1. Risk of Failure

The implementation of the STP is a major project whose success or failure will be central to the health and wellbeing of over 2,000,000 residents in North West London.

As with all large projects the potential for failure increases in relation to the project's complexity. A further concern is the extremely tight timescale for the project's delivery.
This is compounded by the risk that existing hospital based provision will be discontinued before replacement community based facilities have become established and with an inadequate period of 'parallel running'.

A further, and significant, concern is that the STP will not be delivered by a dedicated and accountable management structure. Instead the existing fragmented local and national NHS structures will be used, along with those responsible for local government social services. It is difficult to find an appropriate analogy for such a management structure – perhaps that of a parish fete is relevant.

To summarise, an extremely wide ranging and challenging project is being proposed in an extremely tight timescale, and in the absence of an accountable management structure.

In these circumstances the risks of failure, to some degree, must be high.

NW London Response

We have been consistently clear about the scale of the challenge we face in NW London, however the progress we have made in developing an ambitious but realistic plan, and the depth of commitment shown by both local government and health colleagues reflects the desire to get this done.

Any programme involving multiple independent organisations needs an appropriate governance structure where the individual parties can be held to account and this is set out in Section 5.5 of the Management Case of the SOC

2. **Need for 'bottom-up', rather than 'top-down' design process**

The published versions of the STP and ImBC-SOC1 appear to be based on 'top down' high level assumptions, rather than on 'bottom up' detailed analyses based on patient data etc.

Only by preparing and using detailed 'bottom up' analyses, which can be reconciled back to patient data, can one be certain that projections are robust.

It has not been possible to locate detailed supporting analyses in the STP or the ImBC-SOC1.

The absence of detailed supporting analyses is particularly disappointing as SaHF was first published in the summer of 2012. One would have hoped that the intervening four and a half years would have provided ample time to prepare comprehensive supporting detailed analyses.

There are some indications in the text that detailed plans and analyses will only be prepared after the summary 'top-down' ones have been approved. This approach poses the threat that any errors which subsequently emerge in the 'top down' plans will have to be 'lived with' as there won't be any additional funds to rectify them.

The apparent absence of these supporting analyses must add to the risk that it will not be possible to implement the proposed changes on a comprehensive and timely basis.

NW London response

The top down approach follows the recommendations for a Strategic Outline Case as a detailed 'bottom up' costing exercise would need to be based on a specific set of assumptions, which can only be finalised during the procurement phase of the programme. Detailed plans at this stage would also require expenditure on professional advisors to draw up those plans.

The SOC includes the recommended allowances for capital cost inflation and planning uncertainty

In addition Sections 2.7 of the Economic case and 3.9 of the Financial case of the SOC1 document includes the sensitivity analysis that demonstrates the resilience of the preferred option to changes in key assumptions should the actual experience be different to that projected.

3. Need for up-to-date Detailed Supporting Analyses of current and proposed activities on the Ealing Hospital site

There continues to be a lack of a "before and after" analysis of activities and patient volumes of the healthcare delivered on the Ealing Hospital site.

Table 8 on pages 59 and 60 of the Strategic Case section of SOC1 should be expanded to include a third column showing the services currently being provided at Ealing Hospital and where they will be relocated.

There should be a similar table showing current patient activity volumes by medical speciality at Ealing Hospital, with an accompanying analysis containing columns showing for each speciality where and how these patient episodes, both in-patient and out-patient, will be treated in the future, e.g. at other acute hospitals, Hubs, GP Surgeries, etc.

These workings should include the following:

Firstly quantify existing activity levels. XXXX
These should then be uplifted by the following in order to arrive at the activity level in, say, ten years time.
Uplift factors should include:

- Ageing Population XXX
- Population increases (new homes etc.) XXX
- Deteriorating public health of 40-60 year olds XXX
- Etc. XXX

This will result in an activity subtotal XXXX

This should then be reduced by the projected 'efficiency savings' including:

- Reduced Hospital Admissions (XXX)
- Reduced duration of the residual Hospital Admissions (XXX)
- Reduced GP attendances (XXX)
- Etc. (XXX)

This will result in a residual activity subtotal XXXX

The above is just an indication of the factors which will need to be considered. Further adjustments will be necessary to reflect:

- The 2.9 day longer stay by in-patients when they have been admitted to a hospital which is outside their home CCG boundary – see note at bottom of page 27 of October 2016 version of STP. The proposed closure of all acute wards at Ealing Hospital will mean that all Ealing residents requiring this care will need to be accommodated in out-of-borough hospitals with the associated additional 2.9 days of stay.

- Initial enquiries suggest that the high level STP projections have been based on a 100% bed occupancy. Health professionals suggest that an 85% occupancy is the maximum which it is safe to achieve on a sustained basis. It may therefore be necessary to rework the projections at an 85% occupancy.

NW London Response

The Ealing Local Hospital service model, as set out in the DMBC, consisted of an Urgent Care Centre, an outpatients department, outpatient paediatrics, ante and postnatal care and a limited range of diagnostics (X-ray and ultrasound). In keeping with the Secretary of State's explicit request, Ealing and Charing Cross Hospitals will continue to offer an A&E service although it may be in a different shape or size from that currently offered, and will be developed using guidelines from the Keogh review. We have built on this core set of services to develop more comprehensive proposals for the clinical model for the site, which have been informed by clinical design and feedback from stakeholder engagement. These proposals, and their associated equalities impacts, are part of an ongoing process of design that will continue with local clinicians and residents as we develop the OBC.

Proposed service model							
Service			Now	DMBC (core)	DMBC Alt Proposal	Guided Tour	Proposed
Core and Enhanced Primary Care	GP and nurse appointments Non Trust staff	GP practice(s) Nurse appointments Core GP services	N	N	Y	Y	Y
	High risk patients Non Trust staff	Long-term care co-ordinators	N	N	Y	Y	Y
Rental	Enhanced Primary Care Non Trust staff	Enhanced primary care services and community services	N	N	Y	Y	Y
	Other	Evening and weekend GP services	N	N	Y	Y	Y
Community and hospital	Therapies	Physiotherapy	Y	N	Y	Y	Y
		S&LT	Y	N	Y	Y	Y
		Occupational Therapy	Y	N	Y	Y	Y
		Dieticians	Y	N	Y	Y	Y
		Podiatry	Y	N	Y	Y	Y
		Audiology	Y	N	Y	Y	Y

	Diagnostics	X-Ray	Y	Y	Y	Y	Y
		Ultra-sound (incl. echo)	Y	Y	Y	Y	Y
		CT scanning	Y	N	Y	Y	Y
		MRI scanning	Y	N	Y	Y	Y
		ECG (incl. stress)	Y	N	Y	Y	Y
	Beds	Elective / non-elective inpatient beds	Y	N	Y	Y	Y
		Day case/ assessment centre	Y	N	Y	Y	N
		Palliative care beds (Meadow House)	Y	N	Y	N	Y
		Paediatric inpatient	Y	N	N	N	N
		Frailty (incl. assessment/day care)	N	N	Y	Y	Y
	Ealing Local Hospital	Major A&E	Y	N	N	N	N
		Local A&E	N	N	N	Y	Y
	Outpatients / Access to specialist opinion	Urgent care centre	Y	Y	Y	Y	Y
		• Minor illness	Y	Y	Y	Y	Y
		• Minor injury	Y	Y	Y	Y	Y
		Mental health liaison (non-Trust staff	Y	N	Y	Y	Y
		Endoscopy	Y	N	Y	N	N
		Near patient testing (i.e. phlebotomy or pathology lab)	Y	N	Y	Y	Y
		Ambulatory care (to include frail elderly and medical day unit)	Y	N	Y	Y	Y
		Paediatric day care /rapid access clinic	Y	N	N	N	Y
		• Cardiology • Dermatology • Diabetes centre of excellence • ENT • Geriatric medicine • Gastroenterology and colorectal • Gynaecology • General Medicine • General surgery • Haematology • Infectious diseases including tuberculosis and hepatitis • Clinical oncology • Anti-coagulant • Trauma and orthopaedics	Y	Y	Y	Y	Y

		• Paediatric outpatients • Oral surgery • Neurology • Respiratory • Rheumatology • Sexual health • Urology • Vascular • HIV					
	Maternity	Ante and post natal	Y	Y	Y	N	Y
	Specialist	Renal (provided by Imperial)	Y	N	Y	Y	Y
		Chemotherapy (provided by the trust)	N	N	Y	Y	Y
		Ophthalmology (provided by Moorfields)	Y	Y	Y	Y	Y
		Breast screening (provided by Imperial)	Y	Y	Y	Y	Y
Mental Health	Mental Health non-trust staff	MH outpatients	N	N	N	Y	Y
Other	Based for field teams and meeting space	Base for mental health and social care field teams to support integrated working and assessment	N	N	Y	Y	Y

Additional references

	Service	Now	DMBC (core)	DMBC Alt Proposal	Guided Tour	Proposed	Comments
Additional references	Hospital and community pharmacy (medicines management	N	N	Y	Y	Y	Retail pharmacy remains on site
	Education and research /	Y	N	Y	Y	Y	Covered in community and civic zone on site
	21st century care academy	N	N	N	Y	Y	Covered in community and civic zone on site
	Mental health inpatients	N	N	N	N	N	St Bernards retained
	ICU / ITU / HDU	Y	N	N	N	N	
	Elective surgery	Y	N	N	N	N	
	Inpatient paediatrics	N	N	N	N	N	
	Obstetrics and maternity unit	N	N	N	N	N	

The changes in Out of Hospital care set out in Section 1.3 of the Strategic case will address the needs of all patients, including those admitted to a hospital outside their CCG boundary

4. **Need for evidence that the "efficiency" proposals can be scaled up to deliver the desired savings**

A number of "efficiency" measures are proposed to reduce in-patient admissions and out-patient GP attendances.

These reductions need to be quantified by medical speciality and mode of provision.

Page 11 of the October STP refers to, *"scaling up models that we know have been successful in individual boroughs"*. Unfortunately, no details have been provided of these models, their outcomes and the scaling up envisaged. This lack of specific and comprehensive attribution is disturbing.

There therefore needs to be robust evidence that the proposed "efficiency" reductions can be delivered on the scale envisaged in the STP and ImBC-SOC1.

It is a common experience that multiple difficulties can be encountered when attempting to scale- up small scale efficiency pilots. There is therefore a high risk that the aspiration that healthcare can be delivered with reduced per capita resources will remain unfulfilled.

NW London Response

The evidence supporting the planned reduction in admissions and attendances are summarised in section 1.4 of the Strategic case.

Further updates will be included in the Outline Business cases

5. Divergences from Shaping a Healthier Future (SaHF)

There appear to be significant divergences in both the STP and the ImBC-SOC1 from the approved version of the 2013 SaHF. These divergences need to be documented and explained in an appendix to both the STP and ImBC-SOC1.

Two immediately identifiable matters are:

The reduction in the approved number of Out-of-Hospital Hubs in Ealing from 6 or 8 to just 3:

And the apparent reversal of the decision to retain an A&E on the Ealing Hospital site - as set out in the Secretary of State's statement of 30th November 2013.

NW London response

There hasn't been a divergence between the 2013 proposals and the STP/ImBC-SOC1

The 6 and 8 figures you refer to from the original decision making business case reflect both out of hospital hubs and health centres. The figure '3' in the ImBC-SOC1 refers specifically to out of hospital hubs in Ealing and reflects the investment needed in them.

There has been no reversal of the Secretary of State's 2013 decision. He was clear that Ealing needs to have an A&E but that it should be appropriate for a local hospital.

6. **Inadequate consideration of patient access and public transport connectivity to post reconfiguration facilities**

SOC1 appears to be totally silent as to how patients, their carers, families and friends will access the proposed reconfigured healthcare.

Public transport bus route connectivity will be key to the successful implementation of the proposed reconfiguration changes.

Patients living in the greater Southall area will be particularly affected following the withdrawal of services at Ealing Hospital. Travel from their homes to the following hospitals will often involve three buses: Northwick Park, Central Middlesex, West Middlesex, and Hillingdon.

The public transport implications of the proposed hospital changes and hubs need to be considered in detail at this key stage in the reconfiguration journey.

Their omission is inexcusable and unacceptable to justify, given the four and a half years which have passed since the initial SaHF proposals were published in the summer of 2012. There has been plenty of time to address this key issue.

NW London Response:

The SoC is a specific capital case so does not include other important issues like transport, which were included in the DMBC and will be further analysed in detail during:

- Further patient engagement during 2017
- The next Equality Impact Assessments
- At OBC stage

It is important to remember that the vast majority of Ealing patients - somewhere in the region of 80-90% - will still be treated at Ealing

7. Deprivation

Pages 23 to 25 of the Strategic Chapter of the draft SOC1 identify unacceptable variations in the quality and delivery of services.

There is a significant positive correlation between these areas of above average health need and the areas of high deprivation shown on the map attached in Section 23.

It therefore seems perverse that the previous proposals for Out-of-Hospital Hubs in Southall and Northolt, both areas of high deprivation and health need, appear to have been deleted.

NW London Response

The methodology for assessing hubs is now in appendix H (Out of Hospital option review) in the SOC public release 06 December 2016.

8. Lack of clarity and accountability over the organisational structures

There needs to be greater clarity and ownership over the organisational structures which will be responsible for implementation and operating the proposed reconfiguration.

The reconfiguration is represented as an integrated pathway with seamless transitions. Yet, at the same time, there appears to be a pronounced lack of overarching accountability.

The success of the reconfiguration appears to depend on the goodwill of a diverse grouping of independent health and social care organisations – all of which are suffering from intense budget pressures.

NW London response

There is a clear governance structure set out in the STP which will help us deliver this programme.

9. Consultation, Engagement and Governance

We are concerned at the token nature of the consultation and engagement which has taken place on the STP and the non-existent public consultation over the ImBC-SOC1.

Given the tens of thousands of patients, carers, family and friends who use Ealing Hospital on an annual basis, we believe that a very large number of these key stakeholders must be consulted over the implementation proposals for the reconfiguration of the services currently delivered on the Ealing Hospital site.

There also appears to be a significant absence of robust, rather than token, democratic and patient oversight over the implementation and day-to-day operation of the proposed reconfiguration. This will be of increased concern if the delivery of key aspects of the reconfiguration is let on long term contracts shrouded in 'commercial confidentiality'.

NW London Response

There was a full public consultation on the Shaping a Healthier Future Proposals (SaHF) in 2012. We are currently developing a full engagement strategy, with input from yourself and the local authority amongst others, to shape the programme of events, materials and messaging, as we did with the engagement around the plans for moving both maternity and inpatient paediatric services from Ealing Hospital in line with the JCPCT decision.

10. Economic and Financial Methodologies

It is difficult to understand the economic and financial NHS methodologies used in the SOC1 without a briefing on these methodologies. A briefing should be provided on the methodologies as part of the consultation/engagement when the document is published. This briefing needs to include reconciliation as to how projected patient volumes link into the economic and financial methodologies used in the SOC1 monetary projections.

NW London Response

Briefings on methodologies will be provided as part of the on-going engagement in 2017. More detailed reconciliation data (as to how projected patient volumes link into the economic and financial methodologies used in the SOC1 monetary projections) will be provided at Outline Business Case stage.

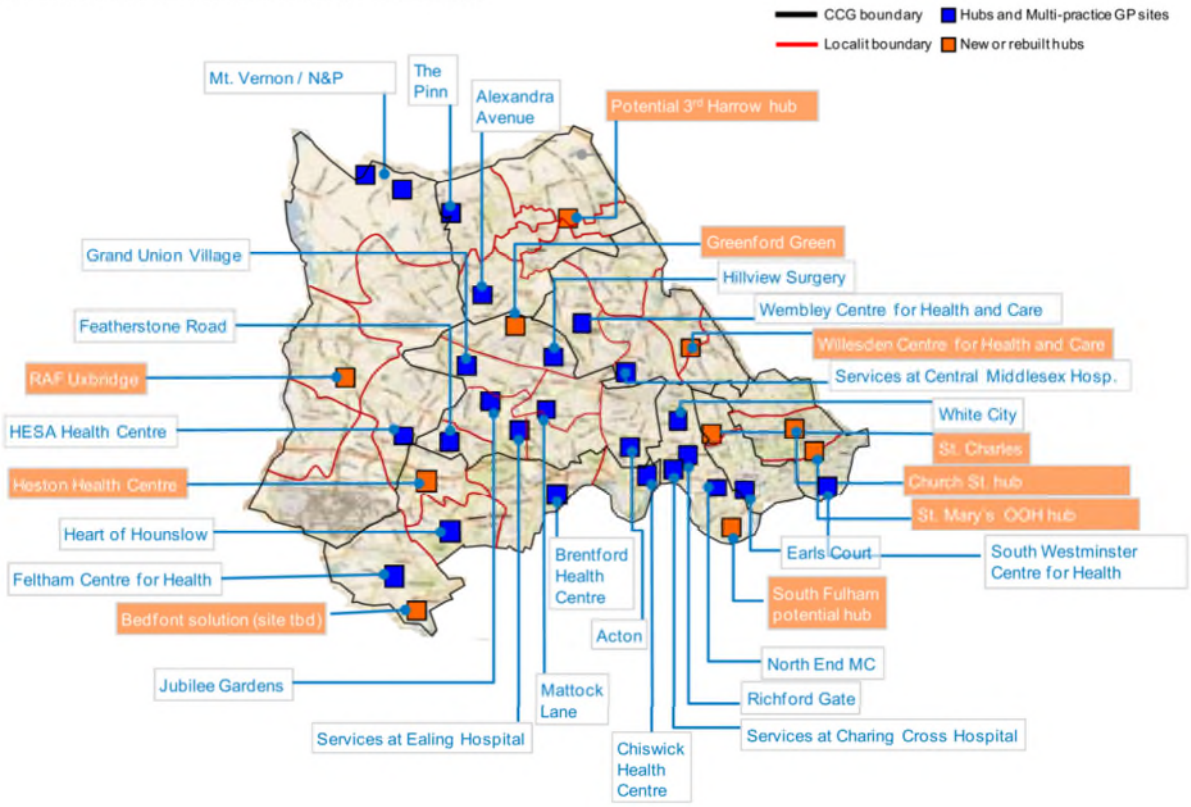
11. Out of Hospital Hubs

Page 36 of the October STP states that *"Hubs . . . are critical in enabling the reconfiguration of acute services"*. Page 34 of the Strategic Chapter of SOC1 states that *"Out of hospital hubs are key to the delivery of our model of care".*

The February 2013 edition of the Decision Making Business Case (DMBC) contains the following two maps of the proposed Hub locations in LB Ealing.

The first map is from page 246 of the DMBC and shows eight Hubs in LB Ealing.

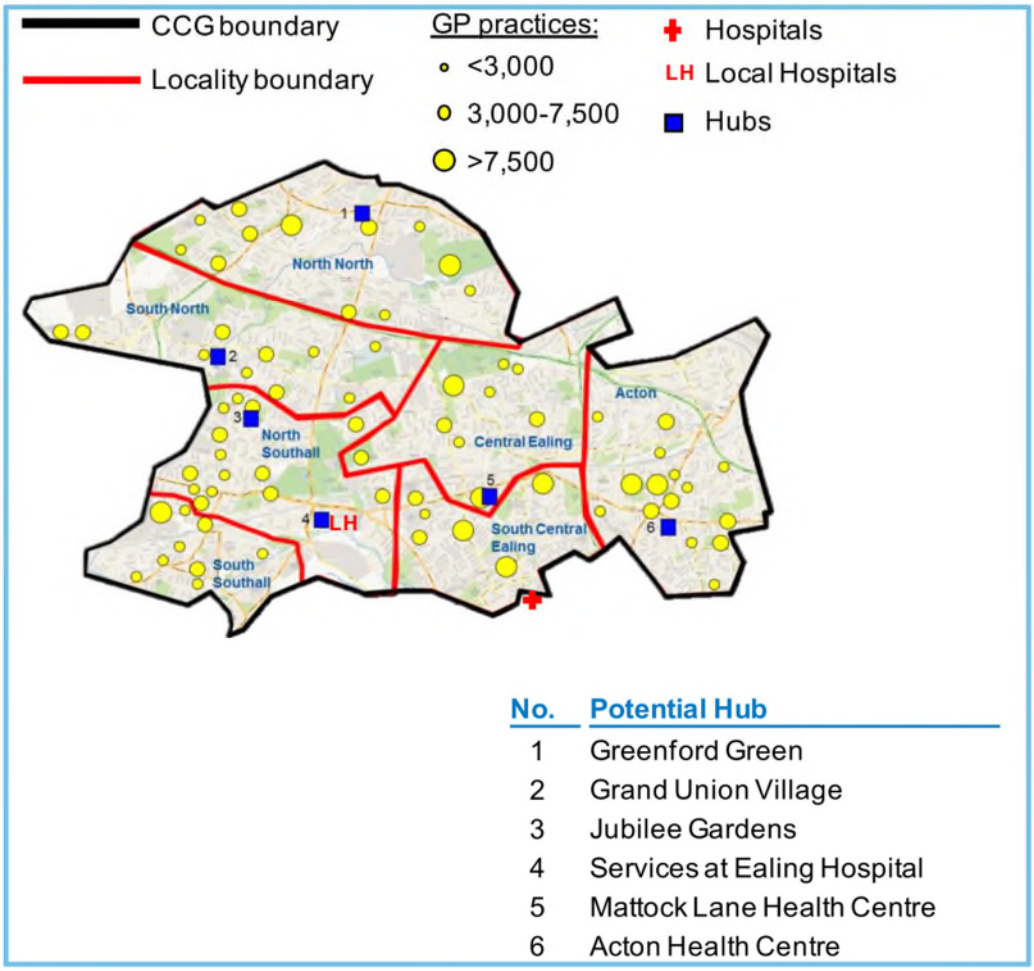
Figure 8.17: Potential hubs/health centres across NW London[3]



The above map shows the original intention of a high density of post reconfiguration Hubs across the LB Ealing. This would have been consistent with Ealing loosing key facilities from its only in-borough hospital,

The second map is from page 622 of the DMBC and shows six Hubs in LB Ealing.

Figure 16.10: Ealing out of hospital networks and hubs/health centres



No.	Potential Hub
1	Greenford Green
2	Grand Union Village
3	Jubilee Gardens
4	Services at Ealing Hospital
5	Mattock Lane Health Centre
6	Acton Health Centre

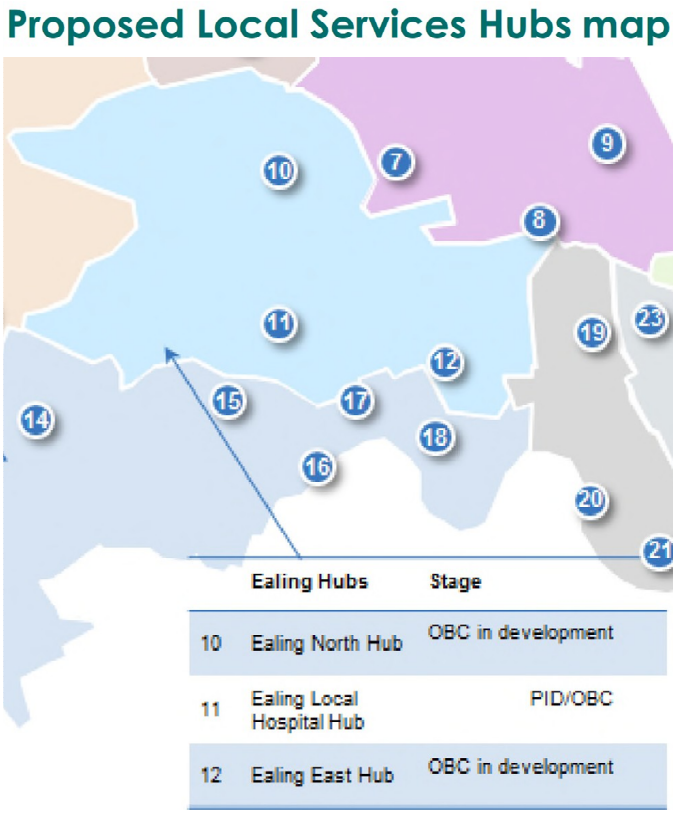
The first map, with eight hubs, locates three of them in the areas of above average deprivation and health need in the west of LB Ealing, i.e. at Grand Union Village, Jubilee Gardens and Featherstone Road.

The second map, with six Hubs, locates two of them in the areas of above average deprivation and health need in the west of the Borough, i.e. at Grand Union Village and Jubilee Gardens.

It is therefore a matter of concern that these Hubs, which were destined for locations of high deprivation and health need have been deleted from the latest proposals contained in the STP and the ImBC-SOC1.

The following extract from the map on page 38 of the October 2016 STP shows a total of only three Hubs in the LB of Ealing, with none in the area of high deprivation and health need along the western edge of the Borough.

October 2017 STP – Only Three Hubs in Ealing



It is difficult to understand why key Hub locations in Ealing which were previously considered essential to the clinical delivery of the SaHF reconfiguration are now no longer required.

It is also difficult to understand how one of the most populous and geographically largest boroughs in London, with high levels of deprivation and health need, can be adequately served by only three Hubs – especially if the creation of Hubs is considered *"critical in enabling the reconfiguration of acute care"* and "*key to the delivery of our model of care*". The reduced number of Hubs is even more perverse as Ealing is losing its only in-borough Acute Hospital.

These concerns are exacerbated by the comparative position with neighbouring boroughs which are both retaining their Acute Hospitals and also retaining a greater number of Hubs per patient.

Appendix 8 to the IMBC-SOC1 includes an estates driven methodology which seems to suggest that Hub locations should only be made available where NHS premises currently exist. A questionable approach which ignores the medical needs of the local community.

NW London response

The methodology for assessing hubs is now in appendix H (Out of Hospital option review) in the SOC public release 06 December 2016.

12. GP Role and Provision

The premise behind the STP is that there will be seismic shift in care from hospital to community care.

There therefore needs to be more detail in the SOC1 about the future operation of GP services and the proposed investment in GP facilities.

NW London Response

SOC Part 1 includes an estimate for the required investment. Further detail will be available as each CCG develops individual business cases

13. Reduced Acute Hospital Admissions

We are unable to locate an analysis which shows, hospital by hospital, existing and projected future acute admissions.

This should include the number of admissions and their duration – with accompanying analysis columns which explain reductions from current activity levels. we note that a 30 percent reduction in acute attendances is referred to in the SOC1.

This analysis should reconcile to the economic and financial projections contained in the SOC1.

NW London Response

See financial case – tables 23 and 24 which show activity by site (before and after SaHF) by POD.

Table 23: Outer Trusts (total activity)

WESTMID	Activity Mar-2016	Activity Mar-2026	% change
Elective	14,208	29,937	**111%**
Non elective	28,640	30,544	**7%**
Outpatient	196,403	208,998	**6%**
A&E	58,870	78,315	**33%**
LNWHT	**Activity Mar-2016**	**Activity Mar-2026**	**% change**
Elective	71,970	68,446	**-5%**
Non elective	69,453	44,396	**-36%**
Outpatient	549,272	544,663	**-1%**
A&E	132,352	116,122	**-12%**
THH	**Activity Mar-2016**	**Activity Mar-2026**	**% change**
Elective	26,231	32,426	**24%**
Non elective	31,273	27,936	**-11%**
Outpatient	341,749	347,263	**2%**
A&E	84,661	89,651	**6%**
TOTAL	**Activity Mar-2016**	**Activity Mar-2026**	**% change**
Elective	**112,409**	**130,810**	**16%**
Non elective	**129,366**	**102,876**	**-20%**
Outpatient	**1,087,424**	**1,100,923**	**1%**
A&E	**275,883**	**284,089**	**3%**

Table 24: Reconfiguration Activity flows

14. Reduced duration (Length of Stay) of Acute Hospital Admissions

Further information and detailed supporting analyses are needed to substantiate the 'high level' assumption that it will be possible to reduce the length of hospital stays by the equivalent of 273 beds across the NW London Region.

This reduction in bed capacity is in addition to the proposed reduction of 592 beds which will be achieved by 'admission avoidance'.

If some of the least ill admissions can be avoided, it seems reasonable to assume that the residual admissions will constitute the most seriously ill patients. It therefore seems doubtful that many of these patients will be eligible for earlier discharge than at present.

Further matters which need checking include the following.

The reconfiguration will mean that all Ealing residents who need acute hospital admission will need to be accommodated in hospitals outside Ealing. Page 27 of the October STP states: *"The average length of stay for a cross-border admission within NW London is 2.9 days longer than one within a CCG boundary."* This cross-border effect must mean that the closure of the acute wards at Ealing Hospital will add to the number of in-patient days.

It seems that the calculation of 273 bed savings due to reductions in the length of hospital stays is based on a 100% bed occupancy. We understand that problems can emerge when hospitals operate at greater than an 85% bed occupancy. It would therefore seem prudent to recalculate any deliverable bed savings at this lower occupancy percentage.

NW London response

The improvements in OOH care set out in section 1.3 of the Strategic case are expected to reduce the intensity of care required for the more complex patients and will therefore reduce their length of stay when admission is appropriate.

The changes in Out of Hospital care set out in Section 1.3 of the Strategic case will address the needs of all patients, including those admitted to a hospital outside their CCG boundary

The projected bed numbers after the reduction in length of stay are consistent with other acute hospital assumptions about their financial projections included in Section 3.2 of the Financial case

15. Reduction in A&E Attendances

We are unable to locate an analysis which shows, hospital by hospital, existing and projected future A&E attendances, and resulting admissions.

Again, this analysis needs to reconcile to the economic and financial projections contained in the SOC1.

NW London Response

See financial case – tables 23 and 24 which show activity by site (before and after SaHF) by POD.

Table 23: Outer Trusts (total activity)

WESTMID	Activity Mar-2016	Activity Mar-2026	% change
Elective	14,208	29,937	**111%**
Non elective	28,640	30,544	**7%**
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Outpatient	**1,087,424**	**1,100,923**	**1%**
A&E	**275,883**	**284,089**	**3%**

Table 24: Reconfiguration Activity flows

16. Ealing Residents using Neighbouring Hospitals

There needs to be far more information and analysis/modelling on the post-reconfiguration impact of Ealing residents using the hospitals in neighbouring NW London boroughs. This could result in a significant resourcing challenge if the projected reductions in demand for acute beds do not materialise.

NW London Response

Further analysis will be provided during 2017 and at OBC stage

17. Cross-border patient flows

There doesn't appear to be any mention, or assessment of the implications, of cross-border flows.

NW London doesn't operate in a vacuum. Some hospitals, such as West Middlesex, support a large number of patients from Richmond upon Thames. Any reduction in acute bed provision in the SW London NHS region is likely to increase the pressures on West Middlesex Hospital.

With the closure of acute provision at Ealing Hospital, Ealing residents will, in effect, be competing with residents from outside NW London for acute beds at the NW London major hospitals.

NW London Response

Future activity / capacity from SW London should have a neutral impact on West-Middlesex Hospital as they would be projecting changes for their own patients.

18. Accelerated Reconfiguration of Ealing Hospital

Pages 61 to 64 of the Strategic Chapter and pages 114 to 117 of the Finance Chapter of the SOC1 refer to an accelerated reconfiguration of the Ealing Hospital site.

It is far from clear from the SOC1 that the replacement hospital, hub and community facilities will be fully operational in advance of the accelerated reconfiguration of Ealing Hospital.

There needs to be a far more detailed supporting analysis of this proposal than is contained in the current draft of the SOC1 and its appendices. This analysis needs to be supported with comprehensive timelines and estimated patient episodes.

NW London Response

Please see section 5.6.16 and Figures 8,9,10 in Management Case (SOC public release 06 December 2016). Further analysis will be provided during 2017 and at OBC stage.

19. Frail/Elderly hospital provision

Both the draft SOC1 and the October STP refer to the provision of Frail Elderly Beds on the post reconfiguration Ealing Hospital Site.

There is a lack of clarity and detail about this proposal in both the SOC1 and the October STP.

Is this provision intended for just the existing elderly patient catchment area of Ealing Hospital, or is it intended to accommodate frail elderly patients from across a far wider geographic area? If the latter it would mean that these patients will be accommodated in a hospital which is likely to be a considerable distance from their homes, family and friends, something which could adversely impact on their recovery and discharge.

There is no discussion of the on-site medical support facilities which can be needed by this category of patients, especially those whose condition can change at short notice. Currently these facilities are provided by the acute and emergency care teams based at Ealing Hospital. It appears that following the reconfiguration this medical support will not be available on the Ealing Hospital site.

NW London Response

Ealing will be a local hospital for local people, so the development of beds for frail older people will be for local people. We are doing work on developing services for older people across NW London.

20. Elective surgery

The SOC1 proposes to concentrate Elective Surgery on the Central Middlesex Hospital site in Park Royal.

Significantly more information should be included about this proposal including the number of patients, medical speciality and the locations where this surgery is currently taking place.

The Central Middlesex Hospital is relatively inaccessible by public transport from central Southall and often needs at least three buses in each direction.

The limited information in the public domain suggests that this proposal could be more a management convenience, rather than one intended to benefit patients and provide them with quality healthcare nearer their home.

NW London Response

London North West Healthcare NHS TRUST has clarified that 28% of patient currently receive treatment at Ealing Hospital as per the SaHF Central Model.

Travel time analysis was considered as part of the Decision Making Business Case. Further analysis will be undertaken at OBC stage.

21. London Ambulance Service

I can't locate any reference to the implications of the A&E and Acute Hospital reconfiguration in NW London on the operations of the LAS.

Page 52 of the October STP contains a somewhat ambiguous reference to the portion of the current LAS deficit which is applicable to NW London.

"There are also particular challenges in relation to . . . .The deficit in London Ambulance Service, of which only the NWL related element is included in this plan, which requires further joint working in order to agree a solution."

It would seem likely that the reconfiguration of Ealing Hospital will result in increased usage of, and cost pressures for, the LAS.

There doesn't appear to be any mention of the additional cost pressures which must result from the proposed closure of A&E and acute hospital care on the Ealing Hospital site.

The closure of these facilities must mean that significantly more Ealing residents will need to be conveyed to out-of-Ealing hospitals by the LAS than at present.

Again, detailed modelling and supporting analyses should be included in the STP and ImBC-SOC1.

NW London Response

Analysis from London Ambulance Service was included in the Decision Making Business Case. Further analysis will be provided during 2017 and at OBC stage.