Independent Healthcare Commission for North West London

Submissions of Written Evidence

Volume 4

Contents:

SUBMISSION TO THE INDEPENDENT HEALTHCARE COMMISSION

for NORTH WEST LONDON

From: John McNeill

[redacted]

I'm a regular user of NHS services in NW London attending GP surgery, clinics, Ealing Hospital, Charing Cross Hospital & Clayponds Hospital.

As a disabled OAP, I use hospital transport for a range of appointments.

I'm a Board Member and Trustee of Healthwatch Ealing

I'm on the National Executive of the National Health Action Party

I'm a Committee Member of SAGE (Seniors Action Group Ealing)

I campaign nationally and locally on Health and Social Care issues.

Pre-retirement, I was employed by Central & NW London NHS Foundation Trust, working in Mental Health and Addictions.

I'm accredited and qualified in the provision of relapse prevention, mediation and associated therapies. In retirement, I work with young offenders for Ealing Youth Justice. Many young offenders have mental health and addiction issues which are not being adequately treated. I'm a member of the Council for Restorative Justice.

I would be prepared to give evidence to the Commission on the results of "Shaping a Healthier Future" which I consider to have been a total waste of time and public money. It has been no more than a cover for cuts, closures and NHS privatisation which are adversely affecting NHS services to the public in NW London. I have a particular interest in hospital patient transport services.

Generally

The consultation on "Shaping a Healthier Future" was a total sham. It soon became obvious that the proposals for re-organisation of services for NW London had been pre-planned and agreed. The consultation exercise was just putting a 'tick in the box' that a consultation process had taken place. The consultation changed little or nothing.

A&E Services

The A&E closures have been severely detrimental to the health, welfare and service accessibility for residents of NW London. People experiencing major illness or requiring emergency injury treatment are now taken miles from their homes or incidents to already overcrowded A&E units. The evidence of their unmet targets has been well publicised.

If I'm taken ill at home, or involved in a serious Road Traffic Accident in Ealing, I would not now be treated locally but taken to a distant location. That loses valuable time in medical attendance and treatment plus causing major inconvenience to any friends and family wishing to visit.

The Risk Register for the Health and Social Care Act 2011 predicted all this, but the government unsurprisingly still refuses its publication.

Hospital Closures

With the impending closure of Ealing Hospital, there will no longer be any inpatient beds in the whole of the London Borough of Ealing. Other hospitals in neighbouring Boroughs are facing cuts and closures despite suggested expansions. This is bad for patient care and for families and friends visiting inpatients this will be difficult, costly and extremely inconvenient. Parking is limited and expensive in and around hospitals and public transport services are difficult for the elderly and disabled.

NHS Fragmentation and Privatisation

The introduction of the internal market and privatisation of NHS services has led to the fragmentation and segmentation of service provision. There has been a breakdown in communication between NHS facilities with patient records not being properly shared. A consultant at Ealing has no automatic access to my test results from Charing Cross.

Hospital Patient Transport Services

I would ask the Commission to particularly focus on this topic and am prepared to give personal evidence to the Commission.

This is a very relevant topic for the Commission in its consideration of the effects of the "Shaping a Healthier Future" process. With hospital cuts and closures, hospital transport will have an increasing role in the patient experience with more and longer journeys.

Just a few years ago, hospital patient transport was directly provided by directly employed and trained NHS staff using NHS ambulances and passenger vehicles. With fragmentation and privatisation, hospital transport has become a lottery for patients in both timing and care.

These services are now being regularly provided by private companies using drivers on minimal pay and untrained in dealing with needs of patients. The vehicles may carry the NHS logo, but are run by profit-motivated companies where income is more important than patient care.

I've been taken to & from hospital by minicab companies booked by private hospital transport companies, probably to the lowest bidder. The untrained and low-paid drivers often have no idea of patient care and can be uncaring and impatient if their passengers are difficult to deal with. I've had drivers who have had to ask me for directions to get to and from hospitals. That is an unacceptable service, unfit for purpose.

If NHS services continue to be centralised and local facilities closed, hospital transport for elderly and disabled patients will become a key part of patient care. Hospital transport provision must be much better regulated and monitored. Staff must be qualified to a minimum care standard and patient care must take precedence over operational profit. Currently, the opposite seems to prevail. This must change as more patients will have to rely on these services in order to be able to attend their appointments and admissions at more distant locations.

I look forward to hearing from you.

John McNeill

23rd February 2015

Smith Peter

From: [redacted]
Sent: 22 February 2015 16:17
To: Smith Peter
Subject: Comments for Health Commission [redacted]

I work for Imperial NHS Trust in a clinical post.

Concerns:
In Maternity implementation of Cerner (new IT system) coincided with closure of one of three antenatal clinics and roll-out of new midwifery group practices.
Midwifery group practices are excellent for women (increased continuity of care, local clinics) but only fully effective if properly resourced.
Now, ten months after implementation midwives still do not have remote access to hospital IT systems, causing significant extra workload to an already over-stretched workforce.
Closure of one of SMH's antenatal clinics (Woodfield Road W9) lost 40 antenatal booking appointments per week.
These were not absorbed by the new group practices which had only started.
This in turn created a backlog in available antenatal booking appointments which meant many women did not get their appointment in time for optimal screening for fetal anomalies (combined screening test) therefore national targets were increasingly breached.

The implementation of Cerner caused chaos for many months as overwhelmed administrative staff struggled to cope with the complexities of the system while dealing with patients both in person and on the phone.Despite Cerner training for all staff many individuals, including myself, felt ill-prepared. Cerner uses up a lot of time and attention for clinical staff, being not particularly user-friendly.
Many administrative staff are poorly supported by their managers, not listened to, however good a job they are doing, and many are really stressed by the huge volume of calls from patients, which vastly outnumber the staff available to deal with them.

Managers request staff to do extra "bank" shifts but have to be chased to authorise these shifts, even after they have been worked.
On occasion I have waited months after doing a bank shift before my manager authorised the shifts and I was paid. Invariably I was only doing the shift to help out at a time of staff shortage.

Clinical staff are overwhelmed by the demands of ever-increasing paperwork and Cerner . every new piece of paperwork must be completed for some highly persuasive reason, but surely there is a limit to how much bureaucracy can be dealt with while giving clinical care?

Please anonymise these comments if used as I do not feel secure against being penalised by my managers if identified.

Smith Peter

From: JazzSingh Gill [redacted]
Sent: 05 February 2015 11:44
To: Smith Peter
Subject: West London NHS Reform

Dear Mr Smith,

It is disgusting that in an area as heavily populated as Hounslow, neighbouring Ealing - another heavily populated area facing health cuts - residents are being FORCED to accept even further neglect in regards to health care.

There is no way this is beneficial to anyone that may need to use this service. We are led to believe that we need to make cuts because of austerity and financial restraints, but even a fool can deduct that money can be cut/culled from elsewhere to support our nhs (corporate tax avoidance/spending on military/MP expenses).

I hope those presiding over this decision realise they are tarnishing the very meaning of democracy by going against the will of the people.

However, we both know the changes will be forced on us (us being the people that use the nhs). I hope the powers that be learn that things like this will only speed up - and add spite to - the revolution.

Feel free to contact me to discuss further.

Kind regards,

Jasveer Singh Gill

Smith Peter

From: j a [redacted]
Sent: 05 February 2015 16:28
To: Smith Peter

Dear Mr Smith Please do not consider any planned further closures or cuts myself and the general public have had enough.

Yours Sincerely

Mr J Ambrosino

Smith Peter

From: Helen Kuttner [redacted]
Sent: 05 February 2015 22:29
To: Smith Peter
Subject: Closures of A&E and other acute NHS services in west London

Dear Mr. Smith,

I am writing as someone who is appalled at the closures that have already happened in West London NHS and to express my fervent hope that the other proposed closures, namely of Charing Cross Hospital A&E and other acute services, will now not take place.

The NHS in West London lies decimated. Already it is clear that this area cannot cope with the closures that have already taken place. Please do not allow the rest of the closures. It will be nothing short of a disaster leading personal tragedies on a weekly basis.

Many thanks for your attention to this grave matter.

Yours sincerely,

Helen Kuttner
[redacted]

SHAPING A HEALTHIER FUTURE – COMMENTS TO INQUIRY COMMISSION

General Observation

We wish to support the comments made by the Save Our Hospitals organisation (SoH).

Personal Observations

Range of Services

We have found it advantageous to have both an A&E department, and a wide range of more routine services on the same site. These should include facilities for consultants to monitor the progression of a possible problem, as well as the ability to take action if necessary. This would avoid problems such as draining a Baker's Cyst. There are indications that such services are being run down at Charing Cross, as I had to go to Chelsea and Westminster for observation and treatment for osteoarthritis on my knee. I also value the urology clinic being so close.

We accept that it may not be possible for **all** hospitals to run **all** services. We found that specialist units such as the orthopaedic unit for fractures at Charing Cross were extremely rly good, perhaps partly because they perform so many. BUT if this is not possible then there should be **free and fast** transport to another hospital for all patients.

There is often a need for urgent action. A friend recently visiting us for lunch started to show symptoms of distress late in the afternoon. For her a long trip to say St. Mary's would have been extremely awkward, as she was vising us from Sutton. Symptoms of a worsening asthma attack were recognised.

Problems with the SAHF Strategy

So we would like to stress the need for a hospital that provides urgent care, and as full a range of urgent care services as possible. We are not satisfied with the vague and incoherent proposals for Charing Cross to become a "local" hospital, since it is far from clear what a local hospital is, or what it could do. In fact we do not accept there is a case for closing **any** hospital or part thereof, and believe the Shaping a Healthier Future (SAHF) plan should be scrapped. In our original submission to the independent review body we noted that the SAHF's own figures showed that closure **any** hospital would mean the remaining number of beds would be insufficient. This has been proved correct. Closure of Charing Cross with the largest number of beds cannot be a serious option.

It is interesting to note from the meetings that SoH had with the CCG that they inherited this plan, but were unable to explain why St. Mary's would be kept open under **all** the options. St. Mary's in the centre of London only a couple of miles from another major hospital (UCLH). , but difficult to access from most of North-West seems a more suitable for closure, whereas Charing Cross and other hospitals are much better arranged. They also insist they are stuck with the SAHF proposals, even though it has never been clear exactly why, This would be laughable, if the consequences were not so serious.

Financial limits suggest there is a need to prepare a new strategy, but with sufficient beds. It should have public involvement, not just consultation. This could perhaps be achieved by drawing up the requirements for a new Plan after fact-finding public discussion. There are many ways of achieving full public involvement without needing to hold acrimonious public meetings. Final plans should be drawn up with several representatives from each council on a new Commission.

A Possible Way forward

Clearly any future plan must recognise that the "customers" for the NHS prefer A&Es, perhaps because facilities for urgent examination and treatment – e.g. by GPs, or out-of-hour are inadequate, and incapable of meeting the demand. I would **not** expect a shop to refuse to sell a particular good because it was too deemed "more expensive than the customer could afford" ! Nor would they attempt to defuse anger by promising facilities that are never delivered, such as urgent care centres, and better social care to relieve the pressure on beds.

We write this on the day the Evening Standard reported that many patients made very frequent visits to A&E units, perhaps contributing to the overload on such units To try and be helpful we suggest some options.

All the hospitals should have both an **A&E unit strictly for emergencies** and a side-by-side **Urgent department** ALL patients not arriving by ambulance would be required to visit the Urgent unit first for **rapid** assessment. Admission to the A&E unit would **only** be allowed if the doctor who carries out the initial assessment gave permission, perhaps by a ticket. If not admitted to A&E the patient would receive treatment in the Urgent department, where fewer senior staff would be needed. This procedure would apply if the patient returns to the hospital, thus cutting down on the number of unnecesary A&E admissions. It should be combined with the dedicated transport provision already outlined.

However our experience, and that of many of our friends, is that caring for elderly relatives is a very difficult task, and we are not convinced many beds can be saved by forcing them out, especially as "community care" by local Councils is woefully inadequate because they too are under-funded, and standard of provision varies both in availability and quality. "Community care" usually means requires considerable input of time, and sometimes money, by a personal carer, usually female.

We hope you find these comments useful

Richard & Theresa Adam

M. Robinson

[redacted]

Dear Mr. Smith

I writing to you in regard to the Campaign to prevent the closure of Charing Cross hospital by Commenting positivly about an experiance I had. A relitive of mine had a serials head injury in late 2005 which required brain Surgery to make better. Knowing that such practices are complex to carry out, I and other family member's feared the worst. The Surgery when as well as could be expected. So I personally would HATE to have the hospital cosed down. I hope the Campaign is a ~~Succes~~ Wins for the Cause.

~~Mr~~

Anne Dowkell.

Interview with Emergency Nurse Practitioner 9.2.15

Public confused about roles of UCC, A&Es, Walk-in Centres, Nurse Practitioners, GPs and Drs in WiCs, UCCs and general practice.

Regularly people with very serious problems requiring an A&E assessment self refer to UCC delaying urgent treatment. Recent examples include an elderly person with confusion after a head injury and someone with a possible diagnosis of appendicitis.

Sometimes people choose the UCC because they think the queues at A&E and the waiting times will be too long. On some occasions patients have travelled past several A&E departments on their way to the UCC. It can be very hard to persuade them that they really need to go to A&E.

There are some occasions when the NP can assess and diagnose at UCC and then refer onto an admitting team at St Marys in which case it's good for the patient because they bypass the time waiting for an A&E assessment. However this can still involve significant waits - on one occasion a man I had referred came back to the UCC in desperation as he had waited 3 hours and had still not been seen by the only specialist on call via A&E. I had to advise him to go back or go to another hospital which deals with that speciality as there was nothing else I could do that would ensure safe treatment of his problem.

More frequently you have to refer the patient (who has already presented and waited his/her turn in UCC) onto A&E for a full assessment. In all of the UCCs I work in neither Drs nor nurses can order scans, access facilities to process urgent bloods, order more than a limited range of X rays etc. If the patient needs these tests and investigations before a diagnosis can be made I have to refer onto A&E. It's particularly confusing for the patient if they know the facility exists in the building but the UCC staff are not allowed to refer patients for investigations with it. Sometimes X ray facilities close

earlier than the UCC so patients either have to return the next day for an xray (if it's safe to manage, immobilise and leave overnight) or go to A&E that night.

I'm not allowed to order xrays for children under 2 so again parents don't know this and bring their child but if they need an xray it's time wasted as I have to refer to A&E.

If patients arrive near to the closing time for a UCC I may have to refer them to A&E because I won't be able to assess, diagnose and treat them effectively in the time remaining.

My biggest worry is when I send a vulnerable person to A&E- Are they going to go? Are they going to be safe? How long will it take before they arrive? If they are really vulnerable I will arrange an ambulance but if the condition is not immediately life threatening they may have to wait a very long time (assuming they are eligible). There have been times when even very sick people have had to wait unacceptably long times. I've heard of an incident where this caused serious patient harm. While they are waiting we have to manage them but this can be challenging with limited access for example to strong analgesia.

Often patients say they'll make their own way because of long ambulance waits. I'll try in that case to make sure they go with a friend. Examples like a person with a head injury, GCS 15 but c/o diplopia or someone with a physical injury and significant mental health problems make me worry about whether they will get to A&E in a timely fashion. Sometimes nurses have given patients money themselves to get a cab as the patient has no money.

Where I work the number of people presenting is unpredictable and changes significantly from day to day. Over the last few years it's certainly true that we see more elderly people with multiple co-morbidities.

There have been a number of occasions recently when I've been unable to refer to the usual team (medics, ENT, plastic surgery etc.) locally and have been asked to divert to other places because they are so busy. Once I had to refer a very serious hand injury to The Royal Free instead of C&W's hand unit because literally there was no reply from the bleep-holder who we tried to contact numerous times.

People seem uninformed about the location of all UCCs in the area. Some for example travel past the UCC at Hammersmith to attend another UCC because they think the Hammersmith UCC has closed.

In K & C some of the practices now have a "redirection policy". (Some of their patients live in H&F so it does affect this borough). They don't want us seeing their patients if they could be seen instead at their GP practice so we have to check with every client if they've tried to get a GP appointment, confirm the situation directly with the GP practice and if there's a space redirect them (with their agreement) back to the GP and document the whole process. It's confusing for the patient, they are often angry at the process and the time wasted. For me it seems unsafe because it's so time consuming, it delays triage and in the interim I might be missing something clinically important.

Patients sometimes have unrealistic expectations of the NPs and DRs who work in UCCs. They ask for referrals (e.g. to a dermatologist or a physio) and don't appreciate that their own GP is the gatekeeper for many referrals – again they can become frustrated and annoyed.

As far as I know staffing of NPs is mainly a problem for night shifts – you need NPs who are confident with both illness and injury and you often find NPs are more comfortable with one or the other. To be honest some of the doctors who work in UCCs are much more comfortable diagnosing and treating illness rather than injury.

There's a lack of consistency in terms of prescribing. Some NPs are independent prescribers which allows them to treat a wider range of conditions, others (including all non-trust NPs on duty) have a more limited role as the can only follow PGDs (Patient Group Directives). Again I think it' potentially confusing for patients.

I don't always get the impression services are working together for the patient's best interest. There are turf wars between 111 and the UCC doctors about who should see particular patients, and now CCGs are wanting to pay UCCs less for seeing patients who could have got an appointment at their GP surgery. It's quite fragmented.

There are also some problems with General Practices who want to use the UCC inappropriately as a replacement for a practice nurse. Some GP practices still don't have any practice nurse at all, others provide no PN holiday cover and expect the UCC to act as a substitute – it means we have less time for our core roles. In terms of the wound management aspect of the NP role there's often a problem with poor discharges from hospital with too little detailed information for us or the patient post surgery.

Primary and Community Health care is not the panacea that SAHF depicts
Introduction

The cuts and closure plans proposed by Shaping a Healthier Future (SAHF) is justified in part by promoting Out of Hospital Care as an equivalent alternative. SOH welcomes the emphasis on the potential of primary and community health teams. Patients often benefit by avoiding a hospital admission with its inherent risks and inconvenience. Clinical innovations allow the management of many conditions traditionally regarded as requiring hospitalisation in an out of hospital setting. Future demographics, societal change and patterns of illness give further impetus to a reorientation to primary and community health care.

However primary and community health care is not the panacea that SAHF depicts and SOH argues that there is neither the evidence, resources or social infrastructure in primary/community care to justify the scale of acute closures proposed which would strip both Charing Cross and Ealing hospitals of almost all their beds and acute services. Switching from acute to community based care does not necessarily reduce the need for acute services. To quote David Oliver President Geriatrics Society, ex national clinical director for older people,:-

"*In July 2014 commissioners throughout England published projections for reductions in urgent admissions to their local hospitals. But the size and speed of these reductions was not informed by any credible peer reviewed evidence – they rarely are.....Local plans are based on how much money commissioners need to "save" on acute activity rather than any realistic expectation of service delivery.*" (Oliver 2014 a)

Equally shortcomings and capacity issues in the delivery of care in the community and attempts to improve them are also longstanding and have been of limited success.

"*In the light of the substantial levels of funding enjoyed by the NHS over the last 10 years and the long standing evidence of relatively poor quality in primary care and the health challenges facing local people it could be argued that the improvement should already have been secured.* (Rideout 2012)

Of course there are new and really positive OOH initiatives that may in themselves in the long term reduce the need for acute hospital based services. However there are opposing trends including an over-burdening of primary and community services and a long term reduction in per capita funding in health and social services which undermine the OOH.

"*It is absolute Lala land to think we're going to be in a position any time soon when older people don't still keep piling through the doors of general hospitals*" (Oliver b)- Oliver's conclusion to improve hospital care not pretend it can be avoided .

Developing community and primary care should be decoupled from cutting acute services. It's illogical and unsafe to close hospitals before alternatives are in place, embedded and have demonstrated that they provide effective services.

Current Situation in Primary and Community Care

There are a number of current high profile OOH projects. Their staffing levels are relatively good and their staff tend to be innovative and motivated. What is not always reported is how these high profile projects are funded (and often staffed) at the expense of less prestigious but utterly essential services like community nursing. An anonymous community nurse demonstrated this point in the question she asked SOH to raise with H&F CCG in December:-

"*It may be useful to ask Tim Spicer etc how much investment has been put into District Nursing in H&F in the past 10 years. The answer is none for more than 10 years now. Significant investment was put into Westminster and K&C but none in H&F. The virtual ward, case managers and Rapid Response / Community Independence Service have been the investments in the past 5 years but these have generated more referrals to the DN Service with no additional funding.*"

In fact there is some evidence that developing new services adds to complexity, costs and overlap and may rather than meet actually increase demand. Tan and Mays (2014) conclude improving existing provision may be most efficient and cost effective in improving access to primary and urgent care (Appendix A).

OOH care requires an adequate number of appropriately trained staff working in established teams who are able to access the necessary range of health & social services in a timely fashion. Pump-primed high profile localised projects have to be translated into a long term, embedded service with sustainable funding. At the moment it often feels like there's more hope than evidence about this.

Head of H&F CCG Dr Spicer wrote,

"*Whilst there has been progress on the implementation of new models of delivery particularly with regard to community nursing and rehabilitation during 13/14, much of this change has yet to be embedded in organizations*" (Spicer 2014)

The fundamental justification for the scale of cuts proposed by SAHF appears flawed as it grossly over estimates the proportion of current secondary care users who do not require secondary input.

"Frail, elderly people" are the group most frequently characterised as receiving inappropriate secondary care. It is certainly the case across the UK that high numbers of elderly people are inappropriately managed in secondary settings. The problem locally and nationally as David Oliver points out is that it is as yet unclear that suitable, effective community services exist.

"*No geriatrician would disagree that too many older people are marooned in hospital beds. However "we simply do not have the capacity in alternative services outside hospital. During the Labour government, when we did have record investment in the NHS for 10 successive years, we missed a trick and didn't invest properly in community alternatives. Now the money has run out, it's hard to change.*" (Oliver c)

Oliver also warns against a worrying trend in current health service planning texts to section off this part of the population as requiring different / less acute services risks introducing a two tier potentially discriminatory system.

"It's inherently ageist to be talking about how older people should be kept away. It's perfectly consistent to say hospitals can be risky places for older people, but if you have a broken hip, if you have a stroke, if you have pneumonia, why should you be denied the full facilities of a general hospital on the grounds of age?" (Oliver c 2014)

(The comment is pertinent. H&F has an extremely high rate of falls related injuries amongst people over 65 and the highest percentage of hip fractures amongst people aged 65 – 79 in England in 2012-13(Public Health England PHE 2015)

A particular concern of SOH is that once frail elderly people are expected to be cared for at home they are less visible, more vulnerable and when things go wrong it's less high profile.

It's ridiculous to suggest as SAHF has done in the past that 85 – 90% of current A&E attendees can be managed in urgent care centres (UCCs) – witness the ENP statement submitted by SOH for an account of the restrictions on UCC scope locally. Widely exaggerated claims for the number of A&E attendees who could in fact be managed in primary care settings were a regular feature of SAHF papers. In fact a Department of Health (DOH) study commissioned by the Primary Care Foundation (2010) found that

"*When we used a consistent definition and a consistent denominator of all emergency department cases we found that the proportion that could be classified as primary care cases (types that are regularly seen in general practice) the proportion was more like 10 – 30% nationally*"

Bed occupancy in England is much higher than Europe; in London (including Imperial NHS Trust) the rates are even higher. As well as potential infection control issues (relevant locally as Imperial NHS Trust has breached infection control targets) this can lead to problems admitting people who need hospitalisation and discharging people too quickly even before SAHF plans are fully implemented. This is not simply a theoretical issue eg H&F has significantly worse rates for hospital readmission within 30 days than the English average (PHE 2015).

SOH is concerned about is that there are still some huge and basic gaps and deficiencies in acute, primary and community care provision and it makes no sense for primary and community health teams to take on vast numbers of new patients who would have previously been admitted whilst there are still basic health interventions carried out by primary and community care workers that are being implemented only partially or sub-optimally in H&F.

To be clear SOH feedback from the public is overwhelmingly positive and appreciative of the work done by GP practices and community health teams. Many people receive excellent care and appreciate innovations that have improved health outcomes and the quality of care. Local people tend to use phrases such as "hard-working", "committed", "professional, "go the extra mile". Poor experiences are usually attributed to "heavy workloads, understaffing, under resourcing". It is also important to note that local health professionals perform in many areas to the same or higher standards than other parts of London. The problem is that local clinicians also face the same pressures, obstacles and restrictions as the rest of London and as elsewhere this will impede their ability to absorb the thousands of patients without access to acute beds if SAHF plans are fully implemented.

The position in H&F is similar to that described across London which Dr Gerada (then RCGP chair) described as a "dire shortage" of family doctors in the capital which was "haemorrhaging staff". (GLA Health Committee Nov 13). The situation seems to be worsening - there was a 15% reduction in GP training applications 13 – 14 (Pulse 2014) and the BMA is reporting "a significant deterioration" since then (Pulse Dec 14). Locally the Medical School at Imperial College is on record (Jan 15) as agreeing that there was a particular issue around longstanding low numbers of Imperial's junior doctors applying to train as GPs.

Simultaneously across the capital there are thousands of community nursing vacancies and a vastly increased workload that making it very difficult for nurses to give anything other than strictly task orientated care. In the last decade there's been a 42% reduction in District Nursing posts. 5 student district nurses started training in London 2011 (Royal College of Nursing 2013). Simon Stevens himself states that in the last decade the number of nurses working in the community has been increased by just 0.65% (Health Service Journal 2014.) In addition across London there's a significant practice nurse shortage. The Nursing Times (2014) comments on the supposed shift from nursing in the acute to the community sector as "incredibly slow".

Locally there has been a reduction of around 80% in qualified district nurses over the last decade. The community health trust (CLCH) would argue that this has been compensated for by increasing numbers of nurses in specialist teams, lower grade community nurses and health care assistants. However workloads have increased exponentially so that community nursing team members routinely visit 16-18 patients daily which inevitably generates a task orientated approach that mitigates against effective chronic disease management. In addition there is a need for experienced nurses with a high level of clinical skills if the aspiration is to prevent unplanned hospital admissions of patients with multiple co-morbidies by skilled nursing during acute episodes and effective support in chronic disease management at other times. Financial pressures on CLCH as it strives to become a Foundation Trust seems to be the rationale for the reduction in qualified district nurses. Other examples of reduced skilled community nursing services include the dwindling funding for student district nurse training, the reduction in clinicians to support patients with continuing care needs and a recent plan to reduce the number of district nurses on call.

The stresses placed on community staff are reflected in high sickness/absence rates (17.3%) and vacancy rates. (CLCH 2014, CLCH 2015). Staff immunisation for influenza is low at 26.2% against a target of 75% - in the bottom decile nationally.

Despite huge efforts and high profile schemes CLCH also reported a significant shortfall in targets for reducing the proportion of bed days lost because of discharge delays and discharging patients from rehabilitation beds. Worryingly the incidence of pressure ulcers across CLCh is high (58 recorded in January (CLCH 2015).

In 2012 Rideout reported that local GP services were highly variable and patient satisfaction scores below national averages ie not consistently delivering high quality primary care. He concluded "*given the relatively low levels of patient confidence in Gp services, improvements need to be made before the burden on those services is further increased as a consequence of reductions in hospital services.*" (Rideout 2012)

The evidence below on health outcomes would suggest that despite huge efforts in GP practices and community care teams some basic primary and community health care is still not at an acceptable standard

Health Outcomes

In 2012 there were 400 excess mortality deaths in H&F – ie unexpectedly early deaths – the borough was in the bottom 10 London boroughs on that basic marker despite it's relative affluence. Between 2011 and 2013 PHE (2015) scored H&F as significantly worse than the English average for

"*mortality rates from causes considered preventable for persons*". This included

mortality rates for cardiovascular diseases in people under 75

mortality rates for cancer considered preventable in people under 75,

mortality rates for liver disease in people under 75 (3rd highest rates in London).

The CCG and CLCH NHS Trust are committed to improving health outcomes through primary prevention:-

"*Working with other primary care providers especially general practitioners, CLCH is committed to take action to reduce the incidence of disease and health problems within the population either through universal measures that reduce lifestyle risks or by targeting high-risk groups.*" (CLCH 2014)

At present however a key primary preventative activity, immunisation is achieving significantly worse outcomes than the English average. Immunisation rates for all diseases are generally very low for all groups - infants, children, adolescents, adults and the elderly (PHE 2105). (In addition see the SOH submission on influenza immunisations.)

Secondary prevention – monitoring for signs of disease at an early stage is vital in improving health outcomes. CLCH's aspiration is that,:-

"*Working with local commissioners, CLCH's clinicians will have a major impact on health outcomes, in terms of improvement in life expectancy and reduction in complications*" (CLCH 2014)

The aspiration is not yet a reality. H&F has relatively poor rates of cancer detection in primary care, often delays between cancer referrals and the start of treatment and a history of relatively poor cancer patient experience. The borough has extremely low rates of breast and cervical cancer screening, poor rates of chlamydia screening and poor rates of diabetic retinopathy screening. Substance misuse management is variable and significantly worse than the English average in relation to smoking cessation and success rates in the rehabilitation of non opiate drug users. Alcohol related hospital admissions are extremely high and have doubled in a decade (PHE 2015).

Ambulatory care sensitive conditions (ACS) describe health problems that if tackled and managed in the early stages by primary/community teams will reduce acute events and unplanned hospital admissions. Given the evidence on local immunisation and screening rates it should be clear that ACS management is not yet an embedded, consistent, successful activity.

Evidence based policy

It is important to note that whilst many schemes aspire to prevent hospital admissions and / or promote quicker discharges to date the evidence about which interventions actually succeed in these aims is patchy and problematic. Indeed Oliver characterises senior NHS strategists in this area as selecting "policy based evidence" as opposed to "evidence based policy". (Oliver d 2014 a)

One of the most comprehensive systematic reviews of evidence on interventions to reduce unplanned hospital admissions was undertaken by Purdy et al (Universities of Bristol and Cardiff and NHS Bristol June 2012). Their conclusions were that that most interventions were either not effective or that there was insufficient evidence to make an assessment. (Appendix A).

Similar conclusions were drawn from Kings College researchers studying COPD unplanned admissions: - "*It's much more difficult to reduce admissions in the general population than we thought up to now.* (White P 2011 – Appendix A)

Virtual wards are a key element in local OOH strategy and may be off great benefit – but to date the evidence is inconclusive:-

"*So even though we did the work we are still cautious about saying that Virtual Wards either do or do not work and are actively trying to re-evaluate one of the sites at the moment.*" (Dr Martin Bardesley director of research at Nuffield trust Guardian 7.11.13)

Issues in access to planned hospital treatment

Less reported but arguably at least as significant as A&E targets has been the recent trend towards a reduction nationally in the accessibility of planned hospital treatment and social care. (Nuffield Trust 2014). Gaps in these areas may confound other initiatives designed to reduce reliance on hospital services. (If you can't be seen in a timely fashion in a planned manner for your health problem you are more likely to present in an unplanned event. In addition "*If people don't have social care support it's not surprising they default into dialling 999 or into acute hospital beds.*" (Oliver c)

Planned hospital treatment takes two forms – planned hospital admissions and outpatient appointments.

There are significant breaches of waiting time targets for planned surgery (backlog of 3,500) within Imperial NHS Trust (Care Quality Commission 2014). They are well documented by other SOH supporters so simply noted in this submission.

Effective outpatient appointments should surely be a key component of the SAHF strategy for reducing levels of hospitalisation by effective management of chronic disease in planned encounters. Given the planned closures of many hospital sites and the corresponding requirements for patients to travel between sites more frequently one would anticipate that an effective OOH strategy would have excellent outpatient and transport facilities in place. In fact the reverse is true.

The local hospitals have been criticised by CQC with outpatients described as "inadequate" at 3 of Imperial's hospitals. CQC has asked Imperial to improve links with primary care, review patient readmissions, improve availability of medical records in outpatients, increase outpatient capacity to meet increased demand, manage quality and risk issues in outpatients more effectively, offer appointments more quickly, reduce waiting times in clinics and reduce the frequency of routine late starts because doctors are late and reduce the number of cancelled outpatients.

Patient transport is a huge problem across London (Strother 2014). It's also a problem in H&F. SOH has been contacted by a number of people who have experienced poor patient transport. Hammersmith hospital's patient transport system was singled out for criticism by the CQC – Hammersmith hospital has just lost it's A&E and is centred in an area of high deprivation with relatively low levels of car ownership.

Integrated Care

In the sense of effective collaboration between community health and social services "Integrated Care" is as uncontroversial as apple pie and makes sense. Even so some research suggests it may not deliver the positive health outcomes anticipated and may even be in some aspects counter-productive (Ernst and Young et al 2012).

Integrated Care is promoted as an at least partial solution to the dilemma of dwindling resources and increasing demand often using the mantra of "Doing More with Less". , but it's not a cheap, £5 billion annually nationally according to the Barker Commission (2014). It seems increasingly clear that funding cannot be delivered through more "efficiencies". Even the Times (2014) agrees - "*There is no vast pot of wasted billions in the NHS*".

The problems caused by the dwindling real health budget are dwarfed by the ever decreasing social services budget. In combination these cuts are likely to exert a positive pressure on use of acute services. A 3.6% cut h7f 14 – 15. H& F has been cushioned from the massive cuts made by neighbouring councils this year – indeed it has removed charging for home care and lowered meals on wheels prices – both actions that cost little but contribute significantly to better access. However even this year there has been a 3.6% social services budget cut and it is clear that social service funding from April 2016 will be much more challenging. The adult social care budget currently £64m is predicted to drop to £56m in 2016/17. The council plan a 10% reduction in Operations staff There are concerns that pilot and jointly funded projects through the Better Care Fund this year eg the Community Independence Service are not adequately funded on a long term basis This is against a background of a massive long term reduction in H&F's overall funding from central government (HASC&SIP&AC 2015)

Furthermore there is a concern that integrating may lead to a levelling down of quality standards - many older people do not want their health care in the future to be modelled on social care models which often translate as care carried out by low paid staff, often on zero hours contracts with relatively low levels of training delivering care within a tightly monitored time slot in a task orientated manner.

H&F is a borough of contrasts with concentrated levels of high deprivation north of largely affluent southern wards. It has concentrated areas with very high levels of childhood poverty and high levels of homelessness and violent crime. People in deprived areas are known to rely disproportionately on acute health services. H&F care users and their carers may be particularly vulnerable to social service cuts as high numbers lack alternative support. Public Health England found high levels of social isolation in H&F for adult social care users and extremely high for their adult carers (PHE 2015). There is a real concern amongst SOH supporters that once irreversible cuts have been made in the secondary sector social care funding is also withdrawn and it is the most vulnerable in our community who will suffer.

References

Bardesley M (Director of research at Nuffield trust) Guardian 7.11.13

The Barker Commission - KingsFund.org.uk 2014

BMJ 18.10.14 349:1: 38 7979

Care Quality Commission Imperial College Healthcare NHS Trust Quality Report 2014

CLCH Annual Report 2013-14

CLCH Jan 15 board papers

CLCH Clinical Framework 2014 to 2017

Ernst and Young, RAND Europe and the University of Cambridge (2012) National evaluation of the Department of Health's integrated care pilots. Department of Health

Greater London Authority Health Committee Nov 13

H&F CCG Final Draft Commissioning intentions (2014)

Health, Adult, Social Care &Social Inclusion Policy & Accountability Committee (2015)

HSJ Live 23.10.2014: The NHS 5 year forward view - reaction and analysis

Nuffield Trust & Foundation report (2014) "Cause for Concern" QualityWatch annual statement

Nursing Times 2014 29.10-4.11 Vol 110 44

Oliver D a BMJ;349:g5538

Oliver D b BMJ; 3491;7980

Oliver D c The Guardian 15.10.14

Primary Care Foundation (2010) Primary Care and Emergency Departments Report from the Primary Care Foundation Carson D, Clay H & Stern R

Public Health Outcomes Framework Public Health England2015

Pulse 5 February 2014

Pulse December 2014

Purdy et al (Universities of Bristol and Cardiff and NHS Bristol June 2012)

Rideout T 2012 " Shaping a Healthier Future: an Independent Review"

Royal College of Nursing 24.5.13 thisis**nursing**.rcn.org.uk/.

Spicer T 2014 CCG Final Draft Commissioning intentions

Strother L 2014 Sick of Waiting: A Report into Patient Transport in London Oct 2014 Greater **London** Forum for Older People

Tan S, Mays N. Impact of initiatives to improve access to, and choice of, primary and urgent care in the England: A systematic review. HealthPolicy(2014) http://dx.doi.org/10.1016/j.healthpol.2014.07.011

Times (23.6.14)

White P 2011 www.pulsetoday.co.uk/flagship-scheme...**admission**.../11053512.article

Appendix A

In Tan and May's study new services generated a more complex system where new and existing providers delivered overlapping services. The new provision did not induce substitution and was likely to have increased overall demand. Conclusion - Initiatives to improve access to existing provision may have greater potential to improve access and convenience at lower marginal costs than developing new forms of provision.

Purdy et al systematically reviewed schemes from a pool of 18,000. The evidence suggested that most interventions do not help reduce unplanned admissions in a wide range of patients (a partial exception was patients with heart failure, this group had best evidence of admission prevention with some of the measures) There was insufficient evidence to determine whether home visits, telemedicine, hospital at home schemes, pay by performance schemes, A & E services and continuity of care, medication reviews, pathways and guidelines reduce unplanned admissions.

Researchers from Kings College London found a COPD project with intermediate care service and round-the-clock telephone support – failed to reduce admissions or to improve prescribing. Research leader Dr Patrick White said 'I'm very enthusiastic about improving care for COPD, but there has to be a question raised about what the Government is doing and how effective it is. It's much more difficult to reduce admissions in the general population than we thought up to now.'

A recent Department of Health evaluation of integrated care pilots in England found that although integration did lead to better processes, the patient themselves did not generally feel that this had translated into an overall improvement in their experience and care continuity had actually declined. (**Ernst and Young**, RAND Europe and the University of Cambridge (2012) National evaluation of the Department of Health's integrated care pilots. Department of Health.

Extracts from email received by SOH from Imperial employee –

I wish to remain anonymous- please respect my request. I am an employee of Imperial College Healthcare NHS Trust based at .....hospital site.

I have serious concerns with the overall management of these hospitals. Excessive volumes of patients being treated .....

Too many patients , not enough resources, not enough out patient clinic slots,nurses or examination rooms to accommodate the volume of patients.

Information that is being fed to the local community is far from reality

Understaffed in clinical areas from admin , through to nurses/midwives - management top heavy with senior managers/ managers/ deputy managers all of which do not provide clinical care they are the clipboard brigade , thats when they are actually seen/ visible in the clinical areas.

Director of nursing informed staff that there are no restrictions on employing extra ad hoc staff known as "bank staff", however in reality the managers are not complying and not ordering / booking same, substantive staff are overworked , often doing the workload of 2 nurses, they become stressed & ill , & the situation is exacerbated.

I have grave concerns for patient safety.

Peter Smith, Clerk to the Commission, at Hammersmith & Fulham Council, Room 39, Hammersmith Town Hall, London W6 9JU

The Mansfield Inquiry
24th February 2015

Dear Mr. Smith,

I am a resident of Hammersmith and Fulham and a patient at Charing Cross Hospital. I have been extremely concerned about what is happening to our healthcare in NW London since the consultation for the reorganization of our healthcare was announced in July 2012 just before the school holidays.

I am resending the evidence of irregularities of The Shaping a Healthier Future Consultation and the impact of changes first sent to the IRP in 2013. It starts with the timescale of the Consultation events and written a breakdown of the flaws in the Shaping a Healthier Future Consultation below.

Both highlight concerns regarding engagement with the public, transparency and the Council's role reversal in its approach to dealing with the consultation in Hammersmith and Fulham. I have incorporated the emails sent with the evidence I attached or forwarded.

I have copied the Health and Scrutiny Committee's Draft report on the Consultation in September 2012 and pasted it into the document. I have not had time to go through every aspect but have highlighted key points in bold. I attended that Committee's first public meeting in September 2012.

In addition, this is followed by the scripted notes from further public meetings in September which are linked to it.

I have also included the notes from the public JPCT meeting in December where legal cogency was described. This led to letters being written to provide evidence and alternatives to the consultation options which brought about the proposed Outpatients Specialist Health and Social Care Centre. I believe all of this is completely relevant to what is happening now. I have hard evidence in files, which I will be bringing in this afternoon.

Consultation Times scale and events

June 2012
NW London NHS *Shaping a Healthier Future* Consultation announced in Chelsea Westminster Hospital news broadsheet *Trust News*, for June / July. Prior to official announcement in the media. Electioneering before voting in consultation announced.

July 2012

- Hammersmith flyover closed for major repairs as in serious danger of collapse
- M4 from Heathrow to A 4 flyover exit section closed - in danger of collapse
- London Olympics about to start. Athletes travelling along A4.
- Schools break for the Summer Holidays
- NW London NHS *Shaping a Healthier Future* Consultation announced in News
- Timing open to question.
- Local paper, the Fulham Chronicle announcement.
- SaHF and LBHF methods of informing the public of major changes to health care with huge impact are open to question. Little serious effort to communicate.

- No leafleting of residents by Hammersmith and Fulham Council to inform of:
  a.) the SaHF Consultation
  b.) the proposed threat of loss of A&Es in the Borough, at Hammersmith Hospital and Charing Cross
  c.) the loss of 500 acute beds at Charing Cross. Major hospital to be demolished to be replaced by a 24 hr GP led Urgent Care Walk in Centre (Misleadingly described as a Local hospital.)
- Save our Hospitals campaign begun.
- Save our Hospitals regular stalls in Hammersmith and Fulham and hospitals to inform patients and residents about the consultation.
- Approached GP practice. Asked to display information about Save our Hospitals and the Consultation for patients to be able to make informed choices. (Lillie Road Surgery) Told could not, as could not be seen to be taking sides.
- Fulham patients referred to Chelsea Westminster Hospital by GPs rather than Charing Cross (first hand experience)
- Patients to be affected uninformed by GPs in surgeries.
- Dr. Sam, at Lillie Road was a representative on the *SaHF* JPCT
- Visited GP surgeries throughout Fulham – no information about consultation and no hard copy documents. Generally not available in GP practices
- No information in Option B and Option C hospitals, only in Option A.

September 2012

- 17th Sept 2012 - London Borough of Hammersmith and Fulham Health and Scrutiny Committee Meeting. Critical of Imperial College Trust and SaHF (See attached scripted notes p. 8-13)

- 18th Sept - LBHF Town Hall public meeting with representatives of the SaHF Board, Save our Hospitals Chair, Carlo Nero and local Council Representatives, Nicolas Botterill and Marcus Ginn (see Fulham Chronicle article) LBHF Council petition set up online. Impression supporting residents and campaigners to Save our Hospitals

- 3rd world Option A hospitals electioneering for Consultation votes since June stepped up. Not monitored by SaHF or LBHF although knowing other Option hospitals under threat in NW London NHS were under information blackout. Voting results open to challenge. (See scripted meeting notes -19th Sept)

- Chelsea Westminster Hospital - open electioneering discovered throughout the hospital. Copies of the hospital's broad sheet, 2 page spread in *Trust News* demonstrated how to simply vote for Option A to save CWH.

- Blue voting cards available on reception desks in every out patients' department at Chelsea Westminster. Tick box cards to send in to SaHF.

- Voting instructions had no explanation of the impact of voting Option A meant closing Charing Cross (CXH) and other hospitals A&Es.

- Hardcopy Consultation booklets delivered throughout Chelsea.

- 19th Sept SaHF meeting with *Age UK,* Kensington Town Hall. Save our Hospitals set up an uninvited stall and participated in workshop. Audience confusion over the workshop implications of the consultation proposals for their healthcare. Member of the board heard to say in an aside to a colleague about their understanding and confusion, " It doesn't matter. We just have to be seen to be consulting."

- 19th Sept 2012 - Concurrent SaHF Meeting at Fulham Broadway Church Hall, next to Chelsea football ground. Hard copy consultation docs available. Save our Hospital reps visited throughout day. Attendance very poor. (See scripted notes p.13 -)

- Timing and location of meeting open to challenge. Organised for the same day and time as major international football match, Chelsea vs Juventus. Poorly advertised, (notice only on SaHF website)

- Only 6 people attending when I went. Stopped from photographing display and attendance. Two crucial questions about Charing Cross and Chelsea Westminster asked. (See attached scripted notes from the meeting - Witness, Anabela Hardwick)

- Save our Hospitals regular stalls continue in Hammersmith and Fulham.

- NW London NHS Joint Primary Care Trusts Public Meeting- Westminster Methodist Hall – The SaHF board shown a copy of Chelsea Westminster Hospital *Trust News.*

- Questioned about why and how such open, active electioneering could be allowed when there were media embargos and blackouts in all the Option B (Charing Cross and Hammersmith) and C Hospitals.

- Unsatisfactory, unacceptable response by representatives responsible for ensuring democratic procedures are followed. - Informed us that "Foundation Trust Hospitals (eg.CWH) were independently funded so could do what they liked". This effectively condoned unmonitored, unequal 3rd world election voting.

- Emailed LBHF Council members with requests for help informing residents and vulnerable community groups in Fulham. A struggle for volunteers informing people in such a short time frame.

- Wrote to local Council again requesting help. No response from LBHF until pleading on behalf of the Borough's electorate. (forwarded & attached email 25th Sept) Consultation deadline fast approaching.

- Cllrs from Fulham Reach ward responded by leafleting the ward about the consultation. Other wards in Fulham did not. No mention the actual threat of closure of Charing Cross in choice of Options.

October 2012

- SaHF public meeting Phoenix School, Hammersmith

- Dr. Tim Spicer, when asked by Doctor why GPS had not been balloted as they had been in Kingston. Replied that it was not necessary as "the PCTS knew what doctors involved thought. Open to question how and who they were.

- Request to Marcus Ginn, LBHF Communications Councillor on Health and Scrutiny committee for help leafleting to reach people before the end of the Consultation. Told too expensive. £43,000 already spent. Question how spent in relation to duty to inform and represent their electorate.

- Consultation closed.

- 80,000 petition submitted to Downing Street

December 2012

- SaHF JPCT meeting at Westminster Methodist Hall – *legal cogency* regarding the public and patients' response to the consultation defined. Dismissive of petition. Only written evidence to be taken account of.

- Save our Hospitals letters written- based on residents and patients' concerns, questions and alternative suggestions (eg. Charing Cross merger with Chelsea Westminster under one management) These were then personalized to make it easier to express concerns.

- Letters printed and handed out with envelopes to all without computer access at stalls. Others sent them in online. (see attached example.)

- Sent to Cllr Lucy Ivimy LBHF Health and Scrutiny committee chair & Jeff Zitron, SaHF Chair.

- Letters prompt limited alteration to original plans. Demolition and destruction of main teaching hospital included.

January / February 2013

- 15th January JPCT meeting – discussion with Daniel Elkeles, Jeff Zitron and and Cllr Peter Graham after overhearing them talking about the closure of CX as a foregone conclusion. Told them not to be so hasty.
- Approx 1000 letters sent in.
- Campaigning at Barons Court - Stopped by Daniel Elkeles from SaHF saying the board had listened to us. Changes not in consultation made in response to letters
- Outpatients Specialist Health and Social Care Centre with 60 day beds and no A&E to replace major teaching hospital with a loss of 500 acute inpatient beds.
- LBHF Council placed two page misleading spread in Fulham Chronicle announcing hospital *SAVED,* Friday prior to SaHF announcement.
- 15th February
- Open to question why a full page misleading image of Charing Cross with SAVED across was in the newspaper when it was to be demolished and replaced by a 16,000 ft Outpatients Centre on the site of the Medical Staff accommodation blocks. It gave impression the hospital was saved when it only meant saved from original plans that no one knew about.
- LBHF leafleting the Borough twice, once with an expensively produced booklet with the same misleading information thus giving the impression the hospital had been saved.
- Taxpayers' money used in publicity used to misinform. Cllr Graham, however said it was funded by the Conservative party, not by the taxpayer.
- SaHF official announcement 19th February, 2013

Shaping a Healthier Future Consultation Flaws
Role of NW London NHS Trust; London Borough of Hammersmith &Fulham Council

Timing

- Timing of the consultation announcement was extremely poor. The dates had been agreed on by the local Council.
- Announced during school exams, just prior to summer holidays and the onset of the Olympics
- Announcement only in the news. Not publicised anywhere in Hammersmith and Fulham other than in the local papers and online on the Council website (dependent on having a

computer and being a regular visitor to the website)

Informing and consulting the public and GPs

- Seriously inadequate public engagement, engagement with doctors and medical students at Charing Cross. All those to be most seriously impacted.
- Little awareness of the Consultation throughout the Borough but particularly in Fulham.
- No attempt to contact vulnerable community groups, patients or residents to be impacted and seriously affected by the proposed major reconfiguration of healthcare in Hammersmith and Fulham by either LBHF or SaHF.
  (*Evidence -LBHF Health and Scrutiny Committee Draft report)*
- No attempt to openly engage with clinicians over concerns in Hammersmith and Fulham. Doctors reluctant to speak out publically.
- (*Evidence – Draft report- Inadequate key engagement with the public and GPs, which they contributed to - 4.2- 4.5, scripted meeting notes)*
- No information in GP surgeries.
- No leafleting of residents in the borough by the Council.
  (*Evidence – letters from residents, emails to the Council and Consultation board, scripted public meeting notes, Draft report*)

Obstacles to taking part in the consultation

- No access or awareness of either the consultation itself or where and how to obtain the hard copy consultation documents.

- No attempt to ensure they were available to the public to enable people to participate. (except at poorly advertised public meetings…Fulham Chronicle Newspaper with limited uneven distribution and LBHF website)

- Hard copy unavailable. To be ordered online. Telephone number only available online. Participation dependent on awareness and computer access and knowledge. Excluded thousands without either.

- The document itself was ridiculously long for a public document, 88 pages.

- Length and being online made it difficult to read without taking notes to be able to answer the questions. A daunting task.

- Its design meant questions were at the end. Not possible to answer without constantly referring back. Answering questions was reliant on content detail so juggling act. Very difficult to do without hard copy.

- Questions were leading questions without genuine choice. Aimed at achieving prescribed answers.

- Options were not consulting or providing genuine choices for beneficiaries of care or to enable them to be participants in of design (Andrew Lansley's first test)

- Options were aimed at closing hospitals and selecting which to close. Patients use both Charing Cross and Chelsea Westminster for different reasons.
- Nowhere was it made clear that voting for Option a and 'saving' Chelsea Westminster meant 'closing' Charing Cross and reducing it to an Urgent Care Centre, the size of a football pitch.

- 4 hours to complete. Daunting and confusing. Leading questions to 'railroad desired answers. Validity open to serious challenge under Trades Description Act.

- It gave the impression that hospitals would be little affected by the closure of A&Es. Reality...Closing of A&Es, when hospitals become local hospitals or specialist hospitals, in reality this means a loss of the hospital to the public.

- Calling them *Specialist or Local* is euphemistic for major downgrading by either limiting hospital accessibility to patients through referral only or complete loss of a 'hospital to be replaced by a 24 hour GP led Urgent Care Walki-in Centre.
  This euphemistic labelling gave the impression they would all continue to be hospitals with inpatient / outpatient treatment. It is effectively a lie.

- The document was written in carefully chosen misleading marketing speak. Misrepresenting the reality of healthcare in hospitals so that what will effectively be a major reduction in healthcare is being sold as a promise of a model of perfection. Glossy Estate agents euphemistic language. Eg. A '*local hospital' with 24 hour care* is a 24 Hour GP led Urgent Care Centre, not a hospital at all. Validity, therefore, open to question.

The consultation process itself

- The choices and configuration do not stand up to the key 4 test criteria laid down by Andrew Lansley, the former Secretary of State, nor do they meet their own criteria. They fail completely on the first that "*patients must be at the heart of everything from beneficiaries of care to participants of design.*"

- This is financially driven, as a business case (profit and loss) and is not about a health service (treatment and standards of care.) Healthcare is not business, it is a service. There is little consideration of what is involved in providing effective a good health service, i.e. investment in the medical workforce *and* its support staff, not corporate business managers with vested interests. This is how medical ***services*** need to be delivered to achieve good outcomes. Cost cutting measures like those proposed by Bruce Keogh, to follow a PC World /Curries model of success of 'less is more' is ludicrous.

- The criteria of 'Value for money' and 'Education' in the options is seriously open to challenge. There is no mention of the cost or consequences of dismantling the major world renowned medical School at Charing Cross nor how this is in the interests of Education. None of the other hospital options could possibly replace it and it would have to be divided between hospitals piecemeal. Doing so would be extremely costly, disruptive and counter productive as it would destroy the medical school. *(Evidence Attachments- 1. Draft report 2. Freedom of information letter from the CEO of Imperial College)*

- No consultation with student body of Medical students.

- No risk assessment done on effect of impact of closing Charing Cross Hospital and A&Es in Hammersmith and Fulham (*Evidence –notes from December 6th public meeting; see Risk assessment documents from SaHF)*

Key questions patients and medical students regularly asked campaigners and in the letters sent in.

These questions were not answered and could not be answered satisfactorily.

Q 1. Why and how are the specialties at Charing Cross to be dismantled in patients' interests?
Q.2 Where are they to go that will be in the interests of patients and medical staff?
Q.3 Charing Cross Hospital is a major teaching hospital and medical school, as is Chelsea

Westminster. How can dismantling them be in the interests of future consultants, medical students and doctors of the future, nurses, medical staff and improving healthcare? How is this meeting the best 'Education' provision, one of the key criteria in the consultation?

Q.4 How will this provide 'Value for money', one of the key criteria in the consultation?

We would like answers to questions asked, including questions of Transparency sent to the consultation board and the local Council. (see Attached)

How were the choices of hospitals to pit against one another chosen? It was not based on the Kings Fund or patient consultation. What was the motivation?

The suggestion of merging Chelsea Westminster and Charing Cross as one major acute hospital on two sites under one management put forward in letters to Lucy Ivimy, the Chair of the Health and Scrutiny Committee and SaHF JPCT Chair, Jeff Zitron, were dismissed by Dr. Tim Spicer at Fulham Broadway public meeting as it '*was not in the brief*'.

Decisions and concerns

- Seriously open to challenge through lack of genuine consultation and resulting poor response.
- Open unmonitored electioneering allowed and encouraged while other hospitals kept in the dark.
- Hard copy Consultation documents delivered throughout Chelsea.
- Lack of public engagement and consultation in Hammersmith and Fulham by either LBHF and SaHF
- Transparency regarding consultation with the public, medical practitioners and staff at Charing Cross and Hammersmith Hospitals.
- Voiced concerns that NW London JPCTs making decisions would be disbanded and no one would be accountable for decisions.
- Website for NW London NHS no longer active (www.northwestlondon.nhs.net) Crucial information to be replaced by NHS Central London CCG, NHS Hammersmith and Fulham CCG; NHS West London CCG, now the joint CWHH CCG, Accountable Chief Officer, Daniel Elekeles (cwhh.complaints@nhs.net) this was not set up until after decisions were made. Many of the board members are the same as those on the JPCT SaHF board.
- Concerns about conflicts of interest in private companies. (*Evidence mail from Stephen Duckworth, Rainsberry Freedom of information letter)*

Hammersmith and Fulham Council approved the Consultation dates, dismissed the findings of their own Draft report on the Consultation to support the decision regardless of major concerns, misled their electorate and finally denied us the right to a judicial review.

There are many questions regarding transparency both NW London NHS and LBHF must answer. The UK is meant to be a democratic country but the processes followed.

LBHF Select Health and Social Care Scrutiny Committee and Shaping a Healthier Future Meetings

Monday 17 September 2012

LBHF Select Health Committee Meeting -Scripted notes

Council Questioning - Steve Mc Manus -

Interim Imperial College Trust Chief Operations (5 weeks)

Cllr Q: *Has Imperial indicated its preferences to the consultation committee?*

SM: *Paper sets out options of sites internally and College on academic study and research. Imperial Trust and College are separate. We are the Academic Health and joint executive between the two.*

Council Q on waiting lists, treatment records for arthritis and cancer patients
Challenge on lost data and waiting lists.

SM: *Still a backlog of 243 patients on lost or incomplete records.*
86 at risk patients not traced.
Referral of arthritis/ orthopaedic and cancer patients not addressed.
Admitted using private sector to shorten waiting times as these were far in excess of 18 week waiting list recommended.
time. Highlighted that it was not a site issue. Trust vague abt position n CXH

Cllrs questioned SM on what was actually doing about the Trust Corporate reputation. – i.e. what led to problems with data entry.

SM: admitted very poor reputation. *Need to do a lot to rebuild. Need to communicate with patients and all relevant bods and organizations.*

Cllr LI –LBHF summary: – *Imperial College needs to be investigated*
A lot of highly paid executives.

- *Council lacks trust in ICT*
- *Requires a page by page analysis of exactly what went wrong*
- *Want to know how far up the management chain / ladder problems went.*
- *Call for an independent review of the government of the Trust; a report and precise analysis to clarify vagueness.*

A. Preferred option –
Council Q: *Is Imperial supporting Option A?*

SM avoided answering the questions. Talked about out of hospital care. Stated the issue around CH is very complex. Not clear whether supporting the proposal of CXH being downgraded to local hospital status. Said 'debate will be had on Weds' 19th Sept.

Cllr. Stephen Cowen (SC): *I'm concerned abt the vagueness of the answer.*

Cllr Peter Graham (PG): Challenging the Trust on their agenda for Weds. (Looked up agenda on phone.) Q. *How can a verbal update lasting 10 minutes be devoted to a decision that will have profound consequences? The paper going to the board for discussion is not on the agenda. This beggars belief.*

Cllr Marcus Ginn (MG): *Imperial have a clear position on this but are not being open about it.*

Cllr PG: *It is reasonable that the board make a copy of the paper available.*

Shift attention to Chelsea Westminster representatives.

Sir Christopher Edwards (CE) – Chair of Trust Govs at CWH and Head of College of Emergency Medicine – role of A&E at CWH:

"Junior doctors are being put off medicine. They do not feel they are properly exposed. There is a30% drop out rate. End up with only 40% that might lead to consultancies."

"This is what this is really about."

Cllr Q: *How on a very constrained site would CWH cope?*

Sir CE: *Current A&E would expand on the ground floor and sideways. Paediatric A&E and oncology The adjacent space opposite could be used.*
What's worrying is when you say 100,000, but this is not real. Blue light ambulances is what we should be talking about.

Cllr Stephen Cowen (SC): Question about outright campaigning on behalf of CWH

Sir CE: *It's not surprising people support their own hospital. It's rather different consequences for CXH.*

Cllr SC*: You are a very successful Foundation Trust Hospital. You have demonstrated you can manage things well.*

Sir CE*: In cash strapped NHS we believe we can invest funds. If we didn't there would be catastrophic consequences. We would have to move Paediatrics and Maternity, our core business, with knock on effects on emergency services We wouldn't have need for specialist surgery.*

Becoming a local hospital means becoming a non-viable hospital. CWH is one of the last new hospitals built.

Cllr Q: Questioning the level playing field: *Do you think it would be inappropriate if you didn't put it in the public domain?*

Sir CE: *Yes, but .... CXH is part of this very large group. They have to look at siting. CWH is compared with Imperial Trust not CXH. The Board of CWH is a Foundation Trust with an independent budget set aside for governors on how to use.*

In the past it was said that Brompton and Marsden should move to CXH. Is it the best thing for the patient? Poorly staffed?
There is an amazing lack of clarity of precisely what will happen if it is downgraded to a local hospital.

We are supportive of Imperial College Trust becoming a Foundation Trust. The main problem with running a three hospital site is almost becoming financially viable.

Cllr SC: *How many services are being duplicated? Could there be a merger with CXH?*

Sir CE: *I have a vested interest in Imperial Trust's success. Could we have a closer link to CXH? That would be entirely up to Imperial Trust. CWH is open to all sorts of options. That's not on their agenda. It's not what they are trying to do.*
We want the best possible outcome for patients and have to put resources to the best use.

Cllr Q: *Are there better solutions?*

Sir CE: *If they split up too much, it won't work. St. Mary's Renal merged to meet patients' needs.*

Cllr SC: - summarising the uneven playing field: *There is no independent objectivity pitting one hospital against another. It isn't going to end well if they are pitted against one another. The critical test will be what NW London NHS does about Imperial Trust. The key issue of 'site' is allotted 10 minutes to the ICT agenda. NW London has to address this. It is side tracking real issues in our community.*

Sir CE: *If there are other options, we would find it very useful if alternatives could be put forward and we would consider.*

NW London NHS representatives - Dr.Tim Spicer; Daniel Elkeles

Responding to the Rideout report and discussion. They believe they corrected the inaccuracies regarding the pre-consultation, present consultation, methodology of choice and addressed the issue of 'not taking the special needs of Hammersmith and Fulham into account , particularly with regard to the specific specialties at CXH and the effect.

Cllr SC: *We do not accept the case for this change. The reasons for solutions are good but the solutions are not. The issue of 'work force for example. How would you solve the issues of workforce.?*

Cllr L.I. (Chair): *We agree with the principles but not the solutions*

Cllr PG: *We were talking about land value the last time you were here. Value across the sites (p.50 Appendix 3)*
At any time have Imperial expressed their opinions?

DE: *When the Trust come to a final decision. Told NW London Imperial are supporting Option A It is what he (CEO) told us He did not want to pre-empt the meeting and decision. There is a debate. I know Mark Davis will discuss this at the meeting on Wednesday.*

Cllr (Joe Carlbach JC?) : *This gives the impression one bit doesn't know what the other is doing. That he hasn't had a discussion yet and there is no firm Trust position on this, implying the opposite of what NW London NHS are saying. I think there is an on going dialogue.*

DE: *Mark Davis said the joint committee preference is for Option A. this does not mean he has made his mind up. There is the option to changeAll Trusts were finally aware shortly before the consultation went out. The Trust Board is having the debate.*

Cllr JC: *This is becoming a farce. We will refer this to the Secretary of State for proper investigation. What exactly is going on here?*

Comment- *Consultees with vested interests - Daniel E passed a note to CWH. What was that about? CWH have a vested interest in outcomes.*

Cllr LI: *would expect having a dialogue with all the major hospitals - but not with CXH, says risks are in a public document in the public domain. All risks PCT has to deal with but.....*

Cllr SC: *p 7 - £1bn savings.*

DE: *We've identified issues and should have gone to NW NHS but only now looking at them.*

Cllr LI: *Not having looked at these risks is astonishing (all the things that could go so wrong)*

Cllr SC: *This is intrinsic to the case of change you are making. This has never been updated. Looks like the cart before the horse.*

Cllr LI: *Are you saying you have a list of mitigating factors considered?*

DE: *Correct. The next report will be in November.*

Cllr SC: *Why have you not been able to say how GPs have responded? CCGs. Considering the four Langley tests.*

DE: *NW never claimed unanimous support.*

Cllr SC: *We would like a percentage.*
Cllr PG: *Land value - You lambasted Tim Rideout about land valuation. You said you had done valuations. Misled the committee twice - led to the wrong page in the document - differentiated between sites.*

Cllr LI - CCGs -GP Surgeries: *Even if H&F doctors disagree, in other words the Shadow or non statutory doctors have no say because they are not in the CCG, the four tests have to be applied.*

DE: *They agreed to the consultation.*

Cllr LI: *That is very different from agreeing to the proposals.*

Dr Tim Spicer (TS): *We want to protect the trust of patients.*

Cllr LI: *They will have to make a decision. What will the decision process be?*

Dr TS: *We have to continue to take soundings of our members.*

Cllr PG: *(ref-Langsley)You must have support of GP commissions - the Secretary of State looks for / reviews the support of practices or commissions.*
The decision is to be made in February He has to consider the 4 tests. Do not believe the decision is in the best interest of local NHS. Is there a better way than A /B/ C?

Dr TS?: *That is the joint committee decision. The Secretary of State does not have to take the decision they have recommended.*

Cllr PG: *If the 4 tests are not met, it will not go ahead. One of the tests is that it must have the support of GP commissions.*

DE: *We will take soundings from the members of the CCG.*

Cllr Q: *Why not a ballot?*

Dr TS: *One of the functions is not just your opinion in order to have confidence in what we can deliver/ can do.*

DE: *True consultancy is not just about counting heads, it's considering best solutions.*

Cllr SC: *What if 60/ 80% of doctors were against the proposals; that makes the position untenable.*

NW NHS: *A majority of colleagues are against Option A (members of CCG but not all doctors.) Dr TS: As clinicians, we have concerns about all the options.*

Cllr LI: *The committee would like a clear understanding of what GPs think. All. Whether these proposals have the support of the GPs. Tim Rideout. (will be polled online) If there is no way of balloting GPs, the Council will make its own decisions.*

LBHF Scrutiny committee's Draft report on consultation
September 2012

Concerns not addressed but Council chose to disassociate, dismiss as if never drawn attention to and sing the unchanged SaHF mantra

The local Council drew up a damning draft report of the consultation in Sept 2012 but then dismissed all the risks they highlighted and singing the same mantra as SaHF. All the concerns have not been resolved and now in January 2015 are proving to be genuinely putting lives at risk. This is gambling with our lives. They knew the risks and decide to go ahead regardless. No one voted for these changes. Risks and concerns are unchanged.

Councillor Lucy Ivimy admitted they had fought hard for the ***non-acute*** services at Charing Cross but said little about the much needed acute services, loss of 500 beds or A&E.

Below was the response the LBHF Conservative Council Health and Scrutiny Committee's response to the SaHF Consultation at the time. (Committee chaired by Lucy Ivimy) Highlighted in blue and yellow are the key concerns made. Once the SAHF reconfiguration was 'approved', given full support, the opposite stance was taken, overiding concerns expressed prior to approval.

All concerns expressed here, then were no longer deemed to be flaws and were either dismissed with the same marketing language used by SaHF or ignored. This was a shock to all who had trusted and believed the Council had supported them in the campaign to Save our Hospitals,

Charing Cross and our A&Es. This however can be used to look back at what was said then and subsequently ignored leading us to where we are now in January 2015. Key questions:

- How many of these concerns and risks are proving to be a reality now?
- Why did the Conservative Council then dismiss these concerns and unquestioningly support Shaping a Healthier Future's arguments, thereby accepting that risk assessments would be done but after decisions to go ahead with major reconfiguration of our NHS hospitals and healthcare rather than before?

I have a file with evidence of how the consultation was mismanaged to ensure the outcomes that the Government wanted. The concerns highlighted below will provide a benchmark for comparison of what is actually happening now and the full impact of these changes.

London Borough of Hammersmith and Fulham **11 September, 2012**
'Shaping a Healthier Future' Consultation Response **v.1 Draft 21**

1. Introduction

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

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

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

2. Context

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

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

2.3 The proposals represent a radical reconfiguration of local health services, with an increased emphasis on out of hospital care and a reconfiguration of NW London's hospitals. For Hammersmith & Fulham, this means a reduction in the *scope and breadth of services provided at Charing Cross Hospital (most notably including a downgrading of the Hospital's A&E and the removal of complex medicine and surgery services) and, to a significantly lesser extent, at Hammersmith Hospital (both hospitals are currently managed by Imperial College Healthcare NHS Trust).*

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

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

3. The Council's position

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

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

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

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

- The objectives of "Shaping a healthier future" are appropriate (i.e. of improving service quality and reducing unwarranted variation, improving the health of local people through the provision of better care, and ensuring that organisations are financially viable for the long term);
- *The* current provision of local healthcare is not acceptable, as it is too often characterised by unacceptable levels of quality and service and unwarranted variation, substantial health inequalities, and an unsustainable financial position;
- The adequacy of the pre-consultation engagement of key stakeholders, notably patients, public, clinicians and the Council itself is open to challenge;
- The extent to which the requirements of the 2010 Equality Act have been met in determining the impact of proposals on protected groups at a borough level is open to challenge;

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

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

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

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

4. The pre-consultation and consultation process

- **Engagement**

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

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

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

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

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

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

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

4.8 The statements made in the **business case relating to wider engagement** and involvement in shaping the proposals are **also open to challenge.** While sound, the stakeholder engagement principles do not address the apparent democratic deficit in the process. It is

difficult to see how such proposals can be legitimised democratically without both the active engagement and support of local government. Currently, significant aspects of the proposals do not have the support of the Council.

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

4.10 While it is intended that more work will be done to engage the public and that "this will include work with local authority colleagues who support voluntary and community sector networks... who are able to access a large number of community members through the work they undertake", this engagement activity should have taken place before the development of the pre-consultation business case.

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

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

- **The "Four Tests"**

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

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

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

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

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

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

- **Equalities Impact Analysis**

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

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

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

- **Timing and decision-making**

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

4.22 Further, the proposals have been developed during a time of major organisational change within the NHS. The 2012 Health Act abolishes Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) from 1 April 2013, replacing them with local CCGs and the NHS Commissioning Board. The business case states that all NW London CCGs have been established. This is not strictly true. The current PCT and SHA structures are still in place (albeit on a clustered basis) and are still statutorily responsible for local health services until 31 March 2013. "Shadow" CCGs have been set up as sub-committees of PCTs and are currently participating in a formal assessment process to support their eventual establishment and authorisation by early 2013 for them to "go live" on 1 April 2013.

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

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

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

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

- **Programme assurance**

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

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

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

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

5. Methodology

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

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

- Insufficient exploration of alternatives to hospital reconfiguration;
- The absence of any detailed independent verification of the baseline financial model provided by local NHS Trusts to support the proposals; and

- The unnecessary combining of much needed proposals to strengthen primary and community services with proposals to reconfigure local hospitals.

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

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

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

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

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

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

- The patient experience assessment, driven by an inappropriate use of estates indicators;
- The patient choice assessment, driven by a spurious argument about the number of NHS Trusts managing Major Hospitals;

- The financial surplus assessment, that has not been subject to verification and the materiality of which is subject to challenge;
- The Net Present Value calculation, that double counts previous measures and is subject to challenge; and
- The workforce assessment that inappropriately underrates Imperial Trust compared with Chelsea & Westminster.

5.7 In more detail:

- **The case for change**

5.8 The proposals are predicated on the need for substantial change that must start now. Included is an assessment of the changing demands on the NHS in NW London but it is not clear if the business case takes account of the fact that more than 20,000 extra homes are planned for Hammersmith & Fulham in the next 10 to 15 years.

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

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

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

- **Principles and objectives**

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

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

5.14 One of the key arguments for hospital reconfiguration and rationalisation is that the limited availability of senior medical personnel (particularly at weekends) has a detrimental impact on clinical outcomes. There are clear indications in fact that many of the current outcomes are satisfactory, notwithstanding the limited availability of senior medical personnel and

specialist teams. The business case does not explore other ways of securing sufficient cover that are not dependent on service rationalisation.

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

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

- **The financial model**

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

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

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

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

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

viable. The differences between Trusts are in reality marginal and subject to significant change depending on changes in the underlying assumptions and actual delivery.

- **Clinical model**

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

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

NB

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

5.25 **The principles and standards proposed for Out of Hospital care are sound.** *However, the practical development of this model for Hammersmith & Fulham should be developed with the full involvement of all parties, including the Council, and should be developed to specifically meet the needs of local people. Currently the eight CCG level strategies appear somewhat generic and lack sufficient detail to support implementation.*

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

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

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

care. This does not require formal consultation and should be decoupled from the case for reconfiguration and implemented as a matter of urgency.

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

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

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

- **Options appraisal**

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

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

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

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

5.36 For example, clinicians concluded that "their desired clinical standards could not be met if all nine current NW London acute sites ... were to become major hospital sites". The business case does not provide the evidence for this conclusion. Given its importance in underpinning

the proposal to reduce services provided at four of the nine sites, including Charing Cross and Hammersmith Hospitals, this is a significant omission.

5.37 The clinicians considered evidence about factors that were judged to contribute to high quality clinical care. The business case states that as a result of this consideration clinicians "identified that there should be between three to five major hospitals in NW London to support the projected population of 2 million", with a view that more than five major hospitals leading to sub-optimal care. The proposals centred on five as the proposed number, primarily in light of current capacity constraints. The detailed evidence base for this decision to propose five major hospitals is not provided with the business case and is therefore open to challenge.

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

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

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

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

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

5.43 In order to evaluate the options, a number of criteria were developed. Some suggested by clinicians and patients were not accommodated, including integration of services, health equality across NW London, and support for preventative care and help for patients to manage their own conditions. These exclusions are open to challenge. Their inclusion would go some way to addressing the inadequate population focus of the current proposals.

5.44 On the clinical quality criterion (the highest ranked by clinicians and patients), the position has been adopted that "current clinical quality at Trust level was not a useable proxy for

future clinical quality at site level after reconfiguration was complete". This is a contentious statement and is open to challenge. It was proposed because the assessment used current mortality rates at Trust rather than site level. Given the importance of the quality aspect of the option appraisal, site level information should have been secured in order to allow for appropriate and necessary comparisons. The management teams of a number of the respective trusts have indicated that this information is available at site level. Regarding distance and time to access the service (again a highly important criterion for patients and the public), the business case places much less emphasis on this issue given that the criterion was a fundamental part of the basis for identifying the eight options. This is open to challenge. A much more detailed analysis on a more granular individual population and group basis should have been used to inform the options appraisal.

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

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

5.47 The patient experience element of the quality criteria includes an assessment of the quality of the respective estates across the nine sites, based on the assumption that there is a correlation between the quality of the hospital or clinic where a patient is treated and their experience (although only very limited theoretical evidence is explicitly quoted to support this statement and it is contrary to local evidence). In order to use this as a comparative measure of patient experience the business case uses nationally collected site level information (from ERIC returns) in terms of the proportion of space deemed to be not functionally suitable as NHS space and the age of the estate. This makes a large assumption that there is direct correlation between the age and the quality of the estate and it does not take into account in any way current patients' views of the respective sites. Therefore the information's use in this way is open to challenge.

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

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

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

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

5.52 In terms of value for money, the evaluation uses a number of criteria. In terms of the estimated capital cost of the additional capacity required by the reconfiguration the only real difference highlighted is between those options that include Hammersmith Hospital as a Major Hospital (Options 1 to 4) and those that don't (Options 5 to 8). In terms of relocating maternity and other services, this has a significant impact on any option where Charing Cross Hospital is designated as a Major Hospital, as it currently has no maternity services at present. If the capital cost of such a relocation is truly prohibitive, this element of the model could be looked at again.

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

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

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

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

challenge, as further more detailed work should be done to secure a better estimate of likely transition costs.

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

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

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

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

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

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

- Changes to the designation of the Major Trauma Centre at St Mary's;
- Current location of stroke units;
- Changes to the location of the Hyper Acute Stroke Unit (HASU) at Charing Cross.

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

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

(DD note: research is one aspect of medical training and education for doctors. Charing Cross is the largest medical school for undergraduates in the UK)

NB

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

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

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

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

- **Readiness**

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

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

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

5.71

6. Clinical outcomes

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

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

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

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

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

7. Impact

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

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

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

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

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

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

7.6 Furthermore, these changes would have a detrimental impact on the new Hammersmith & Fulham CCG's ability to influence the care commissioned for local people. Effectively the proposals fragment Hammersmith & Fulham's health care across many different providers. It is unlikely in consequence that Hammersmith & Fulham will be a major commissioner of any of the receiving NHS Trusts.

8. Additional issues

- **Implementation**

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

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

- **Benefits and disbenefits**

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

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

- **Clinical outcomes**: the potential for these to be adversely affected by increased travel time and delayed access to emergency services, and the impact on the population of the other proposed changes (e.g. to maternity services);
- **Primary care development: the impact of services not being improved** as proposed, whilst hospitals proceed to reduce their capacity;
- **Equality and human rights: the impact on the most vulnerable groups of people (particularly children and** older people) in Hammersmith & Fulham's diverse population;
- **Increased complexity**: the establishment of a new "tiered" system of local healthcare (including "local" and "major" hospitals) has the potential to significantly confuse patients and the public; and
- **Loss of expertise: the potential significant loss of clinical expertise and excellence at Charing Cross Hospital which has established a world-class reputation**

- **Motivation**

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

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

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

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

9. Next steps

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

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

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

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

– ENDS –
LBHF-FCS: CPD-Policy
11 September 2012
Amendments and additions from Draft v1.1

"DRAFT" watermark added
1 Introduction – new three-paragraph section with one each on context, concerns and next steps
3.3 (ex 2.3) first bullet, fourth line – organisation<u>s</u> are…
3.4 (ex 2.4) second line – paragraph ~~1.8~~ <u>3.3</u> and in…
4.16 (ex 3.16) fifth line – business case ~~to~~ states…
7.2 (ex 6.2) rewritten – Analysis of the preferred option indicates that currently each A&E in NW London serves an average population 5% less than the national average. If the preferred option is implemented the cuts will result in each remaining A&E serving an average population that is 52% larger than the national average.
9.2 The Council, through <u>its</u> Scrutiny <u>committee</u>, will therefore ~~seek~~ <u>decide whether</u> to refer…
9.3 The Council, again through <u>its</u> Scrutiny <u>committee</u>, will therefore ~~seek~~ <u>decide whether</u> to refer…
9.4 New paragraph

Approvals process

05/09/2012 – Draft v1.0 – circulated to Peter Smith and David Evans for comments
06/09/2012 – Draft v1.1 – sent to Cllr Ginn for review
10/09/2012 – Draft v1.1 – sent to Sue Perrin for Cllr Ivimy to review ahead of HHASC dispatch
10/09/2012 – Draft v1.1 – Cllr Ginn forwarded for inclusion on Cabinet Briefing agenda
11/09/2012 – Draft v1.2 – incorporating Cllr Ginn's amends and additions
11/09/2012 – Draft v1.21 – incorporating rewritten paragraph 7.2

Fulham Broadway – Fulham Methodist Church - Wednesday 4 pm September 19th
***Shaping a Healthier Future* open meeting** - Summary and scripted notes.

Held the same day as a Chelsea-Juventus match. Football fans flooding the area. It was not advertised. Few people knew about it. 6 attending – 4ish. Small numbers earlier in the day.

Present Daniele Elkeles (DE) and Dr. Tim Spicer (TS), NW NHS rep, Andrew Pike

I was the only person there for a long time. I spoke to Dr. Spicer informally one to one. Opportunity to tell him there were no real options in the consultation. Suggested that a merger of Charing Cross and Chelsea Westminster Hospitals under one management would have saved money and made much more sense. (Took a picture of the display to catch the atmos and they told me I needed permission.)

He *agreed* but said it couldn't happen "as it *was not in the brief. There are workforce issues where they are seriously undermanned. Increasing specialisation brought better outcomes but then it is harder to run services on local sites."*

Discussion called once 6 people , including myself and Anabela Hardwick) 4pm.

QUESTIONS
I bought up the point about the discrepancy between the Option A hospitals electioneering and the other hospitals being prevented from publicising the proposed changes in the consultation. Chelsea Westminster had been campaigning while Charing Cross and Hammersmith Hospitals had a media embargo imposed on them. Confidentiality clauses prevented staff from talking about the consultation or proposed changes. Residents in Fulham and patients in Charing Cross were unaware. There is no publicity or information available in the hospital. There were about 6 copies of the consultation document in the PALS office on a small table, not easily visible.

I held up a copy of the Chelsea Westminster hospital broadsheet, *Trust News* August / September. I said I had collected copies at hospital on several occasions. I pointed to where it clearly explained how to vote Option A to save the hospital. In addition to some of the tick box blue cards held up, I showed the three pages devoted to helping people vote fro CWH. I pointed out that nowhere did it explain that voting Option A would close the A&Es of Hammersmith and Charing Cross Hospitals or effectively reduce CHX to a nothing more than an outpatients, local Urgent Care Centre as a local hospital.

I have copies of all of these as evidence.

I said I had gone into all the departments and on every reception desk there were '*Safe in our Hands'* blue cards for patients and visitors to pick up to tick box option A. I then said this led to 3rd world electioneering tactics and asked what they were going to do about it.

Dr. Spicer tried to be reassuring and replied, "*When it comes to counting the votes, the blue cards will be discounted."*
I said I would remember that when it came to the counting of the votes.

Other questions of concern from the audience were about:

- difficulty of patient transport to hospitals and accessibility
  TS: Patients can book an NHS taxi.
- what will happen to CXH. It has 800 beds – *DE: In the interests of consultants being present more of the time, traded off clinical benefit to 'do- ability'.*
- what is meant if it becomes a local hospital
  TS: Local hospitals will not have an acute side. They will still have outpatients with urgent and social care integrated. Seen as a community facility

Exchange between LBHF resident and Cllr Lucy Ivimy's response to his Open letter

The exchange of emails between Cllr Lucy Ivimy, Ken Bromfield, a resident and patient at Charing Cross, myself, Una Hodgekins, a resident and Jeff Zitron from SaHF consultation below took place shortly after the 'news' of the closure and downgrading of CX hospital. It highlights the depth of feeling at the betrayal. The Council's pre-empted full page SAVED spreads across a picture of Charing Cross before the official announcements shocked the community and prompted this open letter and subsequent exchanges:

To the Editor of the Fulham Chronicle
Please publish the article below! It will redress a depressing imbalance in the HF paper.

The issue of the fate of Charing Cross hospital towers over everything in my 70 plus years as a Hammermith resident. I should be grateful if you would publish the open letter below.
Ken Bromfield MBE. Chartered FCIPD. FIScT

An open letter to Hammersmith Council

When our Council announced to its electorate that it was joining the fight to save Charing Cross Hospital , was its campaign objective for us to end up with Charing Cottage Hospital, with a massive reduction in beds and other services? If this was the case, the Council's was disingenuous, deceitful and utterly opaque, to say the least.

On the other hand, if the Council's campaign purpose was in line with the thousands of concerned residents, to maintain a world class hospital facility in Hammersmith, then its 'efforts' have been a failure. How Councillors can claim victory is beyond me.

What exactly were the success criteria in the Council's exalted 'battle' to save Charing Cross Hospital . Where were they published?

I was a Charing Cross Hospital inpatient for 10 weeks. A vital part of my healing process was the stream of visitors whose love and encouragement helped me out of a dark place. As you know, public transport, including the tube is excellent to our hospital. By comparison, Chelsea Westminster is nowhere near the tube. Parking is nigh on impossible in that area. Councilors should ask themselves whether this will discourage visitors, and if so, what are the consequences?. Should this issue have been put into the decision making process about our NHS medical care?

One bright spark Councillor pointed out to me that A&E doesn't attract visitors. Even if this was so, people do visit patients in the 500 or so beds currently at CHX. When the beds go, the visitors will obviously have to troop off to wherever they are replaced.

We have a rising population in our borough. Even our Council should be able to work out that healthcare needs will rise. If the Council fails to care about this issue for our people, then it leads one to suspect they have alternative health arrangements for themselves or they live in districts unaffected by the debacle.

The public anger at our Council is palpable. The Council should hang its heads in shame, or apologise to people like me who were born, raised, still live, and would be content to die in Hammermith.

Ken Bromfield MBE. Chartered FCIPD. FIScT

[redacted]

[redacted]

Hi Dede

This is the note that I sent to the H&F article comments.

Perhaps the most striking aspect of the Hammersmith Council's treachery when it announced that it was instrumental in "saving" Charing Cross Hospital, was its utter disregard of its electorate's savoir faire and political judgement. Did our Council really believe that we would be taken in? What an insult to us all!

The Councillors are in a hole. Guess what? They are still busy with their shovels. They are tring to justify their deceit with arguments such as "The hospital will continue to treat at least 85% of H&F patients who are currently seen at CXH." This spurious statistic misses the point. We are concerned about the people who need more serious treatment as in-patients. There will be 440 bed losses in the CHX "plan for the future". At only 80% occupancy that's 128,460 in-patient days. Assuming an average stay of 6 days, that's 25,692 patients and their vital visitors, who will have to go elsewhere, probably Chelsea Westminster with its poor access by tube and car. Whatever the vacuous spin churned out by our Council, Charing Cross Hospital has been hugely diminished. *It has not been saved.* The Council's affront to us all needs urgent redress.

Cheers, Ken

Ken Bromfield MBE. Chartered FCIPD. FIScT

[redacted]

Lucy's Reply
What is Charing Cross Social Care Hospital?

Dear Mr Bromfield
Thanks for your email. In summary, original Option A proposals for Charing Cross were for a Local Hospital of 4,000 square feet costing £15m, giving no beds, having no specialisms, and having standard Urgent Care Centre facilities unable to take ambulances.

The new proposals are for a *Specialist Health and Social Care Hospital* of 16,000 square feet costing close to £100m, with 60 beds, retaining all the current **outpatient** specialisms **plus an enhanced Urgent Care Centre** with full diagnostics and able to take some ambulances. It will therefore be four times the size of original proposals.

The NHS announced this substantial u-turn in a presentation to members of the eight borough Joint Health Overview and Scrutiny Committee which I chair. I made a note of what is proposed, but full details in written form will not be available until the agenda for the formal JCPCT meeting next week is published.

Under the new proposals the following specialisms have been saved:
- Oncology - specialist ambulatory cancer care including the cutting edge radiotherapy and chemo treatment
- West London Sexual Health clinic
- Mental Health facility
- Renal care
- Research and teaching in conjunction with Imperial College
- Full range of diagnostics

- An ante and post natal clinic will be added
- The UCC will be enhanced so that it will take ambulances (though **not** blue light emergencies) and be able to treat 70% of all patients who currently present to the A&E
- All current specialist out-patients will continue to be treated under the new proposals
- In total, about 90% of patients currently treated at Charing Cross will still be treated there (As outpatients only)

What will, however, still be lost is:
- Blue light life threatening A&E
- Stroke unit
- Complex acute surgery
- Beds will reduce to 60...only used as day beds

Serious injuries or emergencies such as a stroke, and acute complex surgery are the dramatic aspects of a hospital and take up a large part of the bed space, but actually involve a very small proportion of all patients.

SOH Comment (500 beds being used regularly for inpatient care will be lost)

These patients want to receive and should receive the best treatment, which means a full team of A&E / trauma and stroke specialists should be on hand 24 hours a day, 7 days a week.

Comment - (Because CEO Mark Davis has split up consultancy- specialist teams. He moved and sent them to SMH as with specialties below. Forcing patients from LBHF to go to Westminster for life threatening treatment)

This is not currently the case at Charing Cross, which is why an ambulance with a severe multiple trauma victim will today go to St Mary's Paddington where there are such facilities. Imperial currently has plans to move the stroke unit from Charing Cross to St Mary's in order to co-locate it with the trauma unit where there is a brain surgeon always on hand, as some stroke victims require emergency brain surgery to remove a clot.

SoH NOTE
(Charing /Cross has the best neuroscience and neurosurgical unit in the country at present. A long established team preforming brain surgery and spinal surgery)

This type of organisation saves lives and reduces the degree of permanent disability suffered by patients.

The downside of the additional time in the blue light ambulance (where a patient has already been stabilised) is hugely outweighed by the benefits of immediate specialist treatment once in hospital.

For this reason, I feel that carrying on the battle in order to try and save a full range of A&E at Charing Cross would actually be, from a clinical viewpoint, a mistake.I hope this helps.

Kind regards
Lucy Ivimy, Chair, Joint Health Overview

.....

Subject: 1) Lucy Ivimy's letter and (2) PFI at West Middlesex
Date: Fri, 15 Feb 2013 13:06:08
From: Una Hodgkins [redacted]

To: dede wilson [redacted]
CC: Carlo Nero [redacted] 'Jasmine Pilgrem (Ashchurch Residents Association) [redacted]

Dear Dede,

I live In Hammersmith, in Ravenscourt Ward, which is Lucy Ivimy's!
(1) Thank you for forwarding Ken Bromfield's letter and Lucy's reply. Her letter contains statements, which even she could not possibly believe.
For example it will be impossible to continue training doctors at Charing Cross when the number of beds has been cut from 500 to just 60. I spoke yesterday outside Charing X with a consultant . He said in a bemused tone - they are so weary of change - that transitional arrangements while they split teaching between St Mary's Paddington and Hammersmith Hospital would be "very testing" and would be disruptive to teaching. They would not be staying at Charing Cross with no patients....
(2) While I was outside Turnham Green station last night I spoke with someone who works for West Middlesex hospital. He told me that this hospital was built fairly recently with PFI money, and that it was paying £5M pa in interest payments to the consortium which built it, and because of this it was in a perilous financial position. But it was locked in to paying and keeping the hospital open for years ahead!

So we are in the same mad position as Lewisham of being forced to keep open small financially imperiled small hospitals while closing financially and clinically successful, large ones!!!! Someone, somewhere MUST make a fuss about this total absurdity.

Best wishes,
Una

On 15/02/2013 11:07
From: Cllr IVIMY <cllr.ivimy@btinternet.com>
To: "cllr.ivimy@btinternet.com" <cllr.ivimy@btinternet.com>
Sent: Monday, 18 February 2013, 12:49
Subject: Fwd: NW London NHS Joint Primary Care Trusts
Fwd: (1) Lucy Ivimy's letter and (2) PFI at West Middlesex
Sent from my iPad

Begin forwarded message:
Resent-From: <Lucy.Ivimy@lbhf.gov.uk>**From:** Una Hodgkins [redacted]**Date:** 16 February 2013 09:50:24 GMT**To:** Ivimy Lucy COUNCILLOR <Lucy.Ivimy@lbhf.gov.uk>, <consultation@nw.london.nhs.uk>**Subject: NW London NHS Joint Primary Care Trusts Fwd: (1) Lucy Ivimy's letter and (2) PFI at West Middlesex**

Dear Lucy and Mr Zitron,

I have been talking to various professionals employed in the NHS while I distribute leaflets for Save Our Hospitals (Charing Cross, Hammersmith and Ealing). Can you please note the comments in my e-mail below from (1) the consultant in charge of post-graduate medical training at Charing Cross and (2) an employee at the West Middlesex hospital. The comments of the latter are extremely worrying: we could be closing large, clinically and financially viable hospitals like Charing Cross and Hammersmith in favour of clinically and financially weaker and smaller units. This is crazy!

The NHS consultation should focus EXCLUSIVELY on the provision of hospitals on a medical and geographic basis. The NHS should not take into consideration the value of the land in "North Fulham" for redevelopment - particularly as redevelopment means ADDING more residents, not reducing them in some of London's most densely populated, yet very accessible boroughs.

I propose the following, rational solution to cutting hospitals in NW London: create one "super hospital" with stroke, cardiac and "major trauma" (brain and lung surgery) outside the "nucleus" of Central London, either at Charing Cross or at Hammersmith. These two sites have all the advantages required for larger,

more intense hospitals: existing large buildings, room to expand on nearby car park or Wormwood Scrubs, existing landing space for helicopters, close to M4 and Heathrow, good access by public transport.

Retaining three A &Es in central London (Chelsea and Westminster, University College Hospital and St Mary's) makes no sense, as these are sites which are each deficient in several respects. And we should buy out nonsensical PFI deals before they cripple the NHS. Now is the time to tackle this very poor budgeting.

Yours sincerely (Mrs) Una Hodgkins Save Our Hospitals campaign (http://www.saveourhospitals.net/) [redacted]

----- Forwarded Message -----
From: Lucy Ivimy <cllr.ivimy@btinternet.com>
To: Cllr IVIMY <cllr.ivimy@btinternet.com>
Cc: "una.hodgkins [redacted]
"consultation@nw.london.nhs.uk" <consultation@nw.london.nhs.uk>;
"dedewilson [redacted]
Sent: Monday, 18 February 2013, 15:24
Subject: Re: Fwd: NW London NHS Joint Primary Care Trusts Fwd: (1) Lucy Ivimy's letter and (2) PFI at West Middlesex

Dear Una and Dede,

Thanks for your emails. Please note that neither Charing Cross nor Hammersmith hospitals will close. Hammersmith Hospital is a large specialist hospital, which has a small and under-utilised A&E. The A&E does not take serious trauma cases as Hammersmith Hospital does not have the facilities to deal with this sort of work, and blue light ambulances seldom take patients there. The A&E functions more like a UCC, so downgrading it to that will have minimal impact on the hospital.

Charing Cross will lose its acute specialisms but retain its other specialisms..
It will become a Specialist Hospital – like Hammersmith – but with a different range of specialisms. All the outpatients that it currently treats will continue to be treated there.

(DD: It already is an acute major hospital. The specialisms at Charing Cross are what make it a world renowned centre of excellence. The specialist teams are known for their high quality of care.(see attached article) They are unique and irreplaceable. This is being disregarded and so are the patients receiving their specialist care.

These long established teams are being systematically broken up. This is not in the interests of patients' care or doctors of the future. In fact, in complete contradiction of the need for restructuring as stated in the consultation,.. ' for the best care -to have key acute specialty teams under one roof. " They already are. eg. Neuroscience, neurosurgery with brain and spinal treatment specialties, orthopaedics and complex reconstruction/ kidney and renal surgery/ cancer surgery/ ENT.

The total number of patients at Charing Cross will increase, although they will primarily be outpatients rather than in beds. For example, the stroke unit, which takes relatively few patients but uses a lot of bed space, will go, but specialist ante and post natal clinics will be added, which will treat many patients but take up little, if any, bed space. Charing Cross will therefore continue to function as a teaching hospital.

(DD How can it function as a teaching hospital without any inpatients or genuine overall treatment essential for learning? A&E is crucial for doctors of the future to learn emergency medicine and see how patients are treated from start to finish. It cannot be done piecemeal. This is cosmetic. I am an education consultant and teacher trainer. In educational terms this does not make sense.

Patients at the hospital at present are both inpatient and outpatient, needing acute treatment,

beds and follow up treatment. There needs to be continuity and clear effective teamwork from start to finish. This is what students learn from. Ante natal and post natal also require 'birth' experience for doctors to learn about delivering babies and the potential complications. Crucial confidential data also is less likely to get lost as it stay where patients are treated.)

The NHS is indeed proposing a small number of 'super hospitals', to be called 'major hospitals', with the ability to deal with stroke, cardiac, major traumas and acute complex surgery.
and Chelsea West Charing Cross should be one of them

It proposes five such across the North West London area, each with a fully functioning A&E. Two of these are Chelsea & Westminster and St Mary's and the others out of the town centre.
(DD - But none in our borough.)

Kind regards
Lucy Ivimy

From: dede wilson

To: lucy.ivimy@lbhf.gov.uk; consultation@nw.london.nhs.uk; mark.davis@imperial.nhs.uk

1 Attachment 4.2MB

Report praises under-threat Charing Cross and Hammersmith hospitals - Local News - News - Fulham Chr.webarchive Save

Dear Lucy and all concerned,

I'm afraid this does not answer Una's questions. Saying Charing Cross is SAVED as a hospital is disingenuous. It won't be a hospital. We know the plan is to demolish Charing Cross and replace it with a smaller building with the loss of 500 beds. These are to be replaced by 60 day beds but no beds that require acute specialist care as at present.

All should re-read the article attached about the hospital as a reminder of precisely what the Council has said, how Charing Cross is regarded in the Foster report and what the NHS is proposing to dispose of. Consider what was said then and what is being said now.

English language is being played with here to 'manipulate and railroad residents' into thinking they will have a hospital. We won't. It'll be a a glorified specialist polyclinic.

LBHF will have no beds for residents who need acute A&E care and follow up treatment, (unless the specialty exists at Hammersmith Hospital). Only day care. eg. Cancer patients will have radiotherapy and chemo at CXbut have to travel to St Mary's for surgery.

Effectively, it has been assumed that 90% of us in H&F will never need acute medical care and that it is not needed at present. Residents will not need A&E, acute surgical treatment or hospital beds because we will not have accidents or serious health problems. SaHF, NWLondon NHS and LBHF must consider us to be a uniquely healthy borough with a very small population.

These are peoples' lives, not chess pieces to be moved around on the board. They are real people. We must not to be considered dispensable as is happening at the moment. (Our treatment is to be dispersed around NW London, out of borough far from family and friends.)

Save our Hospitals volunteers are outside the hospital regularly. We talk to patients and people in hospital. We know what is going on and how it is affecting everyone. How many of you have done that?

In your reply below, I have commented on the replacement of our hospital by a this proposed specialist clinic.

Peoples' lives in LBHF are being put at risk. NHS cost cutting compromises care as has been shown at Stafford Hospital. Doctors have been mislead into believing the choices in the consultation were the best solutions to the problems facing the NHS. Alternatives were not considered as both Una and I mentioned

If Chelsea Westminster and Charing Cross were to have merged under one management, but on 2 sites, all the best specialty treatment imaginable would have been under one umbrella with a teaching hospital that would be the envy of the rest of the UK. When I asked Dr. Spicer why this was not an option at the meeting at the Methodist Church Hall in Fulham in September, he responded that it wasn't in the brief. It should have been.

We have one MP who has one leg in Chelsea and one leg in Fulham, the other MP represents the other half of Fulham and Hammersmith. Those of us in Fulham have been split down the middle when we should have been united. Just as those two hospitals should have been.

I have a file with evidence on the mismanagement of the consultation. Tactics used to ensure the outcomes that the Government wanted.

Dede Wilson,
English and Foreign Language Teaching Consultant and Trainer
Save our Hospitals Hammersmith and Fulham
Fulham Reach resident and patient at Charing Cross since 1972.
[redacted]

24th February 2015
Dear Mr. Smith,

I am sending in a report of a patient I have worked with as a complimentary medicine Subtle Energy Practitioner for the last three years. [redacted] went into Charing Cross A&E in June 2014 having collapsed. He had heart failure.

Intensive care saved his life with meticulous care for 3 months at Charing Cross from June to September. They were amazing. He was unconscious for much of the time and full of tubes. In September he was sent down to one of the wards to all intents and purposes to have 6 to 7 weeks of crucial rehabilitation and physio to aid his recovery and get him properly back on his feet. (All of his records are there)

This kind of care on the wards however, did not happen. He was bed ridden, miserable and anxious to get home. He was not in a fit state to cope at home on his own. Sporadic attention was not enough to help genuine recovery. He couldn't walk because of diabetes and muscle weakness. He'd been on a drip throughout most of the time in intensive care. He had lost a lot of weight whilst in intensive care but still weighed 18 stone.

They had nothing to get his feet up off the floor and keep them elevated for his circulation if he was sitting in a chair or give him proper support. He was given outsourced junk food with sugar, cups of tea with lots of sugar and biscuits. None of the treatment real treatment he needed was forthcoming. Neither proper physio and rehab or dietary guidance before sending him home. He was bewildered by it all as there was no set programme and did not know why he was there. As a result, he was even more anxious to get home. He could not walk without a walker and standing was difficult. For me, his going home was a real concern as I knew he could not cope on his own.

His long term partner had Alzheimer's and she had gone into a home when he went into hospital. Going home meant he was going home on his own. It was the first time he'd been on his own in more than 50 years. He was not in a fit physical or mental state to be able to cope without good strong support structures. He weighed 18 stone so it would require a strong, fit physiotherapist to get him up and about, be insistent and work with him.

The kind of rehabilitation and regular strong physio support he should have had in hospital for genuine recovery was not possible at home making it effectively non- existent. Those who came tried their best, but they were women dealing with an 18 stone man whose pain and

difficulty moving made him disinclined to try. His legs were down when they should have been elevated and he should have been moving around but couldn't face it. Whilst the bandages on his legs were changed, they were ulcerated and wet and a cause for concern.

He could not cope at home and booked a cruise ship holiday where he would have care and attention. He died on board. On the 20th January. This should not have happened. The contrast in care from the magnificent intensive care to barely minimal ward and non- existent rehabilitation home recovery programme was shocking. What he genuinely needed was not in place and he could not cope and inevitably died. He was an impassioned supporter of the NHS and the amazing medical teams who have been fighting against the odds to maintain high standards of care without the support or funding needed.

Those ringing these changes to privatization, leaving the hospitals underfunded and understaffed are responsible for his death. It is a direct result of this. They could not provide the care needed to keep the promises made. His records are at the hospital and other records are available from his sister in law.

Deirdre Wilson, [redacted]

To: IRP –Independent Review Panel - Hammersmith and Fulham, 6th Floor, 157-197 Buckingham Palace Road London SW1 9SP – info@irpanel.org.uk (Evidence for Sec of State for Health)

Councillor Lucy Ivimy - LBHF & Joint Health and Scrutiny Committee Chair, lucy.ivimy@lbhf.gov.uk
CC Attn:
Councillors Stephen Cowan, leader of the opposition,
LBHF Health and Scrutiny Committee - NW London NHS Stephen.cowan@lbhf.gov.uk,
Daniel Elkeles, Accountable Chief Officer for Central West London, Hammersmith and Fulham and Hounslow CCGS (**CWHH),** NHS Hammersmith and Fulham CCG, 15 Marylebone Road, NW1 5JD:
consultation@nw.london.nhs.uk ; sahf@nw.london.nhs.uk

Dear Panel,

This is a letter I sent to the local Council and SaHF as a resident of LBHF, a patient and *Save our Hospitals* committee member. I wrote to object to the decisions made about our hospitals in Hammersmith and Fulham by NW London NHS and supported by the local Council in LBHF. Charing Cross is a major teaching hospital is to be demolished with a loss of 500 beds and its A&E. There is no valid reason for doing this as I hope this letter will help to demonstrate through personal evidence and evidence from Mark Davis, the CEO of Charing Cross.

Our heavily populated inner city borough will be left with no A&Es and virtually no acute hospital provision. The Council did not support either its electorates' or its communities' needs for emergency provision and inpatient treatment. In refusing the right of appeal, it agreed to closing the best major hospital in West London as noted by the Dr. Foster and Kings Fund. Doing so would be putting lives in the borough at risk.

The impact of these major changes to our hospitals and local healthcare will seriously affect us. NW London NHS and the Council failed in their duty to inform those to be affected of the threat as demonstrated below.

Lucy Ivimy is the Chair of the Health and Scrutiny committee . She said in her most recent email, the Council fought to save the ***non-acute*** services. Prior to the decision, we had thought the Council was fighting for the whole hospital on behalf of its electorate.

From: Cllr IVIMY <cllr.ivimy@btinternet.com>
To: dede wilson [redacted]
Sent: Tuesday, 20 August 2013, 11:17
Subject: Re: Fw:

Dear Dede

There is nothing disingenuous about my response to your standard form letters. I have spent considerable time hearing evidence at the joint scrutiny committee from clinical experts as well as in discussion with the NHS. I understand that the concentration of acute emergency services and acute services generally onto fewer specialist sites is designed to save lives and should do so.

Where we, and I, fought the NHS hard was to retain as comprehensive a range of non-acute services on the Charing Cross site as possible. I believe that the revised and hugely enhanced NHS proposals achieved this.

You have from the outset refused to acknowledge the massive difference between the original proposals effectively to close Charing Cross and the new proposals which are designed to provide an excellent service to local residents.

Her role in helping us as Chair of the Scrutiny Committee for LBHF was paramount in this respect. She received and dealt with all the personalised handwritten and emailed Save our Hospital letters sent in by residents and patients that were so crucial to bringing about changes to the original plans. This was as a result of the written personal concerns they expressed and suggestions of alternatives. Unlike the petitions, which were disregarded, these held the 'legal cogency'.

With regard to public response to the SaHF proposals, what was considered to be legal and worthy of consideration was not defined until the 6 December JPCT meeting, after the 80,000 petitions handed into Downing Street and dismissed, SaHF declared that only feedback in 'writing' would be considered legal.

Those letters expressing patients' and residents' concerns, however, only brought about the so called 'upgrade' from the 'euphemistically titled 'local hospital' (Urgent care centre) in the consultation to what SaHF coined a Specialist 'Health and Social Care Hospital'. Again a euphemism, as it is not really a 'hospital' but a 'centre'. A *hospital* as described in the dictionary, has beds for inpatient care and treatment and an A&E. This will have neither. It is to be a specialist **non-acute** outpatients' clinic. This major ***teaching*** hospital is to be demolished, not saved, with a loss of 500 beds and its A&E. This is no different from the original plans.

Replacing Charing Cross with a small specialist ***out patients only*** *Health and Social Care Centre* is **not** saving it. All the vulnerable needing hospital treatment in the Borough are now at risk. The Council have repeatedly emphasized the excellence of the outpatient care ignoring our need for inpatient hospital treatment, emergency treatment or operations. This is all be in out of borough, in inaccessible Chelsea or expensive Westminster.

The specialist treatment now available at Charing Cross is being systematically dismantled but no one knows yet where these all the specialist teams are to go as confirmed by Daniel Elkeles, the Accountable Chief Officer for the newly formed CWHH CCGS at the JHOSC meeting on 3rd Sept. We should not need to go to other hospitals for specialist treatment when it already all exists at Charing Cross (see below). The proposed reconfiguration of moving everything to St Mary's will be expensive not be '*value for money*' as stated in the consultation as one of the key criteria. In terms of cost, Daniel Elekeles said at the same meeting that in order to ensure they were able to meet capacity expectations £100s of millions was to be spent rebuilding St. Mary's.

This was taken from the attached letter to Jeff Zitron from Mark Davis., Imperial College Trust CEO

The Imperial AHSC response to Shaping a Healthier Future

The nature of our activities and sites today is as follows:

- Hammersmith is a major research centre with specialist clinical care and maternity that has seen significant academic capital investment on a site where the building stock is very mixed;

- St Mary's is a major acute hospital which will require significant redevelopment over the next ten years and currently operates with Western Eye located 500m away on Marylebone Road;

- Charing Cross is a major acute hospital with significant elective specialisation and is the hub for pathology and medical undergraduate teaching on a functional site that has many tenants;

- All sites have significant postgraduate medical training roles totalling over 600 doctors in

training posts with more than 200 currently at the CXH. □In summary all of SaHF's hospital options reinforce the nature of the Hammersmith as a specialist hospital and St Mary's as a major hospital but propose to significantly change the nature of Charing Cross (option A and C see CXH as a local hospital while option B sees it as a major hospital).

The Council are patronising to its electorate and treat us as if we are children who need to accept that this reconfiguration will be good for us. We disagree. No one voted for these changes and wouldn't have either. It was not in the Conservative party manifesto. See the video.

In the interview below, Michael Portillo said the Conservatives have been planning this move for a long time. In reply to a question as to why it wasn't in the manifesto, he said they knew they would not get voted in if they told people.

> http://www.bbc.co.uk/news/uk-politics-12250186

The impact of these major changes to our hospitals and local healthcare will seriously affect everyone. NW London NHS and the Council failed in their duty to inform all those to be affected.

Both are responsible in this respect. Neither made any real attempt to reach every resident, patient, business, school or community group to be affected. The **Save our Hospitals** campaigners took on this public duty. Requests for help were ignored by the Council.

1. SaHF claimed it informed the public in the email below, but only through the local media, much of which is not regularly delivered nor is it easily obtained. This is no way to ensure everyone is informed:

    a. Local newspapers are not delivered everywhere throughout the borough. I often do not receive it. It is difficult to find in local shops. Many people have 'no junk mail, or free newspaper' signs on their doors. Hence using this as a means of informing the public is severely limited.
    b. There was no information available in GP surgeries in LBHF. I visited them all in Fulham. Why wasn't it, if as SaHF claim, all GPS involved support the changes.

    c. It was not publically displayed, available or visible anywhere in LBHF hospitals.

    d. Patients and hospital staff were not informed. From our experience of campaigning outside the hospital regularly and talking to medical staff and doctors both inside and outside, we discovered they knew nothing about what was happening. They found out through speaking with us. The CEO of Charing Cross has kept things close to his chest.

    e. The 628,384 leaflets and consultation documents that SaHF claim were distributed were not distributed in Hammersmith and Fulham. The Council did no leafleting or delivering of hard copy consultaion documents to inform the public in the borough. These *were* distributed in Kensington and Chelsea however, where the preferred Option A hospital, Chelsea Westminster hospital is located. We have spoken to many Kensington and Chelsea residents who can confirm they were delivered

    f. Questions need answering. Q>How did SaHF decide where to distribute these and where exactly were they distributed? This number of leaflets could not possibly inform the whole of the population to be affected by the impact of these changes. It clearly was not intended to. There are 8,000,000 people in NW London NHS zone.

g. Throughout the consultation there was open electioneering in all the preferred Option A hospitals while there was controlled silence in all the other hospitals. Q> Why did neither SaHF nor LBHF tackle the issue of inequality of open electioneering in Option A preferred hospitals when it was clearly pointed out to them? They ***knew*** there were **blue voting** cards on every department reception desk and instructions on how to vote in CW Hospital news broadsheets available throughout the hospital, whilst there were news blackouts in Hammersmith and Charing Cross Hospitals?

   This is 3rd world politics. Patients, residents, medical and hospital staff only heard about the threats from Save **our** Hospitals campaigners. Almost no one knew about the consultation (and still don't) nor was there any access to hard copy consultation documents unless you had heard about it and you had a computer .

Below is an email from SaHF in response to a letter sent that highlighted the lack of information. This is trying to justify and give the impression they informed the public. It lay the fault of not knowing at the recipient's door when it was entirely their responsibility. All of the reasons for not knowing about the consultation or the proposed changes were expressed in the letters sent in. The articles were only published in the local papers and on the Council website so reached few.

From: Sahf <sahf@nw.london.nhs.uk>
To: debbie golt [redacted]
Sent: Friday, September 6, 2013 10:40 AM
Subject: SHFP 1851: Decisions made about hospitals in LBHF

Dear Debbie Golt,

REF: SHFP 1851

Thank you for your email to Cllr Lucy Imivy. The *Shaping a healthier future* team would like to take the opportunity to provide more information on the points you raise.

We are sorry that you were unaware of the consultation process which took place over a 14 week period. It was extensively advertised in all local newspapers (including a full page advertisement), it was featured on TV and radio news items and was the subject of over 200 articles in local newspapers. In addition we distributed over 628,384 leaflets and consultation documents.

h. Leaflets were not distributed to residents in the borough informing them of the consultation or the threats to A&Es and the hospitals by the local Council. I had attended the LBHF Select Health and Scrutiny committee meeting and wrote to them for help. I expected I would get a positive response to my email (see below) but received no replies from anyone until I wrote again. This surprised me as I thought they were supporting the campaign. I had expected at least the courtesy of a reply with some suggestions.
i. Only the Councillors in Fulham Reach leafleted when it became clear we represented their electorate. This happened nowhere else in Fulham, however.

From: dede wilson
To: Steven.cowen@lbhf.gov.uk p.graham@lbhf.gov.uk Iain.coleman@lbhf.gov.uk l, lucy.ivimy@lbhf.gov.uk Joe.carlebach@lbhf.gov.uk Oliver.craig@lbhf.gov.uk , steve.hamilton@lbhf.gov.uk ',nicolas.botterill@lbhf.gov.uk', mark.loveday@lbhf.gov.uk, gavin.donovan@lbhf.gov.uk, Peter.tobias@lbhf.gov.uk sue.perrin@lbhf.gov.uk, victoria.brocklebank fowler@lbhf.gov.uk , marcus.ginn@lbhf.gov.uk

Dear all,

I am on the committee for SOH and attended your Health and Social Care select committee meeting last night. I was very pleased to see the way you all challenged the Imperial College Trust, the Representatives from Chelsea Westminster Hospital and the Consultation team representatives. Questioning put them all on the spot.

It was a stroke of genius looking up the ICT agenda for their Wednesday meeting. Bringing out the 10 minute discussion time allocated to the decision making for the fate of Charing Cross, made it perfectly clear what the decision was. It was most enlightening to hear the way ICT's Steve Mc Mannis evaded the question on their favoured option. Even more so, the way the others responded

I am writing now as a resident in Fulham Reach, on Petley Road, W6 9ST. Fulham, where Charing Cross hospital is, has been a veritable desert of information since the start of the consultation. Not everyone receives the local paper, which is the only source of information. (We didn't get it last week). In view of the fact that the Council agreed upon the Consultation dates, which coincided with School exams, then holidays, the Olympics and the summer recess of Parliament, the Council have a responsibility to better inform its electorate in Fulham. It's urgent now.

We need the Council to be more proactive in informing schools, governors and PTAS, Residents' Associations, Council Estates and vulnerable community groups in Fulham. Many do not have access to a computer or ways of finding out what is happening. As you all so rightly highlighted last night, it will have a profound effect on the whole community if Charing Cross is lost. Hammersmith and Fulham would be left without a major hospital and no A&Es with a rapidly growing population.

It has been down to those of us on the SOH committee since then to disseminate information about the Consultation, what is happening and how to find out about the consultation and how it will affect everyone. There are not enough of us to reach everyone.

Many residents use both Charing Cross and Chelsea Westminster Hospitals. Responding to the Consultation is almost impossible for those who want to make their views known as they do not have computers and have no way of knowing how to receive hard copies. The attendance at Fulham Methodist Church was extremely sorry as no one knew about it. (6- 10 people at a time dropping in.) It was also scheduled at the same time as a major football match between Chelsea and Juventis.

Hammersmith is the hub into Central London from the West for commuters and visitors arriving from Heathrow. Two near disasters with the Hammersmith Flyover and similarly another on the A4 just before the Olympics meant closing both to avert collapse. Charing Cross is major hospital with the best A& E and specialist hospital access and transport link in the whole of NW London. We are a major inner city borough with a major role to play in healthcare. Help us save our hospitals and raise awareness of the public meeting on Friday.

Dede Wilson

i I spoke to Cllr. Marcus Ginn at the Phoenix School public meeting and asked whether he had received my email. I asked if the Council might leaflet residents and was told by Cllr. Ginn that it was too expensive to do so. He said the Council had already spent £43,000 on the campaign. Thus, the LBHF Council refused to leaflet residents to inform them of a major threat. Q> Why did

the Council refuse to leaflet before the end of the Consultation period when it was really needed on the grounds of expense?

Q> What was the £43,000 taxpayers money spent on? Not on genuinely trying to inform the public, community groups schools etc. The Tim Rideout Report exposing the same sham of the consultation they are now repeating as valid, newspaper ads and articles and?????

Q> Why was it too expensive then, yet the Council had more than enough money to leaflet not once but twice to say the hospital had been SAVED, once the decision to create a non- acute outpatients' centre was made?

Q> Why did they not publically declare it was still the intention was to demolish the main hospital and sell off the property after the decision to *SAVE* it was announced?

Q> Why was this news released by the Council before SaHF made its announcement on the 19th Feb by advertising it in the Fulham Chronicle on the 15th February with a centre page spread? This was most misleading. It gave a thoroughly wrong false impression with the SAVED across a picture of the main hospital.

Q> Was this to bring a halt to the letters the Council had been receiving? It certainly made us question the Council's loyalties and whether the Council had ever supported its electorate in Fulham in the first place.

SaHF and LBHF claim 85% patients will still continue to be treated at CX. Yes, but in a limited capacity.The full health needs of residents and members of the communities in LBHF have been dismissed as unimportant. The 85% outpatients it claims will be treated is **only outpatients**. For continuity of care, patients need ongoing *inpatient* hospital care.

Cancer patients already only receive their chemo or radiology at Charing Cross specialist clinics already and have to go to St Mary's for their scans and operations. No continuity of care for vulnerable patients needing **surgery**. This is out of borough, far from the support network of family and friends.

Q: How is this in the best interests of patients' care and recovery when the best treatment is already available at Charing Cross?

Patients are faced with, expensive daunting travel, affecting their recovery. St Mary's is hazardous and inaccessible for these patients. The 500 beds in CXH deal with the reality of their very genuine overall needs and meet them well. Q> Where will these 500 patients needing these beds be sent?

I have neighbours on [redacted], Fulham, who are in precisely this position. They have to take taxis to St Mary's or Chelsea Westminster. (Not paid for by the NHS as claimed). One has bowel cancer. He has had his chemo at Charing Cross but now has to go St Mary's for his scans and an operations. His wife has become ill with the stress of what is happening because of the difficulties posed by the travel and split treatment. Breast cancer which successfully treated at Charing Cross, has been in remission for many years but she is at risk of it resurfacing. This last year has taken a toll on their health. She was a major fundraiser and campaigner for the Maggie's Centre. She had believed in the Council's support but they now feel abandoned by the Councillors they voted for.

My personal comments and concerns:
Chairng Cross has been my hospital for more than 40 years. Both my daughters were born there, the eldest in the original site on the Strand. It was the first teaching hospital in London. It saved my daughter's life when she was badly concussed after an accident at school. I have had various treatment there over the years both inpatient and outpatient.

Orthopaedics was moved to St Mary's sometime ago. I found myself one of the first casualties to be shifted there where my life was subsequently put at risk. As with all patients with mobility problems being treated in Orthopaedics there, I was faced with daunting travel. I could not wear shoes and had trouble walking. I needed an operation. I was sent to St Mary's for an operation for morton's neuroma in the first round of referrals.

St Mary's, however is hazardous and inaccessible if you are immobile. You have to travel through Paddington Station up and down stairs with no lifts. There is no alternative unless you can afford a taxi. The first time I went into the hospital for what was supposed to be day surgery, they had completely lost my notes. After being prepared for the operation and waiting hours, I was then told it could not take place and sent home.

When I finally had the operation after another date was scheduled, I was wheeled out in the rain to a porto-cabin where the operation was performed. I am highly allergic to many analgesics. As a result, I asked if I could have the operation under a local anaesthetic, preferably with an ankle block. I knew this was possible as I knew someone who had had the same operation this way. I was told 'no', but they could do a spinal (not n epidural). I was not keen as I have back trouble but had no other choice so agreed. I am very glad I did although it caused subsequent back trouble for a considerable time afterwards.

I had liaised with the anaesthetist for a long to discuss my intolerance and allergies to drugs. Despite this, I was given codeine, a drug I specifically told them I was highly allergic to. He admitted as much when he said he had given me just a 'drop' of codeine, because he believed it wouldn't have made any difference.

I suffered a severe reaction and nearly died with my temperature dropping to 34 Degrees. I alerted the nurse to the extreme cold I was feeling. I was shaking uncontrollably. Alarm bells went off everywhere. Had I had a general anaesthetic, I dread to think what would have happened. I spent 3 days in hospital recovering from what should have been day surgery.

Post operative travel had to be done on crutches. I had to go down a long flight of stairs and through Paddington station. There was a puddle on a landing and I skidded and prevented myself from falling completely by grabbing the railing and tearing my rotator cuff ligament in my left shoulder. That injury took 6 months to heal and needed weeks of physiotherapy to treat. I would rather die than be forced to repeat the experience of going to St Mary's. It is the most unpatient friendly hospital I have ever been to. It is a rabbit warren to get around and poses serious Health and Safety risks.

2. I needed a bone density scan last year. My doctor referred me to Chelsea Westminster. When I asked to be sent to CX, which has the most up to date radiology equipment - having spent millions on it recently. I was told that was not possible. I got no answer to 'why' other than they were not to refer patients there. At Chelsea Westminster, the radiologist had disappeared. Several of us had to wait nearly two hours and no apologies were given.

ii. I was involved in an accident with a motor cyclist on Dawes Road. Not far from CX. The ambulance took the motor cyclist to Chelsea Westminster, despite the nearness of CX. He had broken his femur badly and needed several operations and countless subsequent outpatients visits. He lived in Willesden Green and had travel on a train and 3 buses to get to CW. Exceedingly difficult on crutches. If he had gone to CX he would have been able to get there easily because of the straightforward disability friendly public transport.

iii. Recently, I ended up in A&E at Charing Cross with suspected septicaemia and was on a drip for 3 days in June. The treatment was excellent throughout and I recovered well.

It was problematic because of my allergies, not just to analgesics but to antibiotics. *They* listened to me and tried two new antibiotics, one which I had a reaction to but the other I was able to take. This was an enormous relief as I now know there is one I can take. It is a serious problem for me. Had I had to go to St. Mary's, I would have refused because of my experience there.

iv. Because I had been on a drip for so long and was immobile, I was at risk of DVT. I ended up back in A&E shorty afterwards because of terrible pain in my leg and neck. The A&E doctor immediately checked my notes and had tests done. She was wonderful, clarified causes of the problems and dealt with them very efficiently and sensitively. This continuity of care is essential and it is something that would be completely broken up by splitting treatment between sites.

Charing Cross is a major purpose built teaching hospital, a perfect site for overall medical training. All on one site and campus. It is the major source of doctors and consultants with highly respected, well-established teams of medical excellence. It must continue to provide this expertise in future. The downgraded hospital will **not be able** to function fully as a teaching hospital without A&E and inpatient beds for continuity of care. A&E experience is essential for learning emergency diagnosis and treatment, not possible without excessive travel to other sites.

Q.3 Charing Cross Hospital is a major teaching hospital and medical school. How can breaking up the specialist teams and departments, and dismantling it be in the interests of future consultants, medical students and doctors of the future, nurses, medical staff and improving healthcare?

We have spoken to many medical students when we have been outside the hospital over the last year while campaigning. None had any idea the hospital was under threat. This is completely unacceptable and irresponsible on the part of Imperial College Trust, LBHF and SaHF. The hospital and campus are perfect for practical learning, classes and studying. This would all be lost. No one consulted the students.

In an excerpt from a freedom of information letter from Imperial College Trust's CEO Mark Davis to Jeff Zitron, Chair of the JPCTS for SaHF that a graduate doctor obtained, it clearly shows that this is going to be a major problem to solve and it will not be cheap solving it.

This makes a mockery of the decision making criteria: ***Value for money*** and ***Education*** in the consultation for each option and Option A, Chelsea Westminster and St Mary's being the preferred options.

Imperial College
London

Teaching

The anticipated shift in healthcare services provides both substantial opportunities and significant challenges for developing and enhancing medical undergraduate and postgraduate training. Imperial College has one of the largest undergraduate medical schools in UK, with some 2,200 students in total. As SaHF's focus moves from service change to implementation and sustainability the huge implications on teaching multi-disciplinary staff across NWL will need to be considered. Currently Charing Cross (CXH) is the major centre for undergraduate medical education, housing two major lecture theatres (> 300 students) not available elsewhere, major teaching facilities, including anatomy, skills labs and computer rooms, communication teaching suites and various student laboratories. Additionally around

The Imperial AHSC response to Shaping a Healthier Future

1,000 medical students live within walking distance of CXH, which provides a sense of student community on this campus and is the social centre for all the medical students. All in all these facilities occupy in excess of 25,000 square metres of space.

Over time some elements of teaching for undergraduates, nursing and AHPs is likely to take place in primary, community and outpatient settings, requiring the appropriate staffing to teach and the space in which to teach to be available in GP practices and local hospitals. Linked to this, more elements within the system will be exposed to teaching, in parallel with patient care, and this will need to be built into placement re- design, individual services at a patient interaction level and the design of space/ facilities.

These changes are likely to require the reconfiguration of training circuits, via the Local Education and Training Board (LETB), with workforce redesign therefore impacting current medical and non medical commissioning plans. At an individual hospital site level, the stratification of hospital services will necessitate training activities shifting across sites as specific services move location. While this is easier to manage at a postgraduate level, at an undergraduate level it is more complex as sites become more specialised or change their nature significantly, ie. the local hospital model. Specifically, should CXH become a local hospital then it will be necessary to relocate the medical school, re-providing the current teaching facilities, as well as relocating doctors in training. Given that the College occupies over 25,000 square metres at CXH these are obviously significant changes that would require careful planning with an expectation under EL (96) 25 that capex requirements would be NHS funded as a NHS led initiative.

Q> What will happen to the medical school buildings? Where will the students go?

Q> How much wasted travel time to many different sites will they be subjected to in order to complete their training and education to become doctors of the future? A&E training will have to be in Westminster and/ or Chelsea as it would not be possible at Charing Cross. After following patients acute hospital care, they would have to follow patients back to Hammersmith and Fulham for the outpatient continuity of treatment.

Q>What will happen to the nurses' quarters and accommodation for medical staff?
Q> What will happen to them?

Q> How do Imperial College, NW London NHS and the Council propose to spend the claimed £90 million to be used saving the site when they intend to demolish the main hospital?

We cannot lose Charing Cross. It means....

- No A&Es in Hammersmith and Fulham, putting our lives at risk.
- No major **acute** hospital for a population the size of Sheffield and increasing rapidly.
- Loss of the only hospital in W. London with good public transport & mobility access.
- Loss of the only readily available air ambulance access in West London
- Loss of one of the most world renowned purpose built teaching hospitals.
- No emergency cover for schools, major football matches, pop venues or businesses.
- No cover for major disaster potential on scale of Hillsborough.
  - Hammersmith and A4 Flyover near collapse and closure
  - 2 premiership Football grounds QPR, Fulham FC
  - Large pop, drama, comedy venue at the Apollo.

NW London NHS has not taken account of any of these factors, nor did they consider the glowing reports on Charing Cross by the Kings Fund and Dr. Foster on its excellence when deciding to demolish the key hospital. It has provided the specialist teams, the high standards and medical expertise. It is the only hospital out of the three with capacity to develop without substantial cost.

It was shocking to learn at the first JHOSC meeting in Kensington Town Hall that in order to create the capacity and expected standards of specialist care, St. Mary's was to be rebuilt. Daniel Elkeles said they needed to look at the reconfiguration of Imperial because there was not the physical capacity to do it at St. Mary's. To quote Daneil Elekles: *There is going to be a complete redevelopment of St. Mary's. Several £100s of millions will be spent on rebuilding and getting rid of the buildings there now.* Again, so much for the ***value for money*** criteria in the consultation. This was clearly always part of the plan.

This all highlighted a most worrying development. What was going to happen to these specialist teams? Were they all going to be split up and dismantled and that unique specialist expertise lost? There was no answer as to what was going to happen to those specialist teams in the Departments Charing Cross was world renowned for, such as those in the Neurology and Urology departments. This department's specialties are unique in that there is an multidisciplinary team of Renal, Sexual and Gender specialists (the only one in the country) at Charing Cross. It is not known what their fate is to be as "*this was a part of on going discussion with Imperial.*"

As has been said before , but I will reiterate: We need both Charing Cross and Chelsea Westminster Hospitals under one management, **both as acute specialist *inpatient*** hospital sites, but one hospital. Each site complementing the other in their specialties in our two very heavily populated inner city boroughs. It would be an unsurpassable Centre of excellence, as already noted by the Kings Fund.

St Mary's Hospital, Hammersmith and Charing Cross Hospitals are all under Imperial College Trust management. St Mary's in Westminster was never under threat, only its hospitals in Hammersmith and Fulham. I believe we matter. It's time the Council and NW London NHS, restored democracy, listened to our concerns and allowed us to have an Independent Review. I would appreciate a reply.

Name & Address **Dede Wilson,** [redacted]

Comments

Who are these faceless 'clinicians" of whom you speak so highly of who seem to think no one will ever need an A&E? What are their credentials?

Why will they not ballot the doctors and take their genuine concerns on board? If these clinicians are Dr. Mark Spencer and Dr. Tim Spicer. I would rather go to my vet for treatment than go to either of them for any medical condition. Use of the 'passive in language makes it possible to say things that sound very erudite and important but are actually completely meaningless. That's why it is so effective a form of spin used by politicians and those who do not want to take responsibility.

I would like all my questions answered please and my questions on transparency.

Dede Wilson

Smith Peter

From: Sandeep Bafna [redacted]
Sent: 09 February 2015 00:10
To: Smith Peter
Subject: No more cuts, no more closures please

Dear Peter Smith,

As a resident living in West London for many years & having experienced long waiting times at the hospitals, I'd urge you to seriously think again on the knock on effects to further cuts & closures in West London hospitals.

Hope common sense will prevail & win-win solution amicably reached.

Kind regards,
S Bafna

[redacted]

Sent from my iPad

ELIZABETH M. BALSOM

[redacted]

Peter.smith@lbhf.gov.uk

North West London Healthcare Commission

January 5, 2015

I am a patient at Charing Cross Hospital and I am concerned for its future and hence for my care. I describe what has happened to me purely to illustrate the services the hospital provides rather than to bore you with my medical history.

And being a particularly stupid person I do not understand how you can take out the number of hospital beds Imperial is planning and continue to provide adequate health care. Surely the capital's health care should display some degree of integration. If you take out a couple of A&E departments and hundreds of hospital beds in one locality, there will be a knock-on effect. The Evening Standard's headline 5/1/15 shouts "London's Record Population Boom". Even without current population increases, the number of hospital beds per 1000 population is lower in England than in other developed countries. Can we afford to lose more?

BREAST CANCER

In April 2010 I was diagnosed with breast cancer following a routine mammogram at Queen Mary's Hospital, Roehampton. The diagnosis was made by the excellent team at the Duchess of Kent unit at St George's Tooting, but I asked to be treated at Charing Cross. I do not have a car, and the journey by public transport from my home in West Putney to that hospital is tiring and time consuming on two or three buses, depending on how energetic I feel. I knew that traipsing over to Tooting would kill me even if the cancer didn't. In contrast, I can hop on the 430 bus and be at Charing Cross in less than half an hour. The Tooting team understood this and supported me in my decision.

I was lucky in that I was assigned to the team led by Mrs J. Lewis, a plastics and reconstructive as well as cancer surgeon. Charing Cross already performed sentinel node biopsies, sparing patients unnecessary axilliary clearance if appropriate. I was impressed with the quality of care I received on the ward. Was there some dragon matron insisting on high standards? I even enjoyed the food, though my friends all know I am no gourmet cook.

I now wonder what is the outlook for my monitoring. I already have appointments this year for the breast surgery and oncology departments, and follow-up mammograms. Will I continue to be treated at Charing Cross?

HAEMATOLOGY

In 2012, during the drawn-out process of reconstruction I inadvertently crossed the path of the Haematology Department. I confess I wasn't overjoyed at this, but I received such detailed and extensive investigations that I feel immense gratitude to the team. My care was their priority. , These investigations included a bone marrow biopsy at the Hammersmith. I was slightly apprehensive about this and phoned to find out more about the procedure. I was assured that techniques and needles had advanced since a friend had found it painful back in the 1980s, and that people came from all over the world for it to be done. What will happen to this department?

An echocardiogram featured in all my many investigations. The technician said: "we have this record of you for reference if it is needed in future." What will happen to my records?

EYE CARE IN LONDON

I am concerned for the outlook for eye care in London if the Western Ophthalmic closes. I have severe eye problems because of exceptionally high myopia. I have done the rounds of the capital's eye deparments: at the contact lens clinic at the Western Ophthalmic in the 1990s; at St Thomas's in the early noughties where my GP referred me to his friend for cataract surgery; now at Moorfields. Moorfields, as that hospital acknowledges, is desperately overcrowded; stand up and someone pinches your seat. What are the implications for eye care in London, already under pressure, if the Western closes?

A&E

One Friday afternoon in June 2007, probably a lifetime away in NHS terms, I became dizzy and collapsed in Putney High St. I was taken by ambulance to Charing Cross. Medical staff and a bed were waiting for me. By early evening I was feeling better and felt I could leave. But I had mentioned that my father died aged 54 from a heart attack when I was a child and this family history always sets alarm bells ringing. A doctor came to me and explained that if I was happy to stay overnight, they would wake me at 5 am and take blood which would prove definitively whether I had had a heart attack. I would have been foolish to have left at the point. I was grateful that this test was done.

Late last spring my neighbours' son collapsed with a cardiac arrest in Upper Richmond Rd. He was taken to Charing Cross where he died. They speak warmly and appreciatively of the care and compassion he and they were given.

WEST PUTNEY

In September 2012 I did go to a sparsely attended meeting in Wandsworth Town Hall about the future of the North West London hospitals, but West Putney has been largely left out of this consultation. Although people in this neighbourhood use Charing Cross, appreciate its skills, find it convenient and accessible, and when offered a choice, choose to go there, the prospect of its loss is not publicised here. Charing Cross is easy to get at from here; Kingston and St George's involve lengthy tiring journeys. The TfL website illustrates this. What happens in North West London affects us here.

Yours faithfully,

Elizabeth Balsom

Smith Peter

From: Katrina Black [redacted]
Sent: 06 January 2015 17:27
To: Smith Peter
Subject: Charing Cross Hospital

Just wanted to lodge a complaint about the possible reduction in services at Charing Cross Hospital.
I write as a former patient with knowledge of A &E services and routine out patient care in clinics. Both have been excellent in the past. The alternative for those living in Putney is Kingston or St George's Tooting. Experience at both has been less than satisfactory and with Kingston given cause for serious complaint. Additionally the travel time to St George's is excessive particularly for those with significant health problems.
It takes longer to travel to St George's from Putney than it does to travel from one city to another in other parts of the country. As a result people in Putney often opt for treatment at Charing Cross or at Chelsea and Westminster. Any closure or reduction in services at Charing Cross would put additional pressure on Chelsea and Westminster Hospital.
Kingston has had a question mark hanging over its future for so long now that staff are demoralised and many NHS staff are unwilling to take posts there. Please ensure that this is not the outcome at Charing Cross Hospital which has long served the community well and to a high standard.
Your email was given on our local website.
Kind Regards
Katrina Black

Smith Peter

From: dede wilson [redacted]
Sent: 02 February 2015 17:48
To: Smith Peter
Subject: Concern about the future of Charing Cross
Attachments: IRP Letter of concern - impact of SaHF changes .doc; DD's Impact of SaHF changes.docx

Dear Mr. Smith,

I have been a part of the campaign to Save our Hospitals since they were first threatened in the Summer of 2012. I have attached evidence I sent to the Independent Review panel which links original concerns expressed to the Conservative led Hammersmith and Fulham Council about risks to what is happening now. I have couple of files of hard copy evidence that I would like to bring in for the Inquiry to use.

I will be sending in evidence of the impact of these changes on a friend who was magnificently treated at Charing Cross throughout the summer. Unfortunately, he died two weeks ago. Had his treatment been carried through fully as it should have been, this would not have happened.

[redacted] was treated in intensive care in July and August by a team of wonderful consultants and medical staff who they saved his life and got him into a fit state to begin his recovery and rehabilitation. I have regular accounts of his physical and mental state during that time through emails sent by friends who visited him regularly whilst he was being treated. I will compile these.

Problems set in almost as soon as he was sent onto the wards for rehabilitation and recovery in September. His treatment changed abruptly and he was more or less treated as if he was just someone taking up a bed. The care was appalling and he was not given any of the treatment recommended by the consultants who saved his life. He consequently was desperate to get home but was in no fit state to do so.

When he was sent home he was unable to walk or properly care for himself in any way. No rehabilitation, or much needed physio therapy, or care for his ulcerated diabetic legs. He was even no guidance on care, prevention or on 'healthy diabetic food to help him look after himself or to aid recovery. He could not cook because he could not stand for any length of time. He was given a walker and some support for his toilet, but nothing to ensure his legs were elevated for his circulation. All the things that landed him in the hospital in the first place.

[redacted] funeral is next week. It is still too painful and raw for me to write about. I am am so angry and it was soooo unnecessary. This social care in the community is rhetoric. This is about cost cutting not service or care. It's about closing hospitals and getting rid of patients. It is wasting NHS resources and demoralising doctors and medical staff. It is not about helping patients to look after themselves in their own homes so there is "no need to go into hospital.

Not following through with recommended rehabilitation programmes at the point and place of of need, the hospital,is a complete demoralising waste of time, energy and resources for all the doctors and medical staff who care and want the best for their patients only to have them abandoned when they need continued inpatient care the most for their rehabilitation. and recovery.

I will send compile the emails as soon as I can.

Dede Wilson
[redacted]

To: IRP –Independent Review Panel - Hammersmith and Fulham, 6th Floor, 157-197 Buckingham Palace Road London SW1 9SP – info@irpanel.org.uk (Evidence for Sec of State for Health)

Councillor Lucy Ivimy - LBHF & Joint Health and Scrutiny Committee Chair, lucy.ivimy@lbhf.gov.uk
CC Attn:
Councillors Stephen Cowan, leader of the opposition,
LBHF Health and Scrutiny Committee - NW London NHS Stephen.cowan@lbhf.gov.uk,
Daniel Elkeles, Accountable Chief Officer for Central West London, Hammersmith and Fulham and Hounslow CCGS **(CWHH),** NHS Hammersmith and Fulham CCG, 15 Marylebone Road, NW1 5JD:
consultation@nw.london.nhs.uk ; sahf@nw.london.nhs.uk

Dear Panel,

This is a letter I sent to the local Council and SaHF as a resident of LBHF, a patient and *Save our Hospitals* committee member. I wrote to object to the decisions made about our hospitals in Hammersmith and Fulham by NW London NHS and supported by the local Council in LBHF. Charing Cross is a major teaching hospital is to be demolished with a loss of 500 beds and its A&E. There is no valid reason for doing this as I hope this letter will help to demonstrate through personal evidence and evidence from Mark Davis, the CEO of Charing Cross.

Our heavily populated inner city borough will be left with no A&Es and virtually no acute hospital provision. The Council did not support either its electorates' or its communities' needs for emergency provision and inpatient treatment. In refusing the right of appeal, it agreed to closing the best major hospital in West London as noted by the Dr. Foster and Kings Fund. Doing so would be putting lives in the borough at risk.

The impact of these major changes to our hospitals and local healthcare will seriously affect us. NW London NHS and the Council failed in their duty to inform those to be affected of the threat as demonstrated below.

Lucy Ivimy is the Chair of the Health and Scrutiny committee . She said in her most recent email, the Council fought to save the ***non-acute*** services. Prior to the decision, we had thought the Council was fighting for the whole hospital on behalf of its electorate.

From: Cllr IVIMY <cllr.ivimy@btinternet.com>
To: dede wilson [redacted]
Sent: Tuesday, 20 August 2013, 11:17
Subject: Re: Fw:

Dear Dede

There is nothing disingenuous about my response to your standard form letters. I have spent considerable time hearing evidence at the joint scrutiny committee from clinical experts as well as in discussion with the NHS. I understand that the concentration of acute emergency services and acute services generally onto fewer specialist sites is designed to save lives and should do so.

Where we, and I, fought the NHS hard was to retain as comprehensive a range of non-acute services on the Charing Cross site as possible. I believe that the revised and hugely enhanced NHS proposals achieved this.

You have from the outset refused to acknowledge the massive difference between the original proposals effectively to close Charing Cross and the new proposals which are designed to provide an excellent service to local residents.

Her role in helping us as Chair of the Scrutiny Committee for LBHF was paramount in this respect. She received and dealt with all the personalised handwritten and emailed Save our Hospital letters sent in by residents and patients that were so crucial to bringing about changes to the original plans. This was as a result of the written personal concerns they expressed and suggestions of alternatives. Unlike the petitions, which were disregarded, these held the 'legal cogency'.

With regard to public response to the SaHF proposals, what was considered to be legal and worthy of consideration was not defined until the 6 December JPCT meeting, after the 80,000 petitions handed into Downing Street and dismissed, SaHF declared that only feedback in 'writing' would be considered legal.

Those letters expressing patients' and residents' concerns, however, only brought about the so called 'upgrade' from the 'euphemistically titled 'local hospital' (Urgent care centre) in the consultation to what SaHF coined a Specialist 'Health and Social Care Hospital'. Again a euphemism, as it is not really a 'hospital' but a 'centre'. A *hospital* as described in the dictionary, has beds for inpatient care and treatment and an A&E. This will have neither. It is to be a specialist **non-acute** outpatients' clinic. This major ***teaching*** hospital is to be demolished, not saved, with a loss of 500 beds and its A&E. This is no different from the original plans.

Replacing Charing Cross with a small specialist ***out patients only*** *Health and Social Care Centre* is **not** saving it. All the vulnerable needing hospital treatment in the Borough are now at risk. The Council have repeatedly emphasized the excellence of the outpatient care ignoring our need for inpatient hospital treatment, emergency treatment or operations. This is all be in out of borough, in inaccessible Chelsea or expensive Westminster.

The specialist treatment now available at Charing Cross is being systematically dismantled but no one knows yet where these all the specialist teams are to go as confirmed by Daniel Elkeles, the Accountable Chief Officer for the newly formed CWHH CCGS at the JHOSC meeting on 3rd Sept. We should not need to go to other hospitals for specialist treatment when it already all exists at Charing Cross (see below). The proposed reconfiguration of moving everything to St Mary's will be expensive not be *'value for money'* as stated in the consultation as one of the key criteria. In terms of cost, Daniel Elekeles said at the same meeting that in order to ensure they were able to meet capacity expectations £100s of millions was to be spent rebuilding St. Mary's.

This was taken from the attached letter to Jeff Zitron from Mark Davis., Imperial College Trust CEO

The Imperial AHSC response to Shaping a Healthier Future

The nature of our activities and sites today is as follows:

- Hammersmith is a major research centre with specialist clinical care and maternity that has seen significant academic capital investment on a site where the building stock is very mixed;

- St Mary's is a major acute hospital which will require significant redevelopment over the next ten years and currently operates with Western Eye located 500m away on Marylebone Road;

- Charing Cross is a major acute hospital with significant elective specialisation and is the hub for pathology and medical undergraduate teaching on a functional site that has many tenants;

- All sites have significant postgraduate medical training roles totalling over 600 doctors in

training posts with more than 200 currently at the CXH. In summary all of SaHF's hospital options reinforce the nature of the Hammersmith as a specialist hospital and St Mary's as a major hospital but propose to significantly change the nature of Charing Cross (option A and C see CXH as a local hospital while option B sees it as a major hospital).

The Council are patronising to its electorate and treat us as if we are children who need to accept that this reconfiguration will be good for us. We disagree. No one voted for these changes and wouldn't have either. It was not in the Conservative party manifesto. See the video.

In the interview below, Michael Portillo said the Conservatives have been planning this move for a long time. In reply to a question as to why it wasn't in the manifesto, he said they knew they would not get voted in if they told people.

> http://www.bbc.co.uk/news/uk-politics-12250186

The impact of these major changes to our hospitals and local healthcare will seriously affect everyone. NW London NHS and the Council failed in their duty to inform all those to be affected.

Both are responsible in this respect. Neither made any real attempt to reach every resident, patient, business, school or community group to be affected. The **Save our Hospitals** campaigners took on this public duty. Requests for help were ignored by the Council.

1. SaHF claimed it informed the public in the email below, but only through the local media, much of which is not regularly delivered nor is it easily obtained. This is no way to ensure everyone is informed:

    a. Local newspapers are not delivered everywhere throughout the borough. I often do not receive it. It is difficult to find in local shops. Many people have 'no junk mail, or free newspaper' signs on their doors. Hence using this as a means of informing the public is severely limited.
    b. There was no information available in GP surgeries in LBHF. I visited them all in Fulham. Why wasn't it, if as SaHF claim, all GPS involved support the changes.

    c. It was not publically displayed, available or visible anywhere in LBHF hospitals.

    d. Patients and hospital staff were not informed. From our experience of campaigning outside the hospital regularly and talking to medical staff and doctors both inside and outside, we discovered they knew nothing about what was happening. They found out through speaking with us. The CEO of Charing Cross has kept things close to his chest.

    e. The 628,384 leaflets and consultation documents that SaHF claim were distributed were not distributed in Hammersmith and Fulham. The Council did no leafleting or delivering of hard copy consultaion documents to inform the public in the borough. These *were* distributed in Kensington and Chelsea however, where the preferred Option A hospital, Chelsea Westminster hospital is located. We have spoken to many Kensington and Chelsea residents who can confirm they were delivered

    f. Questions need answering. Q>How did SaHF decide where to distribute these and where exactly were they distributed? This number of leaflets could not possibly inform the whole of the population to be affected by the impact of these changes. It clearly was not intended to. There are 8,000,000 people in NW London NHS zone.

g. Throughout the consultation there was open electioneering in all the preferred Option A hospitals while there was controlled silence in all the other hospitals. Q> Why did neither SaHF nor LBHF tackle the issue of inequality of open electioneering in Option A preferred hospitals when it was clearly pointed out to them? They ***knew*** there were **blue voting** cards on every department reception desk and instructions on how to vote in CW Hospital news broadsheets available throughout the hospital, whilst there were news blackouts in Hammersmith and Charing Cross Hospitals?

   This is 3rd world politics. Patients, residents, medical and hospital staff only heard about the threats from Save **our** Hospitals campaigners. Almost no one knew about the consultation (and still don't) nor was there any access to hard copy consultation documents unless you had heard about it and you had a computer .

Below is an email from SaHF in response to a letter sent that highlighted the lack of information. This is trying to justify and give the impression they informed the public. It lay the fault of not knowing at the recipient's door when it was entirely their responsibility. All of the reasons for not knowing about the consultation or the proposed changes were expressed in the letters sent in. The articles were only published in the local papers and on the Council website so reached few.

From: Sahf <sahf@nw.london.nhs.uk>
To: debbie golt[redacted]
Sent: Friday, September 6, 2013 10:40 AM
Subject: SHFP 1851: Decisions made about hospitals in LBHF

Dear Debbie Golt,

REF: SHFP 1851

Thank you for your email to Cllr Lucy Imivy. The *Shaping a healthier future* team would like to take the opportunity to provide more information on the points you raise.

We are sorry that you were unaware of the consultation process which took place over a 14 week period. It was extensively advertised in all local newspapers (including a full page advertisement), it was featured on TV and radio news items and was the subject of over 200 articles in local newspapers. In addition we distributed over 628,384 leaflets and consultation documents.

h. Leaflets were not distributed to residents in the borough informing them of the consultation or the threats to A&Es and the hospitals by the local Council. I had attended the LBHF Select Health and Scrutiny committee meeting and wrote to them for help. I expected I would get a positive response to my email (see below) but received no replies from anyone until I wrote again. This surprised me as I thought they were supporting the campaign. I had expected at least the courtesy of a reply with some suggestions.
i. Only the Councillors in Fulham Reach leafleted when it became clear we represented their electorate. This happened nowhere else in Fulham, however.

From: dede wilson
To:Steven.cowen@lbhf.gov.uk p.graham@lbhf.gov.uk Iain.coleman@lbhf.gov.uk l, lucy.ivimy@lbhf.gov.uk Joe.carlebach@lbhf.gov.uk Oliver.craig@lbhf.gov.uk, steve.hamilton@lbhf.gov.uk','nicolas.botterill@lbhf.gov.uk', mark.loveday@lbhf.gov.uk, gavin.donovan@lbhf.gov.uk, Peter.tobias@lbhf.gov.uk sue.perrin@lbhf.gov.uk, victoria.brocklebank fowler@lbhf.gov.uk, marcus.ginn@lbhf.gov.uk

Dear all,

I am on the committee for SOH and attended your Health and Social Care select committee meeting last night. I was very pleased to see the way you all challenged the Imperial College Trust, the Representatives from Chelsea Westminster Hospital and the Consultation team representatives. Questioning put them all on the spot.

It was a stroke of genius looking up the ICT agenda for their Wednesday meeting. Bringing out the 10 minute discussion time allocated to the decision making for the fate of Charing Cross, made it perfectly clear what the decision was. It was most enlightening to hear the way ICT's Steve Mc Mannis evaded the question on their favoured option. Even more so, the way the others responded

I am writing now as a resident in Fulham Reach, on [redacted] Fulham, where Charing Cross hospital is, has been a veritable desert of information since the start of the consultation. Not everyone receives the local paper, which is the only source of information. (We didn't get it last week). In view of the fact that the Council agreed upon the Consultation dates, which coincided with School exams, then holidays, the Olympics and the summer recess of Parliament, the Council have a responsibility to better inform its electorate in Fulham. It's urgent now.

We need the Council to be more proactive in informing schools, governors and PTAS, Residents' Associations, Council Estates and vulnerable community groups in Fulham. Many do not have access to a computer or ways of finding out what is happening. As you all so rightly highlighted last night, it will have a profound effect on the whole community if Charing Cross is lost. Hammersmith and Fulham would be left without a major hospital and no A&Es with a rapidly growing population.

It has been down to those of us on the SOH committee since then to disseminate information about the Consultation, what is happening and how to find out about the consultation and how it will affect everyone. There are not enough of us to reach everyone.

Many residents use both Charing Cross and Chelsea Westminster Hospitals. Responding to the Consultation is almost impossible for those who want to make their views known as they do not have computers and have no way of knowing how to receive hard copies. The attendance at Fulham Methodist Church was extremely sorry as no one knew about it. (6- 10 people at a time dropping in.) It was also scheduled at the same time as a major football match between Chelsea and Juventis.

Hammersmith is the hub into Central London from the West for commuters and visitors arriving from Heathrow. Two near disasters with the Hammersmith Flyover and similarly another on the A4 just before the Olympics meant closing both to avert collapse. Charing Cross is major hospital with the best A& E and specialist hospital access and transport link in the whole of NW London. We are a major inner city borough with a major role to play in healthcare. Help us save our hospitals and raise awareness of the public meeting on Friday.

Dede Wilson

i I spoke to Cllr. Marcus Ginn at the Phoenix School public meeting and asked whether he had received my email. I asked if the Council might leaflet residents and was told by Cllr. Ginn that it was too expensive to do so. He said the Council had already spent £43,000 on the campaign. Thus, the LBHF Council refused to leaflet residents to inform them of a major threat. Q> Why did

the Council refuse to leaflet before the end of the Consultation period when it was really needed on the grounds of expense?

Q> What was the £43,000 taxpayers money spent on? Not on genuinely trying to inform the public, community groups schools etc. The Tim Rideout Report exposing the same sham of the consultation they are now repeating as valid, newspaper ads and articles and?????

Q> Why was it too expensive then, yet the Council had more than enough money to leaflet not once but twice to say the hospital had been SAVED, once the decision to create a non- acute outpatients' centre was made?

Q> Why did they not publically declare it was still the intention was to demolish the main hospital and sell off the property after the decision to *SAVE* it was announced?

Q> Why was this news released by the Council before SaHF made its announcement on the 19th Feb by advertising it in the Fulham Chronicle on the 15th February with a centre page spread? This was most misleading. It gave a thoroughly wrong false impression with the SAVED across a picture of the main hospital.

Q> Was this to bring a halt to the letters the Council had been receiving? It certainly made us question the Council's loyalties and whether the Council had ever supported its electorate in Fulham in the first place.

SaHF and LBHF claim 85% patients will still continue to be treated at CX. Yes, but in a limited capacity.The full health needs of residents and members of the communities in LBHF have been dismissed as unimportant. The 85% outpatients it claims will be treated is **only outpatients**. For continuity of care, patients need ongoing *inpatient* hospital care.

Cancer patients already only receive their chemo or radiology at Charing Cross specialist clinics already and have to go to St Mary's for their scans and operations. No continuity of care for vulnerable patients needing **surgery**. This is out of borough, far from the support network of family and friends.

Q: How is this in the best interests of patients' care and recovery when the best treatment is already available at Charing Cross?

Patients are faced with, expensive daunting travel, affecting their recovery. St Mary's is hazardous and inaccessible for these patients. The 500 beds in CXH deal with the reality of their very genuine overall needs and meet them well. Q> Where will these 500 patients needing these beds be sent?

I have neighbours on Petley road and Crabtree Lane, Fulham, who are in precisely this position. They have to take taxis to St Mary's or Chelsea Westminster. (Not paid for by the NHS as claimed). One has bowel cancer. He has had his chemo at Charing Cross but now has to go St Mary's for his scans and an operations. His wife has become ill with the stress of what is happening because of the difficulties posed by the travel and split treatment. Breast cancer which successfully treated at Charing Cross, has been in remission for many years but she is at risk of it resurfacing. This last year has taken a toll on their health. She was a major fundraiser and campaigner for the Maggie's Centre. She had believed in the Council's support but they now feel abandoned by the Councillors they voted for.

My personal comments and concerns:
Chairng Cross has been my hospital for more than 40 years. Both my daughters were born there, the eldest in the original site on the Strand. It was the first teaching hospital in London. It saved my daughter's life when she was badly concussed after an accident at school. I have had various treatment there over the years both inpatient and outpatient.

Orthopaedics was moved to St Mary's sometime ago. I found myself one of the first casualties to be shifted there where my life was subsequently put at risk. As with all patients with mobility problems being treated in Orthopaedics there, I was faced with daunting travel. I could not wear shoes and had trouble walking. I needed an operation. I was sent to St Mary's for an operation for morton's neuroma in the first round of referrals.

St Mary's, however is hazardous and inaccessible if you are immobile. You have to travel through Paddington Station up and down stairs with no lifts. There is no alternative unless you can afford a taxi. The first time I went into the hospital for what was supposed to be day surgery, they had completely lost my notes. After being prepared for the operation and waiting hours, I was then told it could not take place and sent home.

When I finally had the operation after another date was scheduled, I was wheeled out in the rain to a porto-cabin where the operation was performed. I am highly allergic to many analgesics. As a result, I asked if I could have the operation under a local anaesthetic, preferably with an ankle block. I knew this was possible as I knew someone who had had the same operation this way. I was told 'no', but they could do a spinal (not n epidural). I was not keen as I have back trouble but had no other choice so agreed. I am very glad I did although it caused subsequent back trouble for a considerable time afterwards.

I had liaised with the anaesthetist for a long to discuss my intolerance and allergies to drugs. Despite this, I was given codeine, a drug I specifically told them I was highly allergic to. He admitted as much when he said he had given me just a 'drop' of codeine, because he believed it wouldn't have made any difference.

I suffered a severe reaction and nearly died with my temperature dropping to 34 Degrees. I alerted the nurse to the extreme cold I was feeling. I was shaking uncontrollably. Alarm bells went off everywhere. Had I had a general anaesthetic, I dread to think what would have happened. I spent 3 days in hospital recovering from what should have been day surgery.

Post operative travel had to be done on crutches. I had to go down a long flight of stairs and through Paddington station. There was a puddle on a landing and I skidded and prevented myself from falling completely by grabbing the railing and tearing my rotator cuff ligament in my left shoulder. That injury took 6 months to heal and needed weeks of physiotherapy to treat. I would rather die than be forced to repeat the experience of going to St Mary's. It is the most unpatient friendly hospital I have ever been to. It is a rabbit warren to get around and poses serious Health and Safety risks.

2. I needed a bone density scan last year. My doctor referred me to Chelsea Westminster. When I asked to be sent to CX, which has the most up to date radiology equipment - having spent millions on it recently. I was told that was not possible. I got no answer to 'why' other than they were not to refer patients there. At Chelsea Westminster, the radiologist had disappeared. Several of us had to wait nearly two hours and no apologies were given.

ii. I was involved in an accident with a motor cyclist on Dawes Road. Not far from CX. The ambulance took the motor cyclist to Chelsea Westminster, despite the nearness of CX. He had broken his femur badly and needed several operations and countless subsequent outpatients visits. He lived in Willesden Green and had travel on a train and 3 buses to get to CW. Exceedingly difficult on crutches. If he had gone to CX he would have been able to get there easily because of the straightforward disability friendly public transport.

iii. Recently, I ended up in A&E at Charing Cross with suspected septicaemia and was on a drip for 3 days in June. The treatment was excellent throughout and I recovered well.

It was problematic because of my allergies, not just to analgesics but to antibiotics. *They* listened to me and tried two new antibiotics, one which I had a reaction to but the other I was able to take. This was an enormous relief as I now know there is one I can take. It is a serious problem for me. Had I had to go to St. Mary's, I would have refused because of my experience there.

iv. Because I had been on a drip for so long and was immobile, I was at risk of DVT. I ended up back in A&E shorty afterwards because of terrible pain in my leg and neck. The A&E doctor immediately checked my notes and had tests done. She was wonderful, clarified causes of the problems and dealt with them very efficiently and sensitively. This continuity of care is essential and it is something that would be completely broken up by splitting treatment between sites.

Charing Cross is a major purpose built teaching hospital, a perfect site for overall medical training. All on one site and campus. It is the major source of doctors and consultants with highly respected, well-established teams of medical excellence. It must continue to provide this expertise in future. The downgraded hospital will **not be able** to function fully as a teaching hospital without A&E and inpatient beds for continuity of care. A&E experience is essential for learning emergency diagnosis and treatment, not possible without excessive travel to other sites.

Q.3 Charing Cross Hospital is a major teaching hospital and medical school. How can breaking up the specialist teams and departments, and dismantling it be in the interests of future consultants, medical students and doctors of the future, nurses, medical staff and improving healthcare?

We have spoken to many medical students when we have been outside the hospital over the last year while campaigning. None had any idea the hospital was under threat. This is completely unacceptable and irresponsible on the part of Imperial College Trust, LBHF and SaHF. The hospital and campus are perfect for practical learning, classes and studying. This would all be lost. No one consulted the students.

In an excerpt from a freedom of information letter from Imperial College Trust's CEO Mark Davis to Jeff Zitron, Chair of the JPCTS for SaHF that a graduate doctor obtained, it clearly shows that this is going to be a major problem to solve and it will not be cheap solving it.

This makes a mockery of the decision making criteria: ***Value for money*** and ***Education*** in the consultation for each option and Option A, Chelsea Westminster and St Mary's being the preferred options.

Imperial College
London

Teaching

The anticipated shift in healthcare services provides both substantial opportunities and significant challenges for developing and enhancing medical undergraduate and postgraduate training. Imperial College has one of the largest undergraduate medical schools in UK, with some 2,200 students in total. As SaHF's focus moves from service change to implementation and sustainability the huge implications on teaching multi-disciplinary staff across NWL will need to be considered. Currently Charing Cross (CXH) is the major centre for undergraduate medical education, housing two major lecture theatres (> 300 students) not available elsewhere, major teaching facilities, including anatomy, skills labs and computer rooms, communication teaching suites and various student laboratories. Additionally around

The Imperial AHSC response to Shaping a Healthier Future

1,000 medical students live within walking distance of CXH, which provides a sense of student community on this campus and is the social centre for all the medical students. All in all these facilities occupy in excess of 25,000 square metres of space.

Over time some elements of teaching for undergraduates, nursing and AHPs is likely to take place in primary, community and outpatient settings, requiring the appropriate staffing to teach and the space in which to teach to be available in GP practices and local hospitals. Linked to this, more elements within the system will be exposed to teaching, in parallel with patient care, and this will need to be built into placement re- design, individual services at a patient interaction level and the design of space/ facilities.

These changes are likely to require the reconfiguration of training circuits, via the Local Education and Training Board (LETB), with workforce redesign therefore impacting current medical and non medical commissioning plans. At an individual hospital site level, the stratification of hospital services will necessitate training activities shifting across sites as specific services move location. While this is easier to manage at a postgraduate level, at an undergraduate level it is more complex as sites become more specialised or change their nature significantly, ie. the local hospital model. Specifically, should CXH become a local hospital then it will be necessary to relocate the medical school, re-providing the current teaching facilities, as well as relocating doctors in training. Given that the College occupies over 25,000 square metres at CXH these are obviously significant changes that would require careful planning with an expectation under EL (96) 25 that capex requirements would be NHS funded as a NHS led initiative.

Q> What will happen to the medical school buildings? Where will the students go?

Q> How much wasted travel time to many different sites will they be subjected to in order to complete their training and education to become doctors of the future? A&E training will have to be in Westminster and/ or Chelsea as it would not be possible at Charing Cross. After following patients acute hospital care, they would have to follow patients back to Hammersmith and Fulham for the outpatient continuity of treatment.

Q>What will happen to the nurses' quarters and accommodation for medical staff?
Q> What will happen to them?

Q> How do Imperial College, NW London NHS and the Council propose to spend the claimed £90 million to be used saving the site when they intend to demolish the main hospital?

We cannot lose Charing Cross. It means....

- No A&Es in Hammersmith and Fulham, putting our lives at risk.
- No major **acute** hospital for a population the size of Sheffield and increasing rapidly.
- Loss of the only hospital in W. London with good public transport & mobility access.
- Loss of the only readily available air ambulance access in West London
- Loss of one of the most world renowned purpose built teaching hospitals.
- No emergency cover for schools, major football matches, pop venues or businesses.
- No cover for major disaster potential on scale of Hillsborough.
  - Hammersmith and A4 Flyover near collapse and closure
  - 2 premiership Football grounds QPR, Fulham FC
  - Large pop, drama, comedy venue at the Apollo.

NW London NHS has not taken account of any of these factors, nor did they consider the glowing reports on Charing Cross by the Kings Fund and Dr. Foster on its excellence when deciding to demolish the key hospital. It has provided the specialist teams, the high standards and medical expertise. It is the only hospital out of the three with capacity to develop without substantial cost.

It was shocking to learn at the first JHOSC meeting in Kensington Town Hall that in order to create the capacity and expected standards of specialist care, St. Mary's was to be rebuilt. Daniel Elkeles said they needed to look at the reconfiguration of Imperial because there was not the physical capacity to do it at St. Mary's. To quote Daneil Elekles: *There is going to be a complete redevelopment of St. Mary's. Several £100s of millions will be spent on rebuilding and getting rid of the buildings there now.* Again, so much for the ***value for money*** criteria in the consultation. This was clearly always part of the plan.

This all highlighted a most worrying development. What was going to happen to these specialist teams? Were they all going to be split up and dismantled and that unique specialist expertise lost? There was no answer as to what was going to happen to those specialist teams in the Departments Charing Cross was world renowned for, such as those in the Neurology and Urology departments. This department's specialties are unique in that there is an multidisciplinary team of Renal, Sexual and Gender specialists (the only one in the country) at Charing Cross. It is not known what their fate is to be as "*this was a part of on going discussion with Imperial.*"

As has been said before , but I will reiterate: We need both Charing Cross and Chelsea Westminster Hospitals under one management, **both as acute specialist *inpatient*** hospital sites, but one hospital. Each site complementing the other in their specialties in our two very heavily populated inner city boroughs. It would be an unsurpassable Centre of excellence, as already noted by the Kings Fund.

St Mary's Hospital, Hammersmith and Charing Cross Hospitals are all under Imperial College Trust management. St Mary's in Westminster was never under threat, only its hospitals in Hammersmith and Fulham. I believe we matter. It's time the Council and NW London NHS, restored democracy, listened to our concerns and allowed us to have an Independent Review. I would appreciate a reply.

Name & Address **Dede Wilson,** [redacted]

Comments

Who are these faceless 'clinicians" of whom you speak so highly of who seem to think no one will ever need an A&E? What are their credentials?

Why will they not ballot the doctors and take their genuine concerns on board? If these clinicians are Dr. Mark Spencer and Dr. Tim Spicer. I would rather go to my vet for treatment than go to either of them for any medical condition. Use of the 'passive in language makes it possible to say things that sound very erudite and important but are actually completely meaningless. That's why it is so effective a form of spin used by politicians and those who do not want to take responsibility.

I would like all my questions answered please and my questions on transparency.

Dede Wilson

Dear Panel,

I am resending the evidence I first sent in August and have complied it onto one document. It starts with the timescale of the Consultation events and written a breakdown of the flaws in the Shaping a Healthier Future Consultation below. Both highlight concerns regarding engagement with the public, transparency and the Council's role reversal in its approach to dealing with the consultation in Hammersmith and Fulham. I have incorporated the emails sent with the evidence I attached or forwarded.

I have copied the Health and Scrutiny Committee's Draft report on the Consultation in September 2012 and pasted it into the document. I have not had time to go through every aspect but have highlighted key points in bold. I attended the Committee's public meeting in September.

In addition, this is followed by the scripted notes from the public meetings in September which are linked to it.

I have also included the notes from the public JPCT meeting in December where legal cogency was described. This led to letters being written to provide evidence and alternatives to the consultation options which brought about the proposed Outpatients Specialist Health and Social Care Centre.

Consultation Times scale and events

June 2012
NW London NHS *Shaping a Healthier Future* Consultation announced in Chelsea Westminster Hospital news broadsheet *Trust News*, for June / July. Prior to official announcement in the media. Electioneering before voting in consultation announced.

July 2012

- Hammersmith flyover closed for major repairs as in serious danger of collapse
- M4 from Heathrow to A 4 flyover exit section closed - in danger of collapse
- London Olympics about to start. Athletes travelling along A4.
- Schools break for the Summer Holidays
- NW London NHS *Shaping a Healthier Future* Consultation announced in News
- Timing open to question.
- Local paper, the Fulham Chronicle announcement.
- SaHF and LBHF methods of informing the public of major changes to health care with huge impact are open to question. Little serious effort to communicate.
- No leafleting of residents by Hammersmith and Fulham Council to inform of:
  a.) the SaHF Consultation
  b.) the proposed threat of loss of A&Es in the Borough, at Hammersmith Hospital and Charing Cross
  c.) the loss of 500 acute beds at Charing Cross. Major hospital to be demolished to be replaced by a 24 hr GP led Urgent Care Walk in Centre (Misleadingly described as a Local hospital.)
- Save our Hospitals campaign begun.
- Save our Hospitals regular stalls in Hammersmith and Fulham and hospitals to inform patients and residents about the consultation.
- Approached GP practice. Asked to display information about Save our Hospitals and the Consultation for patients to be able to make informed choices. (Lillie Road Surgery) Told could not, as could not be seen to be taking sides.
- Fulham patients referred to Chelsea Westminster Hospital by GPs rather than Charing Cross (first hand experience)
- Patients to be affected uninformed by GPs in surgeries.

- Dr. Sam, at Lillie Road was a representative on the *SaHF* JPCT
- Visited GP surgeries throughout Fulham – no information about consultation and no hard copy documents. Generally not available in GP practices
- No information in Option B and Option C hospitals, only in Option A.

September 2012

- 17th Sept 2012 - London Borough of Hammersmith and Fulham Health and Scrutiny Committee Meeting. Critical of Imperial College Trust and SaHF (See attached scripted notes p. 8-13)

- 18th Sept - LBHF Town Hall public meeting with representatives of the SaHF Board, Save our Hospitals Chair, Carlo Nero and local Council Representatives, Nicolas Botterill and Marcus Ginn (see Fulham Chronicle article) LBHF Council petition set up online. Impression supporting residents and campaigners to Save our Hospitals

- 3rd world Option A hospitals electioneering for Consultation votes since June stepped up. Not monitored by SaHF or LBHF although knowing other Option hospitals under threat in NW London NHS were under information blackout. Voting results open to challenge. (See scripted meeting notes -19th Sept)

- Chelsea Westminster Hospital - open electioneering discovered throughout the hospital. Copies of the hospital's broad sheet, 2 page spread in *Trust News* demonstrated how to simply vote for Option A to save CWH.

- Blue voting cards available on reception desks in every out patients' department at Chelsea Westminster. Tick box cards to send in to SaHF.

- Voting instructions had no explanation of the impact of voting Option A meant closing Charing Cross (CXH) and other hospitals A&Es.

- Hardcopy Consultation booklets delivered throughout Chelsea.

- 19th Sept SaHF meeting with *Age UK*, Kensington Town Hall. Save our Hospitals set up an uninvited stall and participated in workshop. Audience confusion over the workshop implications of the consultation proposals for their healthcare. Member of the board heard to say in an aside to a colleague about their understanding and confusion, " It doesn't matter. We just have to be seen to be consulting."

- 19th Sept 2012 - Concurrent SaHF Meeting at Fulham Broadway Church Hall, next to Chelsea football ground. Hard copy consultation docs available. Save our Hospital reps visited throughout day. Attendance very poor. (See scripted notes p.13 -)

- Timing and location of meeting open to challenge. Organised for the same day and time as major international football match, Chelsea vs Juventus. Poorly advertised, (notice only on SaHF website)

- Only 6 people attending when I went. Stopped from photographing display and attendance. Two crucial questions about Charing Cross and Chelsea Westminster asked. (See attached scripted notes from the meeting - Witness, Anabela Hardwick)

- Save our Hospitals regular stalls continue in Hammersmith and Fulham.

- NW London NHS Joint Primary Care Trusts Public Meeting- Westminster Methodist

Hall – The SaHF board shown a copy of Chelsea Westminster Hospital *Trust News*.

- Questioned about why and how such open, active electioneering could be allowed when there were media embargos and blackouts in all the Option B (Charing Cross and Hammersmith) and C Hospitals.

- Unsatisfactory, unacceptable response by representatives responsible for ensuring democratic procedures are followed. - Informed us that "Foundation Trust Hospitals (eg.CWH) were independently funded so could do what they liked". This effectively condoned unmonitored, unequal 3rd world election voting.

- Emailed LBHF Council members with requests for help informing residents and vulnerable community groups in Fulham. A struggle for volunteers informing people in such a short time frame.

- Wrote to local Council again requesting help. No response from LBHF until pleading on behalf of the Borough's electorate. (forwarded & attached email 25th Sept) Consultation deadline fast approaching.

- Cllrs from Fulham Reach ward responded by leafleting the ward about the consultation. Other wards in Fulham did not. No mention the actual threat of closure of Charing Cross in choice of Options.

October 2012

- SaHF public meeting Phoenix School, Hammersmith

- Dr. Tim Spicer, when asked by Doctor why GPS had not been balloted as they had been in Kingston. Replied that it was not necessary as "the PCTS knew what doctors involved thought. Open to question how and who they were.

- Request to Marcus Ginn, LBHF Communications Councillor on Health and Scrutiny committee for help leafleting to reach people before the end of the Consultation. Told too expensive. £43,000 already spent. Question how spent in relation to duty to inform and represent their electorate.

- Consultation closed.

- 80,000 petition submitted to Downing Street

December 2012

- SaHF JPCT meeting at Westminster Methodist Hall – *legal cogency* regarding the public and patients' response to the consultation defined. Dismissive of petition. Only written evidence to be taken account of.

- Save our Hospitals letters written- based on residents and patients' concerns, questions and alternative suggestions (eg. Charing Cross merger with Chelsea Westminster under one management) These were then personalized to make it easier to express concerns.

- Letters printed and handed out with envelopes to all without computer access at stalls. Others sent them in online. (see attached example.)

- Sent to Cllr Lucy Ivimy LBHF Health and Scrutiny committee chair & Jeff Zitron, SaHF Chair.

- Letters prompt limited alteration to original plans. Demolition and destruction of main teaching hospital included.

January / February 2013

- 15th January JPCT meeting – discussion with Daniel Elkeles, Jeff Zitron and and Cllr Peter Graham after overhearing them talking about the closure of CX as a foregone conclusion. Told them not to be so hasty.
- Approx 1000 letters sent in.
- Campaigning at Barons Court - Stopped by Daniel Elkeles from SaHF saying the board had listened to us. Changes not in consultation made in response to letters
- Outpatients Specialist Health and Social Care Centre with 60 day beds and no A&E to replace major teaching hospital with a loss of 500 acute inpatient beds.
- LBHF Council placed two page misleading spread in Fulham Chronicle announcing hospital *SAVED,* Friday prior to SaHF announcement.
- 15th February
- Open to question why a full page misleading image of Charing Cross with SAVED across was in the newspaper when it was to be demolished and replaced by a 16,000 ft Outpatients Centre on the site of the Medical Staff accommodation blocks. It gave impression the hospital was saved when it only meant saved from original plans that no one knew about.
- LBHF leafleting the Borough twice, once with an expensively produced booklet with the same misleading information thus giving the impression the hospital had been saved.
- Taxpayers' money used in publicity used to misinform. Cllr Graham, however said it was funded by the Conservative party, not by the taxpayer.
- SaHF official announcement 19th February, 2013

Shaping a Healthier Future Consultation Flaws
Role of NW London NHS Trust; London Borough of Hammersmith &Fulham Council

Timing

- Timing of the consultation announcement was extremely poor. The dates had been agreed on by the local Council.
- Announced during school exams, just prior to summer holidays and the onset of the Olympics
- Announcement only in the news. Not publicised anywhere in Hammersmith and Fulham other than in the local papers and online on the Council website (dependent on having a computer and being a regular visitor to the website)

Informing and consulting the public and GPs

- Seriously inadequate public engagement, engagement with doctors and medical students at Charing Cross. All those to be most seriously impacted.
- Little awareness of the Consultation throughout the Borough but particularly in Fulham.
- No attempt to contact vulnerable community groups, patients or residents to be impacted and seriously affected by the proposed major reconfiguration of healthcare in Hammersmith and Fulham by either LBHF or SaHF.
  (*Evidence -LBHF Health and Scrutiny Committee Draft report)*
- No attempt to openly engage with clinicians over concerns in Hammersmith and Fulham. Doctors reluctant to speak out publically.
- (*Evidence – Draft report- Inadequate key engagement with the public and GPs, which they contributed to - 4.2- 4.5, scripted meeting notes)*
- No information in GP surgeries.
- No leafleting of residents in the borough by the Council.

(*Evidence – letters from residents, emails to the Council and Consultation board, scripted public meeting notes, Draft report*)

Obstacles to taking part in the consultation

- No access or awareness of either the consultation itself or where and how to obtain the hard copy consultation documents.
- No attempt to ensure they were available to the public to enable people to participate. (except at poorly advertised public meetings…Fulham Chronicle Newspaper with limited uneven distribution and LBHF website)
- Hard copy unavailable. To be ordered online. Telephone number only available online. Participation dependent on awareness and computer access and knowledge. Excluded thousands without either.
- The document itself was ridiculously long for a public document, 88 pages.
- Length and being online made it difficult to read without taking notes to be able to answer the questions. A daunting task.
- Its design meant questions were at the end. Not possible to answer without constantly referring back. Answering questions was reliant on content detail so juggling act. Very difficult to do without hard copy.
- Questions were leading questions without genuine choice. Aimed at achieving prescribed answers.
- Options were not consulting or providing genuine choices for beneficiaries of care or to enable them to be participants in of design (Andrew Lansley's first test)
- Options were aimed at closing hospitals and selecting which to close. Patients use both Charing Cross and Chelsea Westminster for different reasons.
- Nowhere was it made clear that voting for Option a and 'saving' Chelsea Westminster meant 'closing' Charing Cross and reducing it to an Urgent Care Centre, the size of a football pitch.
- 4 hours to complete. Daunting and confusing. Leading questions to 'railroad desired answers. Validity open to serious challenge under Trades Description Act.
- It gave the impression that hospitals would be little affected by the closure of A&Es. Reality…Closing of A&Es, when hospitals become local hospitals or specialist hospitals, in reality this means a loss of the hospital to the public.
- Calling them *Specialist or Local* is euphemistic for major downgrading by either limiting hospital accessibility to patients through referral only or complete loss of a 'hospital to be replaced by a 24 hour GP led Urgent Care Walki-in Centre.
  This euphemistic labelling gave the impression they would all continue to be hospitals with inpatient / outpatient treatment. It is effectively a lie.
- The document was written in carefully chosen misleading marketing speak. Misrepresenting the reality of healthcare in hospitals so that what will effectively be a major reduction in healthcare is being sold as a promise of a model of perfection. Glossy Estate agents euphemistic language. Eg. A '*local hospital' with 24 hour care* is a 24 Hour GP led Urgent Care Centre, not a hospital at all. Validity, therefore, open to question.

The consultation process itself

- The choices and configuration do not stand up to the key 4 test criteria laid down by Andrew Lansley, the former Secretary of State, nor do they meet their own criteria. They fail completely on the first that *"patients must be at the heart of everything from beneficiaries of care to participants of design."*

- This is financially driven, as a business case (profit and loss) and is not about a health service (treatment and standards of care.) Healthcare is not business, it is a service. There is little consideration of what is involved in providing effective a good health service, i.e. investment in the medical workforce *and* its support staff, not corporate business managers with vested interests. This is how medical ***services*** need to be delivered to achieve good outcomes. Cost cutting measures like those proposed by Bruce Keogh, to follow a PC World /Curries model of success of 'less is more' is ludicrous.

- The criteria of 'Value for money' and 'Education' in the options is seriously open to challenge. There is no mention of the cost or consequences of dismantling the major world renowned medical School at Charing Cross nor how this is in the interests of Education. None of the other hospital options could possibly replace it and it would have to be divided between hospitals piecemeal. Doing so would be extremely costly, disruptive and counter productive as it would destroy the medical school. *(Evidence Attachments- 1. Draft report 2. Freedom of information letter from the CEO of Imperial College)*

- No consultation with student body of Medical students.

- No risk assessment done on effect of impact of closing Charing Cross Hospital and A&Es in Hammersmith and Fulham (*Evidence –notes from December 6th public meeting; see Risk assessment documents from SaHF)*

Key questions patients and medical students regularly asked campaigners and in the letters sent in.

These questions were not answered and could not be answered satisfactorily.

Q 1. Why and how are the specialties at Charing Cross to be dismantled in patients' interests?
Q.2 Where are they to go that will be in the interests of patients and medical staff?
Q.3 Charing Cross Hospital is a major teaching hospital and medical school, as is Chelsea Westminster. How can dismantling them be in the interests of future consultants, medical students and doctors of the future, nurses, medical staff and improving healthcare? How is this meeting the best 'Education' provision, one of the key criteria in the consultation?
Q.4 How will this provide 'Value for money', one of the key criteria in the consultation?

We would like answers to questions asked, including questions of Transparency sent to the consultation board and the local Council. (see Attached)

How were the choices of hospitals to pit against one another chosen? It was not based on the Kings Fund or patient consultation. What was the motivation?

The suggestion of merging Chelsea Westminster and Charing Cross as one major acute hospital on two sites under one management put forward in letters to Lucy Ivimy, the Chair of the Health and Scrutiny Committee and SaHF JPCT Chair, Jeff Zitron, were dismissed by Dr. Tim Spicer at Fulham Broadway public meeting as it '*was not in the brief*'.

Decisions and concerns

- Seriously open to challenge through lack of genuine consultation and resulting poor response.
- Open unmonitored electioneering allowed and encouraged while other hospitals kept in the dark.
- Hard copy Consultation documents delivered throughout Chelsea.
- Lack of public engagement and consultation in Hammersmith and Fulham by either LBHF and SaHF
- Transparency regarding consultation with the public, medical practitioners and staff at Charing Cross and Hammersmith Hospitals.
- Voiced concerns that NW London JPCTs making decisions would be disbanded and no one would be accountable for decisions.
- Website for NW London NHS no longer active (www.northwestlondon.nhs.net) Crucial information to be replaced by NHS Central London CCG, NHS Hammersmith and Fulham CCG; NHS West London CCG, now the joint CWHH CCG, Accountable Chief Officer, Daniel Elekeles (cwhh.complaints@nhs.net) this was not set up until after decisions were made. Many of the board members are the same as those on the JPCT SaHF board.
- Concerns about conflicts of interest in private companies. (*Evidence mail from Stephen Duckworth, Rainsberry Freedom of information letter)*

Hammersmith and Fulham Council approved the Consultation dates, dismissed the findings of their own Draft report on the Consultation to support the decision regardless of major concerns, misled their electorate and finally denied us the right to a judicial review.

There are many questions regarding transparency both NW London NHS and LBHF must answer. The UK is meant to be a democratic country but the processes followed.

LBHF Select Health and Social Care Scrutiny Committee and Shaping a Healthier Future Meetings

Monday 17 September 2012
LBHF Select Health Committee Meeting -Scripted notes

Council Questioning - Steve Mc Manus -
Interim Imperial College Trust Chief Operations (5 weeks)

Cllr Q: *Has Imperial indicated its preferences to the consultation committee?*

SM: *Paper sets out options of sites internally and College on academic study and research. Imperial Trust and College are separate. We are the Academic Health and joint executive between the two.*

Council Q on waiting lists, treatment records for arthritis and cancer patients
Challenge on lost data and waiting lists.

SM: *Still a backlog of 243 patients on lost or incomplete records.*
86 at risk patients not traced.
Referral of arthritis/ orthopaedic and cancer patients not addressed.
Admitted using private sector to shorten waiting times as these were

far in excess of 18 week waiting list recommended.
time. Highlighted that it was not a site issue. Trust vague abt position n CXH

Cllrs questioned SM on what was actually doing about the Trust Corporate reputation. – i.e. what led to problems with data entry.

SM: admitted very poor reputation. *Need to do a lot to rebuild. Need to communicate with patients and all relevant bods and organizations.*

Cllr LI –LBHF summary: – *Imperial College needs to be investigated*
A lot of highly paid executives.

- *Council lacks trust in ICT*
- *Requires a page by page analysis of exactly what went wrong*
- *Want to know how far up the management chain / ladder problems went.*
- *Call for an independent review of the government of the Trust; a report and precise analysis to clarify vagueness.*

A. Preferred option –
Council Q: *Is Imperial supporting Option A?*

SM avoided answering the questions. Talked about out of hospital care. Stated the issue around CH is very complex. Not clear whether supporting the proposal of CXH being downgraded to local hospital status. Said 'debate will be had on Weds' 19th Sept.

Cllr. Stephen Cowen (SC): *I'm concerned abt the vagueness of the answer.*

Cllr Peter Graham (PG): Challenging the Trust on their agenda for Weds. (Looked up agenda on phone.) Q. *How can a verbal update lasting 10 minutes be devoted to a decision that will have profound consequences? The paper going to the board for discussion is not on the agenda. This beggars belief.*

Cllr Marcus Ginn (MG): *Imperial have a clear position on this but are not being open about it.*

Cllr PG: *It is reasonable that the board make a copy of the paper available.*

Shift attention to Chelsea Westminster representatives.

Sir Christopher Edwards (CE) – Chair of Trust Govs at CWH and Head of College of Emergency Medicine – role of A&E at CWH:

"Junior doctors are being put off medicine. They do not feel they are properly exposed. There is a30% drop out rate. End up with only 40% that might lead to consultancies."

"This is what this is really about."

Cllr Q: *How on a very constrained site would CWH cope?*

Sir CE: *Current A&E would expand on the ground floor and sideways. Paediatric A&E and oncology The adjacent space opposite could be used.*
What's worrying is when you say 100,000, but this is not real. Blue light ambulances is what we should be talking about.

Cllr Stephen Cowen (SC): Question about outright campaigning on behalf of CWH

Sir CE: *It's not surprising people support their own hospital. It's rather different consequences for CXH.*

Cllr SC*: You are a very successful Foundation Trust Hospital. You have demonstrated you can manage things well.*

Sir CE*: In cash strapped NHS we believe we can invest funds. If we didn't there would be catastrophic consequences. We would have to move Paediatrics and Maternity, our core business, with knock on effects on emergency services We wouldn't have need for specialist surgery.*

Becoming a local hospital means becoming a non-viable hospital. CWH is one of the last new hospitals built.

Cllr Q: Questioning the level playing field: *Do you think it would be inappropriate if you didn't put it in the public domain?*

Sir CE: *Yes, but..... CXH is part of this very large group. They have to look at siting. CWH is compared with Imperial Trust not CXH. The Board of CWH is a Foundation Trust with an independent budget set aside for governors on how to use.*

In the past it was said that Brompton and Marsden should move to CXH. Is it the best thing for the patient? Poorly staffed?
There is an amazing lack of clarity of precisely what will happen if it is downgraded to a local hospital.

We are supportive of Imperial College Trust becoming a Foundation Trust. The main problem with running a three hospital site is almost becoming financially viable.

Cllr SC: *How many services are being duplicated? Could there be a merger with CXH?*

Sir CE: *I have a vested interest in Imperial Trust's success. Could we have a closer link to CXH? That would be entirely up to Imperial Trust. CWH is open to all sorts of options. That's not on their agenda. It's not what they are trying to do.*
We want the best possible outcome for patients and have to put resources to the best use.

Cllr Q*: Are there better solutions?*

Sir CE: *If they split up too much, it won't work. St. Mary's Renal merged to meet patients' needs.*

Cllr SC: - summarising the uneven playing field: *There is no independent objectivity pitting one hospital against another. It isn't going to end well if they are pitted against one another. The critical test will be what NW London NHS does about Imperial Trust. The key issue of 'site' is allotted 10 minutes to the ICT agenda. NW London has to address this. It is side tracking real issues in our community.*

Sir CE: *If there are other options, we would find it very useful if alternatives could be put forward and we would consider.*

NW London NHS representatives - Dr.Tim Spicer; Daniel Elkeles
Responding to the Rideout report and discussion. They believe they corrected the inaccuracies regarding the pre-consultation, present consultation, methodology of choice and addressed the issue of 'not taking the special needs of Hammersmith and Fulham into account , particularly with regard to the specific specialties at CXH and the effect.

Cllr SC: *We do not accept the case for this change. The reasons for solutions are good but the solutions are not. The issue of 'work force for example. How would you solve the issues of workforce.?*

Cllr L.I. (Chair): *We agree with the principles but not the solutions*

Cllr PG: *We were talking about land value the last time you were here. Value across the sites (p.50 Appendix 3)*
At any time have Imperial expressed their opinions?

DE: *When the Trust come to a final decision. Told NW London Imperial are supporting Option A It is what he (CEO) told us He did not want to pre-empt the meeting and decision. There is a debate. I know Mark Davis will discuss this at the meeting on Wednesday.*

Cllr (Joe Carlbach JC?) : *This gives the impression one bit doesn't know what the other is doing. That he hasn't had a discussion yet and there is no firm Trust position on this, implying the opposite of what NW London NHS are saying. I think there is an on going dialogue.*

DE: *Mark Davis said the joint committee preference is for Option A. this does not mean he has made his mind up. There is the option to changeAll Trusts were finally aware shortly before the consultation went out. The Trust Board is having the debate.*

Cllr JC: *This is becoming a farce. We will refer this to the Secretary of State for proper investigation. What exactly is going on here?*

Comment- *Consultees with vested interests - Daniel E passed a note to CWH. What was that about? CWH have a vested interest in outcomes.*

Cllr LI: *would expect having a dialogue with all the major hospitals - but not with CXH, says risks are in a public document in the public domain. All risks PCT has to deal with but.....*

Cllr SC: *p 7 - £1bn savings.*

DE: *We've identified issues and should have gone to NW NHS but only now looking at them.*

Cllr LI: *Not having looked at these risks is astonishing (all the things that could go so wrong)*

Cllr SC: *This is intrinsic to the case of change you are making. This has never been updated. Looks like the cart before the horse.*

Cllr LI: *Are you saying you have a list of mitigating factors considered?*

DE: *Correct. The next report will be in November.*

Cllr SC: *Why have you not been able to say how GPs have responded? CCGs. Considering the four Langley tests.*

DE: *NW never claimed unanimous support.*

Cllr SC: *We would like a percentage.*
Cllr PG: *Land value - You lambasted Tim Rideout about land valuation. You said you had done valuations. Misled the committee twice - led to the wrong page in the document - differentiated between sites.*

Cllr LI - CCGs -GP Surgeries: *Even if H&F doctors disagree, in other words the Shadow or non statutory doctors have no say because they are not in the CCG, the four tests have to be applied.*

DE: *They agreed to the consultation.*

Cllr LI: *That is very different from agreeing to the proposals.*

Dr Tim Spicer (TS): *We want to protect the trust of patients.*

Cllr LI: *They will have to make a decision. What will the decision process be?*

Dr TS: *We have to continue to take soundings of our members.*

Cllr PG: *(ref-Langsley)You must have support of GP commissions - the Secretary of State looks for / reviews the support of practices or commissions.*
The decision is to be made in February He has to consider the 4 tests. Do not believe the decision is in the best interest of local NHS. Is there a better way than A /B/ C?

Dr TS?: *That is the joint committee decision. The Secretary of State does not have to take the decision they have recommended.*

Cllr PG: *If the 4 tests are not met, it will not go ahead. One of the tests is that it must have the support of GP commissions.*

DE: *We will take soundings from the members of the CCG.*

Cllr Q: *Why not a ballot?*

Dr TS: *One of the functions is not just your opinion in order to have confidence in what we can deliver/ can do.*

DE: *True consultancy is not just about counting heads, it's considering best solutions.*

Cllr SC: *What if 60/ 80% of doctors were against the proposals; that makes the position untenable.*

NW NHS: *A majority of colleagues are against Option A (members of CCG but not all doctors.) Dr TS: As clinicians, we have concerns about all the options.*

Cllr LI: *The committee would like a clear understanding of what GPs think. All. Whether these proposals have the support of the GPs. Tim Rideout. (will be polled online) If there is no way of balloting GPs, the Council will make its own decisions.*

LBHF Scrutiny committee's Draft report on consultation
September 2012

Concerns not addressed but Council chose to disassociate, dismiss as if never drawn attention to and sing the unchanged SaHF mantra

The local Council drew up a damning draft report of the consultation in Sept 2012 but then dismissed all the risks they highlighted and singing the same mantra as SaHF. All the concerns have not been resolved and now in January 2015 are proving to be genuinely putting lives at risk. This is gambling with our lives. They knew the risks and decide to go ahead regardless. No one voted for these changes. Risks and concerns are unchanged.

Councillor Lucy Ivimy admitted they had fought hard for the ***non-acute*** services at Charing Cross but said little about the much needed acute services, loss of 500 beds or A&E.

Below was the response the LBHF Conservative Council Health and Scrutiny Committee's response to the SaHF Consultation at the time. (Committee chaired by Lucy Ivimy) Highlighted in blue and yellow are the key concerns made. Once the SAHF reconfiguration was 'approved', given full support, the opposite stance was taken, overiding concerns expressed prior to approval.

All concerns expressed here, then were no longer deemed to be flaws and were either dismissed with the same marketing language used by SaHF or ignored. This was a shock to all who had trusted and believed the Council had supported them in the campaign to Save our Hospitals, Charing Cross and our A&Es. This however can be used to look back at what was said then and subsequently ignored leading us to where we are now in January 2015. Key questions:

- How many of these concerns and risks are proving to be a reality now?
- Why did the Conservative Council then dismiss these concerns and unquestioningly support Shaping a Healthier Future's arguments, thereby accepting that risk assessments would be done but after decisions to go ahead with major reconfiguration of our NHS hospitals and healthcare rather than before?

I have a file with evidence of how the consultation was mismanaged to ensure the outcomes that the Government wanted. The concerns highlighted below will provide a benchmark for comparison of what is actually happening now and the full impact of these changes.

London Borough of Hammersmith and Fulham **11 September, 2012**
'Shaping a Healthier Future' Consultation Response **v.1 Draft 21**

1. Introduction

1.1 "Shaping a healthier future" is NHS North West London's proposed programme of change for both out of hospital and hospital services and this is Hammersmith & Fulham Council's

response to the proposals. They represent *a radical reconfiguration of local health services, including a reduction in the scope and breadth of services provided at Charing Cross Hospital and, to a lesser extent, at Hammersmith Hospital. Given that they will have a profound and lasting impact on local health services, services that are of the utmost importance to local people, the Council is committed to responding fully to the consultation.*

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

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

2. Context

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

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

2.3 The proposals represent a radical reconfiguration of local health services, with an increased emphasis on out of hospital care and a reconfiguration of NW London's hospitals. For Hammersmith & Fulham, this means a reduction in the *scope and breadth of services provided at Charing Cross Hospital (most notably including a downgrading of the Hospital's A&E and the removal of complex medicine and surgery services) and, to a significantly lesser extent, at Hammersmith Hospital (both hospitals are currently managed by Imperial College Healthcare NHS Trust).*

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

2.5 In this context the Council recognises the need for local health services to improve and develop to meet the changing and growing demands of local people, against a backdrop of the increasing financial challenges that have resulted from the overall pressure on public

sector expenditure. Indeed, the Council faces exactly the same challenges in relation to its own services and statutory responsibilities.

3. The Council's position

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

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

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

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

- The objectives of "Shaping a healthier future" are appropriate (i.e. of improving service quality and reducing unwarranted variation, improving the health of local people through the provision of better care, and ensuring that organisations are financially viable for the long term);
- *The* current provision of local healthcare is not acceptable, as it is too often characterised by unacceptable levels of quality and service and unwarranted variation, substantial health inequalities, and an unsustainable financial position;
- The adequacy of the pre-consultation engagement of key stakeholders, notably patients, public, clinicians and the Council itself is open to challenge;
- The extent to which the requirements of the 2010 Equality Act have been met in determining the impact of proposals on protected groups at a borough level is open to challenge;
- **The timing of the consultation is open to challenge**. Consideration should be given to amending the current timetable to allow for further consultation with the affected parties, detailed impact assessment work to be undertaken and revisions to be made to the decision making arrangements;
- The decision making arrangements are inappropriate. Consideration should be given to amending the arrangements to ensure that any decisions are made by the new NHS and local government arrangements that come in to effect on 1 April 2013, rather than key decisions being made by organisations on the eve of their abolition;
- The programme's objectives are appropriate (i.e. of preventing ill health; providing easy access to high quality GPs; and supporting patients with long term conditions and to enable older people to live more independently).
- The assumption that NW London has an over-provision of acute hospitals is open to challenge. If the preferred option for restructuring is adopted, adult acute bed provision in NW London will be reduced to just over half of that required;
- The underlying financial model used to establish the "base financial position" has not been subject to independent verification and cannot necessarily be relied upon to support true comparisons between hospitals. In some cases it is also at odds with organisations' own views of their underlying financial position;
- The proposed clinical standards and visions are appropriate;

- The proposed improvement of Out of Hospital care is appropriate. Given the current shortcomings in primary care, detailed plans should now be developed for urgent implementation;
- The Out of Hospital improvements should be fully implemented before irrevocable decisions and changes are made concerning hospital reconfiguration;
- The methodology used to identify and choose between the various reconfiguration options is open to challenge as it contains a number of fundamental flaws;
- The options appraisal and the resultant preferred option (and secondary options) are open to challenge, on the grounds of the sequential approach (which potentially distorts conclusions), the selective choice of indicators, the absence of an assessment of actual quality and performance, the lack of sufficiently detailed assessment in critical areas (e.g. travel times) and the practical application of the indicators (including a high level of double counting);
- The proposal to designate Charing Cross Hospital a "Local Hospital" and the proposed service reductions at Charing Cross Hospital and Hammersmith Hospital is not based upon a sound premise given the flaws in the methodology;
- The readiness of the local health system to cope with the scale of change proposed has not been demonstrated;
- The scale of change proposed, and in particular the significant and potentially adverse impact on the people of Hammersmith & Fulham, has not been adequately explained or addressed;
- Further significant work should be done to understand, in substantially more detail, the impact on local people; and
- There should be a more transparent articulation by the NHS of the motivations behind the proposals, most notably the need to reduce expenditure.

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

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

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

4. The pre-consultation and consultation process

- **Engagement**

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

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

4.3 *In particular, the work done to engage with hard-to-reach and vulnerable groups is open to challenge. The business case makes reference to section 149 of the Equality Act 2010 and*

briefly references work to engage and consult vulnerable groups. However detail is not explicitly provided on the nature of engagement, the issues and concerns raised by those groups, and the programme's response. This is *an important and unfortunate omission, given the* legal requirements and the diverse nature of Hammersmith & Fulham's population.

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

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

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

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

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

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

4.10 While it is intended that more work will be done to engage the public and that "this will include work with local authority colleagues who support voluntary and community sector networks… who are able to access a large number of community members through the work they undertake", this engagement activity should have taken place before the development of the pre-consultation business case.

4.11 The NHS, in pursuing such service changes, is legally required to engage with Health Overview & Scrutiny Committees. For this programme a Joint HOSC has been set up but this

operated in shadow form until July 2012 and so has not been given sufficient time to be established before being asked to make crucial decisions. The adequacy of engagement with scrutiny is open to challenge.

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

- **The "Four Tests"**

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

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

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

4.16 It is also stated that the clinically led nature of the development of the proposals has "ensured that the clinical vision and standards lead the reconfiguration proposals". This is open to challenge. The achievement of the clinical vision and standards can be decoupled from the reconfiguration proposals. The business case states that "all London providers will be held to account against [the clinical] standards over the next three years and local GPs in their clinical commissioning groups are putting in place processes to ensure they are delivered". This is open to challenge. It suggests that plans are proceeding prior to consultation. It also potentially reinforces the point that the clinical standards can be delivered without the need for radical reconfiguration.

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

- **Equalities Impact Analysis**

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

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

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

- **Timing and decision-making**

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

4.22 Further, the proposals have been developed during a time of major organisational change within the NHS. The 2012 Health Act abolishes Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) from 1 April 2013, replacing them with local CCGs and the NHS Commissioning Board. The business case states that all NW London CCGs have been established. This is not strictly true. The current PCT and SHA structures are still in place (albeit on a clustered basis) and are still statutorily responsible for local health services until 31 March 2013. "Shadow" CCGs have been set up as sub-committees of PCTs and are currently participating in a formal assessment process to support their eventual establishment and authorisation by early 2013 for them to "go live" on 1 April 2013.

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

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

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

4.26 **It would therefore seem *highly inappropriate for significant decisions to be made about local health services just before HWBs are established.*** HWBs should be given an

opportunity to properly consider the implications of "Shaping a healthier future" for their local people and they should be clearly involved in the governance and decision making arrangements.

- **Programme assurance**

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

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

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

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

5. Methodology

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

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

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

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

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

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

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

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

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

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

5.7 In more detail:

- **The case for change**

5.8 The proposals are predicated on the need for substantial change that must start now. Included is an assessment of the changing demands on the NHS in NW London but it is not clear if the business case takes account of the fact that more than 20,000 extra homes are planned for Hammersmith & Fulham in the next 10 to 15 years.

5.9 The business case states that services also need to be redesigned to be more affordable and to ensure that money is spent in the best way. However, the business case does not explore

any real alternatives to service reconfiguration that could be pursued in order to achieve the savings required.

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

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

- **Principles and objectives**

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

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

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

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

5.16 In light of the above, the business case concludes that the area has an overprovision of acute hospitals for the size of the local population when compared with the average for England. This is open to challenge. Comparisons should not just look at the size of

population but also relative complexity and need. It is not clear if this assessment is based on a comparison with similarly complex and growing populations.

- **The financial model**

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

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

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

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

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

- **Clinical model**

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

5.23 A significant part of the business case is devoted to setting out proposals to change and improve Out of Hospital care, including the individual high level strategies developed by the shadow CCGs. While the proposals are sound, a great deal more work is required before implementation. It is stated that the developments planned for Out of Hospital care will take the pressure off local hospitals but the proposals to reconfigure hospital services are due to begin implementation before the Out of Hospital developments have been fully implemented.

The two programmes of development should be decoupled. The Out of Hospital strategies should be fully implemented and evaluated before any final decision is made on hospital reconfiguration, let alone before reconfiguration actually starts.

NB

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

5.25 **The principles and standards proposed for Out of Hospital care are sound.** *However, the practical development of this model for Hammersmith & Fulham should be developed with the full involvement of all parties, including the Council, and should be developed to specifically meet the needs of local people. Currently the eight CCG level strategies appear somewhat generic and lack sufficient detail to support implementation.*

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

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

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

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

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

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

- **Options appraisal**

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

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

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

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

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

5.37 The clinicians considered evidence about factors that were judged to contribute to high quality clinical care. The business case states that as a result of this consideration clinicians "identified that there should be between three to five major hospitals in NW London to support the projected population of 2 million", with a view that more than five major hospitals leading to sub-optimal care. The proposals centred on five as the proposed number, primarily in light of current capacity constraints. The detailed evidence base for this decision to propose five major hospitals is not provided with the business case and is therefore open to challenge.

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

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

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

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

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

5.43 In order to evaluate the options, a number of criteria were developed. Some suggested by clinicians and patients were not accommodated, including integration of services, health equality across NW London, and support for preventative care and help for patients to manage their own conditions. These exclusions are open to challenge. Their inclusion would go some way to addressing the inadequate population focus of the current proposals.

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

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

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

5.47 The patient experience element of the quality criteria includes an assessment of the quality of the respective estates across the nine sites, based on the assumption that there is a correlation between the quality of the hospital or clinic where a patient is treated and their experience (although only very limited theoretical evidence is explicitly quoted to support this statement and it is contrary to local evidence). In order to use this as a comparative measure of patient experience the business case uses nationally collected site level information (from ERIC returns) in terms of the proportion of space deemed to be not functionally suitable as NHS space and the age of the estate. This makes a large assumption that there is direct correlation between the age and the quality of the estate and it does not take into account in any way current patients' views of the respective sites. Therefore the information's use in this way is open to challenge.

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

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

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

5.51 In terms of patient choice (included within the access criteria), emphasis is placed on patient choice benefitting from a greater number of Trusts (not sites) offering services. Specifically **the business case states that "those options that locate a major hospital at Chelsea and Westminster rather than at Charing Cross result in five Trusts having a major hospital. Where Charing Cross is designated a major hospital then only four Trusts have major hospitals, and Imperial Trust would contain two major hospitals instead of**

one". This argument is open to challenge on two counts. Firstly, no evidence is provided to support the proposition that patient choice is enhanced by the number of Trusts as opposed to sites offering services to patients. Secondly, the distribution of sites between NHS organisations is not fixed and can be changed. Were it deemed beneficial, the management of the Charing Cross site could transfer from Imperial Trust to Chelsea & Westminster Trust. In summary, again, the conclusions of this element of the evaluation are open to challenge.

5.52 In terms of value for money, the evaluation uses a number of criteria. In terms of the estimated capital cost of the additional capacity required by the reconfiguration the only real difference highlighted is between those options that include Hammersmith Hospital as a Major Hospital (Options 1 to 4) and those that don't (Options 5 to 8). In terms of relocating maternity and other services, this has a significant impact on any option where Charing Cross Hospital is designated as a Major Hospital, as it currently has no maternity services at present. If the capital cost of such a relocation is truly prohibitive, this element of the model could be looked at again.

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

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

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

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

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

5.58 Finally in terms of value for money, a Net Present Value (NPV) calculation is included, bringing "together all of the financial evaluation issues through a discounted payment profile,

calculated over 20 years". The values are reported relative to the financial base case "do nothing" assessment. In effect, because this calculation uses the previous elements of the value for money calculation, it double counts the impact of each element.

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

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

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

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

- Changes to the designation of the Major Trauma Centre at St Mary's;
- Current location of stroke units;
- Changes to the location of the Hyper Acute Stroke Unit (HASU) at Charing Cross.

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

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

(DD note: research is one aspect of medical training and education for doctors. Charing Cross is the largest medical school for undergraduates in the UK)

NB

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

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

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

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

- **Readiness**

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

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

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

5.71

6. Clinical outcomes

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

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

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

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

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

7. Impact

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

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

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

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

- 40.0% of inpatient admissions
- 11.5% of outpatient attendances

- 23.0% of A&E attendances

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

7.6 Furthermore, these changes would have a detrimental impact on the new Hammersmith & Fulham CCG's ability to influence the care commissioned for local people. Effectively the proposals fragment Hammersmith & Fulham's health care across many different providers. It is unlikely in consequence that Hammersmith & Fulham will be a major commissioner of any of the receiving NHS Trusts.

8. Additional issues

- **Implementation**

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

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

- **Benefits and disbenefits**

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

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

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

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

- **Motivation**

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

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

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

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

9. Next steps

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

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

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

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

– ENDS –
LBHF-FCS: CPD-Policy
11 September 2012
Amendments and additions from Draft v1.1

"DRAFT" watermark added
1 Introduction – new three-paragraph section with one each on context, concerns and next steps
3.3 (ex 2.3) first bullet, fourth line – organisations are…
3.4 (ex 2.4) second line – paragraph ~~1.8~~ 3.3 and in…
4.16 (ex 3.16) fifth line – business case ~~to~~ states…
7.2 (ex 6.2) rewritten – Analysis of the preferred option indicates that currently each A&E in NW London serves an average population 5% less than the national average. If the preferred option is implemented the cuts will result in each remaining A&E serving an average population that is 52% larger than the national average.
9.2 The Council, through its Scrutiny committee, will therefore ~~seek~~ decide whether to refer…
9.3 The Council, again through its Scrutiny committee, will therefore ~~seek~~ decide whether to refer…
9.4 New paragraph

Approvals process

05/09/2012 – Draft v1.0 – circulated to Peter Smith and David Evans for comments
06/09/2012 – Draft v1.1 – sent to Cllr Ginn for review
10/09/2012 – Draft v1.1 – sent to Sue Perrin for Cllr Ivimy to review ahead of HHASC dispatch
10/09/2012 – Draft v1.1 – Cllr Ginn forwarded for inclusion on Cabinet Briefing agenda
11/09/2012 – Draft v1.2 – incorporating Cllr Ginn's amends and additions
11/09/2012 – Draft v1.21 – incorporating rewritten paragraph 7.2

Fulham Broadway – Fulham Methodist Church - Wednesday 4 pm September 19th
***Shaping a Healthier Future* open meeting** - Summary and scripted notes.

Held the same day as a Chelsea-Juventus match. Football fans flooding the area. It was not advertised. Few people knew about it. 6 attending – 4ish. Small numbers earlier in the day.

Present Daniele Elkeles (DE) and Dr. Tim Spicer (TS), NW NHS rep, Andrew Pike

I was the only person there for a long time. I spoke to Dr. Spicer informally one to one. Opportunity to tell him there were no real options in the consultation. Suggested that a merger of Charing Cross and Chelsea Westminster Hospitals under one management would have saved money and made much more sense. (Took a picture of the display to catch the atmos and they told me I needed permission.)

He *agreed* but said it couldn't happen "as it *was not in the brief. There are workforce issues where they are seriously undermanned. Increasing specialisation brought better outcomes but then it is harder to run services on local sites."*

Discussion called once 6 people , including myself and Anabela Hardwick) 4pm.

QUESTIONS
I bought up the point about the discrepancy between the Option A hospitals electioneering and the other hospitals being prevented from publicising the proposed changes in the consultation. Chelsea Westminster had been campaigning while Charing Cross and Hammersmith Hospitals had a media embargo imposed on them. Confidentiality clauses prevented staff from talking about the consultation or proposed changes. Residents in Fulham and patients in Charing Cross were unaware. There is no publicity or information available in the hospital. There were about 6 copies of the consultation document in the PALS office on a small table, not easily visible.

I held up a copy of the Chelsea Westminster hospital broadsheet, *Trust News* August / September. I said I had collected copies at hospital on several occasions. I pointed to where it clearly explained how to vote Option A to save the hospital. In addition to some of the tick box blue cards held up, I showed the three pages devoted to helping people vote fro CWH. I pointed out that nowhere did it explain that voting Option A would close the A&Es of Hammersmith and Charing Cross Hospitals or effectively reduce CHX to a nothing more than an outpatients, local Urgent Care Centre as a local hospital.

I have copies of all of these as evidence.

I said I had gone into all the departments and on every reception desk there were '*Safe in our Hands'* blue cards for patients and visitors to pick up to tick box option A. I then said this led to 3rd world electioneering tactics and asked what they were going to do about it.

Dr. Spicer tried to be reassuring and replied, "*When it comes to counting the votes, the blue cards will be discounted."*
I said I would remember that when it came to the counting of the votes.

Other questions of concern from the audience were about:

- difficulty of patient transport to hospitals and accessibility
  TS: Patients can book an NHS taxi.
- what will happen to CXH. It has 800 beds – *DE: In the interests of consultants being present more of the time, traded off clinical benefit to 'do- ability'.*
- what is meant if it becomes a local hospital
  TS: Local hospitals will not have an acute side. They will still have outpatients with urgent and social care integrated. Seen as a community facility

Exchange between LBHF resident and Cllr Lucy Ivimy's response to his Open letter

The exchange of emails between Cllr Lucy Ivimy, Ken Bromfield, a resident and patient at Charing Cross, myself, Una Hodgekins, a resident and Jeff Zitron from SaHF consultation below took place shortly after the 'news' of the closure and downgrading of CX hospital. It highlights the depth of feeling at the betrayal. The Council's pre-empted full page SAVED spreads across a picture of Charing Cross before the official announcements shocked the community and prompted this open letter and subsequent exchanges:

To the Editor of the Fulham Chronicle
Please publish the article below! It will redress a depressing imbalance in the HF paper.

The issue of the fate of Charing Cross hospital towers over everything in my 70 plus years as a Hammermith resident. I should be grateful if you would publish the open letter below.
Ken Bromfield MBE. Chartered FCIPD. FIScT

An open letter to Hammersmith Council

When our Council announced to its electorate that it was joining the fight to save Charing Cross Hospital , was its campaign objective for us to end up with Charing Cottage Hospital, with a massive reduction in beds and other services? If this was the case, the Council's was disingenuous, deceitful and utterly opaque, to say the least.

On the other hand, if the Council's campaign purpose was in line with the thousands of concerned residents, to maintain a world class hospital facility in Hammersmith, then its 'efforts' have been a failure. How Councillors can claim victory is beyond me.

What exactly were the success criteria in the Council's exalted 'battle' to save Charing Cross Hospital . Where were they published?

I was a Charing Cross Hospital inpatient for 10 weeks. A vital part of my healing process was the stream of visitors whose love and encouragement helped me out of a dark place. As you know, public transport, including the tube is excellent to our hospital. By comparison, Chelsea Westminster is nowhere near the tube. Parking is nigh on impossible in that area. Councilors should ask themselves whether this will discourage visitors, and if so, what are the consequences?. Should this issue have been put into the decision making process about our NHS medical care?

One bright spark Councillor pointed out to me that A&E doesn't attract visitors. Even if this was so, people do visit patients in the 500 or so beds currently at CHX. When the beds go, the visitors will obviously have to troop off to wherever they are replaced.

We have a rising population in our borough. Even our Council should be able to work out that healthcare needs will rise. If the Council fails to care about this issue for our people, then it leads one to suspect they have alternative health arrangements for themselves or they live in districts unaffected by the debacle.

The public anger at our Council is palpable. The Council should hang its heads in shame, or apologise to people like me who were born, raised, still live, and would be content to die in Hammermith.

Ken Bromfield MBE. Chartered FCIPD. FIScT

[redacted]

Hi Dede

This is the note that I sent to the H&F article comments.

Perhaps the most striking aspect of the Hammersmith Council's treachery when it announced that it was instrumental in "saving" Charing Cross Hospital, was its utter disregard of its electorate's savoir faire and political judgement. Did our Council really believe that we would be taken in? What an insult to us all!

The Councillors are in a hole. Guess what? They are still busy with their shovels. They are tring to justify their deceit with arguments such as "The hospital will continue to treat at least 85% of H&F patients who are currently seen at CXH." This spurious statistic misses the point. We are concerned about the people who need more serious treatment as in-patients. There will be 440 bed losses in the CHX "plan for the future". At only 80% occupancy that's 128,460 in-patient days. Assuming an average stay of 6 days,

that's 25,692 patients and their vital visitors, who will have to go elsewhere, probably Chelsea Westminster with its poor access by tube and car. Whatever the vacuous spin churned out by our Council, Charing Cross Hospital has been hugely diminished. *It has not been saved.* The Council's affront to us all needs urgent redress.

Cheers, Ken

Ken Bromfield MBE. Chartered FCIPD. FIScT
[redacted]

Lucy's Reply
What is Charing Cross Social Care Hospital?

Dear Mr Bromfield
Thanks for your email. In summary, original Option A proposals for Charing Cross were for a Local Hospital of 4,000 square feet costing £15m, giving no beds, having no specialisms, and having standard Urgent Care Centre facilities unable to take ambulances.

The new proposals are for a *Specialist Health and Social Care Hospital* of 16,000 square feet costing close to £100m, with 60 beds, retaining all the current **outpatient** specialisms **plus an enhanced Urgent Care Centre** with full diagnostics and able to take some ambulances. It will therefore be four times the size of original proposals.

The NHS announced this substantial u-turn in a presentation to members of the eight borough Joint Health Overview and Scrutiny Committee which I chair. I made a note of what is proposed, but full details in written form will not be available until the agenda for the formal JCPCT meeting next week is published.

Under the new proposals the following specialisms have been saved:
- Oncology - specialist ambulatory cancer care including the cutting edge radiotherapy and chemo treatment
- West London Sexual Health clinic
- Mental Health facility
- Renal care
- Research and teaching in conjunction with Imperial College
- Full range of diagnostics
- An ante and post natal clinic will be added
- The UCC will be enhanced so that it will take ambulances (though **not** blue light emergencies) and be able to treat 70% of all patients who currently present to the A&E
- All current specialist out-patients will continue to be treated under the new proposals
- In total, about 90% of patients currently treated at Charing Cross will still be treated there (As outpatients only)

What will, however, still be lost is:
- Blue light life threatening A&E
- Stroke unit
- Complex acute surgery
- Beds will reduce to 60...only used as day beds

Serious injuries or emergencies such as a stroke, and acute complex surgery are the dramatic aspects of a hospital and take up a large part of the bed space, but actually involve a very small

proportion of all patients.

SOH Comment (500 beds being used regularly for inpatient care will be lost)

These patients want to receive and should receive the best treatment, which means a full team of A&E / trauma and stroke specialists should be on hand 24 hours a day, 7 days a week.

Comment - (Because CEO Mark Davis has split up consultancy- specialist teams. He moved and sent them to SMH as with specialties below. Forcing patients from LBHF to go to Westminster for life threatening treatment)

This is not currently the case at Charing Cross, which is why an ambulance with a severe multiple trauma victim will today go to St Mary's Paddington where there are such facilities. Imperial currently has plans to move the stroke unit from Charing Cross to St Mary's in order to co-locate it with the trauma unit where there is a brain surgeon always on hand, as some stroke victims require emergency brain surgery to remove a clot.

SoH NOTE
(Charing /Cross has the best neuroscience and neurosurgical unit in the country at present. A long established team preforming brain surgery and spinal surgery)

This type of organisation saves lives and reduces the degree of permanent disability suffered by patients.

The downside of the additional time in the blue light ambulance (where a patient has already been stabilised) is hugely outweighed by the benefits of immediate specialist treatment once in hospital.

For this reason, I feel that carrying on the battle in order to try and save a full range of A&E at Charing Cross would actually be, from a clinical viewpoint, a mistake.I hope this helps.

Kind regards
Lucy Ivimy, Chair, Joint Health Overview

.....

Subject: 1) Lucy Ivimy's letter and (2) PFI at West Middlesex
Date: Fri, 15 Feb 2013 13:06:08
From: Una Hodgkins [redacted]
To: dede wilson m[redacted]
CC: Carlo Nero [redacted] "Jasmine Pilgrem (Ashchurch Residents Association)" [redacted]

Dear Dede,

I live In Hammersmith, in Ravenscourt Ward, which is Lucy Ivimy's!
(1) Thank you for forwarding Ken Bromfield's letter and Lucy's reply. Her letter contains statements, which even she could not possibly believe.
For example it will be impossible to continue training doctors at Charing Cross when the number of beds has been cut from 500 to just 60. I spoke yesterday outside Charing X with a consultant . He said in a bemused tone - they are so weary of change - that transitional arrangements while they split teaching between St Mary's Paddington and Hammersmith Hospital would be "very testing" and would be disruptive to teaching. They would not be staying at Charing Cross with no patients....
(2) While I was outside Turnham Green station last night I spoke with someone who works for West Middlesex hospital. He told me that this hospital was built fairly recently with PFI money, and that it was paying £5M pa in interest payments to the consortium which built it, and because of this it was in a perilous financial position. But it was locked in to paying and keeping the hospital open for years ahead!

So we are in the same mad position as Lewisham of being forced to keep open small financially imperiled small hospitals while closing financially and clinically successful, large ones!!!! Someone, somewhere MUST make a fuss about this total absurdity.

Best wishes,
Una

On 15/02/2013 11:07
From: Cllr IVIMY <cllr.ivimy@btinternet.com>
To: "cllr.ivimy@btinternet.com" <cllr.ivimy@btinternet.com>
Sent: Monday, 18 February 2013, 12:49
Subject: Fwd: NW London NHS Joint Primary Care Trusts
Fwd: (1) Lucy Ivimy's letter and (2) PFI at West Middlesex
Sent from my iPad

Begin forwarded message:
Resent-From: <Lucy.Ivimy@lbhf.gov.uk>**From:** Una Hodgkins [redacted]**Date:** 16 February 2013 09:50:24 GMT**To:** Ivimy Lucy COUNCILLOR <Lucy.Ivimy@lbhf.gov.uk>, <consultation@nw.london.nhs.uk>**Subject: NW London NHS Joint Primary Care Trusts Fwd: (1) Lucy Ivimy's letter and (2) PFI at West Middlesex**

Dear Lucy and Mr Zitron,

I have been talking to various professionals employed in the NHS while I distribute leaflets for Save Our Hospitals (Charing Cross, Hammersmith and Ealing). Can you please note the comments in my e-mail below from (1) the consultant in charge of post-graduate medical training at Charing Cross and (2) an employee at the West Middlesex hospital. The comments of the latter are extremely worrying: we could be closing large, clinically and financially viable hospitals like Charing Cross and Hammersmith in favour of clinically and financially weaker and smaller units. This is crazy!

The NHS consultation should focus EXCLUSIVELY on the provision of hospitals on a medical and geographic basis. The NHS should not take into consideration the value of the land in "North Fulham" for redevelopment - particularly as redevelopment means ADDING more residents, not reducing them in some of London's most densely populated, yet very accessible boroughs.

I propose the following, rational solution to cutting hospitals in NW London: create one "super hospital" with stroke, cardiac and "major trauma" (brain and lung surgery) outside the "nucleus" of Central London, either at Charing Cross or at Hammersmith. These two sites have all the advantages required for larger, more intense hospitals: existing large buildings, room to expand on nearby car park or Wormwood Scrubs, existing landing space for helicopters, close to M4 and Heathrow, good access by public transport.

Retaining three A &Es in central London (Chelsea and Westminster, University College Hospital and St Mary's) makes no sense, as these are sites which are each deficient in several respects. And we should buy out nonsensical PFI deals before they cripple the NHS. Now is the time to tackle this very poor budgeting.

Yours sincerely (Mrs) Una Hodgkins Save Our Hospitals campaign (http://www.saveourhospitals.net/) [redacted]

----- Forwarded Message -----
From: Lucy Ivimy <cllr.ivimy@btinternet.com>
To: Cllr IVIMY <cllr.ivimy@btinternet.com>
Cc: "una.hodgkins[redacted]
"consultation@nw.london.nhs.uk" <consultation@nw.london.nhs.uk>;
"dedewilson[redacted]
Sent: Monday, 18 February 2013, 15:24

Subject: Re: Fwd: NW London NHS Joint Primary Care Trusts Fwd: (1) Lucy Ivimy's letter and (2) PFI at West Middlesex

Dear Una and Dede,

Thanks for your emails. Please note that neither Charing Cross nor Hammersmith hospitals will close. Hammersmith Hospital is a large specialist hospital, which has a small and under-utilised A&E. The A&E does not take serious trauma cases as Hammersmith Hospital does not have the facilities to deal with this sort of work, and blue light ambulances seldom take patients there. The A&E functions more like a UCC, so downgrading it to that will have minimal impact on the hospital.

Charing Cross will lose its acute specialisms but retain its other specialisms..
It will become a Specialist Hospital – like Hammersmith – but with a different range of specialisms. All the outpatients that it currently treats will continue to be treated there.

(DD: It already is an acute major hospital. The specialisms at Charing Cross are what make it a world renowned centre of excellence. The specialist teams are known for their high quality of care.(see attached article) They are unique and irreplaceable. This is being disregarded and so are the patients receiving their specialist care.

These long established teams are being systematically broken up. This is not in the interests of patients' care or doctors of the future. In fact, in complete contradiction of the need for restructuring as stated in the consultation,.. ' for the best care -to have key acute specialty teams under one roof. " They already are. eg. Neuroscience, neurosurgery with brain and spinal treatment specialties, orthopaedics and complex reconstruction/ kidney and renal surgery/ cancer surgery/ ENT.

The total number of patients at Charing Cross will increase, although they will primarily be outpatients rather than in beds. For example, the stroke unit, which takes relatively few patients but uses a lot of bed space, will go, but specialist ante and post natal clinics will be added, which will treat many patients but take up little, if any, bed space. Charing Cross will therefore continue to function as a teaching hospital.

(DD How can it function as a teaching hospital without any inpatients or genuine overall treatment essential for learning? A&E is crucial for doctors of the future to learn emergency medicine and see how patients are treated from start to finish. It cannot be done piecemeal. This is cosmetic. I am an education consultant and teacher trainer. In educational terms this does not make sense.

Patients at the hospital at present are both inpatient and outpatient, needing acute treatment, beds and follow up treatment. There needs to be continuity and clear effective teamwork from start to finish. This is what students learn from. Ante natal and post natal also require 'birth' experience for doctors to learn about delivering babies and the potential complications. Crucial confidential data also is less likely to get lost as it stay where patients are treated.)

The NHS is indeed proposing a small number of 'super hospitals', to be called 'major hospitals', with the ability to deal with stroke, cardiac, major traumas and acute complex surgery.
and Chelsea West Charing Cross should be one of them

It proposes five such across the North West London area, each with a fully functioning A&E. Two of these are Chelsea & Westminster and St Mary's and the others out of the town centre.
(DD - But none in our borough.)

Kind regards
Lucy Ivimy

From: dede wilson

To: lucy.ivimy@lbhf.gov.uk; consultation@nw.london.nhs.uk; mark.davis@imperial.nhs.uk

1 **Attachment** 4.2MB

Report praises under-threat Charing Cross and Hammersmith hospitals - Local News - News - Fulham Chr.webarchive Save

Dear Lucy and all concerned,

I'm afraid this does not answer Una's questions. Saying Charing Cross is SAVED as a hospital is disingenuous. It won't be a hospital. We know the plan is to demolish Charing Cross and replace it with a smaller building with the loss of 500 beds. These are to be replaced by 60 day beds but no beds that require acute specialist care as at present.

All should re-read the article attached about the hospital as a reminder of precisely what the Council has said, how Charing Cross is regarded in the Foster report and what the NHS is proposing to dispose of. Consider what was said then and what is being said now.

English language is being played with here to 'manipulate and railroad residents' into thinking they will have a hospital. We won't. It'll be a a glorified specialist polyclinic.

LBHF will have no beds for residents who need acute A&E care and follow up treatment, (unless the specialty exists at Hammersmith Hospital). Only day care. eg. Cancer patients will have radiotherapy and chemo at CXbut have to travel to St Mary's for surgery.

Effectively, it has been assumed that 90% of us in H&F will never need acute medical care and that it is not needed at present. Residents will not need A&E, acute surgical treatment or hospital beds because we will not have accidents or serious health problems. SaHF, NWLondon NHS and LBHF must consider us to be a uniquely healthy borough with a very small population.

These are peoples' lives, not chess pieces to be moved around on the board. They are real people. We must not to be considered dispensable as is happening at the moment. (Our treatment is to be dispersed around NW London, out of borough far from family and friends.)

Save our Hospitals volunteers are outside the hospital regularly. We talk to patients and people in hospital. We know what is going on and how it is affecting everyone. How many of you have done that?

In your reply below, I have commented on the replacement of our hospital by a this proposed specialist clinic.

Peoples' lives in LBHF are being put at risk. NHS cost cutting compromises care as has been shown at Stafford Hospital. Doctors have been mislead into believing the choices in the consultation were the best solutions to the problems facing the NHS. Alternatives were not considered as both Una and I mentioned

If Chelsea Westminster and Charing Cross were to have merged under one management, but on 2 sites, all the best specialty treatment imaginable would have been under one umbrella with a teaching hospital that would be the envy of the rest of the UK. When I asked Dr. Spicer why this was not an option at the meeting at the Methodist Church Hall in Fulham in September, he responded that it wasn't in the brief. It should have been.

We have one MP who has one leg in Chelsea and one leg in Fulham, the other MP represents the other half of Fulham and Hammersmith. Those of us in Fulham have been split down the middle when we should have been united. Just as those two hospitals should have been.

I have a file with evidence on the mismanagement of the consultation. Tactics used to ensure the outcomes that the Government wanted.

Dede Wilson,
English and Foreign Language Teaching Consultant and Trainer
Save our Hospitals Hammersmith and Fulham
Fulham Reach resident and patient at Charing Cross since 1972.
[redacted]

Mary Smith

Seasonal Influenza Immunisation Uptake in General Practice in the London Borough of Hammersmith and Fulham and Comparison with Other London Boroughs

With the recent closure of Hammersmith Hospital Accident and Emergency Department (A&E) and the proposed downgrading of Charing Cross Hospital, including A&E, there is concern on the part of local residents about future healthcare in this locality. Therefore, investigation into the status of community care in the London Borough of Hammersmith and Fulham is warranted.

Analysis of data for Indicators for GP Outcome Standards[1] could be expected to provide information about current community care in the borough, and indicate whether this is of a sufficient standard to absorb local hospital and A&E closures with no adverse effects on residents' health.

Several indicators may be measured to assess outcomes. For the purposes of this document, delivery of seasonal influenza immunisation, a simple deliverable for community care, has been assessed. Influenza is important principally because of the risk for a severe secondary bacterial chest infection, e.g. pneumonia, which is associated with high mortality. As influenza vaccination is usually administered at GP surgeries, the data presented are from GP practices unless otherwise stated.

Data for seasonal influenza immunisation uptake in general practice were compared for the London Boroughs of Hammersmith and Fulham, Kensington and Chelsea, Brent, and Ealing for the years 2010–11, 2011–12, 2012–13, and 2013–14, and for the whole of London where data were available. The data were primarily taken from the website 'myhealthlondon',[1] and other available data sources.[2,3]

Outcomes

Comparison with Neighbouring Boroughs

For people aged 65 years and older, the latest available London average for uptake of seasonal influenza immunisation in general practice was 71.40%. In Hammersmith and Fulham, the uptake was 69.07% in 2010–11, decreasing to 65.73% in 2012–13 (Table 1), which is substantially less than the London average. In neighbouring Kensington and Chelsea, the uptake was much closer to the London average at a

range of 71.46% to 70.29% during the 3-year period. The uptake in Brent was higher than the London average at approximately 73% in each year. Although the uptake in Ealing was slightly less than the London average, the uptake was stable during this period, ranging from 68.51% (2012–13) to 70.40% (2011–12).

Hammersmith and Fulham is the only borough to show both below average and decreasing uptake.

Table 1. Comparison of seasonal influenza immunisation uptake for people aged 65 years and older in the London Boroughs of Hammersmith and Fulham, Kensington and Chelsea, Brent, and Ealing[1]

	Uptake (%)			
Borough	**2010–11**	**2011–12**	**2012–13**	**Comments***
Hammersmith and Fulham	69.07	69.26	65.73	Less than London average and decreasing
Kensington and Chelsea	71.46	71.06	70.29	Approximate London average
Brent	72.89	73.62	73.22	Above London average
Ealing	69.12	70.40	68.51	Less than London average and stable.
*Compared with the London average of 71.40%.				

The results are similar for uptake of seasonal influenza immunisation among people at risk aged younger than 65 years (Table 2). At a range of 41.00% to 43.95%, the uptake in Hammersmith and Fulham is consistently less than the latest available London average of 48.90%, while the uptake in the other three boroughs are consistently above the London average at approximately 50% (Kensington and Chelsea), 55–59% (Brent), and approximately 51% (Ealing).

Table 2. Comparison of seasonal influenza immunisation uptake for people at risk aged younger than 65 years in the London Boroughs of Hammersmith and Fulham, Kensington and Chelsea, Brent, and Ealing[1]

	Uptake (%)			
Borough	**2010–11**	**2011–12**	**2012–13**	**Comments***
Hammersmith and Fulham	41.00%	42.99	43.95	Less than London average and increasing
Kensington and Chelsea	50.91	50.58	50.00	Above London average and stable
Brent	55.00	57.68	58.63	Above London average and increasing
Ealing	51.40	51.73	50.97	Above London average and stable
*Compared with the London average of 48.90%.				

When comparing seasonal influenza immunisation uptake in people aged 65 years and older in three Clinical Commissioning Groups (CCGs) and former Primary Care Trusts (PCTs) in Central and West London from 2011 to 2014, the uptake in Hammersmith and Fulham CCG/PCT of 60–69% is well below the national average of 72–74% for the same period, and shows a substantial decreasing trend (Table 3). The uptake in Hammersmith and Fulham CCG/PCT is also considerably lower than the other two groups of Central London CCG/Westminster PCT and West London CCG/Kensington and Chelsea PCT.

Table 3. Comparison of seasonal influenza immunisation uptake for people aged 65 years and older in three CCGs and former PCTs in Central and West London.

	Uptake (%)			
Borough*	**2011–12**	**2012–13**	**2013–14**	**Comments†**
Hammersmith and Fulham CCG/PCT	68.90	65.50	60.50	Lowest of the 3 areas, well below England average and decreasing
Central London CCG/Westminster PCT	74.80	74.30	66.90	Approximately England average for 2 years, then decreasing
West London CCG/Kensington and Chelsea PCT	70.30	69.90	65.10	Below England average and decreasing
England average	74.00	73.40	72.00	

*As GPs give most seasonal influenza immunisations, the data are presented by GP area.
†Compared with the England average.
CCG, Clinical Commissioning Group; GP, general practitioner; PCT, Primary Care Trust.
Source: Dr Andrew Burnett, Interim Consultant in Public Health Medicine, Deputy Director of Public Health, Royal Borough of Kensington and Chelsea.

Comparison of London Boroughs

In a comparison of all the London boroughs for 2012–2013, seasonal influenza immunisation uptake in the London Borough of Hammersmith and Fulham was the lowest both for people aged 65 years and older (Figure 1) and for people at risk younger than 65 years (Figure 2).[1] This trend continued in 2013–14 for people aged 65 years and older, with 62.9% uptake for the London Borough of Hammersmith and Fulham.[2]

More recent data for seasonal influenza immunisation uptake by people aged 65 years and older from September to December 2014 show a similar trend, with the London Borough of Hammersmith and Fulham being in the bottom three boroughs (Figure 3).[3]

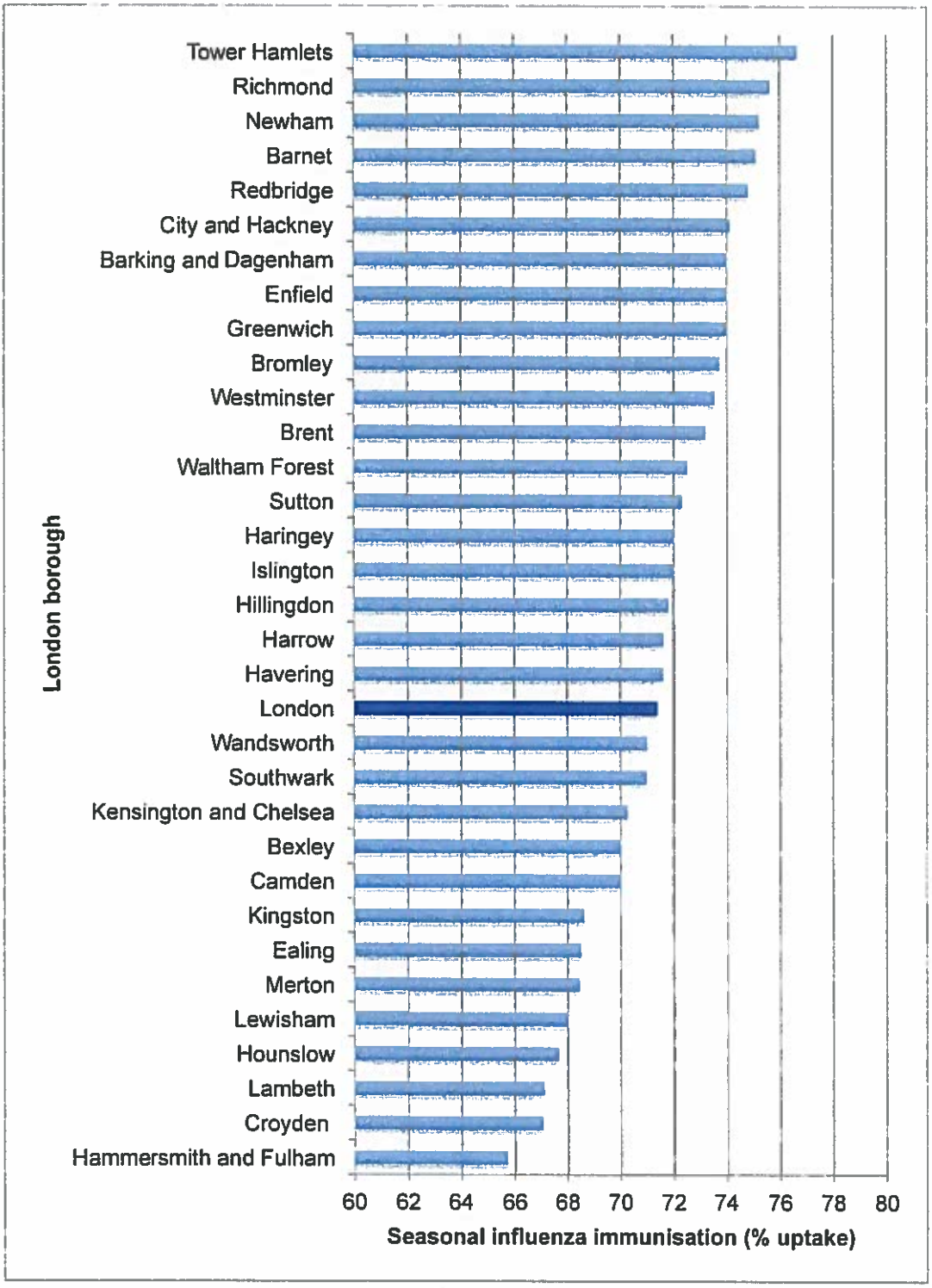


Figure 1. Seasonal influenza immunisation uptake for people aged 65 years and older by London Borough in 2012–13.[1]

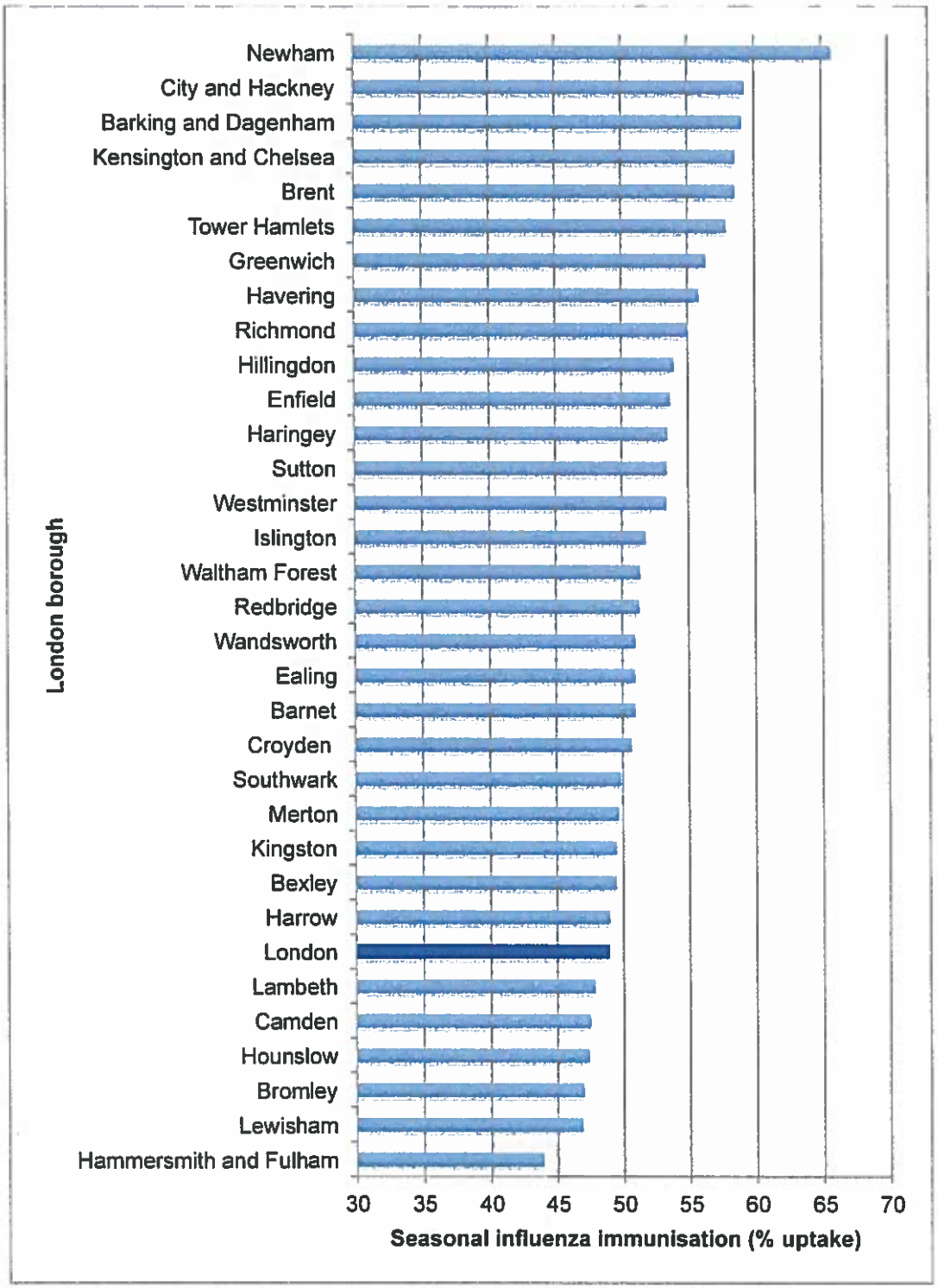


Figure 2. Seasonal influenza immunisation uptake for people at risk younger than 65 years by London Borough in 2012–13.[1]

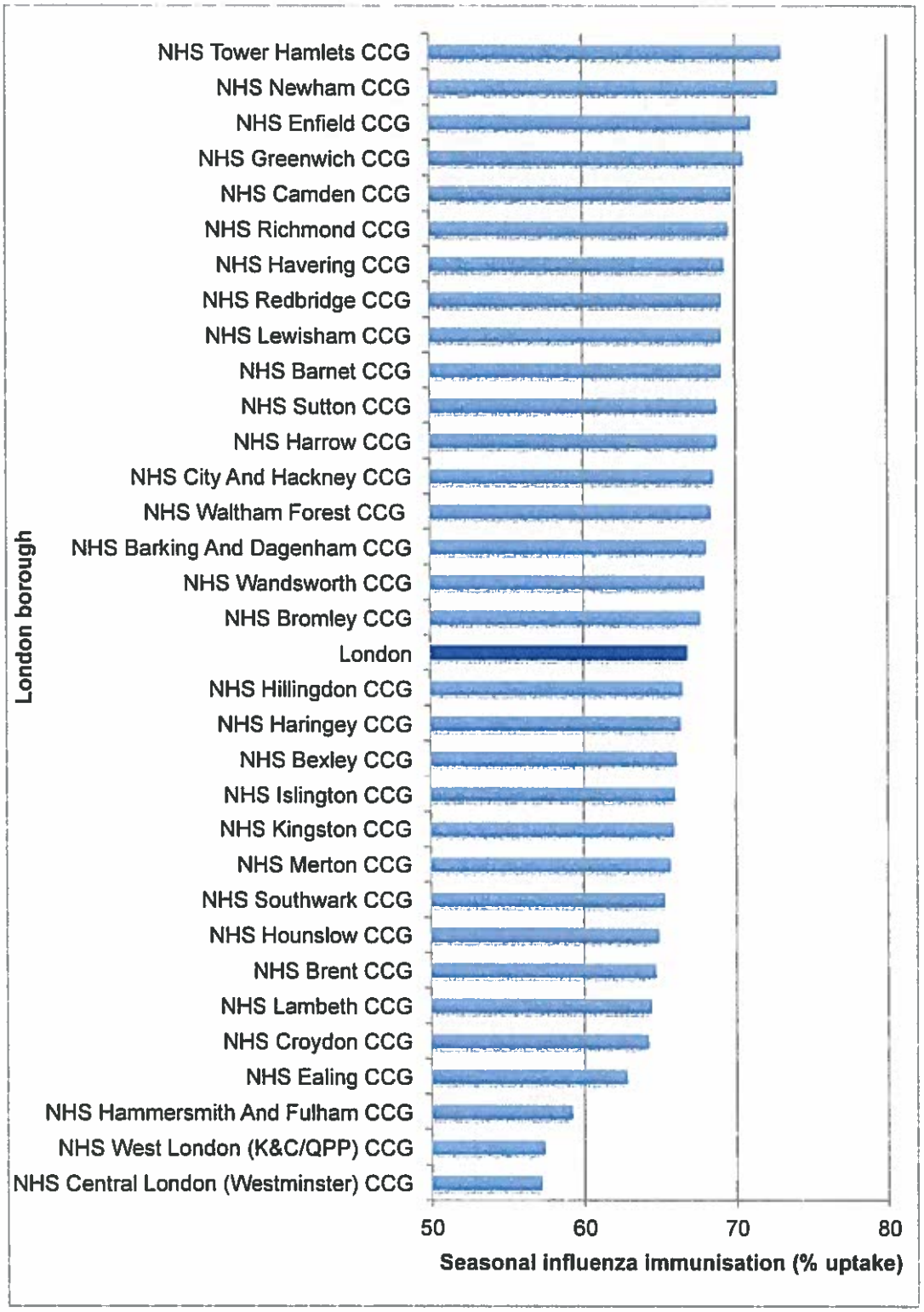


Figure 3. Seasonal influenza immunisation uptake for people aged 65 years and older by CCG from September to December 2014.[3]
Abbreviations: CCG, Clinical Commissioning Group; NHS, National Health Service.

Data for Hammersmith and Fulham

Richford Gate Medical Practice (RGMP), where the Chair of the Hammersmith and Fulham CCG is a general practitioner, is being used in this paper as the benchmark for community care in the borough. Subanalysis of the data for Hammersmith and Fulham was done to ascertain the scenario at this practice. Seasonal influenza immunisation uptake at RGMP has been consistently decreasing year-on-year for the 3-year period for both age groups (people aged 65 years and older, and those at risk aged younger than 65 years) [Table 4]. Comparison with the 31 practices in the borough shows that the position of RGMP has declined between 2010–11 and 2012–13 from ninth to 17th highest uptake for people aged 65 years and older, and from 12th to 19th highest uptake for people at risk aged younger than 65 years.

Uptake of seasonal influenza immunisation at RGMP was below the London average for people at risk aged younger than 65 years in each of the 3 years from 2010 to 2013, and below the London average for people aged 65 years and older in 2011–12 and 2012–13.

In 2012–13, the uptake of seasonal influenza immunisation at RGMP had declined to below the average for the borough in both groups; the uptake was 65.40% for people aged 65 years and older (borough average, 66.00%) and 42.40% for people at risk aged younger than 65 years (borough average, 43.95%).

Table 4. Uptake of seasonal influenza immunisation for people aged 65 years and older and people at risk aged younger than 65 years at Richford Gate Medical Practice.[1]

	Uptake (%) Position*			
Immunisation group	**2010–11**	**2011–12**	**2012–13**	**Comments**
People aged 65 years and older†	73.00 9/31	69.40 18/31	65.40 17/31	Consistently decreasing uptake and decreasing position Years 2011–12 and 2012–13 below London average
People at risk aged younger than 65 years‡	46.00 12/31	45.30 14/31	42.40 19/31	Consistently decreasing uptake and consistently decreasing position Consistently below London average

*Position compared with other practices in the borough (n=31).
†London average of 71.40%.
‡London average of 48.90%.

In 2012–13, there was striking variation in seasonal influenza immunisation uptake at GP practices throughout the borough, ranging from 52.0% to 77.4% for people older than 65 years and from 23.5% to 58.1% for people at risk aged younger than 65 years.

Discussion

In the first three weeks of January 2015, there were 45 037 registered deaths in England and Wales – 25% higher than the average of the past 5 years.[4] Most of the deaths were among people older than 75 years. Ten thousand more people in this age group died in the 3 weeks to 23 January 2015 than in the same period in 2014. Public health experts believe that seasonal influenza is the likely cause of the increase .... Dr John Middleton of the Faculty of Public Health said, "H_3N_2 [flu strain] does particularly impact on older people".[4]

Given the role that influenza may play in increasing mortality among elderly people immunisation against seasonal influenza would seem to be a particularly important primary care activity. If the thrust of the local CCG policy is to reduce hospital admissions one might expect the London Borough of Hammersmith and Fulham to have higher than average immunisation rates for this group. In fact, the latest figures (for September to December 2014) show the borough to have the third worst performing CCG in London for seasonal influenza immunisation.

Overall, the data in this document show clearly that uptake for seasonal influenza immunisation in the London Borough of Hammersmith and Fulham consistently falls well behind both the national and London average uptakes, with a steep trend for decreasing uptake. These results raise questions about the capability of community care to adequately manage the healthcare needs of this borough's residents in light of the current plan for hospital downgrade and closure.

It is noteworthy that the National Health Service has been asked "... to reach or exceed 75% uptake for people aged 65 years and over as recommended by the World Health Organisation (WHO), to reach or exceed 75% uptake for people under age 65 with clinical conditions which put them more at risk from the effects of flu. A reasonable trajectory was forecast for increases in uptake in clinical risk groups and pregnant women to be 60% in 2011/12, 70% in 2012/13 so that an uptake of 75% can be reached or exceeded in 2013/14."[5] The uptake in Hammersmith and Fulham does not come close to these objectives despite it being more than a decade since

the World Health Assembly set the goal of 75% coverage for those in high-risk groups (including elderly people) by 2010 in resolution 56.19.[6]

These findings challenge the SAHF ('Shaping a healthier future') statement that general practice and community health services will cope with the increased demand if local acute beds and services close.

References

1. myhealthlondon. Available from: www.myhealth.london.nhs.uk/ Accessed 15 January 2015
2. NHS Immunisation Statistics. England 2013-14. London: Health and Social Care Information Centre; 2014. Available from: http://www.hscic.gov.uk/catalogue/PUB14949/nhs-immu-stat-eng-2013-14-rep.pdf. Accessed 27 January 2015.
3. Public Health England. Seasonal influenza vaccine uptake amongst GP patients in England. Provisional monthly data for 1 September 2014 to 31 December 2014. London: Public Health England; 2015.
4. Cooper C. Cost of heating may be behind high death rate. Independent; Wednesday 04 February 2015.
5. Public Health England. Influenza Vaccine Uptake amongst GP Patient Groups in England. Winter Season 2012/13. London: Public Health England; 2013.
6. World Health Assembly. Prevention and control of influenza pandemics and annual epidemics. Geneva: World Health Organization; 2003.

Smith Peter

From: Ian Cranna [redacted]
Sent: 03 February 2015 16:23
To: Smith Peter
Cc: andy@andyslaughter.com
Subject: Submission to the Independent Healthcare Commission

Dear Sir,

I wish to add my voice to the chorus of protests about the proposed closure of the A&E department at Charing Cross hospital and the loss of hundreds of beds there, just when they are needed most.

There are others who can speak more eloquently than I about the impact this will have on us locals, not least those whose lives have been saved by the presence of a praised full A&E department and fully-bedded hospital in our own neighbourhood. What will happen to such people in future if these closures go ahead, especially given the traffic congestion in west London? I support their protests.

There is reliable documentation, too, on the adverse impact of the closure of Hammersmith hospital A&E department on the other local A&Es that were supposed to be able to absorb the closure of Charing Cross as well. I read in my MP's newsletter of a patient who had to wait hours in Charing Cross A&E before being moved to Hammersmith hospital because ALREADY a bed could not be found for her. Adding to this pressure for urgent care and beds is self-evidently crazy.

I would also like to draw the Commission's attention to the so-called public consultation by the Imperial Trust before this closure programme was finally adopted. It was the most slanted 'consultation' I have ever seen: not a proper consultation at all but attempting to shepherd responses to rubber-stamp conclusions that had already been decided on, to provide a fig leaf of respectability to a plan that is all about money and not about best patient care. When the public protested and signed petitions, we were told that all these voices only counted as one – a truly shameful way to try and shunt aside public opinion. This consultation was not fit for purpose.

I worry too about the effect that fewer local hospitals will have on the lives and morale of patients and their families. When I had a heart bypass operation in Hammersmith hospital in February 2014, I couldn't help but notice the adverse impact that travelling longer distances had on both patients and families. One elderly gentleman in my bay was desperate to get back home and the joy on his face was a treat to behold when he woke up one afternoon to find his wife, also elderly, had managed to travel some considerable distance to visit him. Equally distressing was his depression when the consultant decided to keep him in longer, rather than move him to Northwick Park, close to his home.

I couldn't help, too, but overhear the stories of visitors to other patients, who had struggled in via long, time-consuming journeys – often involving more than one bus – to see their loved ones. One woman in particular was holding down not two but three jobs while her man was ill. She had to give up one of these jobs so she could travel the long distance from beyond Hounslow to visit him. She was putting on a brave face for her man, but in private, she was stressed and desperately worried about how she could make ends meet. Losing beds from local hospitals doesn't just affect patients – it has a huge impact on families and carers too.

I understand that there are problems with so-called 'bed-blocking' and people attending A&E departments when they shouldn't go there or because they can't get to see a GP. But it is already hard enough to get an appointment with one's own GP as it is, and the BBC's 'Today' programme

tells us GP numbers are falling because of stress and increased paperwork, so how we are expected to have confidence in the mooted GP-led replacement services, especially when care visits in patients' homes are already inadequate, is beyond comprehension. These are the problems that must be sorted out before there is any talk of closing Charing Cross A&E and the loss of hundreds of beds there when they have never been needed more. For the first time in my life, I am beginning to fear for my wellbeing.

If we have to pay more to keep a local hospital – in my case, Charing Cross which is by all accounts popular, well run (and better than its proposed replacements at handling A&E) – with a fully fledged A&E department, then so be it. Most of us residents would be prepared to do that than face not only the loss of our only remaining A&E in Hammersmith, but of a valued local hospital that property prices dictate we will never get back if it is allowed to be demolished. Patient care must come before yet another block of luxury flats, whatever financial tangle the Trust has got itself into. There must be other solutions to that.

Most people are reasonable when others are reasonable with them but the powers that be in this case just aren't being reasonable. If there are to be replacements for the current system, they should be fully tested and tried before the current system is shut down, so that people's lives are not at risk. This is the very least that should happen.

Yours sincerely,

Ian Cranna
[redacted]

Smith Peter

From: Gillian Spragg [redacted]
Sent: 02 February 2015 16:38
To: Smith Peter
Subject: A&E Care at Charing Cross Hospital

Dear Peter Smith

I had a stroke at the end of September 2014. If the A&E at Ealing Hospital had been open, there would have been a chance for me to have been seen within the recommended time of 4 hours. It was a pity that this was denied me. Gold-plated the care may be in other places, but gold-plated was not what I needed. I needed the ordinary, standard care that Ealing Hospital could have afforded me.

That said, I was taken to Charing Cross Hospital where the attention I received was exemplary. The professional care, which my son helped to communicate to me and remember for me, seemed well-thought through, consistent and thorough. The personal approach to me, especially when I was in a very muddled state and could not speak coherently, was sympathetic and considerate, never denying me the dignity which was owed me as an ordinary, though temporarily, confused person. Every thought was given to how I might return home and manage successfully, with special help for my speech.

I made a return visit in mid-December when it looked as though I might be having another stroke. The telephone advice my son received, to take me to Ealing Hospital, was wisely ignored. We knew they did not have the facilities I needed and they did not have my notes of the previous stroke. It seemed complete lunacy that the agent who spoke to us should have made, and insisted on, such a ludicrous suggestion.

Instead we took a taxi to Charing Cross Hospital, who could not understand why I should have been sent elsewhere, where I was seen with very little delay. I underwent a thorough series of tests carried professionally and with in such a thoroughly caring way that I later organised a Christmas card to thank the staff. Fortunately, I had not had a stroke but had picked up a virulent bug.

In both instances, I was sent home with a full report of my stay which was clear and of very great help to my understanding of what had happened to me and how I could best help myself to recover.

With the recent incidents reported, it seems utter madness to close yet more hospitals when there is such a need for immediate help, and help that is not mediocre, but of the highest standard one could wish.

I trust that you and your colleagues will seriously consider that, especially with the A&E closure at Ealing Hospital, further closures are putting people at risk when they are compelled to make longer and longer journeys to received help that they need quickly.

Yours sincerely

Gillian Spragg

Smith Peter

From: [redacted]
Sent: 22 February 2015 14:42
To: Smith Peter
Subject: Ealing hospital

Dear Peter,
I got your email from Tomas Rosembeum.

I am a doctor that lives in Norwood green. Over the years I have worked on and off at Ealing hospital. I passionately believe that this hospital should not have its A&E closed. This morning my mother was diagnosed with a blood clot in a speedy manner and as the hospital is near our house we were able to seek urgent medical care urgently.

I am doing my masters in public health from London school of hygiene and public health and as someone who has studied health economics there is no proof that merging many A&E hospitals is good for patient safety and treatment. The proof shows that this adds to the burden on patients and actually the treatment they receive is not any better but actually having super departments as in usa show poorer outcome.

I urge you to reconsider the closure of Ealing hospital A&E. I as a doctor believe my mothers health was preserved because we were able to be treated in a local place nearby.

I know there is the super A&E being thrown around in Northwick Park but I honk closure of Ealing hospital would be detrimental not only for the patients but also to the doctors.

Ealing hospital is a jewel in our local community!

Best wishes
[redacted]

EALING NOSP. 2

[redacted]

18 January 2015

Peter Smith

Room 39, Hammersmith Townhall

London W6 9JU

Dear Sir, Reference: North West London Care Commission

Having lived in Southall since 1965, I have ample knowledge about the people living in and around this over populated town. The Ealing Hospital is providing most of the essential services to our people. It is very close to us and is easily accessible by virtue of direct and frequent bus service. The other Hospitals e g Northwick Park Hospital, Hillingdon Hospital or the West Middlesex Hospital are much farther and out of our way. There is no direct public transport to them and they are already extremely busy.

The over whelming majority of the local population consists of manual work force and their medical needs are numerous.

The Ealing Hospital is mainly staffed with bilingual professionals, hence more effective with the local patients. It is easy for the family members to visit the patients.

It is a relatively a new modern hospital and a lot of resources have been invested in it. Reducing it or demolishing it will be an inexcusable waste which no health Authority can afford in these hard circumstances.

In the light of these facts I would humbly request The Care Commission not to deprive the people of this area of this well- resourced, well- staffed and highly needed hospital in its present form.

Regards

Mohinder Singh Grewal

Mohinder Singh Grewal [redacted]

Sarah Boston

SATURDAY MORNING AT CARE UK/NHS EALING URGENT CARE CENTRE. The experience

Saturday 22nd November 2014

Yesterday – Saturday 22nd November 2014 – I went to Ealing Hospital Urgent Care Centre run by CARE UK for the NHS. My GPs surgery, Elthorne Park Rd, only see patients on a Saturday morning who have made a prior appointment. Having spent the night with an acute burning pain on passing water: frequency and inability to sleep I was fairly certain, having suffered from urinary infections many years ago, that I had a serious urinary infection and that I needed treatment.

I arrived at Ealing Urgent Care centre at 9.15 am. I was politely greeted almost immediately at the reception desk, asked if I had been abroad recently (Ebola clearly the main concern) and handed a registration form and a small bottle for a sample of urine. I was also warned that the wait to see someone would be at least two hours as they were very busy. Sitting waiting it was clear that they were very busy. At one point the Sister running the reception area was actually 'running around' dealing with patients including a child arriving projectile vomiting in the reception area. I overheard the Sister making a call and saying she was understaffed and needed, urgently, more staff. There was no evidence during my wait of more staff arriving.

At one point the Sister had to do a quick assessment, of a clearly sick child. After the assessment the child and its' parents were immediately directed to A&E . Later a man too, after an assessment, was directed to A&E.

Another phone call I overheard the Sister make was for cleaners to come and clean up the reception floor after the child had vomited. When I left at least an hour later no cleaner had arrived. The staff had, the best as they could, covered it with paper and a warning cone placed on the paper.

After about a two and a quarter hour wait I saw the doctor who confirmed, after questioning me, examining me and testing my urine sample that I had a serious urinary infection. I left with antibiotics. I felt I had been treated throughout my visit with professionalism and courtesy.

It was clear the department was understaffed and stretched, at moments, to their limit. The waiting room was very full including many children and three heavily pregnant women. Despite the pressure the staff were under they all, receptionists, nurses, doctor, remained efficient and calm and just kept going. They even managed a smile or two at times.

COMMENT

STAFFIING

The Urgent Care Centre was understaffed. My question is why was it so understaffed? Was that just a Saturday morning aberration or do Care UK hope to run this centre with staffing levels stretched almost to breaking point.

URGENT CARE/A&E

Watching the young child and the man being quickly directed from Urgent Care to A&E showed the clear benefit to patients of having an A&E department located next to the Urgent Care Centre. Without an A&E would they have had to drive and find an A&E or get an ambulance to take them?

PREGNANCY

Whether the need of the three heavily pregnant women for 'Urgent Care' was related to their pregnancy I could not judge. However **if** it had been at least there were still midwives close by in the maternity unit. If the plan to close the maternity unit goes through in 2015 there will be **no** maternity back-up.

CLEANING

When I was discharged at about 11.45pm the floor in the reception area where the child had vomited. still had not been cleaned. The Sister's request for a cleaner had not been responded to. It was a busy reception area. An area where cleanliness is important not least to limit the spread of infection,

The cleaning company –Compass - Medirest that provides cleaning services to Ealing Hospital– claim on their website to be 'the leading supplier of high-quality cleaning, catering and support' to hospitals. In this case they fell far short of their claim.

23rd November 2014

Sarah Boston

[redacted]

19th January 2015

Dear Sir / Madam,

I am writing this statement as my son advised that it is something that the Commission chaired by Sir Michael Mansfield QC should be looking at as part of his evidence collection.

On the 5th of January 2015, I fell while I was sweeping leaves on my driveway at 10am. I did not think much of it at the time and went about my usual daily activities. At around 3 to 4 pm my hand and wrist area started paining me to the point where I could not cope.

My husband finishes work at 4pm and he got home around 4.15pm or 4.20pm. He could see I was in pain and took me to the GP at the Neasden Medical Centre on Tanfield Avenue. Dr Rasooly said that I should be taken to A&E at Northwick Park hospital and that my wrist might be broken.

My husband then drove be to Northwick Park hospital's A&E. I was seen within the 4 hour waiting limit. They did an X-Ray and told me that the wrist was not broken but it was badly bruised. They said I should rest it for two weeks. Thankfully it did fully heal up within around 5 to 6 days.

My son works very long hours and when he got home he said that what the GP did was wrong. He advised that actually, I should have gone to Central Middlesex Hospital. Yes the A&E is now permanently closed, but there is an Urgent Care Centre there which is 24/7 that could have done your X-Rays on your wrist and given you the same outcome. Instead the GP had unnecessarily put pressure on the A&E when all I needed to do was go to Central Middlesex's UCC. Central Middlesex is also much closer to my home in Neasden and being driven all the way to Northwick Park did mean I had to travel longer to be seen.

Hirbai Hirani

[redacted]

ADDRESS NOT TO BE PUBLISHED!!!!

Smith Peter

From: [redacted]
Sent: 02 February 2015 07:36
To: Smith Peter
Subject: north west London health care inquiry

Good Morning Peter,

I am a member of the Healthwatch Hammersmith & Fulham Local Committee - we are are group of authorised representatives, with portfolios to meet in the community. I have an interest in the service delivery of the 260,000 people that are in Hammersmith & Fulham on a daily basis (Monday to Friday) during the working week. This represents a large number of individuals, potentially needing the support of our local hospitals and emergency services.

I am currently investigating the nature of failures in primary care, to address the needs of residents across many of the boroughs, we as a group of empowered citizens find challenging to understand, in light of an ever growing population, as well as certain doubt of the current proposals, expecting GP primary care services, to cope with the provision of emergency care for patients under the care of their practices.

Most GPs are not geared up to handle any kind of crisis, they inform patients with an ongoing health problem, requiring an emergency referral to call 999, and seek admission through the A&E (Casualty) entrance of our hospitals. A very good example of this is GPs from outside our borough, are requesting patients to use our A&E (Charing Cross), or as recently discovered A&E facilities in Chelsea & Westminster Hospital. We are therefore having a huge strain on our own resources, soon to be closed, with increased pressure on our next available A&E Chelsea & Westminster Hospital, because boroughs like Ealing, have nowhere either to send patients, needing urgent care and treatment through a GP.

The current case I am advocating, has highlighted the plight of primary care health professionals, as well as patients, with nowhere to go, the GP and the A&E both refused to treat a patient, because they have no resources, and have failed a patient because a referral cannot be made, or is indeed non accessible, to the consultants through A&E, which is being closed down by Government Policy in the borough where I live Hammersmith & Fulham.

I am very concerned for our most vulnerable residents, without any access to private healthcare, or indeed NHS healthcare, because services cannot cope now or in the very near future.

John Ryan
Healthwatch representatives Project Group
Healthwatch Central West London
http://healthwatchcwl.co.uk/

TRIP Programme Coordinator - London Borough of Hammersmith & Fulham Social Housing
Resident Involvement Structure - Quality Assurance - Tenant and Resident Inspector Programme (TRIP)

Smith Peter

From: [redacted]
Sent: 01 February 2015 19:09
To: Smith Peter
Subject: North West London Healthcare Commission – Call for Evidence

Dear Mr Smith,

We wish to object most strongly to the plans to downgrade hospitals in North West London. We are in our seventies and at our age, we have had considerable experience of the services offered by these hospitals. Our closest hospital is Hammersmith and we have suffered in particular from the closure of the A&E department there some time back. We have an excellent local urgent care service at St. Charles, but it isn't appropriate for potentially life threatening conditions. The now closed urgent care department at Hammersmith failed to diagnose a life threatening condition one of us was suffering from and eventually we had to go by car to the A&E Department at Chelsea and Westminster Hospital which immediately organised hospitalisation for an operation to deal with a total intestinal blockage caused by diverticulitis which had resulted in a perforation of the colon.

Our experience at St Mary's Paddington has also confirmed the need to have local hospitals with A&E departments. It is difficult for us to get to St Mary's and the parking situation there is impossible. Last night an elderly neighbour with a suspected blood clot was told (after triage) at St. Mary's that he would have to expect a wait of at least six hours whilst sitting next to a woman on a stretcher who was vomiting, coughing and hardly able to breath. When one of us broke a wrist a couple of years ago, the wait there was also well over six hours. It is hard to imagine how St Mary's could cope with the enormous additional demand on its A&E department resulting from the closure of other A&E departments in North-West London.

Yours sincerely

Sebastian Balfour
Grainne Palmer
[redacted]

Smith Peter

From:	Philip Day [redacted]
Sent:	03 February 2015 19:12
To:	Smith Peter
Cc:	sohhandf@gmail.com
Subject:	Submission to Independent Healthcare Commission - PD
Attachments:	Graph A - Type 1 A and E 4h Wait Stats NW London Trusts v the rest, 15m to w-e 25 01 15.PNG; Graph B - Type 1 A and E Patient Volumes, NW London, 15m to w-e 25 01 15.PNG; Graph C - Type 1 A and E Patient Volumes, All-England and London, 15m to w-e 25 01 15.PNG; Email correspondence between Philip Day and Mark Jarvis of Hammersmith and Fulham CCG.docx

Dear Sir,

Cc: Save our Hospitals Hammersmith and Fulham Committee

Please find enclosed the following materials in submission to the Independent Healthcare Commission concerning recent and proposed hospital closures in North West London:

1. Three graphs showing Type 1 A&E performance data and patient volumes, with commentary below
2. Correspondence I have undertaken with HF CCG - attached as word file
3. A link to a recent academic publication investigating changing healthcare demand over time by the elderly - comments below.

Submission 1

The three attached graphs represent data publicly available from NHS England http://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/weekly-ae-sitreps-2014-15. They show weekly time series data from September 2014 to January 2015. I focus on Type 1 A&Es as these are the centers which receive and treat patients with the most serious and urgent treatment requirments.

- **Graph A** shows performance at Type 1 A&Es - the % of patients waiting 4 hours or less from arrival to admission, transfer or discharge. We see performance in the two North West London Trusts* (red and blue lines) beginning to decline sharply around the time of the closure of the A&Es at Central Middlesex and Hammersmith (10th September 2014), represented by the orange vertical line. The purple and green lines showing All-England and All-London suggest there was no corresponding national decline at that time. Later, in December, we see performance at the two NW London Trusts decline to appalling levels before recovering modestly in recent weeks but still well below acceptable levels (latest data available at the time of writing is for the week ending 25th January 2015). In the week ending 21st December, London NW Trust (53.7%) was the worst-performing out of 140 Trusts in England reporting Type 1 data; the next worst Trust was on 61.1%, while Imperial (70.2%) was 8th worst.
- **Graph B** presents patient volumes at Type 1 A&Es for the two NW London Trusts - i.e. demand levels. For the period September 2014- Jan 2015, demand was *lower* than at most times in the preceding 12 months. Even at the depths of the 'winter crisis', patient volumes were still relatively low at NW London Type 1 A&Es, certainly compared to the previous winter.
- **Graph C** shows Type 1 patient volumes for All-England and All-London. London volumes during the weeks of worst performance were only marginally higher than their historic peaks in the last 15 months (c. Apr-July 2014); England volumes were lower than their past peaks. I.e. demand was not particularly high for England nor London compared to past experience.

I submit, therefore, that the appalling performance levels attained by the Type 1 A&Es at the two NW London Trusts were due to a combination of 1) the closures of CM and Hammersmith A&Es on 10th

September 2014 and 2) (later in the winter) a national performance problem, and that neither the local NW London nor the national crisis can be explained by the levels of patient demand.

*London North West Healthcare NHS Trust was created as a merger of North West London Hospitals Trust and Ealing Hospital NHS Trust in October 2014; the graphs here combine the data of the two predecessors before this time.

Please advise if you would like the excel file that produced these graphs, or if you would like them in any other format (e.g. A4 pdf).

Submission 2
I raised my concerns with these figures to Hammersmith and Fulham CCG in November 2014; some correspondence with the CCG is attached (Word file).

Submission 3
I draw to the Inquiry's attention a recent academic report which has not received much media attention but which is relevant to the debates on both NW London's local hospitals, and the general NHS/hospitals crisis.

Understanding Emergency Hospital Admissions of Older People was published by the Centre for Health Service Economics & Organisation in December 2014, having been commissioned by the Department of Health. Its findings contradict a claim we hear regularly, including from Imperial Trust and the local CCGs in their defense of the 'Shaping a Healthier Future' program, that an 'aging population' is putting an increasing 'burden' on hospital services:

Researchers in the Centre for Health Service Economics and Organisation found that people born each year from 1912 were increasingly less likely to need emergency treatment, and spent shorter periods in hospital once they were admitted.

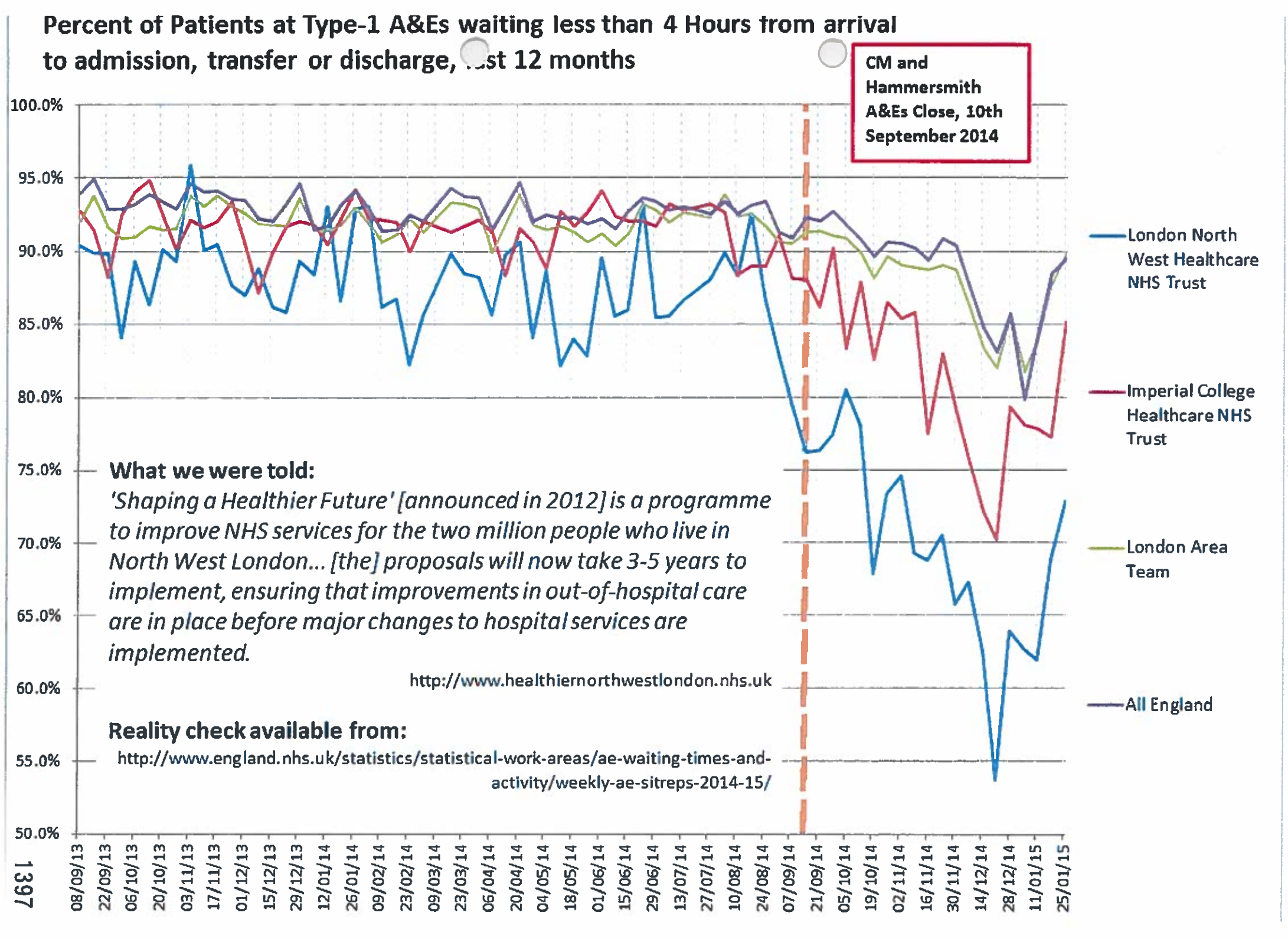
Hospital beds days occupied by persons over 65 fell by 9-10% in the decade to 2012/13, despite the larger numbers of older persons. However, within the over 65 group, bed days fell sharply for those 65-84, and increased for those over 84.

"The perception that elderly people are placing an increasing burden on the hospital system needs to be moderated by a realisation that at each age people are a little bit healthier than they were in previous years and less demanding of hospital admission."

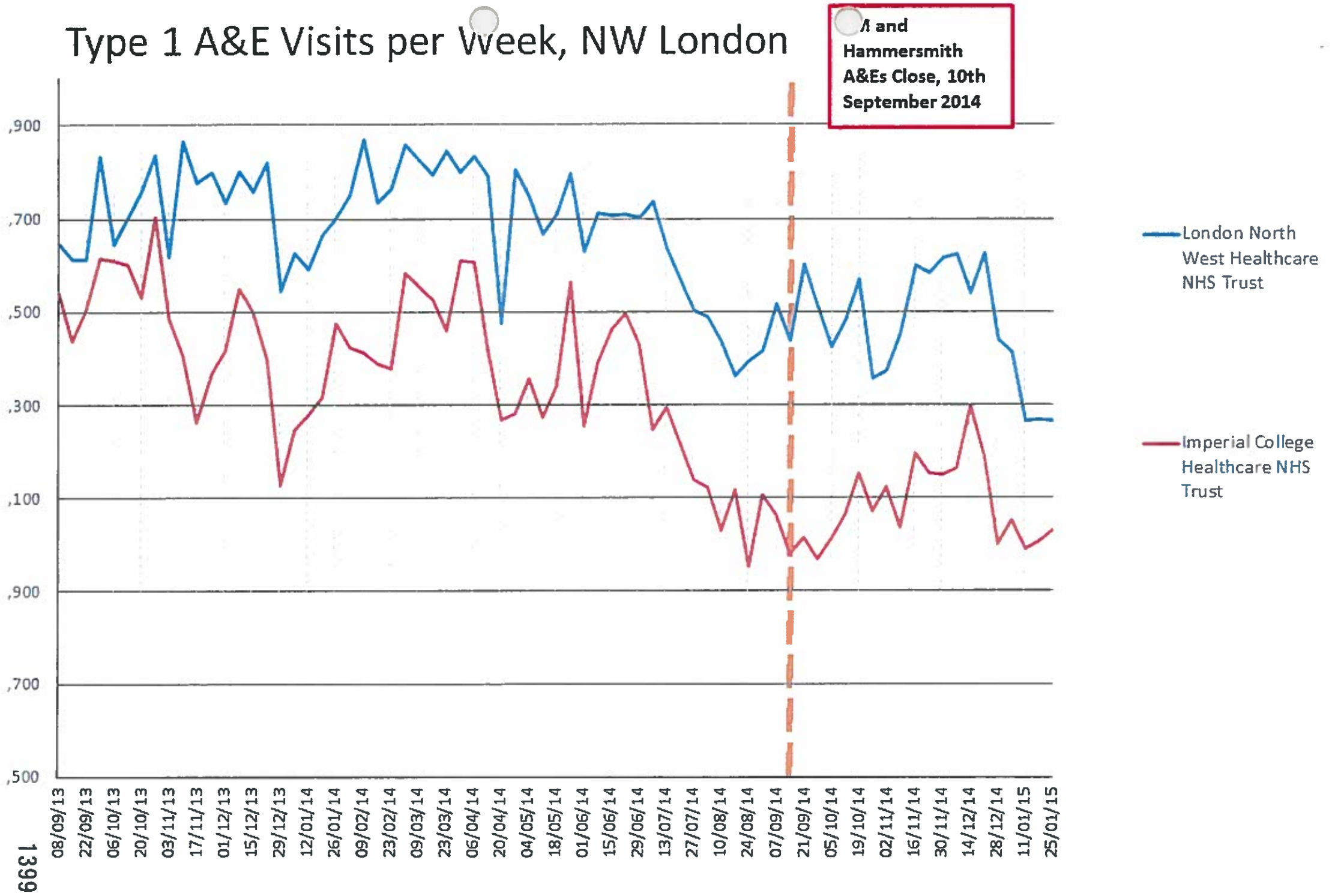
Quotes from a summary article here:
http://www.phc.ox.ac.uk/news/elderly-nhs-burden-2018smaller-than-thought2019
Full article available here:
http://www.chseo.org.uk/downloads/report6-emergencyadmissions.pdf

Thank you and regards,

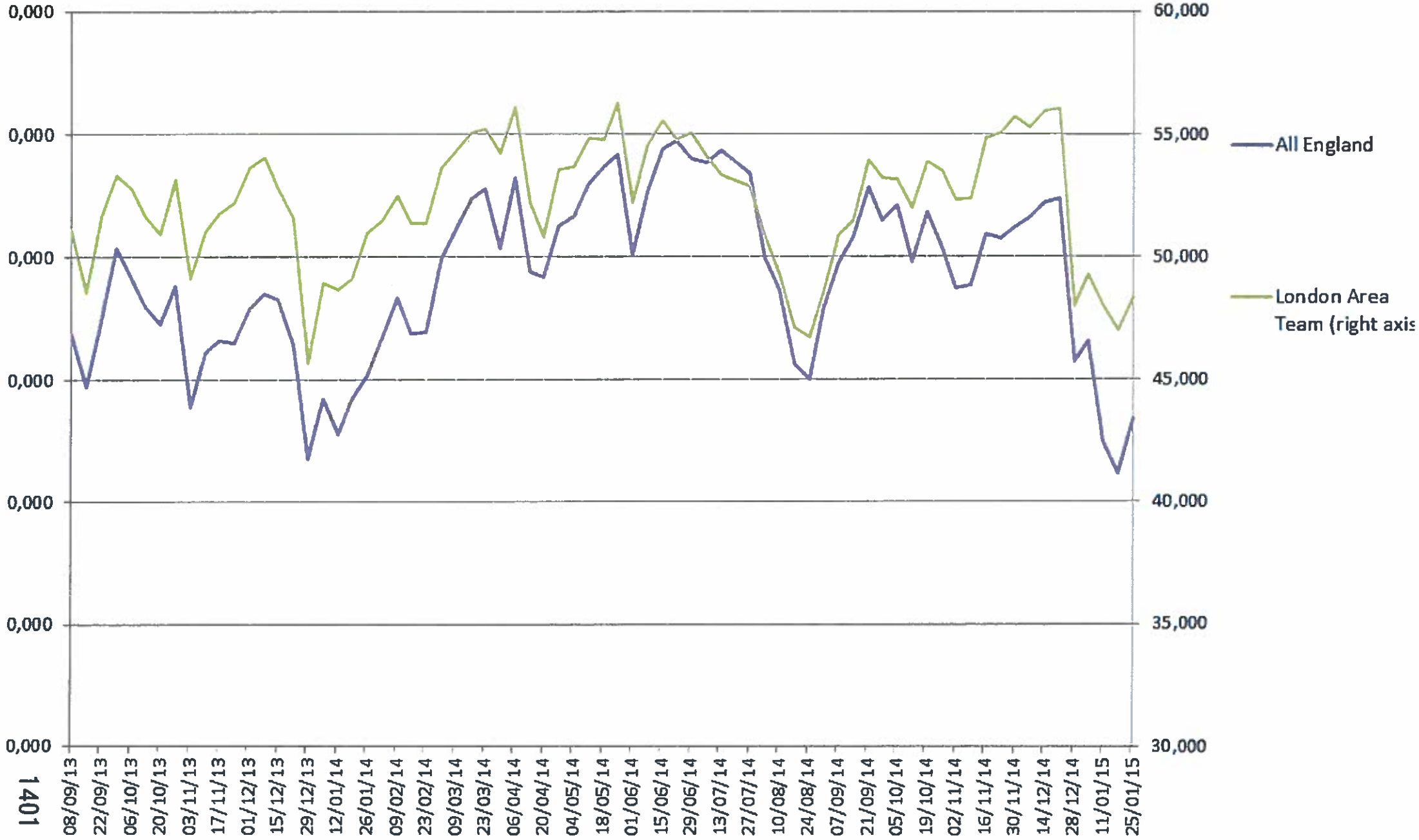
Philip Day


Percent of Patients at Type-1 A&Es waiting less than 4 Hours from arrival to admission, transfer or discharge, last 12 months
CM and Hammersmith A&Es Close, 10th September 2014
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
65.0%
60.0%
55.0%
50.0%
08/09/13
22/09/13
06/10/13
20/10/13
03/11/13
17/11/13
01/12/13
15/12/13
29/12/13
12/01/14
26/01/14
09/02/14
23/02/14
09/03/14
23/03/14
06/04/14
20/04/14
04/05/14
18/05/14
01/06/14
15/06/14
29/06/14
13/07/14
27/07/14
10/08/14
24/08/14
07/09/14
21/09/14
05/10/14
19/10/14
02/11/14
16/11/14
30/11/14
14/12/14
28/12/14
11/01/15
25/01/15
London North West Healthcare NHS Trust
Imperial College Healthcare NHS Trust
London Area Team
All England
What we were told:
'Shaping a Healthier Future' [announced in 2012] is a programme to improve NHS services for the two million people who live in North West London... [the] proposals will now take 3-5 years to implement, ensuring that improvements in out-of-hospital care are in place before major changes to hospital services are implemented.
http://www.healthiernorthwestlondon.nhs.uk
Reality check available from:
http://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/weekly-ae-sitreps-2014-15/

Type 1 A&E Visits per Week, NW London



Type 1 A&E Visits per Week, All England (left axis) and London (right axis)



Email correspondence between Philip Day and Mark Jarvis of Hammersmith and Fulham CCG
Nov – Dec 2014, newest messages at the top

Please note that my intial question for the CCG, dated 10th November 2014, came at a time when Type 1 A&E performance at the two NW London Trusts had declined badly, but before the nadirs they would reach in mid December (see submission 1).

On 17 December 2014 at 15:43, Mark Jarvis <mark.jarvis@nw.london.nhs.uk> wrote:

Dear Mr Day

My apologies for not coming back to you on this. I have asked colleagues to consider your further comments and hope to be able to provide you with a further response very soon.

Mark

From: Philip Day [redacted]
Sent: 17 December 2014 15:36
To: Mark Jarvis
Subject: Re: FW: Question for HF CCG

Hi Mark, I think you were on leave when I sent the email below, I wonder have you had a chance to catch up with it since you came back?

Thanks and regards,

Philip Day

---------- Forwarded message ----------
From: Philip Day [redacted]
Date: 27 November 2014 at 17:05
Subject: Re: FW: Question for HF CCG
To: Mark Jarvis <mark.jarvis@nw.london.nhs.uk>

Hi Mark, thank you for reading out my question at the HF CCG Governing Body meeting and for your report below.

Daniel Elkeles' response to my question is unfortunately not satisfactory.

I find it hard to believe that the vast sums of money spent on the Shaping a Healthier Future could not have been better spent on hiring permanent, full time, qualified professionals to bring staff up to safe levels without using agencies. Closing 2 (to become 4) A&Es is hardly a satisfactory solution!

Even if this problem was insurmountable (which I do not believe), in any case you could have just closed *one of* CM / Hammersmith A&Es and moved all the staff to the other. It is not possible that the staffing shortfall in one of them could have been greater than the entire staff of the other. A glance at any map of NW London hospitals tells us that such a move would have been the least disruptive to staff (relocation of their place of work), and more importantly would have prevented an enormous hole in the centre of the NW London A&E Network.

You quote Daniel Elkeles that, 'the changes had maintained all previous capacity', but you do not quote him quantifying that claim, nor giving an alternative explanation why performance has declined so much.

The statistics quoted in the question were not at all confused - I clearly and accurately quoted stats for Type 1 A&Es, which are published by NHS England. Whether or not the 95% benchmark is conventionally applied to Type 1 A&Es, performance on this metric has dropped alarmingly since the two closures, and since I first wrote to you it has

become even worse - Imperial achieved only 77.5% for Type 1s in the week ending 16th November, placing it 132nd out of 140 Trusts in England reporting that week.

As Daniel Elkeles observed, Type 1 admissions are more 'complex', i.e. the patients are in greater need of care and in greater discomfort. It is all the more alarming then that those patients are the most badly affected by the recent closures.

As well as the data I provided from NHS England (which I'm sure your organisation is looking at anyway), you might have seen this story in the news several times. Most recently it emerged that ambulances are calling central control before taking patients to Northwick Park - the only hospital in London with such controls. The article also stated, "Its board meeting on Wednesday heard that in September ambulances had to wait on 179 occasions for more than 30 minutes to hand over a patient, while 30 patients had to wait more than an hour."
http://www.bbc.com/news/uk-england-london-30215902

Two A&Es have closed and wait times have soared at neighbouring A&Es. There has been no rise in admission volumes in these areas (again, data available from NHS England as I am sure you are aware). It is therefore so obvious that we are experiencing a supply problem due to the closure of service centres, that for Daniel Elkeles to deny it brings into question his credibility and that of the CCG which he represents.

Therefore I re-iterate that Shaping a Healthier Future has been a costly and failure when judged either against its own promises or against acceptable levels of patient care, and must be scrapped. In the meantime I can only hope that no-one experiences serious harm as a consequence.

Thank you again for your response and for your time.

Kind regards,

Philip Day

On 14 November 2014 at 15:52, Mark Jarvis <mark.jarvis@nw.london.nhs.uk> wrote:

Dear Mr Day

Thank you for your question below that was read out and answered at the Hammersmith and Fulham CCG Governing Body meeting on 11 November.

Daniel Elkeles, the CCG's Accountable Officer, commented that the reason for closing the A&E departments was based on the fact that the departments could not be staffed safely and relied on a large number of agency staff. He said that the changes had maintained all previous capacity. He felt that the statistics quoted in the question were confused and explained that patients were divided in to three cohorts – type 1 which were the complex cases, often needing admission, type 2 were patients attending a specialist hospital A&E department and type 3 which were patients with less complex needs attending urgent care centres. He explained that the 95% of patients seen within four hours was a sum of all the categories. He said that Imperial were achieving just over 95% before the changes and were now achieving 94.6%. He went on to say that the majority of patients were type 3 and both Imperial and London North West Trust were seeing the majority of patients within 4 hours. He acknowledged, however, that this was not the case for all type 1 cases and that things were being put in place to deliver improvements. He did not accept that performance had "plummeted" since the changes were implemented.

I would like to thank you for raising this question and hope that you find the response given helpful.

Yours sincerely

Mark Jarvis

Mark Jarvis

Interim Company Secretary

Hammersmith and Fulham Clinical Commissioning Group

NHS Hammersmith and Fulham Clinical Commissioning Group

15 Marylebone Road

London NW1 5JD

Tel: 020 3350 4314

E-mail: mark.jarvis@nw.london.nhs.uk<mailto:mark.jarvis@nw.london.nhs.uk>

Website: www.hammersmithfulhamccg.nhs.uk<http://www.hammersmithfulhamccg.nhs.uk>

From: Philip Day [redacted]
Sent: 10 November 2014 14:55
To: HF CCG hf.ccg@inwl.nhs.uk
Subject: Question for HF CCG

Dear Sir/Madam,

A&E performance in Imperial and London North West Trusts has plummeted since the closure of A&Es at Hammersmith and Central Middlesex on 10th September. Imperial's % of patients at Type-1 A&Es waiting less than 4h, which used to regularly achieve c. 93% in weekly data, dropped to 85.4% last week, which ranks 117/141 for all England Trusts reporting Type-1 data, despite no overall rise in admissions. LNW was much worse, hitting 67.8% in week ending 19th October.
http://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/weekly-ae-sitreps-2014-15/

How can this be possible in light of Shaping a Healthier Future's promises to "improve NHS services... ensuring that improvements in out-of-hospital care are in place before major changes to hospital services are implemented", and is it not now time to scrap the SaHF proposals before serious harm is suffered by people in NW London?

(Quote from http://www.healthiernorthwestlondon.nhs.uk/)

Thank you,

Philip Day

Smith Peter

From: [redacted]
Sent: 05 February 2015 17:29
To: Smith Peter
Subject: My experience

I believe NHS reform to cope with the demand posed by ageing population and increased demand for the public to have a solution for minor and major problems.
I do not believe closing down A and D will be the solution in anyway. The choice of Chelsea and Westminster hospital as a major A and E centre is not the right one as it does not have the speciality that can back up or provide other necessary intervention .
My wife had ectopic pregnancy 4 years ago and the ambulance crew was unsure of where to take her. But I am being a medical doctor I told them to take her to Hammersmith hospital A and E and within an hour she was on operating room. If it was not for the access the hammersmith hospital had gynaecological service, it could have cause loss of life.
Referring patients to charring cross or Hammersmith for further care will put patients at risk.
The saving for NHS should come avoiding unnecessary admission or prevention of re-admission. More OPAT services and better nursing home to improve discharge will save more money than closing A and E and putting the public health at risk .

Kind regards

[redacted]

Sent from my iPhone

Smith Peter

From: Kate Sinclair [redacted]
Sent: 06 February 2015 17:02
To: Smith Peter
Subject: NHS Closures in West London - PROTECT OUR NHS!

Dear Peter Smith

As a resident of LBHF I want to let you know that I am shocked and appalled at planned NHS Closures including that of my local Hospital Charing Cross.

Over the 4 years I have lived here I have had to use the hospital on many occasions. The A and E has undoubtedly on 2 occasions prevented me from becoming seriously ill at a time when my GP surgery was closed and other hospitals much further away. On both occasions I used the 111 service who referred me to A and E and booked an appointment but on one occasion time was of the essence and if I had had to go to another hospital further away that would have probably complicated my condition.

I have also used the excellent facilities and clinics at the hospital for more routine scans and always found it convenient and efficient.

By contrast, my visits to St Mary's, Paddington historically have not been happy experiences. It is a very difficult location to access because there is nowhere for cars to go and because of the conjestion of the station. I have not found my treatment there to be very satisfactory.

If all of these A and E's are closed in this Borough, there will be significant consequences and I am sure deaths. To put so much pressure on a few hospitals with proper A and E departments is madness - people with critical conditions - car crashes, strokes, heart attacks, meningitis etc will die in the future if it takes additional time to get them to hospital or for people to be waiting at the hospital because services have been cut so drastically.

We do not want to be a Borough for Sale! We like our hospitals and we need them. As Council tax paying residents we should be listened to. The time has come to stop all these closures in our Borough.

Very best

Kate Sinclair
[redacted]

Smith Peter

From: Judith Gordon [redacted]
Sent: 10 February 2015 20:30
To: Smith Peter
Subject: Ealing Hospital A&E

Dear Panel,
Last week I went to see the proposed plans for a new development in Ealing Broadway in The Broadway. It involves building 200 new homes but only 60 parking spaces. All of the recent new builds in Ealing have had similar restrictions to car parking and when I queried builders Benson and Elliot about the lack of car parking, they simply replied that they were thus encouraging the use of public transport.
I am 75 and don't drive, new residents will have to use pulibc transport, yet the plan is for Ealing residents to have to travel impossible distances in emergencies to get to an A&E department.
Are we all supposed to take ambulances?
Whatever are you thinking of, closing the only A&E we can reasonably get to?
Very troubled, Judith Gordon

Smith Peter

From: Bob Garner [redacted]
Sent: 11 February 2015 20:27
To: Smith Peter
Subject: Prospect of A@E closure at Ealing hospital

Dear Sir,

I strongly reject any idea of closing the A&E department of Ealing hospital as well as the maternity departments an absolute disgrace, with an ever expanding population in London & specifically here in West London the need for all these departments to remain open is now greater than its ever been. The prospects over the next 20 plus years will be the need for more services in local hospitals not less.
If the A&E departments close the length of time involved with the increase in road traffic for ambulances to get to a hospital that might be over five miles further away would increase the amount of deaths due to the delays.
Already the population of London has increased by over two million & will carry on increasing over the years.
Just cant imagine what it will be like in a few years time with less services & increasing population.
yours sincerely
R.F. Garner

The Labour Party
Richmond Park Constituency

Secretary: Brian Caton.

Starr House,
57 Church Road
Richmond TW10 6LX

Tel: 020 8332 6420
Email: insert address here
brian.caton@ntlworld.co.uk

Please reply to:-
2, Walton Court, Sheen Park
Richmond, TW9 1UL.

11th February 2015

.
Peter Smith
Clerk to the Commission,
Independent Healthcare Commission
For North West London.

Dear Sir,

This CLP wishes to make the following submission in respect of returning full NHS services at Charing Cross Hospital, Hammersmith.

Large areas of our constituency in the London Borough of Richmond upon Thames; especially the wards of Barnes, Barnes Common, Mortlake and East Sheen are just two short bus rides from Charing Cross Hospital and it's A&E, Clinical an d Consultant Services. This far more preferable to referral to St George's (Tooting) or the Kingston General Hospitals where there are no direct bus routes. This is most keenly felt by our elderly and disabled residents, as many of our population are. Such effects are also affecting visitors to the in-patients detrimental to patient rehabilitation.

We believe that the proposed changes to services at Charing Cross Hospital would be to the detriment of a large residential area such as ours with its larger share of elderly patients.

In respect of emergency ambulance journeys, a trip from our North wards would take 5 to 10 minutes when a journey to Kingston 20 to 30 and to St George's considerably longer, valuable time in acute cases!

I hope that this submission is given due consideration as to many of our residents; Charing Cross is considered as their local hospital, for the reasons given.

, .

Yours sincerely,
Brian Caton (Secretary)

Labour

Smith Peter

From: Mairead Liston <Mairead.Liston@cavendishstaffing.co.uk>
Sent: 13 February 2015 15:17
To: Smith Peter
Subject: EALING HOSPITAL

Dear Peter ,

Following the report in the Ealing Gazette I agree that the impact on the residents with the pending closures will have a very serious effect on the health of people in the area I believe that there needs to be more protest especially pre the general elections so the message is brought home .

I live in the area and know the needs of the community please keep me posted .

Kind Regards

Mairead Liston
Registered Nurse Manager
Cavendish Staffing Ltd
Tel: 0203 008 5210
Mob: 07802 454 978
Fax: 0203 008 5211
Email: mairead.liston@cavendishstaffing.co.uk
Website: www.cavendishstaffing.co.uk

Smith Peter

From: Raymond Nurse[redacted]
Sent: 18 February 2015 12:41
To: Smith Peter
Subject: Ealing Hospital

i am writing to plead for Ealing Hospital to stay open as a local hospital. The staff are fantastic and it is very useful
to have a local hospital in an area this size which is easy to get to.

Carol and Ray Nurse

Smith Peter

From: Ruth Bradshaw [redacted]
Sent: 23 February 2015 15:37
To: Smith Peter
Subject: North West London Healthcare Commission - Evidence

Dear Sir

Please forward the following submission to the Independent Healthcare Commission for North West London.

The name "Urgent Care" is too similar to "Accident and Emergency"

A small but possibly life-saving change should have been made when the Accident and Emergency department was removed from Central Middlesex Hospital. The Urgent Care Centre there should have been given a different name. This can still be done.

One of my neighbours was taken ill in the last week of December 2014. His brother, knowing that the Ambulance Service was very busy, took him to Central Middlesex Hospital in a cab. In the Urgent Care Centre his condition worsened and he collapsed. The staff at the Urgent Care Centre had neither the right equipment nor the specialist knowledge to revive him, so they called an ambulance. By the time he was revived, he had not been breathing for about 15 minutes and had suffered brain damage. He died in hospital two weeks later.

The brother does not know whether the outcome would have been different if he had called an ambulance. Nobody can know that. However, in conversation with several neighbours it has become clear to me that most of them do not understand the present provision for emergency care, and that the name "Urgent Care Centre" is misleading. When the Urgent Care Centre was opened, the Accident and Emergency department was in the next room. If something really was urgent, the patient was immediately taken through the door to the Accident and Emergency Department. This has changed completely. An ambulance staffed by paramedics can now offer emergency treatment better and more quickly than the mis-named Urgent Care Centre.

The other "Urgent Care Centre" without an Accident and Emergency department, at Wembley Centre for Health and Care, used to be called a "Minor Accident Treatment Centre" or "Minor Ailment Treatment Service". It was then quite clear that it did not deal with life-threatening conditions. Its name should not have been changed to "Urgent Care Centre".

The minor treatment provision at Edgware Community Hospital, which also has a walk-in GP service, is known to local people simply as "The Walk-In Centre", so it is known that it does not deal with emergencies. However, I am not sure whether it is also now officially called an Urgent Care Centre; if it is, this also is a mistake.

I do not know whether my neighbour would still be alive if the stand-alone Urgent Care Centres had been given a different name. However, I do believe that re-naming them now may save lives in the future. Please recommend this change in your report.

Yours faithfully
Ruth Bradshaw (Mrs)

[redacted]

Smith Peter

From: [redacted]
Sent: 22 February 2015 21:25
To: Smith Peter
Subject: Save Ealing A&E

Dear Sir,

I do not feel it would be in the best interests of the public nor the NHS to close Ealing Hospital A&E.

Regards,

Dr K Rakowski

GPST

Mr. Peter Smith ~ 18-02-15

What malign genius (or joker) put Simon Stevens in charge of NHS England, and even getting guru status from Tory media? He's surely in place to supervise the privatization of the whole show. He's raised in U.S. United Health ~~interests~~ — a grim institution delivering neither, except for profit. In principle & practice, the private permanently prejudic predates & parasites public provision.

I hate the A&E closures, as being driven by hansley ideology, about shrinking the State. The longer term closures of Ealing, e.g, are about clearing the land for posh housing. So Send those south of the Uxbridge Rd (to an already overstretched Northwick Park) is a 3 bus-ride. How to time that for appointments?

There's increasing chatter about avoiding alleged bed-blocking with care in the home/community. But there's no evidence of any forward planning, training courses, & or even ring-fenced funding, from any central budgets. What's being proposed? Equivalent Matrons on bicycles, with sturdy lockable panniers fore and aft? More likely are half-qualified, zero-hours contractors, without paid travel time, car allowance, holidays, insurance, or indeed time to care.

- HEALTH FREE AT POINT OF USE – BUT NOT FROM CONDEM DOGI

» Cuts "Customer" Conservatism
» Coming Care ~ Costs
» Guaranteed Grotty Greatly

Not No
In Independce-
Control Cahoots
Either Endemic

Yours etc

[redacted]

Mr N F C Coward

[redacted]

Smith Peter

From: john green [redacted]
Sent: 21 February 2015 12:07
To: Smith Peter
Subject: re closures and reorganisation of Ealing hospital

Dear Sir

We both wish to express our complete opposition to the planned closures and reorganisations planned for Ealing Hospital. No proper consultation with Ealing's inhabitants has taken place and the reasons given for these planned actions are spurious and disingenuous. Ealing hospital covers a large catchment area and provides a vital service for the borough's citizens. If anything, it needs to be expanded and upgraded, but not have its services pruned and/or closed if it is to cater for and cope with future health needs.

Yours faithfully

John C Green
Dr. Bruni de la Motte
[redacted]

Smith Peter

From: rizwana khan [redacted]
Sent: 22 February 2015 17:37
To: Smith Peter
Subject: Please don't close emergency department in Ealing hospital

Today for some reason I went to emergency department for my self and realised that closing this department is not right action I think this is kind of a blessing to have emergency department and closing this ,Means you are taking away this blessing from thousand of sick patients who use the Ealing hospital emergency department every day and night Please Don't Close Closing emergency is not solving problems is creating new problem Thnaks
Sent from my

Smith Peter

From: Harry [redacted]
Sent: 23 February 2015 18:05
To: Smith Peter
Subject: SUBMISSION TO North West London Healthcare Commission

Dear Mr Smith

In November 2014 my wife was referred to a consultant at Charing Cross hospital following an operation for breast cancer at the same hospital the previous June. Under the new system in NW London all referrals are now required to be reviewed by the local Clinical Commissioning Group. The CCG may refuse the referral but in any case there will be a minimum delay of six weeks. My wife's referral was eventually approved and an appointment has now been made for March 2015. I may say that this system made us unnecessarily anxious about the possibility that the referral might be refused. We were left entirely in the dark about the appointment for months which led to us to make repeated calls and emails. A wait of four months to see a consultant is too long especially where cancer is concerned.

In my view the CCG review of referrals is entirely unnecessary and a complete waste of everybody's time and money. If a doctor thinks a referral is necessary that should be sufficient. So it was until recently in Ealing and so it continues elsewhere eg Kensington as a GP tells me.

Yours sincerely

Harry Alvarez
[redacted]

Smith Peter

From: Helen Savery [redacted]
Sent: 23 February 2015 18:20
To: Smith Peter
Subject: Closure of hospitals

Dear Peter Smith

I would like to raise my concerns about the closure of health services specifically in my borough, Hammersmith and Fulham where the population continues to grow especially in light of a lot of new housing that is being built.

There will be no blue light service in the whole of the borough and we will lose Charing Corss, a hospital that includes so many important departments that have a reputation for their excellence.

I appreciate that the NHS is costing too much and is in debt and therefore changes must be made, but closing down whole chunks of National Health Services without the replacement systems in place to me sounds like a very bad idea. Unfortunately, the evidence is emerging to prove that my concerns are valid.

Yours Sincerely

Helen Savery
[redacted]

Smith Peter

From: Tamara Dragadze [redacted]
Sent: 24 February 2015 00:18
To: Smith Peter
Cc: [redacted] Cllr Lukey Vivienne;
Subject: URGENT Submission for Michael Mansfield QC

Dear Peter Smith,
Could you please ensure my submission below reaches Michael Mansfield QC in time.

SUBMISSION BY DR TAMARA DRAGADZE, RESIDENT FOR 34 YEARS IN FULHAM, LONDON
[redacted]

Dear Michael Mansfield,
General concern
I am writing to you about the issue of distance and transport which has been completely ignored in the plans by the PLAN for our area through Imperial Trust and the UCCG that are being implemented against our wishes.
They have never demonstrated that they factored in distance and transport (including traffic congestion) into their plans and which means of transport they used to make their calculations for their new plans. Neither did McKinsey include the variables of distance and traffic in their original plans. It seems that both they in Chicago and our Imperial CEO in Australia never appreciated that in London one of the crucial factors is distance and transport.
They expect patients to travel away from the closed down A and E's to main centre--by public transport, private car or ambulance? At what times? Congestion for getting to St Mary's Paddington is an important issue.
The fact is that this research has not been done. The plans are working on untried assumptions. So far the results are bad. We do not want this trend to go further, at least until evidence based research results can be monitored.
I spent a life as a university lecturer in Social Science and I have yet to see any evidence presented that has taken this variable into account in their decision making.

Now some concrete examples:

Ambulances:
On 30th June last year, 2013, my son in Sands End Fulham called an ambulance because his wife went into rapid labour. It did not arrive in time because it was caught in traffic; furthermore the rapid response vehicle arrived AFTER the ambulance and it too had been caught in traffic. By the time they arrived my son had delivered his baby himself, following instructions on the telephone from 999. However the placenta was not coming out so a midwife had to be brought. The rapid response car went to fetch her (instead of attending to other emergencies) and my son drove her back in his own private car---such is the transport situation that such midwives have no car of their own. The ambulance finally took my daughter-in-law and baby to the Chelsea and Westminster hospital again in heavy traffic at that time of day (mid morning). That area is congested at the best of times.
Conclusion: if the ambulances are asked to perform even more services because hospitals are closing and are so far away, there will be even more of a black hole than there already is today.

Second example of distance and traffic:

I was standing by chance outside Charing Cross Hospital when I got a phonecall from the police to go to St. Mary's Paddington to attend to someone there who had had a traffic accident and was in their trauma section of A and E. I fortunately had the income to be able to hail a black cab. It took me 48 minutes to get there--in a black cab--at around 1 o'clock in the afternoon.
It is unrealistic to think ambulances can get through to either alternative hospitals in good time. It is all very well that a lot of first aid treatment can be done inside state of the art ambulances on their long journeys to hospitals. But not all ambulances are fully equipped. Once again, it would be best for ambulances to have state of the art services to be set up first before more cuts take place to A and E's.

My own need:
Fifteen years ago I returned from a trip to Azerbaijan and a simple palm tree leaf prick on my knee turned sceptic. Once home I went to the local chemist on Fulham Palace Road but he told me to go straight to A and E. I wandered over--the Charing Cross A and E is eight minutes walk from where I live--and I am an example of the wandering patient who walks into A and E . HOWEVER, I had developed septicaemia and was immediately put into intensive care. I HAD HAD UNDER ONE HOUR TO LIVE. W|hat would have happened to me if I had had to go to St. Mary's hospital, after presenting myself at a so-called urgent care centre elsewhere?? Would I have made it within the hour? Definitely not and I would not be alive today.
There are going to be fatalities that could have been avoided had this senseless scheme not been mooted.

Another example of the importance of factoring in distance:
Last summer I had a near drowning on the South Coast of France. It took an hour and a half to get a heart beat on the beach before I could be moved, but the long attempt was made possible because a team of doctors came out from the hospital in Toulon WHICH WAS ONLY FIFTEEN MINUTES DRIVE AWAY, Whichever way you try to travel, the distance between our hospitals in North West London are all more than fifteen minutes away by ambulance. If I had been near drowned in a swimming pool in my borough I would not be alive today, once again. A hospital being close by was crucial.

Charing Cross Hospital closures already
It is surely wrong to be closing the Charing Cross hospital by stealth, especially when alternatives involve such difficulties because of distance.
When I was flown back by air ambulance to the UK I wanted to be in my local hospital where my family were nearby, but this Charing Cross Hospital had already decided no longer to accept long term patients and I was put in Chelsea and Westminster Hospital despite it being already on black bed alert--and so I was admitted to an unsuitable ward just because it was the only bed available. I endured two months of mayhem until I finally was able to get a place in the Royal Hospital for Neuro-disability.
When discharged though, after March last year, I was supposed to have aqua therapy, but again, the Charing Cross Hospital, in the process of being run down, no longer accepted other hospital or even local GP referrals for their swimming pool and aquatherapy. I was told I could have it at Chelsea and Westminster Hospital instead. BUT OUR LOCAL CCCG WILL NOT PAY FOR PATIENTS TO HAVE CHELSEA AND WESTMINSTER HOSPITAL'S AQUATHERAPY. So if you live in this borough, you simply don't get it.
Finally, the Imperial Trust CEO confirmed that the stroke unit is to be closed at Charing Cross hospital without a scrap of evidence that it will save patients' lives; each moment counts and for all residents as well as Heathrow arrivals (like Andrew Marr) to have to travel in busy traffic to St Mary's Paddington is going to have a severe impact on stroke patients which could be avoided by leaving the unit where it is at Charing Cross.

The above points have been made to emphasise the lack of planning where distance and transport have not been factored in as important variables.

This program must be stopped and thoroughly rethought.
One other factor is that there will be the legal costs and compensation to be paid out which will dwarf the efforts to save on healthcare which is one aim of the new plans.
Fatalities will occur inevitably from these mindless and ILL PREPARED plans that are being implemented without infrastructure and regard to distance and transport traffic.
I therefore ask you please to consider my argument that a moratorium on any further changes must be implemented forthwith.
There is no clinically based evidence to show that a chaotic plan with faulty omissions should go ahead without a very long moratorium so that thorough plans can be made. Evidence and analysis will probably conclude that although having less A and E centres might look good on paper, the transport and distance logistics of our borough and region of London defeat the purpose of saving lives in as little time as possible.
Please do not hesitate to contact me on my email:
[redacted] if you need any explanations or further evidence.
Warm regards,
Tamara Dragadze
DR. TAMARA DRAGADZE B.A. (Kent) D.Phil (Oxon)
[redacted]

Smith Peter

From: Merril Hammer [redacted]
Sent: 24 February 2015 12:10
To: Smith Peter
Subject: Personal Submission to Health Commission

Dear Peter,

Sorry this is so close to the deadline, but hope that it can be submitted.

I am writing here in a personal capacity about some of my own experiences of local health provision over the past few years. My particular concern here is the fragmentation of the services and how, despite excellent service from front line staff, the growing privatisation, the divisions between primary and secondary care and the consequent communications problems are adversely affecting patient care and, undoubtedly, are costing the NHS more to provide than a simpler and more coherent system would – and has in the past.

My first example is based on my experience of dealing with chronic bursitis in my hips over a period of some years from about 2011 to 2014. I was initially referred to the community physiotherapy at Parsons Green where the senior physiotherapist, after there was no significant improvement, eventually referred my for an unltrasound to investigate further what the problem might be. I was referred to what was obviously a privatised clinic at Waterloo where the radiographer suggested that there was an additional problem to the bursitis and it would be sensible for me to seek further medical help. As far as I have been able to determine, a written report was sent to the Parsons Green physio service but with no actual ultrasound evidence; and neither the report nor the ultrasound evidence was sent to my GP. Parsons Green referred my to Rheumatology at Charing Cross which, when I eventually got an appointment (I will refrain from recounting these trials and tribulations but I did need to make a complaint!) has also not received either report or ultrasound evidence. (Again, I will refrain from detailing my treatment from this department, only noting that the letter I received was full of inaccurate information and later had disappeared from my hospital file.) What I do want to stress is that, with services partially privatised 'at the point of delivery', there is no coherent system for conveying information to those who are expected to coordinate and progress treatment for the patient and that treatment is fragmented and delayed with confusion from providers and for the patient.

My second example is more recent. At the end of 2012 I severely sprained my ankle while in Australia. On my return a week later, I immediately sought medical help. When, after some 6+ weeks there was only limited improvement my GP referred my for an ultrasound and for physiotherapy. He said that it might be a 6 week wait for physio (again from the community health providers) but the ultrasound should only be a couple of weeks if I went to Chelsea and Westminster Hospital. Having the ultrasound before physio seems like a sensible idea – that way the therapist will be more sure of just what the problem is. However, while I did indeed have to wait for 6 weeks for physio (- by now some 13 weeks since the fall!), the ultrasound was not done till more than a week later, when the consultant radiologist was concerned enough about the inflammation and what he thought were pieces of bone floating in the ankle that he immediately contacted my GP who immediately managed an appointment for me with in the Orthopaedic Fracture Clinic at Chelsea and Westminster. I cannot praise highly enough the speed and efficiency with which this appointment was made. But I was already seeing a physiotherapist who was not receiving any instruction and advice about the outcome of the ultrasound or from Orthopaedics. I, as the patient, was the only conduit for information … and an inadequate one at that. The physio sessions finished after some 6 sessions … apparently the maximum that can be offered unless there are special circumstances. Throughout this time I felt the physiotherapist was, because I was also being seen at the fracture clinic with which he had no links, unsure of what was the best way to proceed. I am not suggesting any sort of incompetence; but not having a clear diagnosis of the problem left him unsure of how far to push me in terms of exercises. I eventually had the ankle operated on in December and am currently still seeing the orthopaedic specialist AND the HOSPITAL physiotherapy team. Here, where there has been clear communication between departments, where they know and consult with each

other, I again have nothing but praise for the attention I am receiveing. Each department clearly works together – a very pleasant, and effective and confidence-building experience after my previous experiences.

I know, from my engagement with local people, that this fragmentation is increasingly common and, as in my own first instance, can result in patients having to travel out of borough for tests or treatment because local facilities are not available or are overloaded. This added burden for patients is unacceptable – it is time-consuming, causes travel problems and can be a huge expense for many.

Yours sincerely,

Merril Hammer

Smith Peter

From: valerie warrender [redacted]
Sent: 24 February 2015 12:39
To: Smith Peter
Cc: scxandh@gmail.com
Subject: save Hammersmith&CharingX

Dear Sir,
I have been treated in the A and E at Charing X hospital in 2013 and found the care and attention exemplary. My son phoned for an ambulance at 2 am because I was expelling blood from my throat due to an infection. The response was speedy and after various checks I was admitted for the weekend and my condition stabilised.

My treatment for cystic squamous cell carcinoma of the left tonsil has been very good both from the surgical team and the radiotherapy staff who were kind and encouraging when I was finding the process so difficult. I find the followup care is reassuring too.

I think it is sacrilege to think of destroying the good work that is carried out here. Support it instead and acknowledge it's value to the community.

Valerie Hull age 73 grateful patient

Smith Peter

From: J Grealy [redacted]
Sent: 24 February 2015 12:58
To: Smith Peter
Subject: Personal submission to the Health Commission

Dear Peter Smith,

I am submitting this statement on behalf of a friend, and with his permission. He does not have access to the internet and is having ongoing treatment at St Mary's Hospital, to which he was referred by Chelsea and Westminster Hospital. He is happy for this submission to be made but wishes to remain anonymous. He also is strongly supportive of front line staff who have served him well.

Two years ago he was diagnosed with a potentially serious vascular condition which was monitored until he was deemed ready for surgery. At the beginning of January this year he was suddenly given a date for surgery not at Chelsea and Westminster Hospital which he had been attending up till this point but at St Mary's Hospital which he didn't know and, as he lives in Merton, has meant additionally travel.

He turned up on a date in late January (I am not providing exact detail in order to maintain anonymity) at 9.00am as instructed but was not attended to for 3 hours after which he received detailed preparatory treatment prior to surgery. He was in hospital apparel, given a bed, linked to a drip machine and told he could not have food or drink till after the procedure. HE REMAINED IN THIS CONDITION FOR THE NEXT 36 HOURS apparently awaiting surgery. He was frequently seen by junior doctors and nursing staff during this time; they assured him that the procedure would go ahead shortly. At the end of this time, having had no food or drink for more than 36 hours, he was informed that a doctor was not available, that there were emergency circumstances, and that the procedure would not go ahead. He then had to wait several more hours for formal discharge, still without receiving food and drink.

The day following his return home he receive a letter giving a new date for his surgery. He has been very distressed as he had built up anxiety before the procedure which did not take place and then was left without any adequate explanation about why things had not gone ahead.

Several points arise from this:

- My friend is full of praise for the frontline staff who attended him at St Marys
- He is astonished at the lack of explanation from hospital management who had kept him in overnight as to why things were not going to go ahead
- He is disappointed at how long it was before his discharge was complete when he was clearly personally ready to leave for home having not eaten for 1.5 days
- He wonders about the cost of his failed attendance at the hospital – a bed for 1.5 days; preoperation preparation; staff attention etc
- He is worried at possibly being labelled a 'bed-blocker' when the duration of his stay was not of his volition.

There is a further question that needs to be asked. Given the current failures of A&E departments to meet the set standards for seeing emergency patients, and given that my friend was told there was an 'emergency', is this yet another knock-on effect of hospitals simply unable to cope with demand. Is this a further case of cancellation of elective surgery to cover for poor management of emergency services and inadequate facilities out of hospital. That someone should get this close to having surgery and then be discharged is a shocking indictment of patient management across emergency and elective provision.

James Grealy

Attention Peter Smith
Commission Room 39
Hammersmith Town Hall
London
W6 9JU

Mrs P Hughes
[redacted]

I am very concerned at the way the NHS is being controlled, there are a lot of questions to how the money is being spent, years ago our health service was said to be the best in the world.

I live in North Acton and in February 2012, I was taken by ambulance to A&E at Central Middlesex hospital, I spent four weeks in hospital had excellent treatment, I was very angry when the government had the A&E departments at Central Middlesex and Hammersmith Hospital closed.

When I was in hospital I was chatting to a lady who was also brought in to A&E at Central Middlesex by ambulance but lives in Harrow, she was unable to be taken to Northwick Park Hospital as they had no beds, so how can the government justify closing Central Middlesex and Hammersmith A&E departments.

Now they want to close Ealing Hospital, when I was at work I always remember my boss telling me if you put to many people in a boat it will sink, that is what is happening to our Hospitals, GP"s surgeries, they are unable to cope, due to the vast amount of people that are coming to the UK to work and live.

Our hospital are in a very poor state, doctors and nurses are over worked this causes bad judgment and mistakes.

More and more people are coming to our country every day, the government should be opening more hospitals not closing them, also large clinics should be opened and controlled by GP"s and nurses that are open 24 hours, and GP"s to make house calls, as they did 40 years ago.

The government should also stop sending so much money abroad, and spend more on our hospital and NHS, as the government appear to have no control to the amount of people that are flooding into our country.

I feel very nervous if I have to spend any time in hospital and I am sure there are plenty of other people that feel the same way as I do, due to lack of doctors and nurses, plus all the deadly bugs that are going around in our hospitals.

Regards

Mrs P Hughes

Smith Peter

From: MARC LOOST [redacted]
Sent: 24 February 2015 13:27
To: Smith Peter
Subject: Charring Cross Hosp

Peter Smith, Clerk to
Independent Healthcare Commission
Room 39
Hammersmith Town Hall
London W6 9JU

23 February 2015

Dear Sir,

As a resident of North Kensington, I today attended the Charing Cross Hospital as an out-patient only to be alterted that there is a possibility that the Hopsital might be closed and that its land might eventually be used for some other purpose. That other purpose, I suspect, would not likely be of equivalent service to the community. The real stimulus for closing the hospital is less likely to be medical efficiency and service than profit for land developers.

In my experience as an out-patient in two different departments, Charing Cross Hospital is not a particularly satisfying or efficient place, but the hospital is well situated within a community that is probably in need of its facilities and is conveniently reached by bus and tube. It certainly serves a broader catchment area than Hammersmith, and in terms of physical layout and convenience may be no worse than St. Mary's Hospital. One can only wonder where some of the sevices provided at this hospital would be better relocated.

The commercial facilties (shops, coffee shops etc) in the vicinity of the hospital have not improved in the past five years.

I am sending a copy of this message to scxandh@ gmail.com in appreciation of their alert and efforts. I wish their request for feed-back had been more specific to allow me to write a more useful message.

Yours sincerely,

Marc J. Loost

Smith Peter

From: Natasha Harris [redacted]
Sent: 25 February 2015 01:21
To: Smith Peter
Cc: scxandh@gmail.com
Subject: FAO the Health Commission

From: Suzanna Harris
[redacted]

In May 2014 my husband, Walter, was sent to Charing Cross A&E by his GP immediately after an emergency appointment, due to severe abdominal pain. The GP requested admittance to the hospital by letter.

My husband had an emergency operation for an incarcerated hernia, which was life-threatening. It required re-section of the small bowel. Two days afterwards he was taken to Critical Care for, among other conditions, hypoxia and tachycardia. He stayed two days and then returned to the ward. I have no doubt that his life was saved by his treatment in Critical Care.

He stayed at Charing Cross for 10 days, and after discharge was visited regularly by community nurses.

The condition has now recurred and he needs further surgery. This will probably be done at St Mary's, Paddington. I understand that as of a year ago, major elective surgery only takes place there and no longer at Charing Cross.

I also understand that the number of beds in Critical Care at Charing Cross has been halved during the past year. This is of great concern. The combination of technology and one-to-one 24/7 staff-to-patient ratio, while costly, is obviously effective for saving lives.

My husband went to his GP about ten weeks ago because his abdomen had worrying bulges and the operation wound was re-opening. Despite the GP's concern it took about 10 weeks for my husband to get an appointment with the Charing Cross consultant. He was given a scan appointment 10 days after the consultant appointment.

My husband received expert and kind care throughout his treatment last May. I should like to believe that 10 months on these high standards have been maintained.

If he has the operation at St Mary's it will be inconvenient but not very difficult. Visiting will take much longer. We can afford a taxi when he is discharged.
But I know that many people in Hammersmith cannot, and for whom the longer journey will be difficult for visiting.
I have heard from an elderly lady that escorting her husband there from Hammersmith for cancer treatment is exhausting and stressful for them both.

Yours sincerely,

Suzanna Harris.

Dear Mr Smith

I read your article in the Gazette last week. Like you, I am very concerned about these NHS plans, as far as I know they are intending to close A&E's at Ealing and Hammersmith hospitals, leaving the nearest to us either West Middlesex or Northwick Park both about ½ hrs drive from our house. We are in the fortunate position of having private health insurance and I drive or can afford a taxi to Clementine Churchill Hospital.

I am writing to you on behalf of those, especially the elderly, who cannot afford a taxi or drive any longer.

Ealing being one of the biggest Boroughs in London should surely have a local A&E hospital.

I know there are problems with immigrants who sometimes use hospital A&E's because they are not registered with a doctor. I understand this problem is being sorted.

As I said I am especially writing about the elderly, now being one myself! but also because I have worked for the elderly and then set up and became Chairman of Age Concern Ealing Borough. I also set up Ealing Community Transport – ECT – and Ealing Voluntary Services Council – now called something else – supporting & advising voluntary organisations in Ealing.

I may not be able to get to the meeting on March 21st at Ealing Town Hall, depending on the results of tests on my spine, but will be there if I am OK –!

You have my full support

Yours sincerely

Adrienne Talbot – (Mrs)

1451

Ealing Maternity - 18

Smith Peter

From: eylesslade Sadie (LONDON NORTH WEST HEALTHCARE NHS TRUST) <sadie.eylesslade@nhs.net>
Sent: 30 January 2015 05:37
To: Smith Peter
Cc: Salmeron-diaz Luisa (LONDON NORTH WEST HEALTHCARE NHS TRUST); Deacon Lesley (LONDON NORTH WEST HEALTHCARE NHS TRUST)
Subject: Closure of Ealing Hospital Maternity Unit

Attention: Michael Mansfield QC, Chair The North West London Healthcare Commission

I am a midwife at Ealing Hospital, working in the team which jointly staffs the maternity triage and birth centre, and I would like to submit an account of my experience working here for your consideration as you review health care provision in North West London.

I commenced work at Ealing in the summer of 2013, shortly after the opening of the new maternity triage and birth centre areas and so have been with this team from the beginning. Due to these areas being newly refurbished and well led, they have been a great success, with the birth centre exceeding initial targets and taking around 20% of the hospitals births and the triage area offering a specialised area for assessment for all attenders requiring medical review from 18 weeks gestation onwards.

As you will be aware, choice of place of birth, midwifery-led care and a focus on normalisation of care for low risk women in labour are all being advocated by the DoH, the Royal College of Obstetricians and Gynacologists, the Royal College of Midwives and local NHS trusts. However, when I started work at Ealing and offered low risk women in labour the choice of water birth, use of birth stools, mobilisation in labour or other measures commonly used by midwives to support normal birth, I was surprised to find them greeted with a degree of suspicion and surprise by the women we serve. Prior to coming to Ealing I had worked in and around Brighton - a community with a high home birth rate and a well-informed caseload of women demanding midwifery-led care, so this reponse, in turn, surprised me and presented a new challenge of health promotion. However, after about nine months of the team encouraging and supporting women through their births and using the birth pool and facilities where women were happy to, a big change started to happen - suddenly women would attend in labour and say 'I want a normal birth,' 'I want a water birth' and ther families would say the same - these were the same community of Southall women who had previously been asking us when the doctor was coming (despite having no indication for medical review) and had treated our suggestions with suspicion and even, occasionally, derision. I can only conclude that women in the community had talked to each other and also that the work of the community midwives in the antenatal period had informed women of the benefits of attending the birth centre. Certainly I had experienced many births were women who were initally unsure about using the birth centre expressed great happiness with the outcome (more than once a woman has said to me, 'I've never heard of water birth and now I've had one and it's wonderful!'). Being part of this team has been a great pleasure and pride to me. Previously in my career I have supported women in attaining outcomes they were requesting, which was satisfying; but to now be part of a team bringing a huge improvement in both care and outcomes to a population of women not generally well informed of their rights or choices and not demanding, but absoutely no less deserving of, it is a wonderful thing and it has been so lovely to see the change in culture it has brought about it. I should state unequivocably that this change in culture is also occuring in the maternity unit amongst the staff. When the birth centre opened many of the midwives working here were not used to supporting normalisation of birth, supporting unusual requests or unholding choice. Through our work with other teams, the rotation of newer staff through our area and the mentorship of students who have gone on to become Ealing midwives we have seen a steady change in culture and expectation amounting to better care in all areas. These changes have been down in very large part to the excellent leadership offered by our manager Luisa Salmaron-Diaz and the Head of Midwifery Lesley Deacon. Through their support and example we have formed a team which is supportive, robust, within which we are able to learn and challange and provide increasingly proficient and kind care to women. A further success of the unit is in dealing with individualised care for higher risk women requesting a birth centre experience. The team of Supervisors of Midwives in conjunction with the medical team and midwives have negotiated choice, as well as safety, for women on a case-by-case basis and we have seen transfers to the unit from women unhappy with their more conveyor-belt treatment at larger hospitals less willing or able to offer this approach. Within this group of women I have again heard Ealing's praises sung.

Given the universal support currently being vocalised for midwifery-led units and the money and effort that have gone into creating our successful unit, I am utterly aghast that closure would even be an option. Ealing Hospital serves a unique caseload of women, with a very high rate of immigrants and non-English speakers and understands it's caseload well. Further, our outcomes are good and our leadership visionary - I can only imagine the unit going

from strength to strength. I am heartened to hear of your review of local care and now cautiously hopeful for the future of care in Southall.

Smith Peter

From: Njogu Josephine (LONDON NORTH WEST HEALTHCARE NHS TRUST) <josephine.njogu@nhs.net>
Sent: 30 January 2015 01:03
To: Smith Peter
Subject: Why we should keep Ealing Hospital Maternity Open.

Dear Sir,
I am a midwife working at Ealing Hospital Maternity. Since employment, I have attended to dozen of pregnant women and assisted them in delivery of their newborn.
Most women have come back second and third time because they were happy with care provided at Ealing Hospital. Most women having baby's in our hospital live locally, they feel comfortable coming to ealing hospital as their local hospital. Most women are proud of having the maternity with the reach and feel reassured that in case of emergency, the service is a stone throw away.

I personally chose to work for ealing hospital because I trained here as a nurse, I like ealing hospital and transfering me to another hospital feels like I am being evicted from my home.
I have mentored so many students who have then qualified and later progressed to be employed as qualified midwives at Ealing hospital.
Not being able to see the students, midwives and the women that that I have created trust with, will be a loss and a sad one too.
I am currently persuing a Leadership ccourse and I am in the process of applying for funding to employ an extra doctor to see women at Triage and cutting the waiting times.
I feel challenged in applying for this funding because I am not sure whether the funging will be worthwhile if the hospital is closing. "an opportunity lost if we close the unit".
I would like Ealing Hospital to be given a chance, keep us open and running. Keep Ealing hospital maternity open for the sake of local women and staff that are dedicated to offer their services to the local community.
I feel that our Unit has been used as a political battle field. For those wanting to close our unit "Please keep off our NHS". We love our Ealing Hospital Maternity. I shall personally not feel happy working elsewhere.

Michael Mansfield QC
C/O Peter Smith
Clerk to the Commission
Hammersmith & Fulham Council
Room 39
Hammersmith Town Hall
London
W6 9JU

23rd January 2015

Sir,

I really wish that I could give you my name and position, and I know following the Francis Report that I should be able to speak freely, however I do not feel that the culture in the NHS allows me to speak without repercussions.

I understand that you are reviewing the Shaping a Healthier Future (SaHF) programme in relation to the Accident and Emergency (A&E) reconfiguration

I am a midwife working at Ealing Hospital and would urge you please to review the changes proposed to Maternity services as well.

Merger

Ealing hospital has recently "Merged" with Northwick Park Hospital; however the behaviour, culture and attitude of senior staff at Northwick Park have made it expressly obvious that it is a "take over" and not a merger. I fully understand this may not be your remit but wanted to give you context to the position of Ealing staff currently. Prior to merger Northwick Park's A&E performance was poor however Ealing did well against national targets. Since merger both hospitals have struggled to hit targets, however senior management have blamed this on Ealing solely whereas Northwick do everything right.

Background

Originally no changes to maternity were supposed to happen until 2018. When A&E was given a reprieve the focus moved to maternity and the changes were brought forward to 2015.

Over the last 2 years the Maternity Service has improved hugely, our scorecard (attached) shows how well we do, we achieve all our targets. We have fantastic feedback from our service users and Ealing has had better scores in the friends and family test than the London and national averages (attached). It is clear that the performance of the unit is not being taken into account by SaHF team. Ealing maternity is one of the safest units to have a baby in the north west sector and women have a fantastic experience.

The majority of women that use our service do not speak English and they do not understand that the unit is due to close. The public consultation run by SaHF did not cater for the client population of the maternity unit.

I know someone who works at Chelsea & Westminster Hospital and was told that they had a team at the main entrance of the hospital encouraging patients and staff to vote in favour of the recommendations put forward by SaHF. As staff working at Ealing we were told that we were not able to respond as staff but only able to respond if they were residents of Ealing. This concerns me that the groups affected more had less voice that others.

Concerns to care for women

Ealing maternity unit caters for a large number of diabetic women who need specialist care throughout their pregnancy. Diabetic women having babies have significant risks to the outcome of their pregnancy, for example, higher stillbirth rates.

A specialist clinic is held in the antenatal clinic where the specialist Obstetrician, Endocrinologist, Diabetic Nurse, Diabetic Midwife and Dietician offer a one-stop shop model for women. Following the changes the care for these vulnerable women will be completely fragmented. When women become pregnant following the changes they will no longer continue care with the team at Ealing and will be cared for by a completely separate trust. I am really concerned that the changes will specifically put this group of women at significant risk.

Current service provision offered by the Community Midwives from Ealing hospital, care for women who live in the Ealing borough (excluding Acton). Regardless of where they deliver their baby, community midwives from Ealing Hospital provide antenatal care to women with them receiving continuity of care for over 80% of their pregnancy. When these women return home following delivery we actively offer continuity postnatally by ensuring a midwife

known to the woman in the antenatal period visits at home postnatally. Following the changes the community area is to be completely carved up across the other providers. This means for women antenatally, they will have to travel to ensure continuity of care and following delivery some women will not get the same midwife at home, which for some will be midwives from a completely different trust.

The changes potentially put women at risk and increase potential of serious incidents occuring. Women will still come to Ealing Hospital in labour and that A&E will have to manage these women without the support of midwifery or medical staff.

Staff Concerns

As a member of staff I have been kept informed by the midwifery management team throughout the whole process, however staff believe that the full picture has not been taken into account. However as a midwife I do not feel that SaHF have our interests in mind. Originally a decision on date of closure was supposed to be made in October 2014. This decision was postponed and we were given a new decision date of the 22nd November. We were given job consultation papers on 14th October 2014. We had open days at Ealing where staff from the other trusts came to visit; we were able to visit the other units and we also had the opportunity to talk with the Head of Midwifery (HoM) from the other trusts. We then had to submit our preferences for which trust we wanted to work at in order of priority by the 5th December. The week before the November date we were informed by our HoM that the decision on closure had again been deferred until January 2015.

At one of the open forums held by our HoM, 2 members of the SaHF team came to talk with the staff. At this meeting we (staff) all explained to the SaHF team that a further delay to decision making was not tolerable by the staff. We were promised by the visitors that January would be the final date of a decision and that further delays would not occur. We all have personal lives, mortgages, childcare arrangements and most of all we had chosen to work at Ealing. The morale of staff is low; staff are continuing to offer fantastic care and service whilst not knowing their own future. Midwives and support workers are unsettled, frightened, worried and completely confused as to the future which is putting strain on personal lives and undue stress on us all.

On 17th December we were given our letters from our HoM confirming which unit we had been allocated to work at following closure. Not all staff got their first choice. Then on the 22nd December, just before Christmas we received an e-mail informing us that the decision

had yet again been postponed till the end of February. Our concerns, feelings and views have been completely ignored by SaHF and we feel that we are not important at all. The meeting now seems like a tick box exercise that they can say they have engaged us but in fact they have not listened at all, which I guess was their intention from the beginning.

Please will you give the midwives (who know the population of Ealing so well) the opportunity to have their voices heard. Please contact the senior management team or our Head of Midwifery for the evidence of our good performance. Please offer us the opportunity of Midwives talking with you; I know that there is a group of us that would be willing to meet you as a group.

Yours Faithfully,

A very concerned Midwife

Ealing Hospital

London North West Healthcare NHS
NHS Trust

Ealing Hospital
Maternity Performance Report

November 2014

Ealing Hosptial Maternity Performance Scorecard: November 2014

12-Week Assessment

Target booking numbers is an internal target to monitor the activity within the Maternity unit.

Booking by 12 weeks & 6 days is a national target; the minimum standard is 90%. In 2012 we worked on an action plan to support achievement of this target. The ASAP campaign was launched in July 2012. Women who are referred early are being booked in time; women are also being booked within 2 weeks of the referral being received.

Indicator MY02b excludes the late referrals, and against this measure the Trust is constantly achieving the minimum standard of 90%. Indicator MY02c includes late referral received which is why the target is not achieved.

We continue to work with our health partners to improve the timeliness of the referrals where this has been identified as a continuing problem. Following discussion at the CQG a request was made for a letter to be sent to GP's following late referrals, which is now in place and being sent. A spread sheet of the GP's from whom late referrals are made will be sent to the CCG.

Antenatal Screening

These are national targets which rely on data from both internal and external sources. The Trust has achieved all the targets for the month of November. MY05 and MY07 data is provided in arrears due to the timing of the testing and validation of this standard is done by an internal source hence data is always in arrears. This month the MY07 September figures were reported and achieved. We are awaiting final validation of MY07 October figures. This fluctuation in results for this target is due to maternal choice and all women are repeatedly offered screening however women do not have to accept the screening. MY05 data for October has achieved the target, November has not been completely validated as we are waiting for confirmation of due dates of women who booked at the end of October to confirm gestation at the time of test.

1:1 Care In Labour

1:1 care in labour records the availability of a midwife solely to a woman whilst in established labour (4cms +). The birth to midwife ratio is a national standard of 1:28, however NHS London has a target of 1:30. In November, the Trust achieved the standard for 1:1 care. Midwifery staffing establishment meets the required 1:30 ratio.

Ealing Hosptial Maternity Performance Scorecard: November 2014

Type of Birth

There is a strict system of booking elective caesarean sections by a consultant only. In November, the elective caesarean section rate has decreased significantly and is below the 12% target at 6.9%. The emergency rate has increased again in November to 21.3%, with the overall rate dropping to 28.2% for November. The normal delivery rate increased again to 64.4%, however the instrumental rate has decreased again this month to 7.4%. There has been a consistent increase in deliveries within the birth centre which has increased to around 17% with some months achieving 20% which was our year 2 targets. In November 17.3% of all deliveries were delivered in the birth centre and we continue to promote the usage. Although there were homebirths due, no homebirths were conducted for various reasons in November but are still on target for the year.

3rd & 4th Degree Tears

This is the percentage of 3rd and 4th degree tears sustained by women measured against national recommendations. In November there was an increase in the number of 3rd degree tears to 2.7% (5) still within acceptable margin. There was no 4th degree tear in October.

Massive Obstetric Haemorrhage (MOH)

This is in line with the national definition and agreed North West London sector definition of MOH. There is no target set currently but the current numbers are not at a level that would cause concern. There were no MOH's in November.

Workforce

This monitors the Royal College of Obstetricians and Gynaecologists recommendations for consultant presence on a labour ward. This is associated with the number of deliveries conducted by the unit; we should have 60 hours a week or 240 hours a month as delivery rate is over 2,500 births. We have a strict rota to ensure that this level is maintained. This section will also monitor the turnover, vacancy, sickness and appraisal rates for the workforce. The overall vacancy rate should be below 5% and the appraisal rate is to be agreed.

Consultant cover is at the level expected. The figures for the workforce section are in the process of being validated as it is important to separate the different cohorts of staff.

Ealing Hosptial Maternity Performance Scorecard: November 2014

Re-admissions following Delivery

This section identifies the re-admissions for mothers and babies within 28 days of delivery. In November, the numbers of readmissions are remaining consistent. There were 2 maternal readmissions and a reduction to 7 baby readmissions. The readmission rate has halved since last year and the beginning of this year which is the consequence of a lot of work with primary care and promoting the correct pathways through maternity triage for women and babies as well as extra breastfeeding support to reduce jaundice and weight loss admissions.

Patient Safety

This section monitors our serious incidents, Maternal Deaths and number of complaints. We do not have a high level of serious incidents when benchmarked with other maternity units. There were no SI's and no complaints received in November.

Patient Experience

This section looks at the response rates for the Family and Friends Test. The national response rate is 15% for all categories. The response rates in November have decreased on last month's figures however all have achieved target except Postnatal Community. High level promotion of the test and clarification of the collection processes have started again. Staff have been encouraged to remind women to complete the surveys and the importance of their feedback.

Breastfeeding

This monitors the initiation of breastfeeding at delivery, and exclusive (not giving formula) at discharge from Ealing Hospital. It also monitors breast feeding rates at 10 days discharge from the community midwife. There is a work stream to continue the improvement to the initiation and continuation of exclusive breastfeeding.

Baby Friendly Certificate of Intention has been received and an action plan has been formulated in line with gaining Unicef Breastfeeding accreditation. The implementation visit from Baby friendly was on the 6th February and application for Stage 1 will be made in the next month after all evidence is collated together.

Ealing Hosptial Maternity Performance Scorecard: November 2014

In November, the initiation rate was over 90% and we have achieved over 90% of women discharged exclusively breastfeeding. The focus has now moved to the community and we have proactively supported women in the community regardless of place of delivery to improve this target. Over the last year the breastfeeding rate at 10 days has increased to over 60% for women who have delivered at Ealing and increased to between 40% & 50% for women delivering in other units.

Smoking Cessation

This looks at the percentage of women not smoking at time of delivery. The target is 90% and this is consistently met.

Newborn Screening

This section monitors the Neonatal screening targets for BCG's, Newborn Blood Spot test, Hearing Tests and Examination of the Newborn. In November, all these targets have been met.

Ealing Hospital Maternity Performance Scorecard
Month 08 - November 2014

London North West Healthcare NHS
NHS Trust

Ref	Metric	Target	Actual Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative YTD
12-Week Assessment															
MY01	Number of Bookings	Actual	244	241	245	234	190	271	241	175					1,841
		Target	No target set												
MY02b	Maternity bookings: % booked and seen by 12 weeks & 6 days excluding late bookings during the month	Actual	99.0%	100.0%	100.0%	98.9%	100.0%	99.6%	100.0%	100.0%					99.7%
		Target	95%	95%	95%	95%	95%	95%	95%	95%					95%
MY02c	Maternity bookings: % booked and seen by 12 weeks & 6 days including late bookings during the month	Actual	80.7%	79.3%	80.0%	79.1%	78.4%	81.9%	85.5%	84.0%					81.1%
		Target	90%	90%	90%	90%	90%	90%	90%	90%					90%
Antenatal Screening															
MY03	% Screening for haemoglobinopathies offered	Actual	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					100.0%
		Target	100%	100%	100%	100%	100%	100%	100%	100%					100%
MY04	% Screening for haemoglobinopathies uptake	Actual	99.6%	100.0%	100.0%	100.0%	98.9%	100.0%	99.2%	100.0%					99.9%
		Target	95%	95%	95%	95%	95%	95%	95%	95%					95%
MY05	% Timeliness of test for haemoglobinopathies (10+ weeks)	Actual	65.9%	55.0%	58.2%	58.9%	52.6%	50.2%	52.5%						59.5%
		Target	50%	50%	50%	50%	50%	50%	50%						50%
MY06	% Screening for Down's syndrome offered to eligible women	Actual	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%							100.0%
		Target	100%	100%	100%	100%	100%	100%							100%
MY07	% Screening for Down's syndrome uptake to eligible women *(reported in arrears)*	Actual	81.0%	79.4%	78.1%	77.8%	81.4%	83.6%							79.5%
		Target	80%	80%	80%	80%	80%	80%							80.0%
MY09	% USS screening for structural anomalies offered	Actual	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					100.0%
		Target	100%	100%	100%	100%	100%	100%	100%	100%					100%
MY10	% USS screening for structural anomalies uptake	Actual	97.9%	97.8%	98.9%	97.7%	97.1%	98.0%	98.5%	98.2%					98.1%
		Target	90%	90%	90%	90%	90%	90%	90%	90%					90%
MY11	% Screening for infections offered (HIV, Hep.B, Syphilis & Rubella)	Actual	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					100.0%
		Target	100%	100%	100%	100%	100%	100%	100%	100%					100%
MY12	% Screening for infections uptake	Actual	100.0%	99.6%	100.0%	100.0%	99.5%	100.0%	99.2%	100.0%					99.9%
		Target	90%	90%	90%	90%	90%	90%	90%	90%					90%
1:1 Care In Labour															
MY13	Audit of Ratio of Midwives to Women in labour	Actual	100.0%	99.0%	100.0%	100.0%	99.1%	100.0%	100.0%	99.4%					99.7%
		Target	95%	95%	95%	95%	95%	95%	95%	95%					100%
MY14	WTE Midwife figure (Midwife to birth ratio)	Actual	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30					1.30
		Target	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30					1.30
MY15	Number of Deliveries	Actual	211	235	237	206	241	224	203	188					1,745
		Target	No target set												

Ealing Hospital Maternity Performance Scorecard
Month 08 - November 2014

London North West Healthcare NHS
NHS Trust

Ref	Metric	Target	Actual Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative YTD
Type of Birth															
MY16	% of Emergency C/S	Actual	20.9%	20.9%	20.7%	18.9%	18.3%	19.2%	19.7%	21.3%					19.9%
		Target	15%	15%	15%	15%	15%	15%	15%	15%					15%
MY17	% of Elective / Planned C/S	Actual	4.7%	12.8%	11.0%	11.2%	13.3%	12.5%	12.3%	6.9%					10.7%
		Target	12%	12%	12%	12%	12%	12%	12%	12%					12%
MY18	% Normal deliveries	Actual	63.5%	55.3%	60.3%	63.1%	59.6%	58.5%	59.6%	64.4%					60.4%
		Target	No target set												
MY19	% Assisted deliveries	Actual	10.9%	11.1%	8.0%	6.8%	8.7%	9.8%	8.4%	7.4%					9.2%
		Target	No target set												
MY20	% Home births of Deliveries	Actual	0.95%	0.00%	0.42%	0.95%	0.41%	0.44%	0.00%	0.00%					0.55%
		Target	0.49%	0.49%	0.49%	0.49%	0.49%	0.49%	0.49%	0.49%					0.49%
MY21	% Birth Centre of Deliveries	Actual	16.0%	16.0%	20.1%	17.1%	22.0%	18.1%	17.7%	17.3%					18.1%
		Target	No target set												
MY22	% Still Births	Actual	1.4%	0.4%	0.0%	0.5%	0.4%	0.4%	0.5%	0.0%					0.5%
		Target	No target set												
3rd & 4th Degree Tears															
MY23	Actual number of women with a 3rd degree tear (No more than 5% of total deliveries)	Actual %	4.7%	3.8%	3.0%	2.9%	2.5%	0.9%	2.0%	2.7%					2.8%
		Actual No	10	8	7	6	6	2	4	5					49
		Target	5%	5%	5%	5%	5%	5%	5%	5%					5%
MY24	Actual number of women with a 4th degree tear	Actual	0	0	0	0	1	0	0	0					1
		Target	No target set												
Massive Obstetric Haemorrhage															
MY25	Number of Vaginal deliveries that had a MOH >= 2000 ML	Actual	1	1	0	0	0	1	0	0					3
		Target	No target set												
MY26	Number of LSCS deliveries that had a MOH >= 2000 ML	Actual	0	0	1	2	1	0	1	0					5
		Target	No target set												
Workforce															
MY27	Consultant cover hours per week	Actual	60	60	60	60	60	60	60	60					60
		Target	60	60	60	60	60	60	60	60					60

Ealing Hospital Maternity Performance Scorecard
Month 08 - November 2014

London North West Healthcare NHS
NHS Trust

Ref	Metric	Target	Actual Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative YTD
Re-Admissions Following Delivery															
MY32	Number of readmissions <28 days under the care of Ealing team - Mother	Actual	2	2	3	1	2	2	2	2					16
		Target	No target set												
MY33	Number of readmissions <28 days under the care of Ealing team - Baby	Actual	13	12	8	8	7	8	9	7					72
		Target	No target set												
Patient Safety															
MY34	Number of Serious Untoward Incidents (SUIs) reported	Actual	0	0	1	0	0	0	0	0					1
		Target	No target set												
MY35	Number of Neonate SUIs reported	Actual	0	2	0	3	0	0	0	0					5
		Target	No target set												
MY36	Maternal Deaths	Actual	0	0	1	0	0	0	0	0					1
		Target	No target set												
MY37	Number of Complaints Received	Actual	1	0	0	0	1	1	0	0					3
		Target	No target set												
Patient Experience - Friends and Family Test (FFT)															
MY38a	Antenatal Care - **% Response Rate**	Actual	23.2%	9.4%	32.1%	26.2%	11.6%	20.1%	33.0%	21.3%					22.1%
		Target	15%												
MY38b	Antenatal Care - **Score**	Actual	54	68	58	64	69	56	56	83					64
		Target	No target set												
MY39a	Birth - **% Response Rate**	Actual	21.3%	6.4%	11.0%	9.7%	9.5%	17.4%	40.4%	28.2%					18.0%
		Target	15%												
MY39b	Birth - **Score**	Actual	67	86	65	65	95	84	84	57					75
		Target	No target set												
MY40a	Care On Postnatal Ward - **% Response Rate**	Actual	13.1%	5.6%	24.7%	12.3%	10.1%	28.9%	46.5%	17.9%					19.9%
		Target	15%												
MY40b	Care On Postnatal Ward - **Score**	Actual	69	17	51	48	29	64	64	67					51
		Target	No target set												
MY41a	Postnatal Community Provision - **% Response Rate**	Actual	24.8%	12.4%	49.6%	29.0%	24.6%	28.7%	37.0%	13.3%					27.4%
		Target	15%												
MY41b	Postnatal Community Provision - **Score**	Actual	69	75	73	78	83	77	77	79					76
		Target	No target set												

Ealing Hospital Maternity Performance Scorecard
Month 08 - November 2014

London North West Healthcare NHS
NHS Trust

Ref	Metric	Target	Actual												Cumulative YTD
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Breast feeding															
MY42	% Breast feeding initiated at delivery rate at Ealing Hospital	Actual	90.2%	94.6%	95.4%	93.8%	95.6%	94.2%	94.6%	95.7%					94.3%
		Target	90%	90%	90%	90%	90%	90%	90%	90%					90%
MY43	% Exclusively breast feeding on discharge from Ealing Hospital	Actual	91.2%	93.7%	95.8%	93.4%	93.9%	90.8%	95.0%	91.9%					93.6%
		Target	90%	90%	90%	90%	90%	90%	90%	90%					90%
MY44	% Ealing Hospital women exclusively breast feeding at 10 days	Actual	42.9%	56.6%	34.1%	65.0%	62.4%	62.7%	67.2%	64.0%					56.9%
			No target set												
MY45	% Non Ealing Hospital women exclusively breast feeding at 10 days	Actual	41.9%	42.9%	44.5%	56.4%	41.7%	45.0%	50.7%	52.1%					46.9%
			No target set												
Smoking at Time of Delivery															
MY46	% of women not smoking at time of delivery	Actual	97.2%	94.0%	96.2%	92.7%	95.0%	96.4%	96.1%	96.8%					95.1%
		Target	90%	90%	90%	90%	90%	90%	90%	90%					90%
Newborn Screening															
MY47	% BCG offered	Actual	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					100.0%
		Target	100%	100%	100%	100%	100%	100%	100%	100%					100%
MY48	% BCG uptake	Actual	92.6%	93.3%	91.0%	99.0%	99.5%	99.1%	90.0%	95.1%					94.9%
		Target	90%	90%	90%	90%	90%	90%	90%	90%					90%
MY49	% Blood spot offered	Actual	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					100.0%
		Target	100%	100%	100%	100%	100%	100%	100%	100%					100%
MY50	% Blood spot uptake	Actual	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					100.0%
		Target	95%	95%	95%	95%	95%	95%	95%	95%					95%
MY51	% New born and infant physical examination performed	Actual	100.0%	98.0%	99.0%	99.5%	98.7%	99.1%	98.9%	97.8%					98.9%
		Target	95%	95%	95%	95%	95%	95%	95%	95%					95%

Note: N/A indicates data not currently available

October data 2014	Percentage of Patients who recommended the Trust.			
Friends and Family	England	London	Ealing Hospital NHS Trust	Northwest London Hospitals NHS Trust
In-Patient	94	93	81	93-94
Accident and Emergency	87	86	87	56
Maternity Q1	95	92	91	88
Maternity Q2	95	94	98	91
Maternity Q3	91	89	93	85
Maternity Q4	96	96		

October data 2014	Percentage of Staff who recommended the Trust.			
Friends and Family	England	London	Ealing Hospital NHS Trust	Northwest London Hospitals NHS Trust
Staff - Work	61	63	67	57
Staff - Care	77	77	71	60

Smith Peter

From: [redacted]

Sent: 01 February 2015 23:37
To: Smith Peter
Subject: Keep Ealing Maternity Unit Open

Dear Sir/Madam,

The closure of Ealing maternity unit is something I feel very passionately against. I feel the closure is not in the best interest of our women and children in Ealing. My reasons are as follow:

1. There will be a general problem of distance for patients when the hospital care moves from Ealing to other trusts. This will probably have a greater impact on our women at Ealing as most of them are from more underprivileged homes than average. The distance will pose a risk to our women as the time it takes to get to hospital increases. This along with the added costs (for those without a car, for which there are many, it is at least a two bus journey to other hospitals) may dissuade women from coming to the hospital when needed for essential appointments and emergency care. This poses a great risk to the women's health and their unborn or new born baby. In turn it may have a knock on impact to hospital and midwives as it may cost more to treat these additional problems and take more of the midwifes time at a later date.

The distance and greater difficulty in travel may also increase in the number of babies born before they arrive to the hospital.

2. I think that the change will put additional mental stress on vulnerable and underprivileged women who are not used to going outside their community and area they are familiar with. As mentioned above they will be less inclined to use services that are not on their doorstep or may use it at a lower frequency that is detrimental to their health. Many women have told me that they are not at ease with using services outside their areas as EHT is easy to deal with, they feel comfortable with the staff as they are more familiar with and understand the local community and their ways.

3. Ealing has a great deal of expertise in dealing with language issues across the local demographic. It may be difficult for the other hospitals to provide the same level of expertise to make sure language issues do not compromise women and their baby's care and health.

4. The larger healthcare units that will inevitably result from the loss of Ealing and its amalgamation into the other trusts will cause reduced job satisfaction; this will have a resulting impact on women's care and staff wanting to work in these trusts.

Currently the communications within EHT are very good. I feel communications necessary for our women's care will become more difficult across the trusts that absorb EHT women and children.

I feel that the points I have mentioned above will have a huge impact on our women at Ealing and am saddened that the choice to close Ealing could be detrimental to their health and the future of their babies/children.

Kind Regards,

[redacted]

****
*****

This message may contain confidential information. If you are not the intended recipient please inform the sender that you have received the message in error before deleting it.
Please do not disclose, copy or distribute information in this e-mail or take any action in reliance on its contents:
to do so is strictly prohibited and may be unlawful.

Thank you for your co-operation.

NHSmail is the secure email and directory service available for all NHS staff in England and Scotland NHSmail is approved for exchanging patient data and other sensitive information with NHSmail and GSi recipients NHSmail provides an email address for your career in the NHS and can be accessed anywhere

****
*****

Smith Peter

From: hayley archer [redacted]
Sent: 25 January 2015 19:43
To: Smith Peter
Subject: Ealing Hospital Merger Evidence

Dear Peter Smith,

I am writing in regards to Michael Mansfield's notification about evidence to keep Ealing Hospital's maternity unit open.

As a 2nd year midwifery student of Ealing hospital since the start of my training I have loved every second. The midwives, obstetricians and nurses are highly devoted and loyal members of staff not just to the women and families we care for but to Ealing as a unit. I can speak for a vast majority of staff that we do not want to see Ealing close; it would be as though losing our home.

The teamwork and commitment displayed day in and out has not faltered under any pressure or worry the hospital merger has caused staff. The patients I have cared for have said they are worried and disappointed not only because they are losing a service they desperately need but also for the staff who are wholeheartedly dedicated to Ealing Hospital.

I sincerely hope there will be enough evidence for the decision to be reconsidered. However I would also like to take this time to thank you for reading and if I could help in any way at all please don't hesitate to contact.

Yours sincerely,

Hayley Archer

Smith Peter

From: [redacted]
Sent: 26 January 2015 21:36
To: Smith Peter
Subject: Ealing Mat unit call for evidence

Dear Peter,

I have been informed that you are reviewing the planned changes to the maternity units in the North-West London sector and would like to express my view on this matter. I would like to ask you kindly to keep my personal details confidential in case that any disclosure of information could be used against me in future employment.

Ten years ago, the UK was faced with a dramatic shortage of midwives. To meet the demands of an ever increasing birth rate, particularly in the borough of Ealing, I was recruited from [redacted] to join the Ealing maternity team in 2005. A lot has changed since then: Ealing has literally become my second home. I got married and have since delivered three children at Ealing Hospital.

In 2014, I consciously decided to have my third child at Ealing, although I live [redacted] now. As a member of staff and a mother who had given birth at Ealing twice before, I trusted the team completely. Moreover, I preferred the personal and familiar atmosphere at Ealing in comparison to some of the bigger hospitals around. I think it was the home- like environment of the birth centre in particular which made me feel safe and secure and helped me achieve three normal births without medical intervention.

The smaller size of the Ealing maternity unit is not only an advantage for women who are looking for a personal birth experience. It also allows staff to familiarize themselves with new and updated policies quickly and efficiently. This makes the practice of the service safer. Members of the midwifery team know each other and their clinical skills. Like me, a lot of the staff have been at Ealing for more than ten years and have built up their lives around their jobs at Ealing. They have bought houses close to the hospital to accommodate on-calls for homebirths and are often willing to work unpaid overtime because they identify themselves with being a midwife at Ealing. It's like being part of a big family.

I think it will take a long time for me and my colleagues to integrate into the service of the units we are meant to transfer to and some might not be willing to go the "extra mile". After attending the open days at the other units, I also worry about their ability to cope with the extra influx of women from Ealing. We were shown a recovery bay in one of the hospitals. This area only accommodates two women at a time. It does not make any sense at all to close a brand new four bedded obstetric recovery at Ealing and leave a two bedded one to cope with double the amount of women! This is just one example. When we asked whether there were plans to extend the building, the answer was that there are no such plans for the near future.

During my time as midwife at Ealing, I have spent a considerable amount on the delivery suite. From my own experience, I know that many of our mothers rely on public transport to get to the hospital, in particular the women from Southall. Despite educating them about the use of the ambulance services, they often arrive

unnecessarily in an ambulance when in labour. I am afraid they will do the same when Ealing closes especially if the distance to their intended place of delivery is even further.

I personally have been very fortunate with the outcome of the staff consultation as I will be able to transfer to the unit of my choice but many of my colleagues have not been that lucky. I think the closure of Ealing Maternity will be a great loss for the North-West London sector for both the women and their families as well as for staff. Working on the front line, I would even go as far as saying I have serious concerns about the lives of our mothers and babies. Please keep our unit open!

If you have any further questions, please do not hesitate to contact me.

Yours sincerely,

[redacted] Midwife [redacted]

Ealing Hospital Maternity Unit

London North West Hospitals NHS Trust

Uxbridge Road

Southall

London

UB1 3HW

5th February 2015

For the attention of: Michael Mansfield QC

Dear Dr Mohini Parmar and Thirza Sawtell,

We the midwives of Ealing Hospital are a truly exceptional group of professionals. Collectively we have accumulated 1767 years of service to the NHS, most of those being dedicated to the care and wellbeing of the families of the Borough of Ealing.

Following the Francis Report and in the theme of being able to express our concerns freely and without fear of retribution, we are documenting our feelings collectively as there is still little faith held that if singled out, we would not suffer as a result of putting pen to paper and expressing our worries about the future of our maternity service, the safety of the women and families we care for and the extreme pressure under which we are all expected to work at present.

We are all aware that in 2011 our service was in the spotlight with concerns being addressed by an external review. This in itself was a difficult time. However, since a change in the management structure in 2012, we have all contributed to addressing the concerns identified leading our service from strength to strength and success to success. We can boast a fantastic scorecard, excellent client feedback in the 2013 CQC Picker survey and a service which only continues to improve. With the exception of our own internal board and management team, we have had no acknowledgement of the improvements made and the continued momentum of those improvements today by any part of the CCG.

Since October 2012 when a decision was made by the Secretary of State for Health to progress plans for closure of Ealing Hospital Maternity Unit under the Shaping a Healthier Future (SAHF) plan, the staff of Ealing Maternity Unit have lived under a constant cloud in wondering how and when this would happen. This caused anxiety and consternation regarding how this decision would affect and impact upon the lives of the staff and the women and families they serve.

On 1st October 2014, Ealing Hospital NHS Trust joined forces with North West London Hospitals NHS Trust and out of this union was born London North West Healthcare NHS Trust. The ethos and driver which led the merger was 'Stronger Together' and all of the Ealing Maternity staff embraced this and looked forward to extending our service to become bigger and better in a new merged Trust. The mood was one of optimism and hope and the buzz was that our very successful and beautiful Birth Centre may be the centre of Ealing's part in the joint organisation.

Sadly this was not to be and on 14th October 2014 further progress towards the plans for closure of Ealing Maternity Unit were presented to us by way of all midwifery and Maternity Support Work staff being put under a staff consultation. The aim of the consultation was to decide where the staff would be redeployed following closure of the Maternity Unit which if plans progressed seamlessly would be at the end of March 2015.

The decision date for confirmation of closure of the Maternity Unit should have been announced on 26th October 2014. This was then deferred and we were told that an announcement would be made on 22nd November 2014. However a week prior to this we were informed by email that the decision would not be made until January 2015.

Our consultation progressed as planned through the diligence and dedication of our Head of Midwifery and Management team.

Although reassured that the process should be smooth and that we would be welcomed by the receiving Trusts, this was not always the lived experience and indeed some members of receiving Trusts were hostile and discouraging when they were questioned by Ealing midwives about opportunities in their Trusts for our future employment. This dampened spirits considerably and left a lot of doubt in our minds that our careers would be safe in the hands of the SAHF programme. However, by 17th December, all staff members were informed of where their future lay. There was inevitably disappointment for those who received news that they would not be allocated their first choice.

On 22nd December 2014, email communication further informed us of delay in the progress of SAHF. The decision date had yet again been deferred. This time, we were informed that the decision would be made at the end of February 2015. How many more times can we be given a date to work towards only to be let down and kept dangling on a string again?

The staff members of Ealing Maternity Unit are for the most part residents of the borough of Ealing and service users of Ealing Hospital themselves. They have their homes, friends, families and schools, nurseries and child minders for their children locally to Ealing Hospital where they have also built their careers. Many of our staff members have given birth to their own babies at Ealing Maternity Unit, with care delivered by colleagues who are close and lifelong friends. Leaving Ealing behind for

us transcends the 'just going to another job' – for many of us it is a whole way of life change.

Midwives are passionate people who care deeply about the quality of care they offer. Ealing has a very diverse population with very specific needs and very specific health needs. Our service is tailored to meet those needs further to years of refinement and planning which has made it the best and safest possible service to suit our population. One of its great assets is that its locality being in the heart of our most deprived population area making it accessible for the most vulnerable of our clients.

During all of this flux of change and uncertainty, the staff have maintained and presented an absolutely professional outer shell and done their utmost to ensure that 'business as usual' continues and the service is still provided with excellence at its core so that the women we care for do not suffer in the centre of the whole SAHF debacle. We are very proud to be able to announce to the world that within the North West London Sector we can boast the best results for safety and quality amongst our neighbours.

As a group of midwives, we feel that SAHF has not only 'planned' a fracture in the provision of service to the women we care deeply about, but has also impacted on our career opportunities which have in some cases been impeded by the commitment to stay at Ealing until the bitter end. This has led to some midwives disengaging from our service completely, some leaving London for midwifery roles elsewhere, some retiring earlier than they may have originally planned to and some completely reconsidering whether they continue in a career in midwifery at all. This is a systematic erosion of highly skilled and valued individuals and an indescribable loss to the midwifery profession. This loss from Ealing will in turn impact of the ability of other services in the North West London sector coping with an increased high risk maternity population post closure of Ealing Hospital.

Our management team have battled to support staff morale during this period of uncertainty to keep our service running safely whilst also complying with endless demands of the SAHF team in the provision of statistical support for their proposed changes. This is in addition to their already overfilled and challenging day jobs. Our management team have kept us informed of the changes in timeframes and had to deal with the 'fall out' from the seemingly poorly considered decisions of the SAHF team.

The whole team have maintained a corporate approach to the processes of change which have been enforced upon us but it is becoming increasingly difficult to bear and is impacting on the physical and mental health of many of our staff.

We know through indirect feedback to us that GPs have long since been instructed by the CCG to stop referring women to Ealing for their maternity care. This is completely contrary to the plan agreed to keep Ealing an open and safe 'going

concern' until the point of a planned and carefully considered closure of the unit. As a result, we can see our client numbers diminishing and our service rotting away in front of our eyes. It is also reported to us by women we care for that their choices are not being considered or respected when they are being allocated a booking hospital by their GPs.

In addition to this we have heard today that the trainee doctors working in Ealing Maternity Unit have received communication from the deanery 2 weeks ago informing them that they would be remaining at Ealing until October 2015. Our senior management team were unaware of this and nobody had the decency to inform us of the change before we heard it from others. It really speaks volumes that 120 midwives are not important enough to inform of change afoot but 2-3 trainee doctors are. This level of discrimination with regard to information sharing is truly appalling.

Our confidence in and respect for the SAHF team is dwindling daily. We fear for our futures and for the future of the women we care for.

We are all aware of the impact of the recent A&E closures in the North West London sector which has led to a serious impairment of care and service provision to the most seriously ill people in our community. Our concerns are that similar impairment will inevitably occur in maternity care provision and the very vulnerable women and families we see daily will not be able to access the services that they so badly need. How many mothers' lives will be lost in evidencing this observation? It is too sad to even consider…

In the midst of a population of whom only 40% have English as a first language, we have a population whose voice is seldom heard. The minority who do voice their opinions publically are seldom listened to. This is evident from the flawed consultation at the inception of the SAHF plan in how the opinion of the population of Ealing was canvassed.

We as a group of professionals are no longer prepared to sit quietly and be 'done to'. We demand that the impact of SAHF process on us as a group of professionals who give our very selves to our job is made public. We demand that our feelings are taken into consideration and that we are not just overlooked in favour of a flawed political agenda. This has happened to us and continues to do so as I write. I imagine that there are more midwives than you would imagine who will have yet another broken night's sleep tonight, but not for the joy of helping another little being into the world, but for the stress and anxiety caused to us by the SAHF programme. We as a group sincerely hope that there is true learning achieved from the grave mistakes which have been made in the implementation of the SAHF programme so that when this recurs in the future – because it will, those who are directly affected are given far more respect and consideration.

The only carrot on a stick offered to us throughout this whole process has been the promise of a £500 learning account per midwife - realistically this will not even pay

for an average 1 day study day. Today we learn that perhaps 2 extra days of annual leave may help compensate us! We are not just numbers to be redistributed or 'bums on seats,' we are real people and deserve a whole lot more.

We would like the opportunity to meet with the SAHF team members including Mark Gammage, Pippa Nightingale and Dr Mohini Parmar to discuss our concerns further and would appreciate it if this were convened at the earliest opportunity.

Yours sincerely

A group of the Midwifery Staff of Ealing Hospital

Cc: Mr Jeremy Hunt - Secretary of State for Health

Mr Michael Mansfield QC

Mark Gammage – Programme Human Resources Lead for SAHF

Pippa Nightingale – Programme Senior Responsible Officer SAHF Maternity and Neonatal Transition Project

Cathy Warwick - CEO of the Royal College of Midwives

Dr Peter Carter – CEO of the Royal College of Nursing

Jessica Reed – Local Supervising Authority Midwifery Officer

Simon Stevens – CEO of NHS England

Ross Lydall – Chief News Correspondent and Health Editor London Evening Standard

Steve Bax - News Editor Ealing Gazette

John Appleby – Chief Economist, Health Policy, The Kings Fund

Stephen Pound – Member of Parliament for Ealing North

Angie Bray - Member of Parliament for Ealing Acton

Virendra Sharma - Member of Parliament for Ealing Southall

Julian Bell - Council Leader for Ealing

Hitesh Taylor – Counsillor Ealing Council


CONSTERNATION ...NO TRUST IN....LIVES
IMPACT redeployment destructive
process.....DOUBT...DELAY...let down....MINDS
FALL OUTNEGATIVE FEELINGS PLANNING!No choice
Lack of concern ???SAFETY?? GRIEF..UNSAFE
Sadness?Future career? Uncertainty
++Grey areas ANNOUNCEMENTS!! DEVALUATION++
LACKING..Team work.....noSAHF---
NEWS*Inaccuracy* Lack of communication
NOFEEDBACK sadness ???
Indecision ANXIETY sleeplessness MENTAL HEALTH!!!!
BEREAVEMENT ... faith TRUST LEADERSHIP..heavy
hearts Under.. 'CLOUD' ...Worry
SAHF IMPACT

Smith Peter

From: Linda Stewart [redacted]
Sent: 25 January 2015 19:58
To: Smith Peter
Subject: Ealing Hospital - Maternity unit

Dear Peter

I understand that the final decision with regard to the future of ealing hospital's maternity unit has been delayed. I wish to outline my views on this matter, which I hope will be taken into consideration.

I delivered my first child in the birth centre at ealing in July 2014. My pregnancy had been quite complicated and throughout my pregnancy, I received outstanding care from the team at ealing. I had to attend frequent appointments which I was able to fit around my working day, due to the vicinity of the hospital.

I am a resident of ealing and when I had to stay in hospital for 8 days my partner was able to reach me & visit each day after work. I believe that had I been in a unit which was further away, this would have been less likely.

My baby was delivered 45 minutes after arriving at ealing hospital. My partner & I wish to have more children and I am genuinely very concerned about my ability to travel to units located further afield given the speed of my 1st delivery and traffic congestion in West London.

My care during labour & immediately afterwards was outstanding. The postnatal midwife team were wonderful to deal with and extremely supportive. At the preset time, ealing offers a dedicated Breastfeeding support service - I have used this service extensively immediately prior to & since delivering my daughter. This support has been invaluable. Without the team's support, reassurance and encouragement, I genuinely believe I would have given up Breastfeeding within the first 2/3 weeks of delivering my baby. However, she is now 6 months old and continues to be exclusively breastfed.

The ealing maternity unit is wonderful and given that ealing has the 3rd highest birth rate in London, I believe it is absolutely necessary to support our community.

I hope that the decision will be made to keep this unit open.

Warm regards
Linda Stewart

Sent from my iPhone

Smith Peter

From: Tamara Walker-Moore [redacted]
Sent: 27 January 2015 07:15
To: Smith Peter
Subject: Ealing Hospital's maternity unit

Dear Mr Mansfield,
The work carried out by the midwives from Ealing Hospital is key to ensuring healthy mums and babies across the borough. Any downgrading of its offering that makes these services just the smallest bit less accessible will have a disproportionate impact, especially post-nataly when physical and emotional constraints are at their peak.

Breastfeeding Support Group

Breastfeeding is natural, and really hard work. We all know that breastfeeding is best for babies, but sticking with it is difficult. The support and advice that Caroline Neale provides has helped me, and other mums, keep going. Ultimately making for healthier babies.

The physical benefits of the service that Caroline provides are clear, but I think more important are the mental health benefits that come with the support and advice provided. At a time when it would be easy for self-doubt, sleep deprivation, and a whole heap of crazy to push one close to the edge, or sending one hurtling over it, the value of what she does becomes immeasurable.

Mental health resources are notoriously stretched - Caroline's work goes a long way to prevent them being even more so by new mums who aren't coping. I'm sure that a business case can be produced that adequately shows the cost to the health authority of mental health treatment for a new mum against the cost of running a couple of breastfeeding support groups across the borough.

Whilst I appreciate the need to do more with less, it would be short-sighted to think that taking away mums and babies best options around maternity care is unlikely to have a negative, and more costly effect down the line.

Six months in I have a healthy, happy, exclusively breastfed son - who save for his jabs has not needed to visit the GP.

Kind regards,

Tamara Walker-Moore

Sent from my iPhone

Smith Peter

From: Stewart Derrick [redacted]
Sent: 25 January 2015 21:55
To: Smith Peter
Subject: Ealing maternity - keep open

To whom it may concern

Ealing hospital maternity was fantastic throughout my partners pregnancy, labour and postnatal care.

Linda had gestational diabetes and developed a DVT during pregnancy and required a lot of care - the skills and care from the staff and importantly the vicinity of the hospital to ealing Broadway was paramount to linda getting better and me able to see her.

Lindas labour was incredibly quick - we arrived at 10:15 and our baby was born at 10:59 _ the fact we were at ealing was the only reason we made it. If it was hammersmith we would have been on the tube or in traffic giving birth.

Postnatal - linda really wanted to breastfeed but suffering from mastitis it was really tough, and we would have given up if it was not for the fantastic breastfeeding support from the hospital - available anytime, all week, day or night - I was actually surprised how much the support went above and beyond what I thought we would have received.

Happy to provide more information if required. I fully support keeping the maternity unit open

Thanks
Stewart Derrick

Sent from my Sony Xperia™ smartphone

Smith Peter

From: kate [redacted]
Sent: 27 January 2015 22:00
To: Smith Peter
Subject: Ealing Maternity Feedback

Dear Mr Smith,

I have heard that the decision regarding the closure of Ealing Maternity Unit has been deferred. I am writing to tell you about the positive experiences I have had during my pregnancy and subsequent post natal care, in the hope that it will help keep Ealing Maternity Unit open in the future.

The birthing centre at Ealing Hospital was a very professional, yet friendly and supportive place to give birth. The birth centre itself provides a fantastic atmosphere for labour, and has only recently been refurbished and has great modern facilities. It seems a huge shame that this centre will be lost to the people of Ealing. The midwives who attended me through my very long labour were brilliant and all went beyond the call of duty in supporting me, for example one of the midwives did not take her lunch break as she wanted to stay with me.

Some of the best support I have had post pregnancy has come from the specialist breastfeeding midwife, Caroline Neale. On the morning after my labour I requested some support with breastfeeding as I was struggling to feed my newborn son. Caroline came to see me and spent lots of time with me supporting me. I continued to struggle with feeding after being discharged from hospital, but was able to have 1:1 support from Caroline on numerous occasions. I feel certain that without this support I would have given up on breastfeeding. My son is now 6 months old and has been exclusively breastfed from birth. Caroline also runs a breastfeeding support session on Wednesdays which I have attended on numerous occasions. These sessions are a great opportunity to get breastfeeding support as well as meet other breastfeeding mums who might be facing the same problems.

I feel passionately that the mathernity unit at Ealing Hospital should be kept open, and would be very happy to provide feedback verbally to support the unit if this would be of help.

Yours Sincerely,

Kate Dowdall

Smith Peter

From: Rae Bowdler [redacted]
Sent: 27 January 2015 07:40
To: Smith Peter
Subject: Ealing maternity unit

Dear Peter,

I have been shocked with the news of the closure of the Ealing maternity unit.

As a recent new mum Ealing maternity unit have been absolutely brilliant throughout my pregnancy. Not only have I attended excellent classes specifically to do with breast feeding, I have had so much support from the midwives, the breast feeding specialist and the most excellent doctors that were on call during my delivery. It's because of the midwives and the doctors there that I was able to deliver Chloe successfully as without them I don't think I'd have much to report. They managed to pull Chloe out as recognised the early signs of danger. I am appalled that this incredible service is being considered for closure and I sincerely hope that this decision will be reviewed. Living in hanwell, I'm incredibly proud of our local service at ealing and have received excellent post natal care after my labour too.

Rae Bowdler
[redacted]

Smith Peter

From: Elaine Griffin [redacted]
Sent: 26 January 2015 22:33
To: Smith Peter
Subject: Ealing Maternity Unit

Dear Peter,

I would like to express my reasons towards reversing the decision to close Ealing Maternity Unit. I gave birth to my son in Ealing in September and had a wonderful experience from beginning to end. I had complications which meant I needed scans every two weeks after the 12 week scan and the care at the antenatal clinic was fantastic. My husband and I attended the antenatal class in the unit as well as the Breastfeeding Class, both of which were invaluable in helping us prepare for the arrival of our first child. The location of the hospital was particularly convenient for me as I was able to get there easily by bus from my work and although I had frequent appointments, it didn't cause too much disruption to my work day. In addition, I attended the triage on a couple of occasions as well as receiving phone advice which provided diagnosis when required and allayed any fears or concerns.

The birth and aftercare at the hospital was excellent and the midwives we encountered were exceptional professionals. The midwives who visited my home in the days following the birth were very caring and efficient and I was comfortable enough to discuss all "new mother concerns" with them. I have attended a breast feeding support group since giving birth and am successfully exclusively breastfeeding my baby thanks to the support of the midwife, both at the group and also by email and phone.

I will be also be attending the meeting this Wednesday afternoon in Ealing Town Hall and have shared the event with many other new mothers in the borough.

Kind regards,
Elaine Griffin
[redacted]

Smith Peter

From: Lúcia Cavalcanti-Vervecken [redacted]
Sent: 26 January 2015 20:30
To: Smith Peter
Subject: Evidence submission - Independent Healthcare Commission for North West London

For the attention of the Independent Healthcare Commission for North West London

Dear Peter,

I write to you in a bid to keep the maternity services open at Ealing Hospital. I was very fortunate to have had my whole antenatal care and the birth of my child done at this hospital because the quality I encountered was very high, and I would love for it to happen to other families also. The birth of a child is the most important moment for a family, and it is essential that everybody feels confident in the staff who will deliver the baby. That confidence, that trust, takes time to build, so closing this unit will undermine the great work achieved so far.

My experience was great. I was able to walk to the hospital on a Sunday morning and walk back with our baby in the sling the next day at night. Living less than 10 minutes away from the hospital gave me the confidence to wait as long as possible for contractions, and to trust the natural birth I dreamt of was going to be a reality. I can see I would have been more agitated if I lived far from the hospital, and the natural hormones you need during labour might not have been released. I'm sure other ladies feel the same. Surely if mothers-to-be cannot relax and let nature run its course, cesarean sections are more likely to result, in turn making the whole process more expensive to the government. New official guidelines indicate that home births should be pursued in low risk pregnancies, but surely mothers will feel a whole lot safer knowing the hospital is at a stone throw's away should they need it.

The reasons for closing this and other maternity units is financial and I think this is a travesty. This government is likely contributing for the disintegration of the NHS with such measures. I'm originally from Brazil, a country which likewise offers universal medical care. That is, on paper, because decades ago private health care providers lobbied successfully for the government to cut down on Health expenditure, bringing about the demise of such a noble endeavour. Everybody should have access to good and state-sponsored medical care, this is at the core of a civilised society. I'll happily pay higher taxes to that end.

I feel very passionate about the NHS and the maternity unit at Ealing Hospital. When I tell friends abroad of how well I was treated and of the high level of care provided, I can hear their longing for the same to happen in their countries. Closing this unit is a step backwards.

We must be very careful of trying to cut costs in Health. How about getting all those companies to pay their due UK tax, I'm sure that would go a long way in saving precious hospital units.

Please don't close Ealing Hospital maternity unit!

Yours faithfully,
Lucia Cavalcanti Vervecken

Smith Peter

From: Jessica Hall [redacted]
Sent: 26 January 2015 22:00
To: Smith Peter
Subject: Keep Ealing Hospital Maternity Unit - written evidence

Dear Mr Smith,

It has been brought to my attention that the decision about the closure of Ealing Hospital's maternity unit has been delayed and there is now a relaunch of the campaign to save Ealing. As a recent first time mother who gave birth at Ealing Hospital I just wanted to contact you to give evidence that I have benefited greatly from Ealing's services.

My daughter was born in Oct 2014 by emergency C-section at a low birth weight, something that didn't appear in our regular scans. She had trouble feeding and as first time parents my husband and I were extremely worried about her. The maternity unit at Ealing hospital has been an invaluable support in these first few months. We attended ante-natal classes in the hospital, which were excellent, and the breastfeeding midwife who led the class visited us on the ward when our daughter was born to offer additional support. I continued to see the midwife afterwards at breast feeding support groups and she was the one to spot that our daughter had tongue tie, which was affecting her ability to feed. She referred us to a specialist who could assess and fix the problem and get our daughter feeding properly.

As a mother who really wanted to breastfeed and give my child the best start, I was disappointed how quick health visitors were to push us towards formula when my daughter was a low birth weight. Without the services offered by ealing maternity unit I would not have had that essential advice from a breastfeeding midwife and the weekly breastfeeding support group at the Grange also gave me the confidence to stick with our feeding plan.

I am pleased to report that with their help our daughter is a happy, healthy baby and we are happy parents who continue to rely on Ealing's maternity unit for guidance and support. it would be a real shame to lose such a fantastic team of people.

Kind Regards
Jessica Hall

Smith Peter

From: Giulia Bove [redacted]
Sent: 26 January 2015 08:27
To: Smith Peter
Subject: Keep ealing hospital open

Hello Peter,

My son Max was born in Ealing hospital via an emergency C section in June 2014. All the staff from midwifes to surgeons was amazing and incredibly supportive. Both Max and I received great care. The facilities were also great I intended to have a water birth and was very surprised at how comfy and clean everything was. I also had most of my antenatal appointments in hospital and living in ealing this made everything very easy especially towards the end of my pregnancy. Closing the hospital is a Huge mistake which will affect a lot of mothers and parents to be

Giulia

Sent from my iPhone

Smith Peter

From: Sonal Patel [redacted]
Sent: 28 January 2015 23:17
To: Smith Peter
Subject: Keep going Ealing Maternity Cemtre

Dear,
Please keep going the team of Ealing Hospital Maternity Ward. They are providing good maternity service. We are happy with their service and our child was born there.

Thanks,
Sonal Patel.

Sent from Yahoo! Mail for Windows 8

Smith Peter

From: Christrine Merrigan [redacted]
Sent: 26 January 2015 00:39
To: Smith Peter
Subject: My Experience of Ealing Maternity Services

Mr Smith,

I have recently delivered my first child at Ealing hospital and can honestly not speak highly enough of the quality of service I received there. From the moment I discovered I was pregnant and began visiting the community midwives based at Grand Union Village I have felt cared for, reassured and taken seriously. Throughout my pregnancy I had several complications and made many visits to the maternity unit and every member of staff I came into contact with made my husband and I feel confident in their professional abilities and excellent bedside manner.

I was diagnosed with gestational diabetes and therefore had extra contact with the staff at the hospital. I was contacted via phone (after hours) the day after I had the test and was instantly referred to the diabetic team specialising in gestational diabetes. I was offered lots of extra support, group meetings and an extra growth scan. This condition was taken very seriously and I was closely monitored.

My labor also had some complications as my baby was in distress but the midwives and doctor present maintained a calm environment whist delivering the baby with an efficient sense if urgency. Unfortunately my baby had to spend a week in the special care baby unit at Ealing hospital and the staff here were truly amazing. Their job is not only to look after the poorly babies but they also offer an incredible source of support for parents going through a very difficult time. During my child's stay at SCBU the midwife who delivered my baby made a point of coming to see how we were doing.

Due to my son's stay at SCBU I was unable to breastfeed for a week and therefore needed extra support with this. I was able to contact the Breastfeeding midwife and had a one to one session with her which was invaluable. I will also be attending the weekly Breastfeeding support groups.

My story is just one of many. I have had such a positive experience (despite complications during pregnancy and afterwards) of every facet of the maternity services offered and cannot understand the logic behind closing this clearly valuable service. I do hope you and your team look closely again at the true value of the maternity service at Ealing hospital and the impact that the loss of this will have to thousands of parents and babies. The team are doing such an amazing job and it would be a shame if the public and the NHS lost this.

Regards
Christine Merrigan

Sent from my iPhone

Smith Peter

From: Rosa Suarez Ortiz [redacted]
Sent: 15 February 2015 14:10
To: Smith Peter
Subject: Evidence of use of services

Dear Mr Smith,

I will be brief. I had my daughter 8 months ago at Ealing Hospital, using all their services during prenatal and postnatal care. The staff were amazing, really helpful and professional. If anything, I think the unit could be extended, since the area has a very high fertility rate and all the resources were over stretched so, if any changes, what hospital needs is more resources and staff in the maternity unit. For example, I had my daughter without anaesthetics, because the only anaesthetists available were busy,

I have also used the emergency unit twice with my baby daughter. I could get there easily taking only one bus.
Have they taken into account the changes they would need to make in the hospitals nearby to serve the demand that would be directed there? What about the public transport services towards the hospital? Have they ever visited Southall, and checked the needs of this population with a massive portion of young people and very high fertility rate?

I hope this helps as evidence of the use of services

Thanks,
Rosa

Smith Peter

From: lalita jain [redacted]
Sent: 25 January 2015 20:29
To: Smith Peter
Subject: Regarding keeping maternity unit open

Hi Peter,
My name is Lalita Nagrajan. I stay in west ealing. I had come across of the information that maternity unit in ealing hospital is planning to be closed.
Hearing this information I was pretty disappointed and would be happy if this decision is reverted back. Though I had not personally delivered there but I had been to the breastfeeding support and found the services extremely helpful and got my confidence in breastfeeding back. I had heard many positive stories from lot of friends around about the antenatal and postnatal services.
The fact that it is placed in centralised location in Ealing, it would be very convenient and helpful for many to be mums.
I would kindly request you to reconsider the decision of closing the maternity unit and let it continue and providing more funds for improving the infrastructure as well

Regards,
Lalita

Smith Peter

From: Julia O'Connell [redacted]
Sent: 02 February 2015 10:34
To: Smith Peter
Subject: Closure of Ealing's maternity unit services

Dear Mr Smith,

I would like to express my dissatisfaction regarding the closure of Ealing's maternity unit services. I believe the London Borough of Ealing is making a serious error in judgement closing these services.

My son was born on 8th November 2014 at Ealing Hospital by emergency Caesarian. I live in Hanwell and if I had to travel to another hospital he may not be alive and well. My pregnancy was complicated with frequent visits to the maternity unit at Ealing hospital. Such visits would have been difficult and stressful had I been made to travel to a hospital further afield. Not to mention the travel expenses I would have incurred.

I received first class Breastfeeding support from Caroline Neale the Breastfeeding midwife based at Ealing hospital both antenatal & postnatal. Other recent mothers who gave birth at Queen Charlottes ("QC") around the same time as me report a distinct lack of Breastfeeding support and as a result only one out of 5 of the mothers from my NCT group who gave birth at QC's is exclusively Breastfeeding. In fact the ladies who are combination feeding are now trying to seek help from Caroline Neale in order to try and Breastfeed. One QC mother reports she actually begged for Breastfeeding help while in the QC hospital recovering from a complicated delivery and no help was available.

In conclusion, in my opinion as a new mother who has had a recent and full experience of the maternity unit at Ealing Hospital, the care I received particularly in the Breastfeeding support and the antenatal classes was first class. As a result I have a happy, healthy Breastfeeding baby boy. He is my miracle child and if I hadn't received the care from Ealing hospital maternity services he may not be alive, well and thriving today. For the sake of future mothers in the borough of Ealing I beg you please do not close the maternity unit. In particular please do not cut the Breastfeeding support in the borough. These services are fantastic. I put it to you & to coin a phrase: "If it ain't broke why fix it?"

Yours sincerely,
Ms Julia OConnell

Sent from my iPhone

Smith Peter

From: Charlotte Abbott [redacted]
Sent: 30 January 2015 14:27
To: Smith Peter
Subject: Ealing Hospital maternity unit

Dear Mr Smith,

I understand you are the person to contact with representations about the potential closure of Ealing Hospital's maternity unit.

I had my baby there in November 2013 and was hugely impressed with the facilities (I had a clearly brand-new private room with an enormous birthing pool) and the skills and professionalism of staff there. My experience of giving birth was overwhelmingly positive and I am hugely disappointed at the prospect of not being able to use this hospital again for baby 2.

Towards the end of my labour I required urgent intervention to deliver my baby when his heart-rate dropped. The speed at which this took place was remarkable, as was the calm atmosphere in which the matter was resolved. It is only because my husband asked after the event that we were aware that a serious situation had occurred at all!

As a tax-payer I am horrified at the thought that these new and excellent facilities being closed down over what appears to be a management issue.

I do not, of course, know all the statistics about patient satisfaction at local hospitals, but I have spoken to a great many new mums since having my baby and have heard repeated horror stories about births at Queen Charlotte's, West Middlesex and other local hospitals such as to make me extremely nervous about entrusting my future care to any one of them. The only new mums I am aware of who were totally happy with their experiences are a friend who used Ealing Hospital and me.

I hope that these views can be taken into consideration. I am sure that they will reflect those of many others in the area who will not get around to emailing you.

Kind regards,

Charlotte Abbott

Sent from my iPhone

Smith Peter

From: Nikki Daniel [redacted]
Sent: 30 January 2015 14:36
To: Smith Peter
Subject: Ealing Hospital Maternity Unit

Dear Mr Smith

I would like to request that Ealing Hospital Maternity Unit be kept open for a number of reasons:

1) I had my daughter there and had an excellent experience
2) The nearest hospitals are too far to get to via public transport easily and they are heavily oversubscribed
3) A number of friends had their second babies at Ealing and were able to show it is far superior to Queen Charlotte's in terms of care during labour and after-care
4) Ealing is a huge borough that depends on Ealing Hospital and its many services; the maternity unit is rated far superior to other services provided on this site - why does it need to close?
5) I'm not convinced a proper consultation has taken place
6) The hospital site has already been decimated for private property profiteering, which has already disgruntled many locals
7) There has been no satisfactory replacement recommended

I'm also cross because of the promises to keep the NHS public and available. There is no hurry to do anything until after the election anyway.

Yours faithfully,

Nikki Daniel

[redacted]

Smith Peter

From: Vic Cowan [redacted]
Sent: 30 January 2015 16:00
To: Smith Peter
Subject: Ealing maternity unit

Please reconsider the closure of Ealing's maternity unit.

I had both of my children there, in Jan 2012 and Nov 2014, and had very positive experiences. I valued being at local hospital which I could easily access via public transport for my antenatal check ups, reach quickly when I went into labour, and was close to my home. This was especially important with my first which was an emergency c-section and required a stay in hospital. My husband could visit me easily.

The department was busy and I cannot imagine where we would have all gone if we could not have gone to Ealing. Having said that I never had to wait too long for appointments and I could not fault the care I had from the staff and the students.

Mrs Cowan

Smith Peter

From: Cathleen Dittrich [redacted]
Sent: 04 February 2015 21:49
To: Smith Peter
Subject: Ealing Maternity Unit

Dear Peter Smith,
Dear Sir or Madam,

I realize that the deadline of sending this email has passed as I missed the deadline but I'm hoping that my and my babies voice is still heard.

It makes me very sad that the Ealing Maternity Unit may be closing down. I think it is shocking and does not make sense to close this amazing Maternity Unit considering that Ealing is the biggest borough in London. Where are all the mums going to give birth? They would be forced to go elsewhere outside the borough where maternity wards are most likely already stretched. I had my baby at the Ealing Birthing Centre last September; now I can't speak of other maternity units and their services however I can say that our experience at the Ealing Unit was the best we could ever have received from start to finish. Pre birth I had some problems and every time we were at the maternity unit we were always helped in a professional and caring manner. The midwifes and paedeatricians were amazing and really helped us to have a good birth and the facilities helped me to feel comfortable and therefore a birth free of complications. Pregnancy and child birth is a natural process - not a medical one - and therefore the natural environment at the birthing centre helped me to have a natural and I suppose "low cost" birth as I didn't need epidural etc. which costs money.

So many families will be thrilled to hear that the unit is not closing down.

Many thanks,

Cathleen

Smith Peter

From: Fiona Gibson [redacted]
Sent: 31 January 2015 20:37
To: Smith Peter
Cc: Fiona Gibson
Subject: Ealing Maternity Unit

Dear All,

I write to you and the healthcare commission to ask you to reconsider the closure of Ealing Hospital Maternity unit. I received all my antenatal care and gave birth to my son there in July 2014. I found this unit incredibly helpful and I do not understand the reasons for closing it. I was diagnosed with step b during the late stages of my pregnancy and the care I received was fantastic in this respect. No risks were taken, I was never made to feel like a neurotic new mum. Throughout my labour my midwife did not leave my side and all precautions were taken to ensure I delivered my baby safely.

In addition to this the scans, parent craft and breastfeeding classes were second to none. All my scans and tests were all on time opposed to the 3-4 hour wait I hear about at Queen Charlottes. As a working pregnant lady this was/is/will be very important.

I do not understand when the other maternity units in the area are struggling under the weight of their own local women, the commission want to close Ealing.

How can it be safe to close a busy unit? GP's are not allowed to refer patients there so of course Ealing will not currently be as busy as other units but if they were receiving referrals I'm sure they would also be at capacity also.

No woman should be turned away from a maternity unit because there are no beds. It is too dangerous.

Given the UK's shameful still birth and infant death rate I find it hard to understand why women in Ealing are being put at further risk by having a perfectly safe and local unit taken away from them. For many of us the other units are either too far away or too difficult to get to (particularly in rush hour) placing us and our babies at risk.

Please reconsider this decision or I fear there will be dire consequences for the women of Ealing and their babies if this closure goes ahead.

Regards
Fiona Gibson

Smith Peter

From: Rebecca Amery [redacted]
Sent: 30 January 2015 23:17
To: Smith Peter
Subject: Fwd: Closure of Ealing Maternity Unit

> Dear Peter,

> I am extremely concerned about the planned closure of Ealing Maternity Unit. I am due to have my first baby at Ealing in the next few weeks. The care that I have received during my pregnancy has been absolutely amazing. I have rarely been kept waiting more than 10 minutes for an appointment. I have found all staff, consultants and especially the midwives to be caring, reassuring and knowledgeable and the convenience of the hospital (I live in W13) has been an enormous help during my pregnancy.
>
> I am hoping to have my baby in the midwife lead birth centre which I spent a short amount of time after a minor car accident. This facility is wonderful. I felt comfortable, safe and relaxed, something that I believe will be of vital importance when the time comes for me to have my baby. Again the midwives were wonderful, giving me the treatment I needed as well as plenty of time and attention, reassuring me that everything was fine with the baby after the accident.
>
> I have read that there is a concern over the number of consultants available for women at Ealing. Whilst I of course am not aware of all of the statistics I can comment on my personal experience which is that it seems that every aspect of mine and my baby's health has been closely monitored. Whenever a concern has arisen no matter how minor I have been able to see a consultant in a very timely manor.
>
> During the course of my pregnancy I have encountered many, many women who have had babies and Ealing and have had a fantastic experience. Indeed this is the reason I chose Ealing for my baby. At NCT groups and online forums I have heard nothing but shock and disappointment at the decision to close the unit. Many women, including myself are extremely concerned about having to go to hospitals much further afield to have any future children. Many women report extremely long wait times for appointments and maternity units clearly under staffed in many of the hospitals that will have to take on the additional women from Ealing. Should I be lucky enough to have another baby I really dread the thought of having to make difficult journeys to hospital for appointments and being kept waiting or feeling that staff have little time for me.
>
> I very much believe that as well as the practical implications of this decision for the mums of Ealing, the impact of this decision on the mental wellbeing of mothers must be considered. The additional stress of having to travel further and potentially feeling as though they aren't getting the support and attention they require could have a very damaging effect on mothers. The importance of mums feeling relaxed and confident as they approach the birth of their child is just vital to a straight forward birth as having consultants on hand to deal with complications.
>
> I sincerely hope that not only my concerns but the concerns of many, many other women in Ealing will be considered over the coming weeks. I would very much appreciate it if you would be able to pass this e-mail on to those who hold this very important decision in their hands.
>
> Kind regards
>
> Rebecca Amery
> Ealing Mum to be

Smith Peter

From: Sapna [redacted]
Sent: 30 January 2015 21:15
To: Smith Peter
Subject: Keep Ealing maternity services open

Hi Peter,

I am writing in support of keeping Ealing maternity services open. I had my baby boy in October and was originally receiving ante natal care at QCH. I felt unhappy with the care I received and therefore transferred to Ealing at week 36 of my pregnancy.

I immediately felt more confident. The team at Ealing are nothing short of amazing. Rather than being treated like another 'client' I was treated like a human being and more importantly, how I feel a first time mother should be treated.

They were willing to listen to my concerns and wishes for the type of birth I hoped for. I felt like the staff worked with me to ensure that I had the birth I wanted whilst mitigating risks as much as possible. Following their care and support I had a calm and natural birth at the birth centre with a labour that lasted 4.5 hours.

I believe this is largely due to the the collaborative and common sense approach taken by the staff.

The post natal support, especially that from Caroline Neale was above and beyond. She took the time to give us advice anytime we asked. As a result my son is now exclusively breastfed and is a beautiful happy, healthy boy.

Without the team my birth could have gone a different way and it is due to the dedication and encouragement of women to birth naturally that we can look back on the birth in such a positive light and remember it as the amazing experience it was.

I implore you not to shut down this service. It has received so much positive feedback and is a great example for maternity services around the rest of the UK.

The other hospitals given as alternatives if Ealing were to close are already turning people away so how are we to get the quality of care given at Ealing?

It would be a great loss to the community and to the NHS if this wonderful maternity service were to close so please don't do this to the mothers and potential future mothers in our local area.

Regards,
Sapna

Sent from my iPhone

Smith Peter

From: Gen Capazorio [redacted]
Sent: 02 February 2015 19:51
To: Smith Peter
Subject: Keep Ealing Maternity Unit open

Dear Sir

I write in support to keep this amazing, diverse and safe haven for women, babies and families open.

From my very first antenatal appointment to my last, the staff were genuinely caring, informative and the whole process was professional and seamless with fantastic follow through if any abnormalities or concerns were picked up.

Following a rather protracted and eventually emergency delivery by Caesarean section, I always felt safe in the hands of my midwifes, obstetrician, anaesthetist, ODA and every person who contributed to the safe delivery of our son and my recovery following a post natal haemorrhage - even when things got really scary.

In my thank you letters to the hospital, I still vouch for our midwife who is / was our hero of the day. She never once deviated from such close monitoring of the guy who gave her such a hard time in my tummy!

Due to circumstances I spent a Tuesday to Sunday on the postnatal ward and again the staff looking after the ladies and babies do so with passion and dedication.

From the physiotherapist who came to visit my bedside who gave me invaluable insight to tips and exercises for home which probably help speed up my recovery, to helping me get out of bed!

My specialist Breastfeeding midwife needs a special medal and honour!
Sitting at my bedside at 9pm coaching, comforting and encouraging me in what turned out to be a wonderful experience between my son and I; I am eternally grateful for.

I chose to Ealing Maternity Unit over Queen Charlottes and other maternity services. Having had experience with Queen Charlottes, I can 100% say that the care received antenatally and postnatally cannot compare and I recommend Ealing to anybody I talk to!

We are an alternative family and the openness we received during our time with Ealing made our experience even more worthwhile to our family.

The question should not be how can we keep Ealing Maternity Unit open but how can you even think to close it.

With our best wishes and support to all the staff at Ealing Maternity.

G. Capazorio and family.

Sent from my iPhone

Smith Peter

From: Abi Luffman [redacted]
Sent: 04 February 2015 21:22
To: Smith Peter
Subject: North West London Healthcare Commission – Call for Evidence

Dear Mr Peter Smith,

My apologies this is late, I do hope you will still take my email into consideration.

I write to give evidence as to how, in my experience, patient care will be adversely affected by the closure of Ealing Hospital's Maternity Unit.

Throughout my pregnancy I was given superb antenatal support by the Ealing Midwifery Team. The fact that this support is local was of great benefit to me. Travelling to another site in the later stages of pregnancy would have been very stressful. The midwifes provided me with their mobile numbers, and I was told I could call or text at any time for advice. This is an incredible service which would be greatly missed if we are to lose this local team of friendly and caring midwifes.

After my baby was born I found the home visit midwife to be extremely knowledgable and reassuring. Again, it was wonderful to know – as a first time mother that this help was to hand, and most importantly that it was local. Again, the midwife provided me with her mobile number for advice at anytime. As she was always in the area she could come by to see me and my new baby easily at any time if I had trouble.

I have also regularly attended the Breastfeeding Support Group which is held on a weekly basis at the Grange Children's Centre. This is run by an extremely knowledgeable and experienced midwife from Ealing Hospital. These sessions proved absolutely invaluable to me and many other local women. The midwife provided me with one-to-one counselling to overcome my breastfeeding issues and help my baby gain weight. I emailed and texted this midwife for advice on many occasion – she was able to give me excellent same day replies to overcome my breastfeeding problems, including mastitis, thrush, and blocked ducts. This proved an absolute lifeline for me and my young baby who was struggling with slow weight gain. I strongly believe this was the only reason I was able to continue breastfeeding. If I am honest, I was not impressed by the advice given by my GP surgery, which was much less supportive of breastfeeding.

Who will provide us with breastfeeding support if Ealing Maternity Unit is closed? The NHS strongly advises mothers to breastfeed, yet without a local support group such as this run by Ealing Hospital hundreds of us would have given up! This would undoubtedly lead to an increase in postnatal depression.

One only has to glance around the streets of Ealing to see how many young families there are. How can Queen Charlotte's be expected to take on the extra numbers when they can barely cope as it is?

Why spend such a huge amount of taxpayers money creating an excellent local birth centre, only to close it down and replace it with an old one with less facilities at Queen Charlotte's?

We strongly urge you to keep the fantastic and valuable service at Ealing Maternity Unit open.

I do hope you will consider the points and questions raised in my email. Again my apologies for the lateness.

Kind Regards,
Abigail Richardson

Smith Peter

From: WYT D. [redacted]
Sent: 01 February 2015 15:34
To: Smith Peter
Subject: Please do NOT close Ealing Maternity Unit

Dear Mr Smith,

I gave birth to my baby at the Ealing Hospital Maternity Unit on 14th December 2014. My husband and I have found the postnatal care fantastic. The staff looked after my baby and me until they felt we were well enough to go home.

In particular, I found the breastfeeding support at Ealing Hospital provided by Caroline Neale second to none. It really helped me persist and got through the difficult early days of establishing breastfeeding. We all know the benefits of breastfeeding and how it can save the NHS millions from the recent media coverages.

The Ealing area is fast growing. Its residents really need a good maternity unit at close proximity to support them. I sincerely hope you will be compassionate in keeping the Ealing Hospital Maternity Unit open and support its further development.

Yours faithfully,

Winsa Dai

Smith Peter

From: Karah [redacted]
Sent: 30 January 2015 16:40
To: Smith Peter
Subject: Please keep Ealing Maternity Unit Open

Dear Peter

I have been asked to email you to tell you what closing Ealing Maternity Unit would mean for me. It would be bad, very bad. If you have ever been in labour you would know that you would choose to go to the closest possible hospital, as travelling whilst having contractions is not fun, not fun at all, even the couple of miles I travelled to Ealing, let alone going further afield. And then the possibility of being turned away because the hospital is full, or you are not dilated enough, doesn't bare thinking about. Luckily I was able to go to Ealing, and I hope others will in the future, and perhaps myself again one day.

I thought I would let you know how I have found the whole process.

My initial midwife appointments were in Perivale Children's Centre, which I think is a brilliant idea. Less queuing than in hospital, and the chance to see the same midwife each time. Brilliant. My midwife was an absolute star as well (more later).

My scans were at Ealing hospital, and due to minor complications I had to also see a consultant. Initially I was worried this would mean I wouldn't be able to use the birth centre, however they were very down to earth and sensible, and this restriction was not put upon me (phew!). Almost every single midwife I met were fantastic, and you could tell they really enjoyed being part of what was a great team (sadly this is already ending as people have already had to find new jobs, very sad).

I attended the antenatal class at the hospital, which again was very informative and much more realistic than the NCT classes I also did. I also attended the breastfeeding class, which was absolutely outstanding, and again very realistic. It also put me in touch with the breastfeeding midwife, who I cannot praise highly enough (again more later).

During my labour the midwives present were amazing, they read my birth plan, and let me follow it as much as possible, and where we diverted from it explained everything and let me make the decisions, rightly so. The birth centre was amazing, the rooms were spacious and well equipped with everything you would need to have an active natural birth. The pool was brilliant, and really helped with pain relief. I'm pleased to say I had a natural vaginal birth, which is what I really wanted. We stayed in the room after the birth for a period of time because the post natal ward was full, and the room was so comfortable and pleasant to be in. I don't understand why £300k would be spent on this lovely birth centre to then close it barely a year or so after opening, it doesn't make any sense at all to me whatsoever.

My son had an infection upon birth, and so we had to stay in hospital for a week. I cannot praise some of the midwives highly enough. My midwife from the Childrens centre came to see me almost every day, and I can't tell you how much that lifted my spirits. That first week was very teary for me, partly the normal hormones etc, and partly because I was in hospital unexpectedly for a week. Seeing a familiar face really really helped. The midwife who helped me hand express colostrum because I was worried my son hadn't fed. The midwife who filled a glove with hot and cold water to use as a compress on my sore back. The list goes on.

The breastfeeding midwife is the most amazing lady in the world. She watched a video of my feeding my son and advised me that he was indeed drinking, but gave me tips to stop me getting sore. She came to see me multiple times whilst on the ward. I was always keen on breastfeeding, but without her support who knows whether I would have made it.

The post natal groups I have attended have been brilliant, particularly the weekly breastfeeding group I attend at the Grange Childrens Centre, it's the one group I do not like to miss. The support we get at that group is outstanding.

This is probably just a snapshot of everything that is great about Ealing maternity because I am very sleep deprived, so there is probably more. But I hope this helps a bit. Please don't close the unit, the babies of Ealing depend on it, we do not want to to travel further to Queens Charlotte or Northwick Park, we want to go to Ealing. We want the amazing birth centre to remain open. We want the midwives to stay. They are brilliant.

Please let me know if there is anything else I can provide.

Regards.

Karah