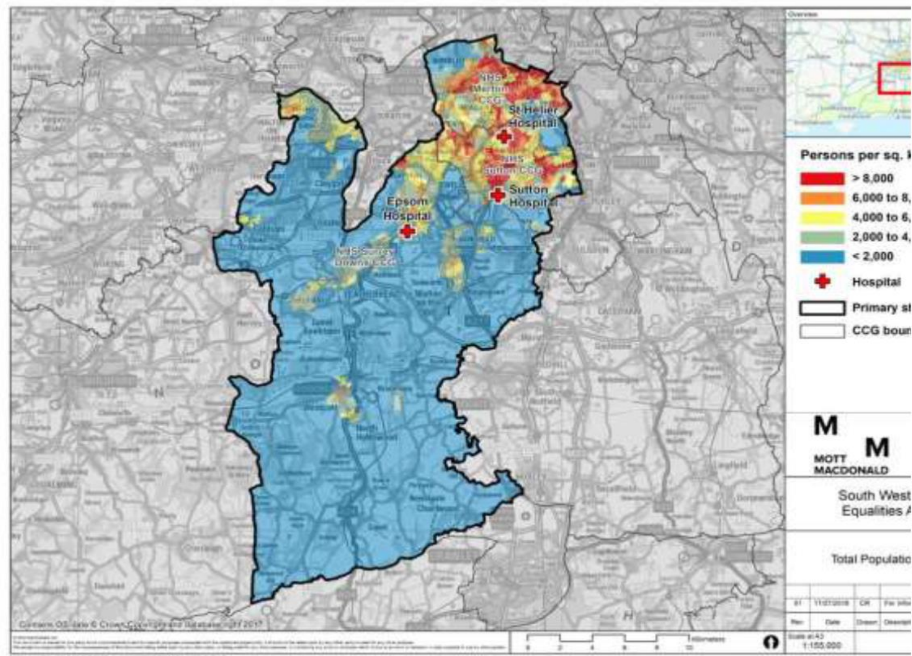
Figure 14: Overall deprivation quantiles for the study areas



Source: Mott MacDonald

This diagram coupled with the separate diagram on population density below speaks to the benefits of a two centre solution and the location of services close to St Helier:

Figure 2: Population density



Furthermore additional analysis conducted on the Lower Super Output Areas (the most deprived areas) in the Trust's catchment area copied by researchers for the local MP Siobhain McDonagh shows that:

- The more deprived the area the higher the reliance that area has on Epsom and St Helier's A&Es.
- Of the 51 most deprived parts of the Trust's catchment, just 1 is nearest to the Belmont/Sutton site. Meanwhile, 42 out of the 51 are nearest to St Helier Hospital.

6 Process Improvements

The Introduction touched on the problems with large scale reconfigurations and planning of controversial schemes. This has triggered the creation of comprehensive guidance for those promoting schemes, those assuring them and decision makers. I would add there is a comprehensive literature of where things have gone wrong in the past and is summed up in the following list of the reasons for errors in large scale projects, as summarised by King and Crewe [38].

- *Cultural Disconnect: The people behind some of the ideas didn't understand what they were talking about. They were on another planet culturally.*

[38] The Blunders of Our Governments by Anthony King and Ivor Crewe (2013)

- *Groupthink: The problems that arise when people become focused on doing something forgetting to ask whether it is the right thing to do.*
- *Intellectual Prejudices: These can act to rule out more obvious options.*
- *Operational Disconnect: Most focus is placed on this and the military example of nominating those responsible for planning with the responsibility for implementation is commended.*
- *Decision making in a hurry driven by panic, and the need for symbolic victories and political spin*

It doesn't take a great leap of imagination to see how these errors may have intruded in this case. Thus clinicians, eager for funding for a new hospital or expanded community services, may not appreciate that there are revenue costs and that for most people access to services is more important than creating the very best healthcare facilities.

It is clear that a group of clinical leaders have become convinced amongst themselves that a new Sutton site is the answer, even if the supporting arguments have changed over the years and remain weak. Obvious alternatives seem to have been dismissed out of hand.

In my view these risks should be acknowledged before decisions are taken.

The NHS in its current guidance[39]recommends tests of the proposals to try to avoid such risks. The five tests are:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- Clear, clinical evidence base
- Support for proposals from commissioners.
- Additional checks where significant bed closures are planned to :
    - demonstrate that sufficient alternative provision, such as increased GP or
      community services, is being put in place alongside or ahead of bed closures,
      and that the new workforce will be there to deliver it; and/or
    - show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or

[39] NHS England, *Planning, assuring and delivering service change for patients*, 2018, page 8

- where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time Programme).

In my view although the PCBC puts its case strongly in presenting its case for passing these tests on pages 305-308, it has in reality failed to persuade and engage the vast majority of the local population, with the numbers involved in the processes very small and in situations where lay interests are surrounded by health professionals. It would be very difficult to express opposition in these circumstances. Despite this there is ample evidence from Healthwatch, local scrutiny committees and from carers that there is a strong undercurrent of opposition.

In reality choice is limited because for the majority of people in the area there is no choice but to travel further for major services.

The clinical evidence has not focussed on the real issue of what lies at the root of staffing difficulties and whether the proposals represent a full and adequate solution.

The discussion of bed numbers is conducted in vague and general terms, focussing on a total figure that includes day only beds, maternity beds, "District" beds and community beds as well as the crucial numbers of acute beds. This appears to seek to avoid any focused discussion on what would be the near-halving of numbers of front line acute beds open overnight to just 386, and the significant reduction in numbers of downgraded beds at both Epsom and St Helier. Although local commissioners are said to be in favour it is not clear that GPs have been fully consulted, or explored the full details. Nor is it clear whether successor bodies will necessarily be bound by the decisions of the current committees, who are due to be merged shortly.

The checks requesting demonstration of evidence justifying reduction in bed numbers beds are not presented in detail to enable proper scrutiny. In fact some evidence cited actually says the opposite of the implied use[40].

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[40] Sixteen references are made to "Imison et al Insights from the clinical assurance of service reconfiguration in the NHS: the drivers of reconfiguration and the evidence that underpins it – a mixed-methods study. Health Services and Delivery Research, No. 3.9 "We could not find

It is not clear in reading the PCBC document whether it has actually received a letter of support from the Chief Financial Officer of NHS England as required.

A very large portion of the PCBC is devoted to a detailed description of the methodology and tests that have succeeded in reducing the options given serious analysis, and to denying consideration of the option many people would want of simply improving existing services. Broadly what is presented is a simplified multi criteria analysis which attempts to reduce the acknowledged complexities of the decision involving multiple stakeholders to a quantified scoring system.

Although it attempts to present a rational mask, such methodologies are only as good as the base data. In this case it is based on small numbers of people who may or may not be representative of local communities and service users, and who have either established criteria or success factors, or scored options. It is not clear that invitees and participants were well briefed or can be relied upon to reflect public opinion, views of staff, carers or the range of stakeholders.

They may indeed have given too much attention to the views of senior clinical staff in arriving at conclusions. The level of openness and transparency does not extend to explaining clearly why a do minimum option, or options retaining either of the existing hospital plus the other as a district hospital have not been examined more fully as cheaper options to the one recommended. As described by HM Treasury, only 'gold plated 'options have been examined.

The summary analysis fails to present a complete net position for the NHS and public sector as a whole and merely looks at the local position for the Trust.

The financial analysis seems contrived to demonstrate the affordability of the three chosen options. Estimated costs of the new hospital are not substantiated with any supporting detail. However given the rapid increase in the estimated cost of rebuilding the William Harvey Hospital in Ashford – from £160m in November 2017 to £351m now[41],

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evidence that service reconfiguration would save significant amounts of money. There is also little evidence to help hospitals find ways of overcoming their staffing difficulties."

[41] https://www.hsj.co.uk/finance-and-efficiency/cost-of-hospital-building-project-doubles-in-18-months/7026896.article

and similar large and rapid increases in the costing of previous plans for Epsom & St Helier, there must be doubts over the reliability of these estimates.

It appears that although the NHS submitted draft proposals to scrutiny committees and other stakeholders, decisions were made to proceed to public consultation despite expressed reservations on the data presented and the processes undertaken.

The analysis is presented as objective, summarising rankings on both financial grounds and non-financial grounds. It does not attempt to differentiate the differing views of stakeholders or to identify additional areas for investigation or analysis to be undertaken prior to the Decision Making Business Case being presented. At present neither risk nor the level of uncertainty involved in the decision have been quantified, although some unquantified sensitivity analysis is presented which does not change the ranking of the options.

As it stands therefore there is a risk that CCGs will proceed quickly to DMBC and will attempt to assert that the Sutton option is the dominant option for which further discussion is pointless. But this would be to miss an opportunity to properly reflect on the results contained in the process so far.

Section 7.6 of the Manual on Multi Criteria analysis referenced earlier (see footnote 8) attempts to illustrate how the methodology might be used more positively.

In their words (pps 109-11), analysis very early in the life of the project *'can guide the search for further information '.*

The first attempt at modelling will highlight many inadequacies, in identifying and defining options and criteria, in the provision of data, in the inability to agree scores, and in judgements of trade-offs. At this point, the newcomer to Multi Criteria Decision Analysis (MCDA) may become discouraged, but, take heart, this is a good sign, for it identifies areas where further work is required. Thus, the MCDA modelling process provides an agenda for systematically tackling difficult issues, and shows which issues are important because their resolution could affect the overall result.

…the process should be an open consultative process

…the analysis reveals the value judgements that are a necessary part of any informed decision, so the social process must allow for the open expression of those views in the appropriate forum.

…it is an iterative fashion. There is no need to get every input to the model correct on the first go.

… Subject vague inputs to sensitivity analyses, and find which inputs really matter to the overall results.

… Leave time to explore the model fully. The model is a 'divide and conquer' strategy in the sense that a complex issue is subdivided into parts that are easier to deal with separately,

… Creating different displays, changing scores to explore disagreements, doing sensitivity analyses on weights, all these help participants to gain a better qualitative feel for the issues. That leads to increased confidence in taking a decision.

People make decisions, not models. … models can assist people in making decisions, but the assistance can take many different forms: providing structure to debates, ensuring quality conversations,

documenting the process of analysing the decision, separating matters of fact from matters of judgement, making value judgements explicit, bringing judgements about trade-offs between conflicting objectives to the attention of decision makers, creating shared understanding about the issues, generating a sense of common purpose, and, often, gaining agreement about the way forward.

…there is no theory of objective decision making, decision making is necessarily a human function.

…The methods covered in this manual draw on decades of psychological research showing how it is possible to elicit from people judgements that are precise, reliable and accurate…and highlights the key value judgements, providing realistic freedom of choice, within bounds, for the decision maker.

Taken in the right spirit therefore the analysis and work done so far can be used positively to better isolate where more work is required so that information on the issues can be better presented to decision makers and stakeholders to clarify for them the trade-offs that may be necessary in making final decisions.

In the event of disagreements the Local authority can however ask for reconfiguration proposals to be referred to the Secretary of State, which by precedent involves referral to the Independent Reconfiguration Panel. This often leads to delays and requests for adjustment to plans.

In addition there is a history of independent legal challenges through requests for judicial review.

In my direct experience these are successful more often than the NHS expects. The NHS falls foul of rushed decision making, failure to present its case following guidance and failing to convince a significant number of key stakeholders. On occasion they have acted ultra vires (outside their legal powers) and often the NHS agrees to go back and resubmit plans more properly and with significant changes. The Independent Reconfiguration Panel publishes reports and periodic reviews detailing the many changes that have taken place as a result of local challenges to decisions.

As outlined in the introduction grounds for referral are:

• The consultation has been inadequate in relation to the content or the amount of time allowed.

• The NHS body has given inadequate reasons where it has not consulted for reasons of urgency relating to the safety or welfare of patients or staff.

• A proposal would not be in the interests of the health service in its area.

In the final analysis the local authority and others will take account of the following legal issues:

Reasonableness

It is accepted that the threshold for intervention by the Courts should be high. In the normal course of events CCG Boards and Public Authorities can be trusted to work within their powers such that when questions of major importance come to be discussed and decisions made, there is an assumption, made reasonably, that arguments take place at the decision making forum within a reasonable range, where guidance has been followed and due process observed.

In this case however there seems to be a misunderstanding of the powers and responsibilities of the CCGs in respect of the PCBC. The IHT programme appear to think that decisions binding their consideration of options have already been made, that the requirement to follow guidance is not obligatory; that errors in either completeness, accuracy or in relation to the range of strategic options that should be considered cannot be corrected, and that the duty to complete due diligence does not fall on them but others; and that it is a waste of time to delay.

An argument could be made therefore that there is unreasonable behaviour.

Vires

The powers of the CCGs are not untrammelled and their general powers do not excuse them from following guidance in relation to investment decisions. In particular in the context of the forthcoming abolition of CCGs and the creation of two separate Integrated Care Systems covering the area considered, it appears that existing office holders are looking to bind the hands and pre-empt the powers of those that will succeed them. This appears controversial as an outside observer and could be challenged.

Pre-judgement

By doggedly pursuing reconfiguration as a goal prior to the presentation of a business case and securing the necessary resources the CCG's could be prejudging whether in the

particular circumstances applying in the locality this makes strategic or operational sense given the costs and risks involved.

Bias and conflicts of interest

Without pointing fingers there are risks that in decisions of this nature that bias and vested interests will fail to be fully recognised and allowed for. Both GPs and consultants working in hospitals make high earnings from the NHS, directly (contractually for GPs) and indirectly (private practice), which can be significantly affected by decisions to reconfigure services.

This makes it more important that proposals are subjected to high levels of detailed scrutiny and that conflicts of interest are fully disclosed.

Proportionality

It is very often the case that the pro-reconfiguration lobby is able to expend very considerable resources on what is in effect propaganda in pursuit of their aim.

By contrast the resources available to read, digest, and understand and then to challenge the case put are tiny and the opportunities to make an effective intervention scarce.

So much so that the Institute for Government has in a recent publication[42] recommended the French approach for large contentious public infrastructure schemes:

"The French Commission Nationale du Débat Public (CNDP) provides a particularly good model for how this can work in practice. The CNDP was founded in the late 1980s in a similar context to that facing the UK now: declining central state power and well organised local opposition to strategically important rail projects. In response, the French Government set up the CNDP to ensure 'public participation in the decision making processes of major infrastructure projects of national interest that present important socio-economic stakes'.

To do this, the CNDP hosts local public debates on contentious major projects as early as possible in their development. All participants – for or against a project – are given equal resources to make their cases. The CNDP then summarises these views in a report, to which project sponsors must respond.

The CNDP has no ability to enforce recommendations; but most project sponsors act on them. Of the 61 projects on which the CNDP facilitated debates between 2002 and 2012, 38 made modifications, including 25 that changed their plans based on options that emerged from the public debate (see Figure 2).

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[42] How to transform infrastructure decision making in the UK. Institute of Government February 2018

French project sponsors have come to view the CNDP process as a valuable exercise in public engagement and data collection, rather than as a burden or threat."

The principle that there should be a more open debate, where each side of the debate can be properly represented and resourced seems to me a good one that should be applied to the NHS in decisions of this nature, where the scale of the commitment is so large and the consequences will be so long lasting.

7. Conclusions and the Way forward

In this briefing I have considered the arguments in favour of the proposals.

My conclusions in respect of the main categories of argument are:

Clinical:

7.1 The objectives being pursued, of defining the best healthcare as compliance with "London" clinical quality standards are unrealistic and restrictive. The CCGs also prejudge the issue of reconfiguration and whether this is really the answer to London's problems or more particularly the clinical issues in Merton, Sutton and Surrey Downs.

7.2 The preferred option is promoted without properly discussing the potential benefits of other more modest, realistic options.

7.3 There is a major risk that plans will not adequately provide for the increased demand expected in future years and that assumptions that major reductions in beds can be achieved will not be borne out in reality. This has been the case over the last twenty years. Various assumptions that the development of out of hospital care could substitute for hospital beds have remained unproven to the extent claimed. NB Better Healthcare Closer to Home (BHCH) claimed in 2003 up to 50% cuts in activity were possible.

7.4 There is a further major risk that the solution promoted to overcome current staffing problems will not succeed, and that the national and London wide staffing issues will transfer into the new improved premises – or be displaced to elsewhere in SW London.

7.5 There is a real risk that by offering the opportunity for further sub-specialisation (see Impact assessment) and the development of specialised services at Sutton that the focus of services will shift towards the interests of clinicians and not the interests of patients needing generalist services and skills.

7.6 There is a prima facie case that the proposed reductions in A&E catchment areas incorporated in plans for the preferred option (16%), reductions in consultant staff available

(69wte), middle ranking and junior medical staff (73wte), qualified nurses (33%) and in access to major acute beds (452 beds) are not in the interests of local health services.

Financial/Economic

7.7 The options appraisal does not offer a proper consideration of lower cost options, including Business as Usual (BAU), a do –minimum option and retention of just the two existing sites, with either one as the centralised facility.

7.8 The benefits of the 3-site "centralised" option appear mis-stated and misleading. Further scrutiny and assurance is required. It appears costs are merely being shifted to other trusts in SW London who will face the additional operational costs and problems of the shift in patient flows being directed away from St Helier and Epsom sites.

7.9 Claims that the resulting three site configuration will be cheaper, more efficient and will solve staffing problems appear unrealistic and overoptimistic.

7.10 The risks of the proposals have not been quantified in the financial analysis

7.11 There is a significant risk that cost overruns in the main project at Sutton would "crowd out" the viability and investment funds available at the other sites and resources available to invest in out of hospital services

Access

7.12 The proposed preferred option is worse than BAU or any option retaining services at two sites. It is significantly worse for those relying on public transport and in deprived groups.

7.13The weighting given to access issues and transport issues appears small in the overall weighting in the Multi criteria analysis.

7.14 LB Merton may wish to consider undertaking its own research on the importance of access to services for local people.

Process

7.15 The public consultation seems to have been initiated too soon before issues relating to the options considered and the impact assessment were fully understood and agreed.

7.16 Important information on assurance and on the supporting detail to the proposals is missing at time of public consultation.

7.17 There is still time for shortfalls in the process to be corrected but it is unlikely that the flaws in the process will be corrected in the absence of a fuller, balanced, and detailed evaluation and discussion.

7.18 There is a major risk that the NHS will proceed to DMBC with the proposals substantially the same without any further opportunity for stakeholders to be consulted and to influence the decision.

The final question of why the local NHS seems so keen on these proposals to build a new hospital at Sutton remains hanging in the air. Various arguments have come to the fore at various times;

- either beds were not needed and there was an opportunity to save money as patients transferred to services in the community;
- or that patients would die and existing services were unsafe ;
- or that the buildings were falling down and were incapable of being refurbished;
- or, more recently that staff were impossible to recruit.

None of these arguments have been or are convincing.

Recommendations

Discussions with stakeholders have in the limited time available confirmed modified and crystallized my findings and have enabled me to propose the following recommendations:

Recommendation 1: LB Merton should formally express its opposition to the PCBC as drafted.

Recommendation 2: LB Merton should call for further work on lower capital cost options for services on two sites not three.

Recommendation 3: The NHS should seek additional trainees, rota changes and incentives to staff to improve recruitment and retention.

Recommendation 4: The local Health and Wellbeing Board should reappraise the longer term priorities and the need for additional savings in the light of the government's stated intentions to respond to disquiet on the funding of the NHS and the current crisis which has exposed the lack of capacity within the NHS.

Way Forward

In line with the final recommendation above the clear way forward is to jointly reappraise plans across the new planning boundaries, to pool resources and look again at priorities.

It is clear to me that the results of such a process are unlikely to result in the reduction of major acute services at this time.

The priority for investment should be increasing the staffing capacity and additional acute and intensive care capacity; not their reduction. In addition the existence of two A&E departments is likely to be a more resilient solution than one.

My advice would be to not rush to make decisions on irrevocable long term reconfigurations before there are a better understanding, better plans, a broader range of options examined and more confidence amongst stakeholders that plans can be achieved without excessive risks and that makes the best use of resources, both existing and future investment .

Roger Steer 22.03.2020

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