It's not an Accident
But it is an Emergency

A response to the Public Consultation on the "IMPROVING HEALTH TOGETHER 2020-2030" proposals, led by Merton, Sutton and Surrey Downs Clinical Commissioning Groups - on behalf of KOSHH (Keep Our St Helier Hospital) and KOEH (Keep Our Epsom Hospital) campaign.

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Keep Our St Helier Hospital *
koshh.org

CUTS COST LIVES

This is no Accident, but it is an Emergency

In these extraordinary times KOSHH would like to take this opportunity to offer our thanks and gratitude to all medical clinical and support staff working in and around the NHS.

FORMAL RESPONSE BY THE KEEP OUR ST HELIER HOSPITAL (KOSHH) AND KEEP OUR EPSOM HOSPITAL (KOEH) CAMPAIGN ON THE PROPOSALS OUTLINED IN THE "IMPROVING HEALTHCARE TOGETHER 2020-2030" PLAN, A PROPOSAL BEING LED BY MERTON, SUTTON, AND SURREY DOWNS CLINICAL COMMISSIONING GROUPS.

Introduction
The proposals laid out in the "Improving Healthcare Together 2020-2030" (IHT) Public Consultation involve the removal of all acute care from Epsom Hospital, St Helier Hospital (including Queen Mary's Children's Hospital) or, in their preferred option to remove those services from both of these existing major acute hospitals.

They plan to substitute those two major acute hospitals with a single, smaller, more distant, acute facility, which would have many fewer beds, fewer consultant doctors, and would only be accessible via GP referral or via Emergency Ambulance.

None of the options outlined in the IHT business case would improve healthcare. None of the arguments in support of the proposed changes are sustainable.

The IHT Pre-consultation business case can be seen at:
https://improvinghealthcaretogether.org.uk/wp-content/uploads/2019/12/Committees-in-Common_Paper_Pre-Consultation-Business-Case.pdf

The Keep Our St Helier Hospital (KOSHH) and Keep Our Epsom Hospital (KOEH) Campaign rejects all of these proposals in their entirety and demands their immediate and permanent abandonment.

We believe the plans to be:
- Clinically, financially, logistically and morally flawed.
- Ill considered
- Without adequate evidence and crucially…
- Fail to meet the three declared objectives of IHT themselves.

We already have inadequate provision of NHS hospitals, acute facilities, hospital beds, doctors, nurses and support staff. Even before the current Coronavirus pandemic, our NHS was at breaking point through cuts, closures and downgrades.

To even consider pushing forward with these plans at such a time is both reckless and dangerous in the extreme.

Evidence shows that both the local and National Health Service is already grossly underprovided. Over the last decade, thousands of people have died through lack of NHS provision.

Research by The London School of Hygiene and Tropical Medicine and Oxford University identified a 12.5% spike in deaths during 2015. It was found that, if the rise in mortality were to continue, overall life expectancy will reverse for the first time since World War II".

Since then, life expectancy has already declined for women living in the poorest areas. Infant mortality has also increased. It urges governments to investigate the causes.

Meanwhile, mortality has continued to improve in all other European Countries.

http://www.ox.ac.uk/news/2017-02-20-30000-excess-deaths-2015-linked-cuts-health-and-social-care
https://www.independent.co.uk/news/health/tory-austerity-deaths-study-report-people-die-social-care-government-policy-a8057306.html
https://www.mirror.co.uk/news/uk-news/10000-extra-nhs-deaths-seven-12189257

During the current crisis, many thousands, and potentially tens or hundreds of thousands more, are predicted to lose their lives due to the Coronavirus pandemic in the UK. At least some of those deaths may have been avoided, had the NHS not already seen hospitals closed and downgraded, and suffered a loss of **50% of the existing NHS hospital beds over the last 30 years**.

https://www.kingsfund.org.uk/press/press-releases/hospital-bed-cuts
https://www.telegraph.co.uk/news/2017/09/29/number-nhs-beds-hashalved-30-years-major-study-warns/

The IHT plan goes against the latest planning guidance from NHS England which calls for front line bed numbers to be maintained, at least at the level of provision during the winter of 2019/20.

It was evident, even **before the pandemic**, that we needed **more** NHS provision, **not less**.

The NHS, and indeed the world, is currently facing one of the biggest crises in over 100 years, perhaps ever. Now is certainly not the time to further reduce NHS provision.

KOSHH call on all involved CCGs, Councils, MPs, NHS England, The Secretary of State for Health and Social Care, and the Government to:

- **Abandon permanently all plans to downgrade Epsom hospital or St Helier Hospital by removing their essential acute services.**
- **Keep all existing A&E, Maternity, Paediatric, Intensive Care, Cancer Care, Coronary Care, Emergency Medicine and Emergency Surgery provision on all current sites**
- **Cease all NHS land sales**

We call on them to protect, maintain and improve all existing services at St Helier, Epsom, Croydon, Kingston and St Georges and retain all five Major Acute Hospitals we already benefit from in South West London & Surrey.

The IHT proposals

The three proposals outlined in the plan each result in the removal of all acute services from Epsom hospital, St Helier hospital or both of these Major Acute Hospitals. We believe that to be both dangerous and reckless and would greatly increase the risk of serious harm and death to patients in South West London and Surrey.
These effects would be most directly felt in the current catchment population of at least 700,000, but they would clearly also be felt across a far wider area.

The proposals are presented as if they are the result of an attempt to resolve **clinical, financial** and **estates** challenges. In reality, they are driven by demands made in the South West London Sustainability and Transformation Plan (STP) and the requirement to cut almost £1 billion from NHS spending in South West London.

The local STP plans are clearly laid out tin the SW London STP entitled" SW London Five Year Forward View".
https://www.swlondon.nhs.uk/our-plan/our-plan-for-south-west-london/

The misleadingly titled "Improving Healthcare Together 2020-2030" (IHT) plan is the latest in a long line of plans over the last 30 years to close, downgrade or reduce hospital provision and hospital bed numbers in this part of SW London. These have included "Investing in Excellence", "Better Healthcare Closer to Home", "Better Services Better Value", the dramatically revealed 800 bed "Traingate" "Super Hospital", which led to "Providing high-quality healthcare services 2020 to 2030". They all had inappropriately positive names but were actually various forms of cuts, closures and involved taking healthcare further away from patients.

In essence they all proposed the removal of services from Epsom Hospital, St Helier Hospital or, as is the case with the latest proposal, both Epsom hospital and St Helier hospital.

The definition of an Acute Hospital is one that provides:

- A&E
- Maternity
- Intensive Care
- Paediatrics- Children's inpatient care
- Emergency Medicine
- Emergency Surgery
- Coronary Care
- Cancer Care

The IHT plan proposes to remove ALL of the above services from:

- Epsom hospital **or**
- St Helier hospital **or**
- The so-called "preferred option" is to remove **all** acute services from **both** Epsom hospital **and** St Helier hospital.

BACKGROUND

The Health and Social Care Act 2012, brought in by the Conservative & Liberal Democrat Coalition Government of 2010-2015, did 3 major things.

1. It removed the Secretary of State for Health's legal duty to provide us with a National Health Service.

2. It increased the percentage of income that a Hospital Trust could earn from private sources from just 2% to an astonishing 49%.
   https://chpi.org.uk/wp-content/uploads/2018/03/CHPI-NHS-Private-Patients-Mar18.pdf

   Note: The NHS Trust leading this "Dash for Private Cash" is the Royal Marsden
   https://www.thetimes.co.uk/article/nhs-in-dash-for-private-cash-nsnjw569z

3. It required NHS services to be put out to competitive tender and allowed such contracts to be awarded to "Any Qualified Provider". The processing and letting of such contracts is costing the NHS of billions of pounds every year, money which could and should be used to provide more frontline services.

The NHS became the "the worlds biggest QUANGO" and Simon Stephens (now Sir Simon Stevens) was brought in to take charge of NHS England in 2014.
https://www.kingsfund.org.uk/publications/worlds-biggest-quango-nhs-england

At Simon Stevens' instructions, in December 2015, the entire English NHS was divided up into 44 areas or "Footprints" and each was tasked with quickly planning ways to cut £23 billion from NHS spending. These plans were called "Sustainability and Transformation Plans" (STPs).

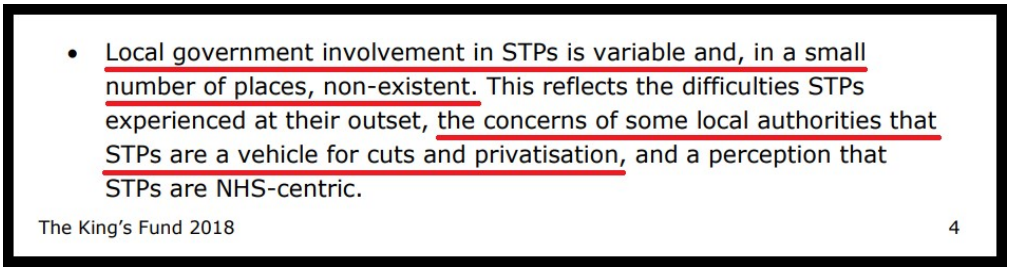
Within each "Footprint" area, all NHS Trusts, the Clinical Commissioning Groups (CCGs), who hold most of the health budget in an area, and Local Authorities (who, up until then were mainly responsible for providing Social Care) were supposed to "work together" to devise their local STP. This obligation was acknowledged on page 2 of the SW London STP document
https://www.swlondon.nhs.uk/our-plan/our-plan-for-south-west-london/

There is **no evidence** of there having been any substantive participation by Local Authorities in the preparation of the IHT plan or its predecessor, which was supervised by the Epsom and St Helier Trust.

The IHT Pre-Consultation Business Case (PCBC) was not even made available to Local Authority representatives in order to inform any Health Overview and Scrutiny Committee meetings, or Joint Health and Overview Scrutiny Committee meetings, despite frequent requests from those bodies for access to it.

The "pre-consultation business case" was not published until the 6th of January 2020, two days before the start of the formal Consultation period.

As this 2018 independent review into STPs by the Kings Fund says on page 4 (emphasis added):



- Local government involvement in STPs is variable and, in a small number of places, non-existent. This reflects the difficulties STPs experienced at their outset, the concerns of some local authorities that STPs are a vehicle for cuts and privatisation, and a perception that STPs are NHS-centric.

The King's Fund 2018 4

https://www.kingsfund.org.uk/sites/default/files/2018-10/London%20STPs%20independent%20review%20October%202018.pdf

NHS England gave lots of guidance on how to cut spending. Areas could restrict access to treatments, to GP referrals, and to medicines, but perhaps the biggest savings were to be made by closing, downgrading and cutting hospital services and reducing bed numbers.

The South West London "Footprint" area was told that the Trusts, CCGs and Councils had to work together to cut ~£1 billion from NHS spending in our area.

The South West London STP was published in 2016.
https://www.swlondon.nhs.uk/our-plan/our-plan-for-south-west-london/

It is not clear who wrote the plan, but on 22/10/2016, the Leader of Sutton Council, Ruth Dombey, said:

> *"as Leader of Sutton Council and the Health Lead for the 6 South West London boroughs, I have already written to the NHS on behalf of all the boroughs to confirm that we will not be endorsing the STP for our area."*

It would therefore appear that the six boroughs were not involved in the drafting of the STP for SW London.

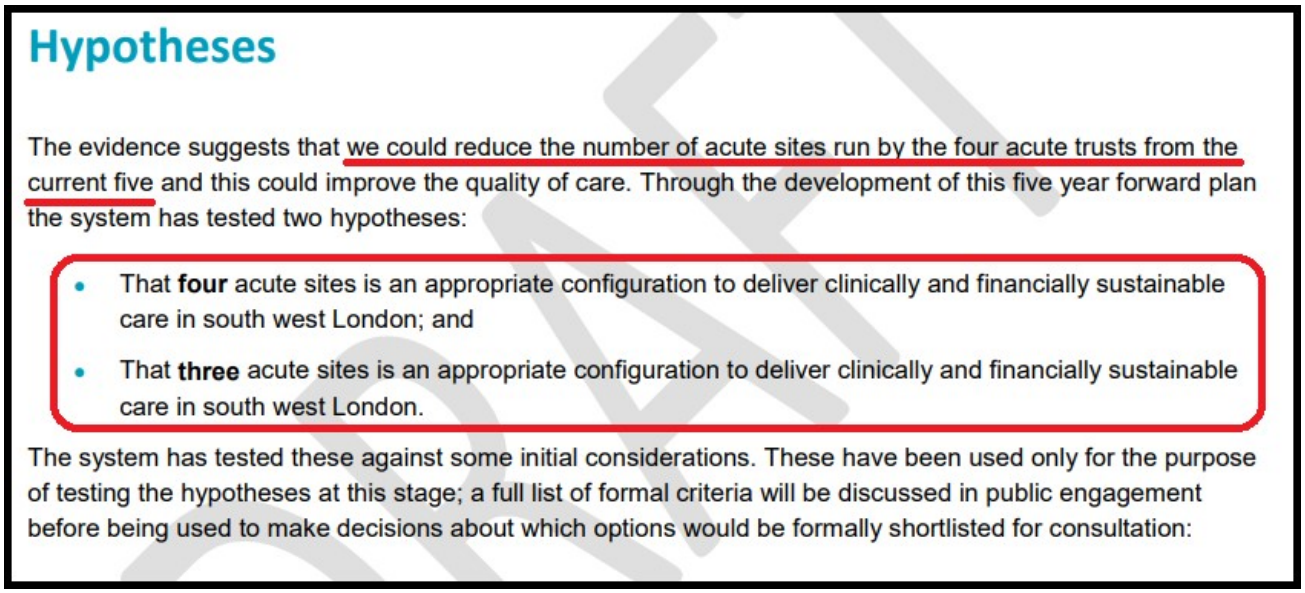
Sutton Council may have changed their position more recently.

As far as KOSHH have been able to establish, Merton Council have reserved their right to refer the IHT plan back to the Secretary of State for Health and Social Care.

The STP for south west London made multiple proposals for cuts to NHS provision. Including many other things, it proposed:
- A significant reduction in the number of patients who may be admitted to hospitals
- The restriction of, or complete denial of a whole list of services which were previously available
- Close monitoring of, and the reduction in the number of GP referrals
- Cuts to the range of prescriptions which GPs were able to prescribe

The biggest money saver however was to be the removal of Acute Hospital provision from one or two of the existing five major acute hospitals in our area.

The STP stated that we currently have five major acute hospitals in SW London and stated that this could be reduced to four or even three.



Hypotheses

The evidence suggests that we could reduce the number of acute sites run by the four acute trusts from the current five and this could improve the quality of care. Through the development of this five year forward plan the system has tested two hypotheses:

- That **four** acute sites is an appropriate configuration to deliver clinically and financially sustainable care in south west London; and
- That **three** acute sites is an appropriate configuration to deliver clinically and financially sustainable care in south west London.

The system has tested these against some initial considerations. These have been used only for the purpose of testing the hypotheses at this stage; a full list of formal criteria will be discussed in public engagement before being used to make decisions about which options would be formally shortlisted for consultation:

Figure 1: South West London STP Document, Page 28 - emphasis added
https://www.swlondon.nhs.uk/wp-content/uploads/2016/11/SWL-Five-Year-Forward-Plan-21-October-2016.pdf

In the STP document, it was made very clear that the targeted hospitals for closure or downgrading were St Helier Hospital and Epsom Hospital, with St Helier Hospital being first in line:

- **St Helier** has been assessed by the CQC as having the 16th highest critical infrastructure backlog requirements nationally. Its 1930s structure prevents it from ever being made compliant with modern standards for safe and high quality healthcare, for example insufficient side rooms to provide the appropriate standards of infection control practice.

Figure 2: South West London STP Document, Page 31 - emphasis added

It further stated that ST Georges was the only "fixed point":

The only site which we believe is a 'fixed point' is St George's Hospital in Tooting, since it provides hyper-acute stroke, major trauma and other services which are serviced by highly specialised equipment and estates, which would be very expensive to re-provide elsewhere in south west London. St George's is currently part of the review of specialised services for south London (see next section) but we anticipate that in any scenario it will continue to provide major trauma and hyper-acute stroke services, as well as some other specialised services and acute care.

Figure 3: South West London STP Document, Page 31 - emphasis added

The IHT proposals are completely aligned with the STP for South West London, are clearly written as a response to the STP, and are evidently a product of the motivation to cut NHS spending, not to improve anything for anyone.

It is noteworthy that more half of the 44 "Footprint" areas responded to their STP by planning to remove A&Es, Maternity and other services from their respective areas. In some, they planned the total closure of hospitals.
https://chpi.org.uk/wp-content/uploads/2017/04/DrSandhu_AE-closures-NW-London_CHPI_FINAL_19Apr.pdf
https://www.bbc.co.uk/news/health-39031546

CYGNUS

In 2016 an exercise called CYGNUS was conducted by Imperial College epidemiologists. It modelled the ability of the NHS to cope with an Asian respiratory virus similar to COVID-19.

It found that the NHS would be inadequately resourced to cope with an epidemic.

The report was unpublished and, far from remedying the inadequacies, NHS England continued overseeing implementation of its STP cuts and closures.

NHS England is failing to meet its statutory requirements for **Emergency Preparedness, Resilience and Response** (EPRR), placed upon it by the Civil Contingencies Act (2004) and the NHS Act (2006) as amended by the Health and Social Care Act (2012).

Implementation of the IHT proposals would significantly increase the extent of that failure.
https://www.dailymail.co.uk/news/article-8164389/2016-Government-pandemic-exercise-revealed-NHS-shortages-lack-protective-equipment.html?fbclid=IwAR16kMBEpcrwUlw_0EGcmfIkXdWaRn0w14AKldvAN63rCGZGFCdQ_GNgLNc

The "Improving Healthcare Together 2020-2030" (IHT) Proposals

The 3 Issues or "Challenges" stated in the IHT proposal's "Case for change" are listed as Estates, Clinical and Finance. We shall break these down below:

Estates:

On the one hand, the Epsom & St Helier University Hospitals NHS Trust have repeatedly claimed that continued use of the existing hospital buildings is "unsustainable" because they are old, crumbling, not capable of being modified to provide 21st century healthcare and are too expensive to continue maintaining.

On the other hand however, the options on offer in the Consultation, all involve the Trust continuing to provide "85% of current services" in those very buildings which they claim are unfit for use, and cannot be made fit for use, including outpatients and day surgery.
Since the "85% of care remaining at both hospitals" calculation was first declared, no adjustment has been made in light of new NHS policy.

It would appear, given the statement by Sir Simon Stevens, that "the NHS outpatients model is obsolete", that the IHT plan may conceal an intention to discontinue a significant proportion of the 85% of services they say would continue.

Figure 4: Health Service Journal Report on Simon Stevens' comments
https://www.hsj.co.uk/quality-and-performance/nhs-outpatients-model-obsolete-says-stevens-/7022652.article

It is proposed to spend £80m on refurbishing the existing estate, in addition to £100m that the Trust says they are already spending on it.

Internally Inconsistent

The IHT preferred option is to build a new facility adjacent to the Royal Marsden Hospital in Belmont. This proposal is inconsistent with their declared case for change.
If the maintenance costs of the current two hospitals are unsustainable, how can adding the maintenance costs of an additional hospital be more sustainable?

Many of the arguments laid out by the IHT team are internally inconsistent.

The only thing about the issue of "Estates" that is unsustainable is the demonstrably flawed "case for change".

It is noteworthy that the buildings at E&STH would not be in such a condition or indeed have such a large "maintenance backlog", had they been properly maintained for the last two decades or more.

As quoted in the Get Surrey Newspaper:

> *"When asked why this backlog has not been addressed sooner, Mr Elkeles (CEO of the Epsom and St Helier Trust) said: "There was uncertainty over whether both the hospitals were going to stay so there was no point investing money into either of them."*
> https://www.getsurrey.co.uk/news/surrey-news/epsom-hospital-buildings-demolished-land-14496851

This is a very clear indicator of the long standing intention to close or downgrade, both Epsom hospital and St Helier hospital.

It is completely unacceptable that the population should now suffer the consequences of the deliberate failure of duty by those responsible for maintaining and safeguarding our hospital buildings, and that the results of this flagrant mismanagement, should now be used to justify the downgrading of Epsom and St Helier Hospitals.

Uncertainty about the future of Epsom hospital and St Helier hospital has undoubtedly had a detrimental impact on staff retention and recruitment over the last decade or so.

Land Sales:

The Trust recently sold land and buildings at Epsom Hospital. They claim to have sold ~20% of the site to Legal and General. The developers, Guild Living on the other hand, say they purchased 25% of the land. It is hard to know which of these is the true figure.

In either case, the sale of up to 25% of Epsom hospital's land and buildings has put a huge portion of the estate beyond future use. This land could and should have been used to cater for predicted future demands and emergencies.

Figure 5: Video taken at an Epsom & St Helier Trust Board Meeting where the land sale was announced
https://youtu.be/J_Szo8JXlnk

The Trust was offered £40m for the land, but rejected that offer because, they claimed, it would have resulted in a high rise housing development. Instead, they accepted an offer of £18.bm from a company wishing to build of expensive retirement homes. At the next board meeting attempts were made by the Trust's Chief Executive, Daniel Elkeles to present the development as being for "Social Care".

This is clearly not the case and it was roundly challenged by the public and Councillors present. The £18,6m offer was accepted, with, it transpired, no caveats as to future use of the site. This factor threw the stated rationale for accepting the much lower offer into considerable doubt.

Currently the developers are planning to build 300+ expensive retirement homes in 3 tower blocks. Some of the penthouse flats are predicted by the developers to cost over £1m.
https://www.guildliving.co.uk/guild-living-submits-plans-for-epsom-later-living-community/

This description of the intent of the developer is very revealing:
https://www.telegraph.co.uk/business/2019/05/09/lg-targets-last-time-buyers-building-retirement-villages/

The trust initially reported having made just £15m profit from the deal, in later board papers it was revealed that they had made an even lower figure of £11.6m profit from the sale.

Figure 6: Video taken at an Epsom & St Helier Trust Board, at which the land sale proceeds were discussed
https://youtu.be/qaV3bMzDQKg

Many services that were on the sold land have since needed to be re-provided elsewhere on the site and in Epsom town centre, at considerable expense. These include all of the therapies, clerical offices, the boiler house, union offices, and a private skin clinic. It is more than likely that the expense of this re-provision in inferior buildings, exceeded the "profits" made from the sale.

Also lost, as a result of the sale were 50 or more staff flats. These were not re-provided on site.
The staff living in the flats were simply given two months notice to quit.

Many NHS staff are not terribly well paid and many would find it hard to afford accommodation in Epsom, where housing is very expensive. Not only have people lost their homes but the lack of staff accommodation could impact on recruitment and retention.

If any of this land was actually surplus at this time, which we doubt, a better use might have been to build more staff accommodation. This would at least have retained the option to expand clinical services at a future date when the need inevitably arose.

On the portion of the site which was sold were solid brick built buildings. With some refurbishment and proper maintenance they could have lasted for decades more. To re-house some of the facilities lost in the sale, temporary, Portacabins have been built and covered in a skim of fake brick. They are unlikely to last as long as the conventional buildings they replace and it is likely that the cost of this re-provision could well have exceeded the very small profits gained through the sale. Admin support and clerical services which had been co located with the hospital have been forced out to rented offices in Epsom town some distance away. It seems entirely illogical sell land and to then to rent office space some distance away. There are now many reports of lack of office space for senior medical staff, who report the lack of desks, their own computers or phones.

There are plans to sell land at St Helier hospital for housing, and then, assuming the existing acute services are removed, yet more land would be sold from both the Epsom and St Helier hospital sites. It is likely that such sales would also be to property developers. The Trust Board's stated plan for sales of St Helier Hospital land, are to build "high density housing" (see video above). This would seem to indicate a desire for yet more tower blocks – the very reason the Trust gave for rejecting the £40m offer.

KOSHH believe that the land we currently have on both existing sites is needed to expand NHS services to cope with current and future needs. Right now, there is just about sufficient space to build new and to extend hospital provision. It is foolhardy and reckless to sell further land when expansion of NHS services is and will be desperately needed.

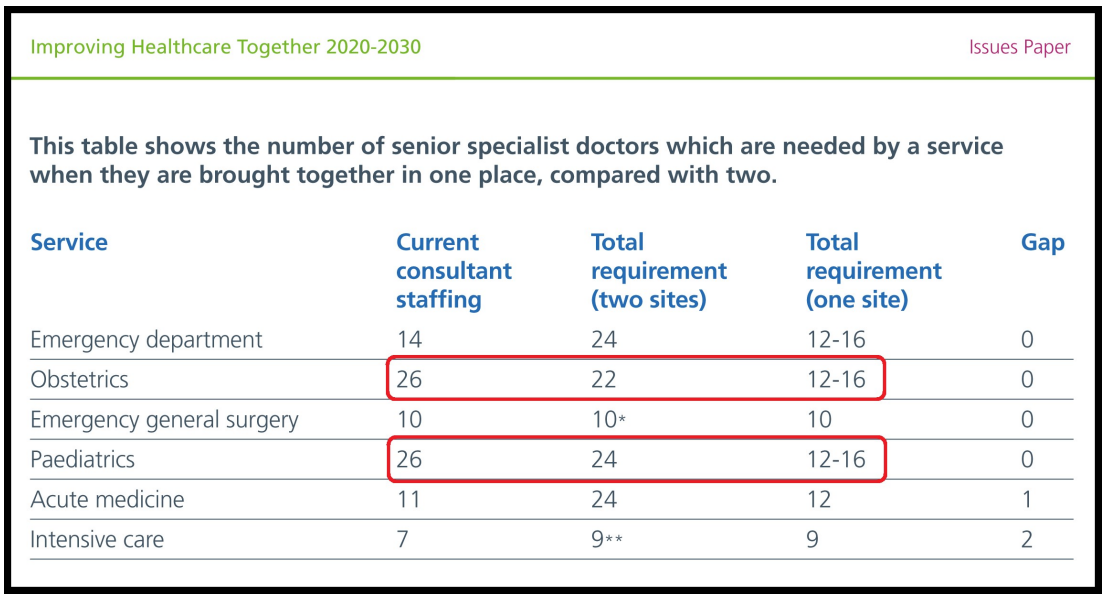
The NHS is a system to be very proud of, but it has been systematically and deliberately under funded under provided and under staffed for decades. It is now less well provided with hospitals, beds and clinical staff than almost every other developed country in the world. This has forced our NHS to near breaking point and only the good will of the wonderful workforce has prevented the system from total collapse.

Clinical (Staffing)

NHS hospital bed provision in England is lower than most other comparable countries, and the local bed provision is already well below the UK average.

The IHT plan does not address the very poor performance of the Trust against the 4 key performance targets, or the lack of sufficient beds to meet current, let alone future needs.

The Trust say that they cannot provide high quality healthcare in their two (actually three – including Queen Marys Hospital for Children which is also slated to be closed under two of the three options offered) hospitals as they cannot provide sufficient Consultants to staff all the Acute services on two sites. The table in the IHT Issues paper (page 15) shows that they currently employ 94 Consultants (or, so called "Senior Specialist Doctors") and intend to employ as few as something between 67 and 79 in the proposed new Acute facility:



Improving Healthcare Together 2020-2030 — Issues Paper

This table shows the number of senior specialist doctors which are needed by a service when they are brought together in one place, compared with two.

Service	Current consultant staffing	Total requirement (two sites)	Total requirement (one site)	Gap
Emergency department	14	24	12-16	0
Obstetrics	26	22	12-16	0
Emergency general surgery	10	10*	10	0
Paediatrics	26	24	12-16	0
Acute medicine	11	24	12	1
Intensive care	7	9**	9	2

Figure 7: Improving Healthcare Together - "Issues Paper", Page 15
https://improvinghealthcaretogether.org.uk/wp-content/uploads/2019/05/Improving-Healthcare-Together-Issues-Paper-June-2018.pdf

The argument that the majority of the population served by Epsom hospital, St Helier hospital and Queen Mary's Hospital for Children, will receive higher quality Care when it is provided by up to 27 fewer Consultants is evidently false and unsustainable.

It is also worth pointing out that recruitment and retention of Consultants is made more difficult when the Trust is continuously subject to an uncertain future, let alone when the number of Consultant posts is planned to be cut. A doctor's chance of promotion within a Trust is affected by number of more senior posts available.

It is also worth noting that "senior specialist doctors", as quoted at the top of page 15 of the IHT "Issues Paper" are not the same thing as Consultants, and would not necessarily have the same qualifications as Consultants. This appears to be an intention to down-skill a number of key specialist roles.

A main element of the clinical case is lack of available Consultants, or so called "Specialist doctors". It costs £250,000 to train a doctor. It would cost £5.5 million to train 22 doctors. Considerably less than the £511m that the IHT proposes to spend. Fast tracking junior doctors to consultant posts could solve the Consultant staffing levels much more cheaply than building a third facility.

If they intend to have Consultants or "Senior Specialist Doctors" available across all three sites, the reduced number they propose employing would be spread very much more thinly than they now are across two sites.

Adequately staffing three sites with medical, ancillary, clerical and other support staff cannot, by definition, be as efficient as staffing two sites.

Financial

Prime Minister Johnson announced the funding for "six new hospitals" on the Andrew Marr show on BBC. The following day in Parliament, the Shadow Sec of State for Health, Jonathan Ashworth, said "Its not new money to build a new hospitals at Epsom and St Helier, its money to downgrade both of them" This is evidently true.

Figure 8: The Prime Minister's Misleading Statement on the Andrew Marr show & challenge in Parliament (VIDEO)
https://youtu.be/skZ4aDWKmuo

In all the publicity about the £500m (or £511m) on offer, it has been presented as if it's a gift. This is another example of the disingenuous nature of the Consultation.

There will be additional revenue costs including interest payments, capital charges and depreciation costs. Some Trusts have voiced their concerns about their ability to afford this "new" money. One Trust described it as being like an "interest only mortgage".
https://www.hsj.co.uk/finance-and-efficiency/trusts-in-line-for-new-hospitals-will-face-extra-charges/7026444.article

At a time when interest rates are at an all time low, the Government are charging 6% interest. The cost of this could have a very significant impact on the Trust's finances and might put its future financial viability at risk. It might also mean that services could be cut even further than the dangerous cuts already being proposed by IHT.
https://inews.co.uk/news/politics/nhs-trusts-bill-interest-payments-government-debts-mount-571089

These costs would presumably have to be met by savings from elsewhere. Is this to be done by cutting beds despite the growing population, despite the fact that population growth has been estimated by the ONS to be 24% by 2039? Or Simon Stevens' statement last June that bed cuts have gone too far? This was before the Covid-19 crisis very clearly demonstrated the woeful and extraordinary lack of capacity in the UK.
https://www.theguardian.com/society/2019/jun/19/hospital-bed-cutbacks-have-gone-too-far-nhs-england-boss-simon-stevens-says

The money on offer for this project is variously described as £500m and £511m. On questioning at a public meeting this was challenged and the IHT team confirmed that it is in fact £511m. £11m is a considerable sum of money to be omitted from most documentation.

Due to the way that NHS hospitals are now funded, the Accident and Emergency department is often described as the gateway or "front door" to a hospital. Acute services are responsible for a significant proportion of a hospital's income. Little or no account has been taken of the loss of income that the proposed removal of acute services from Epsom and St Helier Hospitals would cause and nor is the loss of income to "other providers" taken into account.

KOSHH fear that this reduction in income could quickly be used to declare Epsom and St Helier Hospitals financially unsustainable, as has been seen in other cases around the country.

The Option Appraisal fails to follow the mandatory obligation to present a "do minimum" option, a "business as usual" option and "lower costs option", on the short list of options evaluated.

Why has this not been done? It is an invalid Consultation without that option.

The plan clearly states that the existing two hospitals will be refurbished and used for 85% of patient interactions. The option to refurbish and extend the current sites as required has not been costed or considered.

Plans to significantly extend St Helier were well advanced, architect drawings made, costed at £219m and presented to the public in 2009. After an election in 2010 the incoming Government gave assurances that the money would still be available. The whole scheme was then mysteriously withdrawn.

KOSHH believe that a similar project could be a cost effective solution to the so-called "estate" problems at both Epsom and St Helier hospitals.

Financial savings could be made by avoiding the additional costs of planning and building a whole, brand new hospital.

The costs of any new building always rise significantly above the original estimate, they can even double as was the case with Canterbury Hospital.
https://www.hsj.co.uk/finance-and-efficiency/cost-of-hospital-building-project-doubles-in-18-months/7026896.article

New builds can be beset by unforeseen costs and teething troubles, thus increasing costs. There is a danger that costs could increase to such an extent that a new acute hospital build be started but not be completed, or that the Trust could not afford to staff it. It would not be the first instance of such a disaster for the population and the NHS.
https://www.liverpoolecho.co.uk/news/liverpool-news/doomed-royal-liverpool-hospital-costs-17579952

Savings from new technology are claimed despite these savings being available if on existing sites if the investment were to be made. Savings are claimed based on existing staffing levels not on the cost of full establishment.

Other cost disadvantages not attended to in the PCBC include:

- increased estate required to be built
- diseconomies of scale in co-ordinating care over three sites instead of two
- additional costs and inconvenience to staff, patients and visitors
- changes needed to public transport arrangements

- increased costs associated with potential legal claims against the NHS or the Trust caused by cuts in provision

The Trust now runs its own patient transfer operation. In addition the Trust also spends a significant sum on Taxis to move patients; this can not be sound financial model.
With three sites such costs seem likely to increase. There is no evidence that this been costed.

Many of the savings claimed seem entirely spurious.

BEDS:

The IHT consultation document says that The Epsom and St Helier Trust currently have 1,048 beds and they say that they plan to have just 1,052 beds in the future. This minimal apparent increase is much vaunted as a great improvement. See Page 231 and 232 of the Pre-consultation business case:
https://improvinghealthcaretogether.org.uk/wp-content/uploads/2019/12/Pre-consultation-Business-Case-9-Jan-2020.pdf

This, on its own is an astonishing, proposal.

They then say, that their own predictions indicate that they will need 1,082 beds for the population in 2026/26. **This need for 1,082 beds** is then completely ignored for the rest of the document.

The Clinical senate criticised the PCBC for not forecasting population growth and hospital bed provision beyond 2025/2026, especially when their title of the review is:

> "Improving healthcare Together 2020 - **2030"**.

However it becomes apparent that far from intending to provide an increase of just 4 beds they actually intend to dramatically **cut** the number of beds. On page 231 and 232 of the PCBC it itemises the beds they propose to have in each of the three options.

They intend to provide:
- ONLY 1002 beds if the Royal Marsden option is chosen
- ONLY 971 if the St Helier site were chosen
- ONLY 848 if the only acute facility were to be co-located with Epsom hospital.

On even a cursory examination of the numbers of beds proposed, it becomes clear that they plan to cut the number of beds by 50, 81 or 205 dependant on which option is selected. Every single option results in a significant cut to the number of available hospital beds.

This wide disparity between the numbers claimed and the actuality is because they are counting phantom beds. 50 to 205 beds that they say will be supplied by "other providers". During the Consultation Listening Events it was said that St Georges and Croydon Hospitals could each provide an additional 100 beds, and Surrey Hospitals could provide 50 extra beds.

Given the failure to achieve any of the key targets at St Georges or Croydon this seems like a very unlikely proposition. The CEO of Croydon Healthcare Services NHS Trust, Mathew Kershaw, has recently had to publicly apologise for the extraordinarily bad figures for the 4 hour wait target and bed occupancy levels in Croydon were as high as 99%. Does this sound like a provider who has sufficient staff and accommodation to provide up to 100 of these phantom beds?
https://www.yourlocalguardian.co.uk/news/18227638.chief-executive-apologises-croydon-university-hospital-fails-meet-standards/

Northwick Park Hospital has still not received the money for the 30 acute beds it was promised in order to help it cope with the closure of several surrounding A&Es after the major hospital closures in NW London under the title "Shaping a Healthier Future". A similar review to ours, for which the current Chief Executive of the Epsom & St Helier Hospitals NHS Trust, Daniel Elkeles, was the Senior Responsible Officer. That scheme was halted in 2019 after much damage was done to acute services in NW London
https://www.andyslaughter.co.uk/legacy/2014/07/25/devastating_news_for_local_health_service_as_a_e_closures_and_charing_cross_demolition_get_go_ahead-2/
https://www.epsom-sthelier.nhs.uk/meet-our-board
https://www.theguardian.com/society/2019/jul/24/millions-wasted-in-failed-nhs-hospital-closure-programme

Northwick Park was immediately and remains one of the worst performing hospitals for the 4 hour A&E wait time target, due largely to the cuts carried out under that review.

There is little reason to believe that 200, 81 or 50 beds would ever actually materialise.

KOSHH totally rejects any plan to cut the number of beds in our area.

The current catchment is for over 720,000 people. If we currently have the stated 1,048 beds for that number of people, we have just 1.46 beds per 1000 people. If we just had 848 beds we would have a ratio of just 1.18 beds for every 1000 of the population.

This is a dangerous and recklessly low number of beds to provide.

Great Britain has an average of just 2.54 beds per 1000 people.

This figure is amongst the worst in the developed world. Japan has 13 beds per 1000 people, Germany has 8 per 1000, France 6, and Italy has and 3.18 hospital beds per 1000 population.

To suggest that it would "improve" our healthcare to have such an astonishingly low ratio of beds to population is breathtaking.

An area as congested and cosmopolitan as South West London, where disease is most likely to spread, as is being demonstrated by the fact that, as of 30/03/2020 the South West London STP area has seen the highest number of Covid-19 deaths in the country.

We should clearly have a higher than UK average NHS bed ratio, not a dramatically worse ratio.

Furthermore, this proposal is supposedly meant to cover our health needs for the next 10-20 years, and no additional bed capacity is planned, but the Office for National Statistics says that the population in Merton, Sutton and Surrey Downs is predicted to rise by 24% by 2039.

It would seem reasonable, when planning such major changes to health provision, at such a large cost, with significant health implications for an existing population of over 720,000 people, longer timescales might be wise. It is significant that the timetable for completion of the proposed acute hospital would not be before 2025/26, and yet the Pre-Consultation Business Case only projects population growth up until 2025, and their figures do not match those of the ONS.

NHS hospitals are already under enormous pressure and it's now common to see 12 hour trolley waits and in some cases, even 30 hour waits in A&E. The NHS has been desperately short of capacity for the last few years – it's clearly incredibly dangerous to propose to close or remove A&E units, when there simply isn't sufficient capacity to cope with these patients elsewhere. The 4 hour A&E waiting time targets are not being met and nor are many other key targets.
https://www.theguardian.com/society/2017/feb/06/one-in-six-ae-departments-at-risk-of-closure-or-downgrade

Between 1987/88 and 2019/20, the total number of NHS hospital beds fell by 53 per cent – from 299,4000 to 141,000 (Kings Fund report below)
https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers?fbclid=IwAR1VSQ1oaJkjziVTxeFkmCk5rrq0wN1TtoJ1BbTOSdbxW-AaJywhaTcQKjE

Wikipedia. List of countries, showing the ratio of hospital beds
https://en.wikipedia.org/wiki/List_of_countries_by_hospital_beds

In a Kings Fund report published in January 2020,in response to the latest stats they said that they:

> "show an alarming decline in accident and emergency (A&E) performance with performance against the four-hour target in major A&E units reaching a new low point. More shockingly still, there has been a stark jump in number of people stuck waiting a very long time on a trolley before being admitted to hospital. The number of people who are waiting more than 12 hours after the point it was decided to admit them has more than doubled since the previous month to over 2,300, more than 8 times higher than the number last year. 'Hospital bed numbers have fallen significantly over the past decade. With hospitals running full to capacity and patients waiting an unacceptably long time for the urgent care they need**, it is clear that bed reductions have gone too far."**

The report also says:

> "we need a new review of the number of beds and appropriate staffing levels needed to cope with this rising demand on NHS hospitals. Critically, if we are to open more hospital beds, we will need additional nurses and doctors to staff them and the NHS is currently in the grips of a major workforce crisis."

Note: We emphasise, that this report was written before the Covid-19 crisis really took hold
https://www.kingsfund.org.uk/press/press-releases/winter-pressure-hospital-bed-numbers

The Kings Fund report on STPs in London says that these STPs:

> "…include plans to reduce hospital use and in some cases the number of acute hospital beds. Our analysis suggests that reductions in hospital use on the scale proposed in London's STPs are not credible. Recent analysis by the Royal College of Emergency Medicine – looking at hospital use right across the UK – also suggests that the NHS is likely to require additional beds this year to achieve safe bed-occupancy levels and hit waiting times targets (Royal College of Emergency Medicine 2017)."

The same report goes on to say:

> "South West London's plan, for example, states that house prices in London are now around 11 times the average London NHS salary, compared to 8.4 times in 2010. North East London also highlights the lack of affordable housing as an important workforce issue."

This problem has of course been made worse by the recent sale of staff accommodation at Epsom hospital.

The Kings fund report also says (p44):

> "**Recent reductions in beds appear to have been made at the expense of increases in bed-occupancy levels** (the proportion of hospital beds filled) both nationally and in London (see Table A2 in Appendix A). Bed-occupancy levels in London have been at 87 per cent or above since 2005/6. The **current level of bed occupancy in London – at around 90 per cent – is unlikely to be sustainable and leaves the health system vulnerable to fluctuations in demand, with a knock-on effect on its ability to handle emergency admissions and discharge patients** (Department of Health 2000). Patients face increasing risks once bed- 45 occupancy rates exceed 85 per cent, including risk of acquiring health care acquired infections (Kaier et al 2012; Bagust et al 1999)."

…and also (p42):

> **"There is little evidence to suggest that efforts to date to shift care into the community have significantly reduced costs of care – and in some cases the evidence suggests that community-based care can increase costs (Imison et al 2017; Nolte and Pitchforth 2014)."**

…additionally (p7):

> "…reductions in hospital use on the scale proposed are not credible. Heroic efforts will be needed simply to manage rising demand with existing hospital capacity"

…and also (p51):

> "At 85 per cent bed occupancy, our analysis suggests that London may need 1,600 additional acute and general hospital beds by 2021 to keep up with demographic changes alone."

…and (p53, emphasis added):

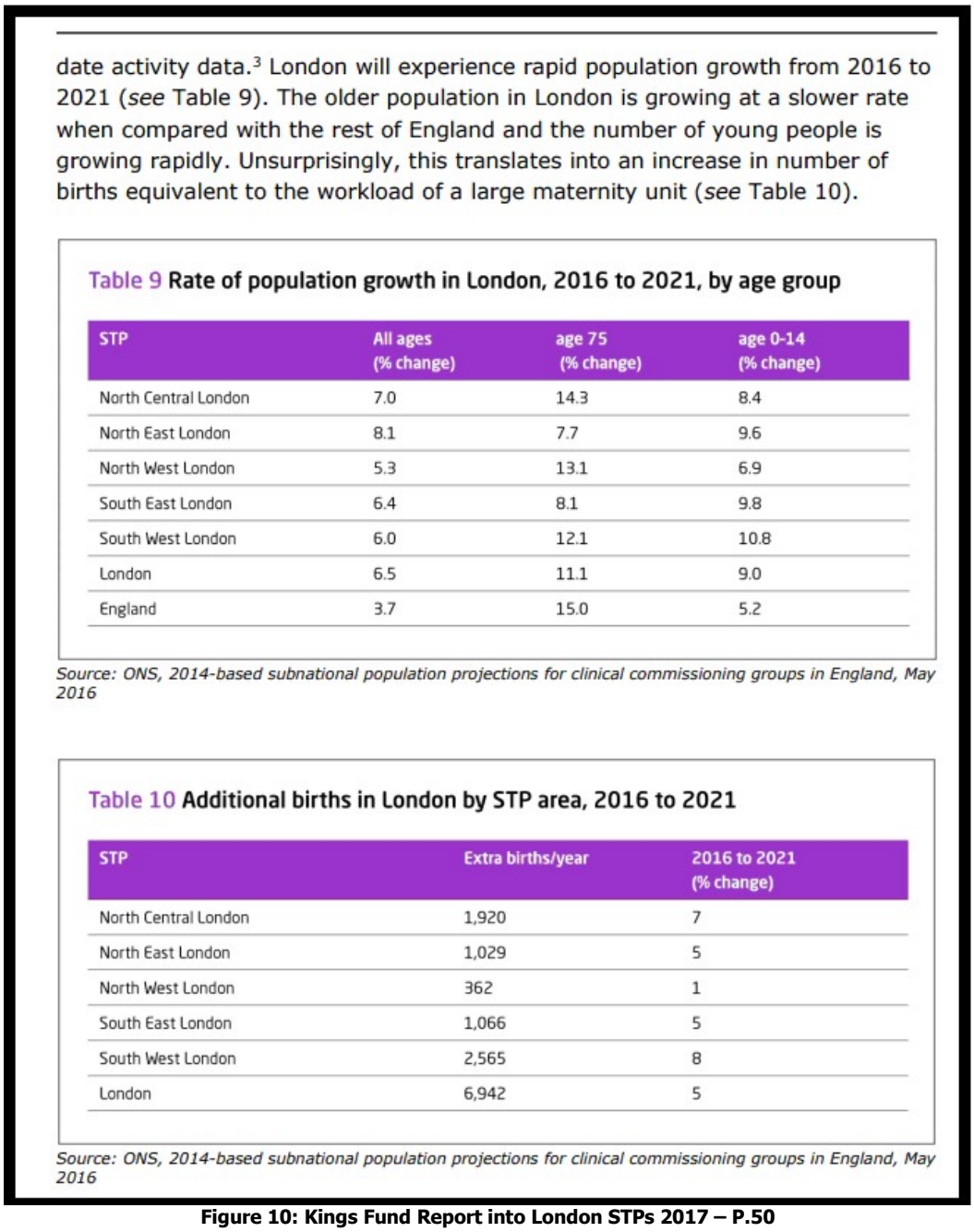
Table 12 Potential growth in general and acute bed days in London, 2016 to 2021, for given bed-occupancy rates

STP	Bed day growth (% change)	Additional beds needed, for given occupancy rate		
		80%	85%	90%
North Central London	11.0	290	273	258
North East London	9.9	364	343	324
North West London	10.4	436	411	388
South East London	8.9	327	307	290
South West London	9.6	283	266	252
London	9.9	1,700	1,600	1,511
England	9.0	11,218	10,558	9,971

Source: Authors' projections

Figure 9: Kings Fund Report into London STPs, page 53
https://www.kingsfund.org.uk/sites/default/files/2017-09/STPs-London-Kings-Fund-September-2017_1.pdf

The Kings Fund report into London STPs, also contains these tables:



date activity data.[3] London will experience rapid population growth from 2016 to 2021 (*see* Table 9). The older population in London is growing at a slower rate when compared with the rest of England and the number of young people is growing rapidly. Unsurprisingly, this translates into an increase in number of births equivalent to the workload of a large maternity unit (*see* Table 10).

Table 9 Rate of population growth in London, 2016 to 2021, by age group

STP	All ages (% change)	age 75 (% change)	age 0-14 (% change)
North Central London	7.0	14.3	8.4
North East London	8.1	7.7	9.6
North West London	5.3	13.1	6.9
South East London	6.4	8.1	9.8
South West London	6.0	12.1	10.8
London	6.5	11.1	9.0
England	3.7	15.0	5.2

Source: ONS, 2014-based subnational population projections for clinical commissioning groups in England, May 2016

Table 10 Additional births in London by STP area, 2016 to 2021

STP	Extra births/year	2016 to 2021 (% change)
North Central London	1,920	7
North East London	1,029	5
North West London	362	1
South East London	1,066	5
South West London	2,565	8
London	6,942	5

Source: ONS, 2014-based subnational population projections for clinical commissioning groups in England, May 2016

Figure 10: Kings Fund Report into London STPs 2017 – P.50
https://www.kingsfund.org.uk/sites/default/files/2017-09/STPs-London-Kings-Fund-September-2017_1.pdf

This minimal projection does not include the range of other factors (such as expanding treatments and new technologies) that have historically increased activity over and above the impact of demographic changes.

As the second and third columns of Table 9 above show, the rate of growth in the very young and the very old population in London is higher than in other age groups. This will have a striking impact on the likely number of acute and general hospital beds required by as soon as 2021.

Page 45 of the same Kings Fund report says:

> "Overall acute hospital activity in London has been increasing over recent years as it has been elsewhere in England These activity levels – as in the rest of England – are significantly above the levels of increase that would have been predicted purely by population growth and other changes in demography."

The ONS has predicted that the population in the catchment area of the SW London footprint will increase by 24% by 2039 from 2014

Population projections - local authority based by single year of age

ONS Crown Copyright Reserved [from Nomis on 20 March 2018]

	All Ages			
	2016 pop est	2039 projections (2014 based)	change	% change
Croydon	382,304	476,250	93,946	24.6
Kingston upon Thames	176,107	224,483	48,376	27.5
Merton	205,029	251,758	46,729	22.8
Sutton	202,220	253,078	50,858	25.1
Wandsworth	316,096	377,199	61,103	19.3
Richmond upon Thames	195,846	246,693	50,847	26
Epsom and Ewell	79,588	100,298	20,710	26
Total	1,557,190	1,929,759	372,569	23.9

Figure 11: ONS Population projections by local authority, based by single year of age
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/2014basednationalpopulationprojectionstableofcontents

It is clear that proper projections of the population growth going forward to a reasonable time, have not been done.

The fast growing population, the exceptionally high number of young people in the area and the likelihood of an increase in health provision required, due to innovation, clearly show that the number of beds in the IHT proposals fall far short of what will be needed for safe, or even minimal health provision.

Dr Tajek Hassan, former president of the Royal College of Emergency Medicine (RCEM), said:

> "These (STP) plans that are emerging via different routes, if true, **are potentially catastrophic** and will put lives at risk"

In June 2019, the BMA called for 3,000 more NHS beds.

> "The government must ensure the 'core bed stock' grows by at least 3,000 beds to reach a level that can cope with year-round demand, reserving escalation beds for responses to peaks in demand and addressing dangerous bed occupancy levels."
> https://www.bma.org.uk/collective-voice/policy-and-research/nhs-structure-and-delivery/monitoring-quality-in-the-nhs/beds-in-the-nhs

The RCEM said in October 2019:

> **"**The NHS in England will need at least 4,000 extra beds to prevent thousands of patients being treated in corridors this winter."
> https://www.rcem.ac.uk/RCEM/News/News_2019/NHS_in_England_needs_over_4000_extra_beds_this_winter.aspx

Even the Chief Executive of NHS England, Sir Simon Stevens has said that bed cuts have gone too far:

> "Simon Stevens, chief executive of NHS England, said the policy had gone too far and that hospital beds had become "overly pressurised" as a result of years of closures."
> https://www.theguardian.com/society/2019/jun/19/hospital-bed-cutbacks-have-gone-too-far-nhs-england-boss-simon-stevens-says

There is clearly no medical, financial or moral justification to continue with this current proposal to cut up to 205 beds in our locality.

There is clear evidence that we locally and nationally need many more hospital beds, not fewer.

And yet still IHT, against all the informed advice on offer, persist with the assertion that, not only should they plan to downgrade two major acute hospitals in London, take away A&Es Critical Care Units, Emergency Medicine and Surgery provision, Maternity and Paediatrics, drastically reduce the number of beds and Medical staff - they even claim that doing so would somehow "Improve Healthcare".

Covid-19

Thousands of patients have died waiting for treatment and our doctors and nurses have been under intolerable strain for many years. The entire system was at breaking point, even before the Covid-19 crisis.

The HSJ has reported that, as of 30/03/2020, the South West London STP area has suffered more Covid-19 deaths than any other STP footprint:

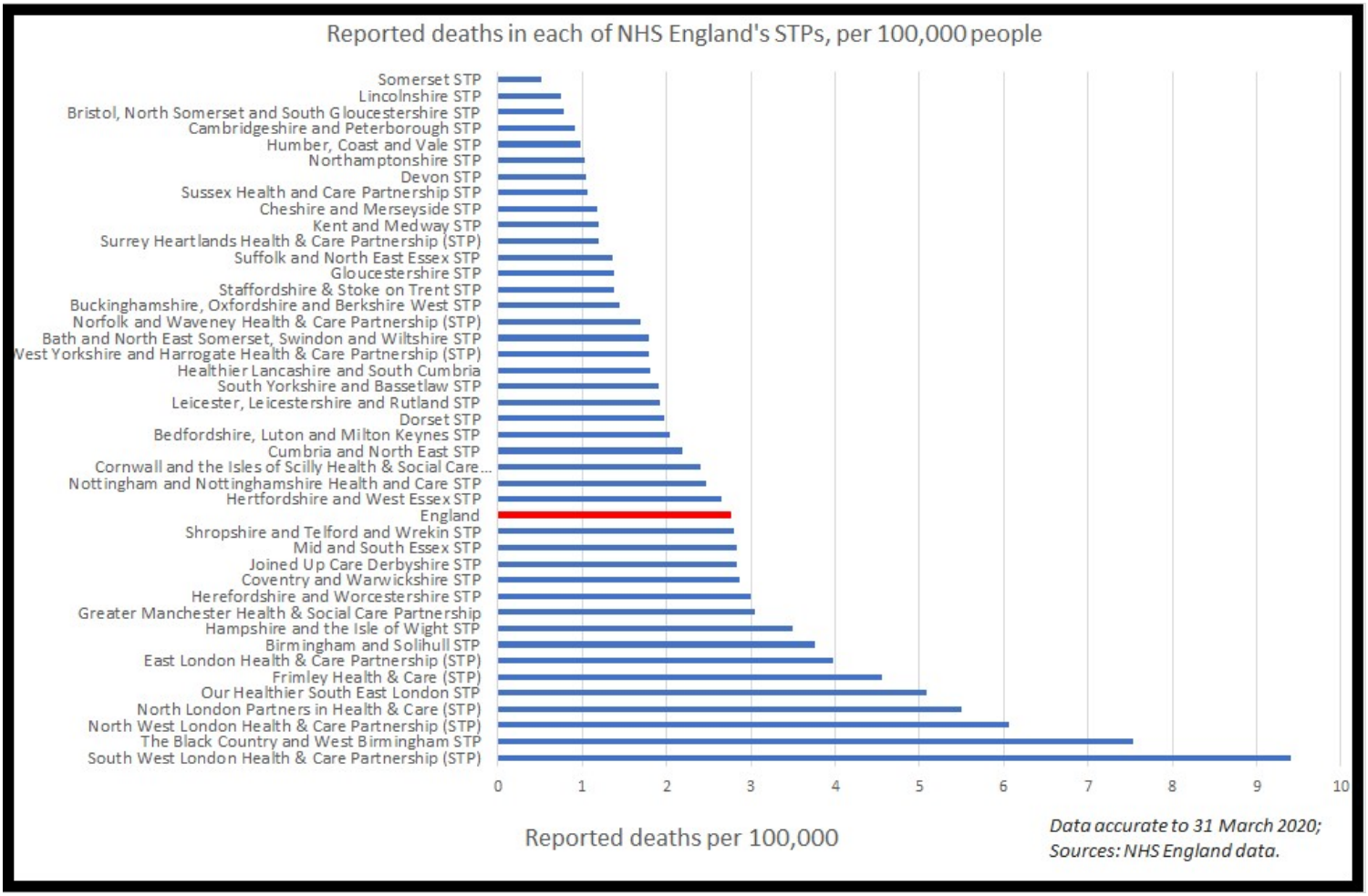


Figure 12: More deaths in SW London STP footprint than any footprint in England
https://www.hsj.co.uk/news/coronavirus-mortality-mapped-10-trusts-have-seen-at-least-30-deaths/7027212.article

It is, for what ever reason a hot spot for infection and at present, more patients are actually losing their lives to this awful disease here, than any other place in the country.

This must be taken as a very clear evidence that we need more, much more, in terms of Acute Hospital provision. **We must retain all five of the existing major acute hospitals**, in fact it suggests that we need more, in order to provide safe healthcare to the people in the area. The high density population and its cosmopolitan culture is presumably a factor. This is unlikely to change. **We will continue to need more healthcare into the future.**

We evidently need more beds. We currently have even fewer beds per 1,000 people, than the rest of the UK. The UK has fewer hospital beds than practically every other developed country in the world.

The IHT proposal is to have a significantly fewer hospital beds than we have now, and the local population is predicted to rise faster than most others - in part due to the proportion of young people in the area.

On 17th March this year Sir Simon Stevens was interviewed by Ex Sec of State for Health, Jeremy Hunt, in his role as chair of the House of Commons Health and Social Care Committee:
https://parliamentlive.tv/event/index/cced67ec-c445-4698-a21b-7d9ff8a01354 (14 minutes onwards)

Simon Stevens said that, at that time we had only:

98,000 adult acute beds in the country
3,700 Critical care beds in England
5,000 Critical Care beds the whole of the UK

Simon Stevens said he hoped to free up one third of the general and acute beds to enable 30,000 to be available for Covid-19 patients.

He calculated that 4% of Covid-19 patients will need a hospital bed, 30% of those will need Critical care. He said that the worst case scenario was an 81% infection rate

When Mr Hunt asked if we will have enough Intensive care beds, Stevens said,
"no health system in the world will cope if the situation is unmediated."

KOSHH say that the UK would be better able to cope with such a crisis in we had been at least as well provided in terms of hospitals, doctors, beds and equipment as other comparable countries.

At the start of the Covid-19 pandemic, the UK had just 6.6 critical care beds per 100,000 of the population.
France had 11.6
Italy 12.5
Germany 29.2

This should be a matter of shame to the Government and the NHS.
Such unpreparedness is unforgivable, especially in the light of finding produced in the CYGNUS report.
It is probable that 1,000s of further excess deaths could be due to the exceptionally low level of NHS provision.

An NHS procurement chief has been quoted in the HSJ:
https://www.hsj.co.uk/im-losing-the-will-to-live-god-help-us-all-despair-of-nhs-procurement-chief/7027266.article

"I'm losing the will to live, god help us all".

The article says that:

"**Gowns for front-line staff were not included in the national pandemic stockpile of personal protective equipment, procurement chiefs have been told."**

"A spokesman for Public Health England confirmed to *HSJ* that gowns were not currently part of the pandemic influenza stockpile, but said the body was implementing a commission to include them. PHE is responsible for maintaining the stockpile, while its contents are determined by the DHSC."

"NHS Supply Chain and the Department of Health and Social Care have come under fire in recent weeks for delivering inadequate and unpredictable supplies of both PPE and "business as usual" stock to trusts. This has intensified with the deaths of two consultants from covid-19 and reports of staff being unwilling to treat patients without World Health Organisation-compliant PPE."

It is inconceivable that the IHT plans have not already been totally and permanently abandoned, most particularly in light of the current situation.

An article by an ICU doctor in the Guardian quotes him as saying:
https://www.theguardian.com/commentisfree/2020/mar/03/icu-doctor-nhs-coronavirus-pandemic-hospitals

> "So let's look at some statistics: it is likely that more than 30% of the whole UK population will get Covid-19 – it may be as high as 60% in some estimates. Most will have no or mild illness but maybe one in seven will need hospital admission. Of patients in hospital up to one in five may need ICU care – that would be an unprecedented number of people admitted to ICU. As many as one in 50 of patients known to have Covid-19 may die from it".

The covid-19 pandemic has throw into sharp focus the consequences of many years of cuts, downgrades and closures. Many people were experiencing undue waits, prolonged suffering and even death, even before the current crisis.

SW London is being disproportionably affected by this virus.

We clearly need more health provision not less.

The consequences of these cuts are now going to shake the country to its core.

Thousands may die and mortuaries could overflow.
https://www.gmb.org.uk/news/major-risk-life-government-must-stop-plans-shut-aes-and-icus

The closure of A&Es

The IHT plan proposes the removal of A&E departments from Epsom and St Helier hospitals and suggests substituting them with a single A&E, with an UTC at each hospital site.
They further propose to that all admissions to the one remaining A&E would be via blue-light ambulance or GP referral.

KOSHH do not believe that the loss of one or both A&E departments is safe for patients. Having only one A&E instead of two, moves emergency services further away from most patients, in all emergency situations. This would mean longer journey times. Longer journey times have been found to cause increased patient harm and death.

Requiring that all patients (other than Maternity) wait for an ambulance even if they happen to live close to the department or were able to make their own way to the hospital would create further unnecessary delay.

The increased demands that this arrangement would put on the ambulance service, is likely to extend wait times even further. Patients are already waiting unacceptably long times, even in the case of heart attacks and strokes.
https://www.bbc.co.uk/news/health-51269618

Dr Tajek Hassan, when he was president of the RCEM, said (emphasis added):

> "These plans that are emerging via different routes, if true, are potentially catastrophic and will put lives at risk. A number of systems around the country are already at breaking point and this will be the straw that breaks the camel's back for them. Others that previously were just coping will become unstable and unsafe. of these STP plans that were then emerging, where emergency department closures in one third of STPs will put lives at risk- they are potentially catastrophic."
>
> "The multitude of problems facing emergency departments – including the worst four-hour performance for a decade, staffing shortages and overcrowding – will not be solved by closing units and removing beds. Patients will not simply disappear."
>
> **"On this basis STPs will certainly not create sustainability and any transformation that results will not be safe, effective or patient centred."**
>
> http://www.nationalhealthexecutive.com/Health-Care-News/emergency-department-closures-in-one-third-of-stps-will-put-lives-at-risk

The Health Service Journal reports:
https://www.hsj.co.uk/quality-and-performance/record-collapse-in-emergency-care-performance/7026655.article

> "Performance against the four-hour A&E target in December overall slumped to a record low of 79.8 per cent"

…and even more shockingly:

> "Performance for major "type one" emergency departments in December hit a record low of 68.6 per cent."
>
> "There were a record 4,185 trolley waits for quarter three 2019-20."

NHS medical director Stephen Powis said:

"A&Es across the country are currently very busy – in 2019 we treated over a million more patients in our A&Es than the previous year. The continued increase in people's need for care underlines the need for **more beds** and staff across hospital and community services."

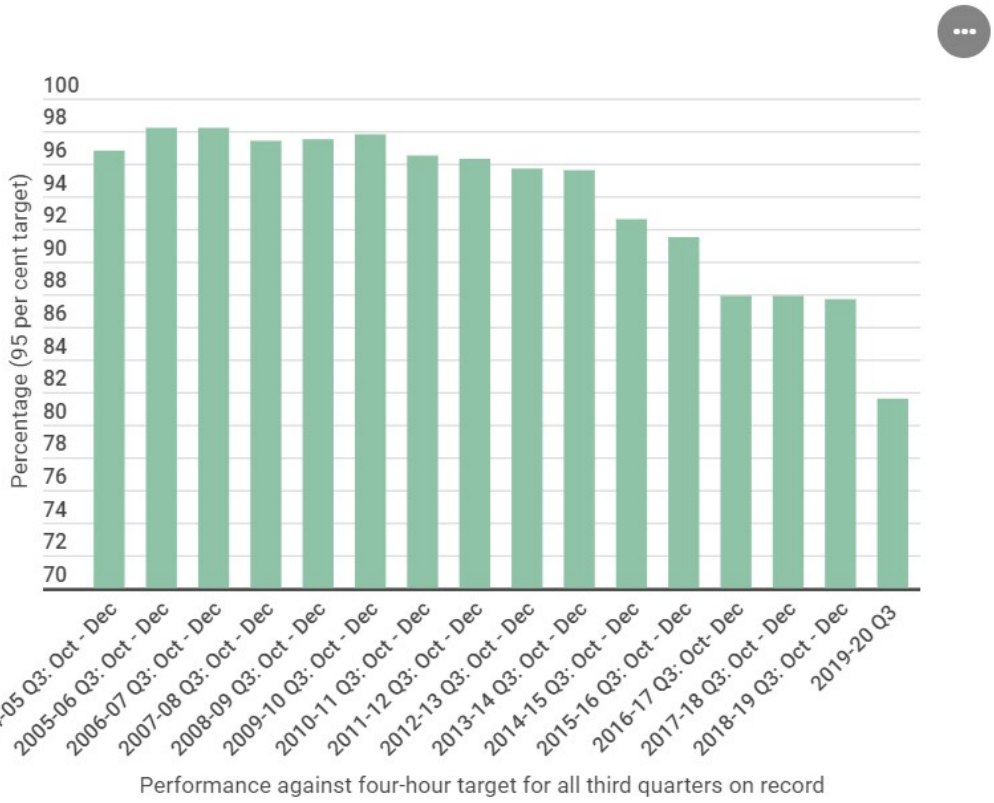


Figure 13: HSJ Report into performance against four-hour target for all third quarters on record
https://www.hsj.co.uk/quality-and-performance/record-collapse-in-emergency-care-performance/7026655.article

Journey times

KOSHH have repeatedly asked for evidence that a plan which involved increased journey times would improve outcomes. No such evidence has been forthcoming.

A BMA study into The relationship between distance to hospital and patient mortality in emergencies concluded that:

> "Increased distance was associated with increased risk of death This association was not changed by adjustment for confounding by age, sex, clinical category or illness severity. Patients with respiratory emergencies showed the greatest association between distance and mortality. Increased journey distance to hospital appears to be associated with increased risk of mortality. Our data suggest that a 10-km increase in straight-line distance is associated with around a 1% absolute increase in mortality."

The IHT figures on journey times however, are not in line with realty. They drastically underestimate the increased time it would take to reach one acute site as opposed to the current two.

The calculations take no account of the ability to make connections between various forms of transport and no account of waiting times.

South West London and the surrounds of Epsom hospital suffer from extreme traffic congestion for large parts of the day. It takes very little to bring the whole area into logjam where even a blue light ambulance would have trouble fighting its way through.

To move acute facilities further away than they currently are will make journey times very much worse and cause much longer journey times than those estimated by Mott MacDonald.

IHT have admitted in several of their public consultation meetings that the research into travel times needs to be reviewed.

It is unclear how a proper consultation can take place when such an important consideration has not been dealt with effectively.

Sir Bruce Keogh, government health advisor, laid out his plans to reduce the number of number of major A&E to between 40 and 70, at a time when there were 140 A&E departments in England. This number bares a striking synergy with the number of Footprint areas set up in 2015 by Simon Stevens. It could suggest that the longer term plan might be to have one major acute hospital in each Footprint. This could result in St Georges becoming the only Acute hospital in South West London as suggested by Dr Paul Hobday in an article in "Pulse".
https://www.theguardian.com/society/2013/nov/12/plan-a-and-e-crisis
http://www.pulsetoday.co.uk/views/opinion/nothing-will-hit-nhs-gps-as-hard-as-the-five-year-forward-view/20009891.article

It is claimed that cuts to acute hospital services could be made if more use was made of GP services.

The number of GPs leaving the service and the low levels of GP recruitment make this increasingly unlikely.

The NHS plans to significantly cut the number of GP surgeries from the then 7,500 to only 1,500 GP Hubs makes this even more unlikely to be successful
https://www.telegraph.co.uk/news/2017/03/16/nhs-plan-7500-gp-practices-become-1500-superhubs-revealed/

The IHT has as its "aspirational model" the Northumbria Specialist Emergency Care Hospital in Cramlington. It is the only example of this type of acute only hospital in England. Its exceptionally bad performance led to front page articles in several newspapers with the headline "The picture that shames Britain."

An NHS whistleblower at the hospital said "centralising A&E care for serious illness and injury in such - "super" hospitals at the expense of other NHS units was not good for patient care". He believed it meant longer travel time for patients and waits for ambulance crews."
https://www.mirror.co.uk/news/uk-news/picture-jeremy-hunts-flagship-hospital-6876036

The Northumbria hospital was also the subject of more than one BBC documentary because of its extreme failure to provide safe and timely provision of A&E services and the long waits for ambulance crews to hand over patients. According to local Councillor the situation has more recently become even worse.

Figure 14: BBC Look North coverage of problems at the Northumbria Specialist Emergency Hospital
https://youtu.be/IdUDrHbO4is

Urgent Care Centres in place of A&Es

The IHT plan is to provide Urgent care centres in place of the current A&Es. In the preferred option both of the current full A&E units would close.

They say that only 1 in 3 patients that attend A&Es, actually need to be there and they could be seen in an urgent care centre. One problem is that no one knows in advance which patients they may be.

This Daily mail article says:
dailymail.co.uk/news/article-2173704/Closed-casualty-units-Shocking-truth-axed-A-E-wards-hour-reach-casualty.html

> "But critics, including many doctors, say the closures are being rushed through – putting patients' lives at risk and depriving the affected hospitals of 'patient intake'. **This means they are likely – as has happened in the past – to lose many of their remaining services**."
>
> "The centres are allowed to handle only the simplest injuries and mild illnesses. An NHS document obtained by this newspaper reveals they are legally forbidden from treating a vast array of serious and life-threatening conditions, including shock, internal bleeding, and most types of broken bones, breathing difficulties, stab or gunshot wounds, heart attacks, strokes and head injuries. Extraordinarily, they are also banned from treating patients suffering from 'severe pain'"
>
> "But replacing A&Es altogether has two glaring drawbacks. First, patients who need treatment that urgent care centres can't provide face long journeys – often after already waiting."
>
> "They can change wound dressings and stitch shallow, but not deep, cuts. They can handle head injuries where there is no sign of concussion or loss of consciousness, minor facial injuries which do not need stitches, fractured collar bones and fingers, and 'minor medical conditions' such as 'sore throats'. But anything more serious is legally ruled out."

Closing A&E and maternity departments means millions of patients will be forced to use existing facilities which are already under great pressure.

The A&E closures mean serious diagnostic errors and untreated conditions are likely to become more common. And some patients now face an hour's journey to reach a full hospital A&E department.

Maternity

The IHT proposal would be to remove maternity care from Epsom or St Helier Hospitals or in the preferred option, from both. They propose that there be just one maternity unit in place of two.

This would mean longer journey times for most mothers in Labour. This will put more mothers and babies at risk of harm or death.

It would make visiting longer, more complicated and more expensive. New mothers need the help and support of families after birth, and family cohesion is enhanced by close and frequent contact at such a time. Longer journey times also extend the time needed for childcare of older siblings.

There appears to have been no equalities impact assessment on the women and children in the IHT plans.

In the IHT Issues paper it is shown that the plan is to cut between 10 and 14 Obstetric consultant posts-(26 currently, down to 12-14 posts)) and cut between 10 and 14 paediatric consultant posts (26 currently down to 12-16 posts).

These are massive reductions, which impact on mothers and children and they form the totality of the proposed cuts in consulting levels as shown on page 15 of the IHT Issues paper
https://improvinghealthcaretogether.org.uk/wp-content/uploads/2019/05/Improving-Healthcare-Together-Issues-Paper-June-2018.pdf

In England infant mortality is increasing and the mortality rate is increasing for poor women.
https://www.rcpch.ac.uk/news-events/news/infant-mortality-rates-extremely-worrying
https://wbg.org.uk/blog/life-expectancy-has-declined-for-the-poorest-women/

The government have called for measures to improve maternity services. This clearly will not be achieved by removing entire maternity departments, forcing longer journey times for women in labour, reducing maternity capacity, decreasing the number of beds and cutting the number of Obstetric and paediatric Consultants in the Trust.

In 2016 there were 382 occasions when maternity units had to close. This figure is slightly higher than the 375 occasions from the year before, and an almost 70% increase on the 225 cases in 2014.

Prof Mary-Ann Lumsden, vice president of the Royal College of Obstetricians and Gynaecologists (RCOG), said (emphasis added):
https://www.theguardian.com/society/2017/aug/08/nhs-maternity-wards-england-forced-closures-labour

> **"**Unit closures may be due to insufficient midwifery, obstetric or paediatric staffs, as well as inadequate capacity….the pressures on maternity services are growing, which could compromise the experience for women and their families. Stretched and understaffed services also affect the quality of care provided to both mothers and babies."
>
> **"If the UK governments are serious about improving the safety of maternity services, these staffing and capacity issues must be addressed as a matter of urgency."**

The Royal College of Medicine CEO said:
https://www.rcm.org.uk/news-views/news/maternity-unit-closures-highlighted-in-new-data/
https://www.independent.co.uk/news/uk/politics/labour-warning-nhs-midwives-england-maternity-crisis-a8509941.html

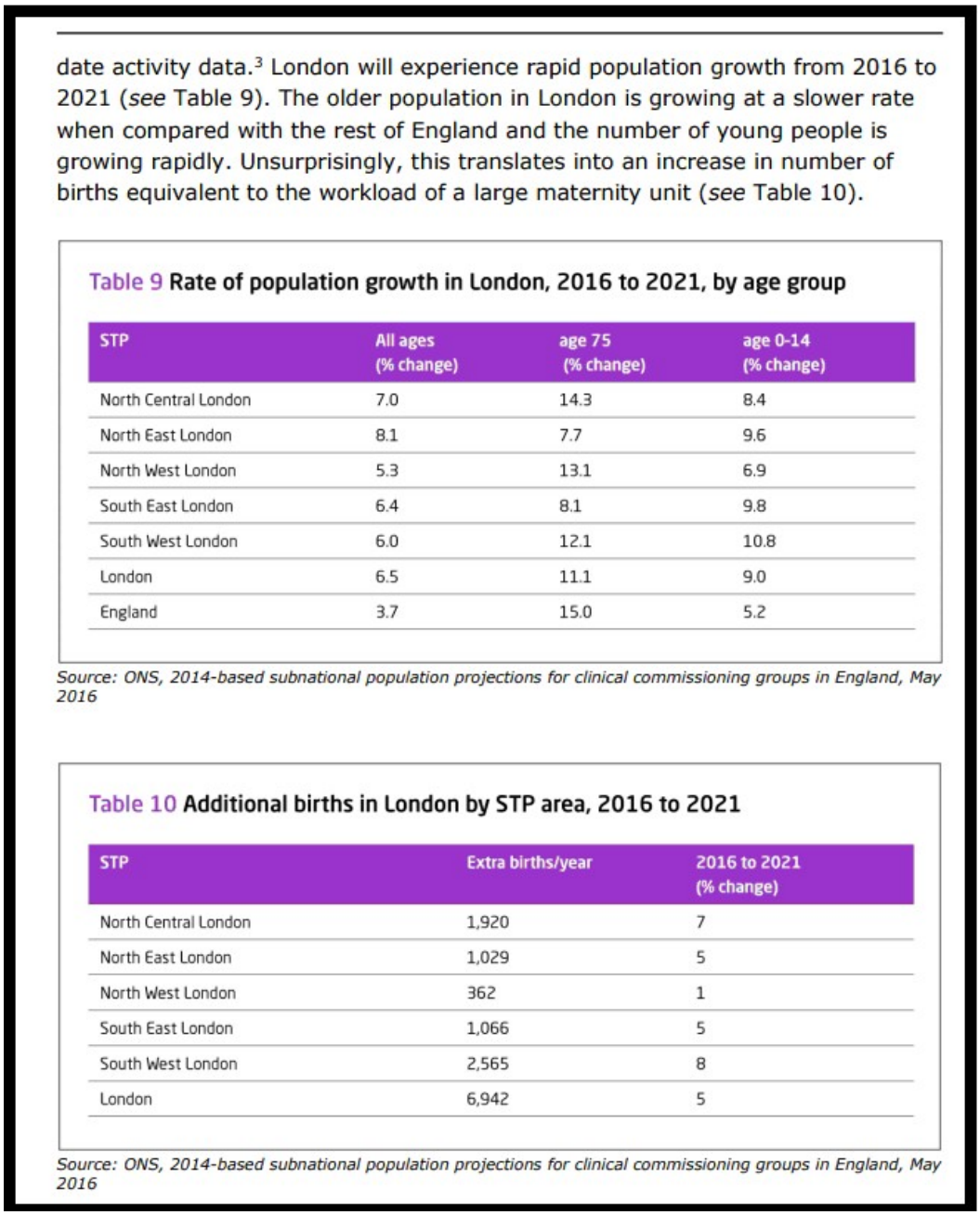
> "We know trusts are facing huge pressures to save money demanded by the government, but this cannot be at the expense of safety. We remain 3500 midwives short in England and if some maternity units regularly have to close their doors it suggests there is an underlying problem around capacity staffing levels."

Cuts in provision of maternity services could potentially increase the incidence of claims made against the Trust. The law gazette says:
https://www.lawgazette.co.uk/commentary-and-opinion/nhs-must-be-helped-to-learn-from-its-mistakes/5068613.article
https://www.womenandbirth.org/article/S1871-5192(14)00058-4/fulltext

> "Total costs to the NHS relating to mistakes made during birth, which can involve the need for life-long care due to serious brain injury, amounted to a staggering £2.2bn."
>
> "The human cost for the individual child and for their family is unspeakable".

The IHT proposal is to cut over half of all current in-hospital maternity services at Epsom and St Helier. Home births are suddenly and inexplicably promoted, in sharp contrast to all previous advice on the advisability or safety of such births. One wonders if this drastic change in policy owes more to the desire to provide less maternity cover and employ fewer staff, than a desire to improve healthcare for mothers and babies.

This could become an expensive option if mothers or babies are harmed. Legal claims against the Trust could be significant.



date activity data.[3] London will experience rapid population growth from 2016 to 2021 (*see* Table 9). The older population in London is growing at a slower rate when compared with the rest of England and the number of young people is growing rapidly. Unsurprisingly, this translates into an increase in number of births equivalent to the workload of a large maternity unit (*see* Table 10).

Table 9 **Rate of population growth in London, 2016 to 2021, by age group**

STP	All ages (% change)	age 75 (% change)	age 0-14 (% change)
North Central London	7.0	14.3	8.4
North East London	8.1	7.7	9.6
North West London	5.3	13.1	6.9
South East London	6.4	8.1	9.8
South West London	6.0	12.1	10.8
London	6.5	11.1	9.0
England	3.7	15.0	5.2

Source: ONS, 2014-based subnational population projections for clinical commissioning groups in England, May 2016

Table 10 **Additional births in London by STP area, 2016 to 2021**

STP	Extra births/year	2016 to 2021 (% change)
North Central London	1,920	7
North East London	1,029	5
North West London	362	1
South East London	1,066	5
South West London	2,565	8
London	6,942	5

Source: ONS, 2014-based subnational population projections for clinical commissioning groups in England, May 2016

Figure 15: Kings Fund Report into London STPs 2017 – P.50
https://www.kingsfund.org.uk/sites/default/files/2017-09/STPs-London-Kings-Fund-September-2017_1.pdf

It can be seen from these charts that the predicted birth rate in SW London is significantly higher than surrounding areas. The report by the Kings Fund says:

> "The predicted increase in the number of births is equivalent to the workload of a large maternity unit."

This evidence alone indicates the folly of removing one or two existing maternity units.
There is evidence that smaller, more local maternity units are safer for mothers and babies.

London is being hit hardest by the Coronavirus, presumably because of the high population density. This clearly proves that London needs a higher ratio of beds to 100,000 people than is needed in other less densely populated, cosmopolitan communities. It certainly can not afford to have less than the average national figure of just 2.5 beds per 100.000 populations. The proposition to take the local ratio down to 1.4 or 1.2 per 100,000 is clearly totally unjustifiable.

Inequalities

In the option to have the only acute faculties at the Epsom Hospital site, the poorer communities which are nearest to St Helier Hospital would be seriously disadvantaged. Life expectancy in these areas is already many years less than that in richer areas. The life expectancy of people in Mitcham is only 76.4 years, Epsom and Ewell is 81.7 whilst in Wimbledon life expectancy is 84.4years. That is a massive 8 year gap. Poverty clearly effects life expectancy and health. Poorer communities use and need acute hospital services more often than wealthier areas and this proposal moves them further away from them. Longer journey times in emergencies are proved to adversely impact outcomes.

The option to have acute services only at Epsom or at the Royal Marsden would significantly disadvantage those who live on the St Helier Estate which surrounds the hospital. The hospital was built to serve the estate. When the estate was built it was the largest council estate in Europe. The hospital is of great social as well as medical importance to the surrounding population. The expense of longer journeys, and the fact that poorer people are less likely to own a car, or be able to afford taxis, results in a disproportionate impact on poorer people.

The Royal College of Paediatric and Child Health say:
https://www.rcpch.ac.uk/news-events/news/infant-mortality-rates-extremely-worrying

> ”Social inequalities are a major factor in causing infant deaths, and the risk of a baby dying dramatically increases with the level of maternal deprivation. Infants are more than twice as likely to die in England and Wales if they are born into a poor family rather than a wealthy one, and the gap is widening.”
>
> “We welcomed the announcements on improvements in maternal and newborn services in the NHS Long-term Plan but need to see these delivered urgently. We also call for a reversal of the cuts to public health budgets which have slashed health visitor numbers. Babies and their mothers deserve better.”

Any reduction in the number of maternity units is medically unjustified and appears to contradict calls from the government to improve maternity services. it is clearly especially dangerous to mothers and babies to remove maternity care from a poorer area.

The option to have the only acute facility at St Helier would have an unfair impact on the older population that lives in the more affluent, but older people who live in Epsom. They would have much longer journey times and would need A&E more frequently than younger people as they are more likely to have existing health conditions making them require A&E and Emergency care more frequently than the young and healthy do.

The Marsden option moves acute services further away from almost everyone. Meaning longer journey times which have proved to cause more harm and deaths. The traffic in the area is congested and this is likely to get worse when the new school on the old Sutton Hospital site vastly increases its intake over the next 4 years. It has poor transport links and is situated in one of the richest parts of the catchments.

In the IHT Issues paper it is shown that the plan is to cut between 10 and 14 Obstetric consultant posts-(26 currently, down to 12-14 posts)) and cut between 10 and 14 paediatric consultant posts (26 currently down to 12-16 posts).

These are massive reductions, which impact on mothers and children and they form the totality of the proposed cuts in consulting levels as shown on page 15 of the IHT Issues paper
https://improvinghealthcaretogether.org.uk/wp-content/uploads/2019/05/Improving-Healthcare-Together-Issues-Paper-June-2018.pdf

All three options in the IHT proposal would seriously disadvantage large groups of people.

Epsom and St Helier hospitals were built to serve the communities that surround them. There have been no significant medical or financial reasons to change the status quo and put so many special groups at even greater disadvantage.

Increased demand on the Ambulance Service

The IHT PCBC says that patients will only be admitted via blue light ambulance or GP referral. This was not made clear to the public in the Consultation.

This would means that even if a patient lived very close to a single acute facility they would still have to wait for an ambulance to arrive. Evidence shows that this could mean a considerable delay
https://www.bbc.co.uk/news/health-51269618

Such an arrangement would put considerable extra demand on the already overstretched ambulance services and would delay treatment to patients.

We note that the plan is to transfer patients who need acute care from other hospitals to a single acute centre. It is also intended, after a few days, to discharge patients or move them out of the single acute centre to a non acute or hospital.

Patients who then deteriorated again, would have to be moved back, via ambulance, to the acute centre.

This again this would put considerable additional strain on the ambulance service.
There is no evidence that you have not detailed how the necessary extra ambulances and trained crews would be provided, nor have you offered any comments on the feasibility of such a proposal from the LAS or South East Coast Ambulance.

The Trust now runs its own patient transfer operation. In addition the Trust also spends a significant sum on Taxis to move patients; this can not be sound financial model.
With three sites such costs seem likely to increase.

Has this been costed?

Transfer of care

One of the reasons given in the IHT Consultation for the necessity for change is that at the moment, some patients, occasionally have to be moved about the site of St Helier Hospital by ambulance. They say that such moves are not good for patients. These moves are only required when certain lifts break down, for a small number of patients.

They also claim that one of the benefits of having the only acute centre at the Marsden is that cancer patients will not have to be moved to other hospitals if they require intensive care.

Under the IHT all patients requiring acute care will be moved by ambulance.

All patients in a non acute hospital who develop a need for acute care would need to be moved, not to another part of the same hospital, but to another hospital, many miles away - By ambulance.

All patients who are still sick, but not deemed to need further critical care, would be moved, not to another part of the same hospital as occasionally happens now at St Helier, but to a different hospital, many miles away, by ambulance.

Transferring patients from one hospital to another is inherently risky.

At the Royal Marsden it was found that poor transfers of care left "Babies dying in agony"
The argument for having acute services at the Marsden is to avoid such avoidable deaths.
It is not a reasonable augment for forcing such transfers onto all other patients.
The Royal Marsden has enormous private income, it has a bigger percentage of private income than any other UK hospital. Perhaps the Marsden hospital should consider building their own intensive care unit. This would perhaps allow Epsom and St Helier Hospitals to retain their acute services and their acute hospital status.

An article in the Health Service Journal says a report by Professor Stevens into was buried. It had been "commissioned following the death in 2011 of Alice Mason which led to a coroner's warning in 2013 about the safety of the shared care model and fears it could lead to future deaths. Alice's father Gareth told *HSJ* his daughter died in "terrible agony""

Professor Stevens said:
https://www.hsj.co.uk/policy-and-regulation/investigation-the-cancer-service-failings-covered-up-for-years/7025313.article

> "the conclusions "should have been shared openly". "It was, and remains, a matter of concern to me that Cally Palmer, as the national cancer director, is also the chief executive of the Royal Marsden," he said. "This creates an obvious conflict of interest." He said she should step aside from the decision making and there should be an open discussion of the findings."

An article on the same report in the Telegraph said "The document was never made public, however, and yesterday (Wednesday) the former NHS medical director for London, Dr Andy Mitchell, accused the head of NHS England, Simon Stevens, and Cally Palmer, England's National Cancer Director, of suppressing its publication."

Ms Palmer is also the chief executive of the Royal Marsden NHS Trust.

Dr Mitchell told the Health Service Journal (HSJ): "I can't imagine any other individuals having the power and influence to be able to stop this report moving forward."

https://www.telegraph.co.uk/news/2019/06/19/nhs-accused-burying-damning-child-cancer-report-patients-unnecessarily/

None of this gives any confidence in the IHT plans to have a single acute specialist hospital, which by its very nature requires frequent transfers of care.

It is ironic that in solving the risks to Marsden patient inherent in the current need to transfer acutely ill patients to other hospitals, the preferred option will expose all Epsom and St Helier patients to the same risks.

The Preferred Option

The Preferred Option in the IHT proposal is to remove all acute services from both Epsom and St Helier Hospitals and downgrade them to a newly coined title of "District Hospital". This title alone appears designed to confuse and give false assurances.

It would co locate all of the acute services for the whole area with the Royal Marsden in Belmont. It would be built into and the buildings would become one with the Marsden and have many share facilities.

KOSHH strongly opposes this option, as we do the only other two options on offer by IHT

The Marsden model has not proved safe with regard to transfer of care.

Frequent transfers of care are inherent in the Acute Hospital Model and this carries risk and would cause massive extra demands on the ambulance service.

KOSHH strongly opposes this option, as we do the only other two options on offer by IHT

The Marsden model has not proved safe in regards to transfer of care.

Frequent transfers of care are inherent in the Acute Hospital Model and this carries risk and would cause massive extra demands on the ambulance service.

Private income at the Royal Marsden

The Royal Marsden receives a higher proportion of its income than any other NHS Trust in Britain. It is close to breaching the 49% now allowed under the H&SC Act 2012. According to an article in the Sunday Times They continue however to strive for more. They report that Royal Marsden's Documents say:

> "To go beyond £100m *[of private patient income]*, we envisage an appropriately separated private model," suggesting that it may hive of some of its facilities, or leave the NHS altogether. If the latter, it would still treat NHS patients but as a private contractor."

See "NHS dash for private Cash":
https://www.thetimes.co.uk/article/nhs-in-dash-for-private-cash-nsnjw569z

This raises serious concerns that should the only acute facilities in our catchment area be co-located with the Royal Marsden there is the risk that some time in the future they might be privatised in line with the Royal Marsden's stated position. This would leave the area with no acute services at all.

Two tier system

If our only acute services were co located with the Marsden there is a danger that the NHS would be adversely impacted by the demands of the private patients in the Royal Marsden. There is a danger that private patients could be prioritised over NHS patients. We fear the demand on of the private patients would further adversely impact on the vastly reduced number of beds in the IHT plan.

In the PCBC page 222 it claims as a benefit of the plan "Sutton option identified through working with RMH", and an emphasis on "synergies", It later says it would like to expand ESTH's private work, picking up work from the Royal Marsden. (see pages 256 and 266)
It could be seen as part of the clear desire to have vastly increased the number of private rooms?

This process has been framed as a three CCG initiative. All six local CCGs have very recently become amalgamated. It looks rather as if this hurried plan is a last ditch attempt to push the plan through before the other SW London CCGs, who might have a different take, are involved in the decision.

KOSHH believe that before a significant change in NHS provision is proposed, a public consultation on this change should first take place.

The first proposed change is the plan to reduce the number of acute hospitals in SW London from the current five, to four or three.

This has not been the subject of a consultation and we believe it should have.

The IHT Consultation is on WHICH hospitals should cease to be major Acute Hospitals, not on whether any of their options are acceptable or desirable.

We suggest that that should have been the subject of a SECOND Public Consultation, if the first produced the result that the three CCGS wanted.

Page 2 of the SW London STP acknowledges that Councils were meant to be part of the planning.
In the eventuality despite each Council holding regular Health Scrutiny Meetings, and in addition holding Joint Health Overview and Scrutiny Meetings for four years, the councils were denied access to the PCBC until a day before the start of the Formal Consultation Process. This must contravene procedure.

https://www.swlondon.nhs.uk/our-plan/our-plan-for-south-west-london/

The primary decision to reduce the number of acute hospitals from five to four or three was not consulted on. We believe that such a major change to NHS provision has to the subject of a Public Consultation. We believe the law was broken

The Consultation is flawed, the documentation is vague, designed to conceal and mislead.

The PCBC ignores most of the recommendations of the Clinical senate's report.

The IHT proposals offer up no real evidence of benefit, either medical or financial.

Every time KOSHH has asked for evidence, as opposed to opinions, we have been told about the success of concentrating treatment for fractured neck of femur and stroke care onto one site - Not a real indicator for the success of concentrating all acute services onto one, smaller, more remotes site with fewer "senior clinicians" and many fewer beds has ever been given.

Figure 16: KOSHH asking ESTH Trust Board for evidence in Nov 2017
https://youtu.be/-wV_fSBUIYQ

Figure 17: KOSHH asking IHT Board for evidence in Jan 2020
https://youtu.be/Gk62XdoEHSY

Planned public meetings were cancelled for the last two weeks of the 12 week period. Thus effectively shortening any real Consultation or "listening" opportunities and

When the Prime Minister announced the money for "six new hospitals", in Parliament the Shadow Sec of State for Health, John Ashworth, said "Its not new money to build a new hospitals at Epsom and St Helier, its money to downgrade both of them". This is self evidently true.

Figure 18: Prime Minister's Misleading statement and Jon Ashworth challenge in Parliament
https://youtu.be/skZ4aDWKmuo

The money now "on offer" to the Trust is variously described as £500m and £511m. On questioning at a public meeting this was challenged and the IHT team confirmed that it is in fact £511m. £11m is a considerable sum of money to be omitted from most documentation.

The Option Appraisal fails to follow the mandatory obligation to present a "do minimum" option, a "business as usual" option and "lower costs option, on the short list of options evaluated.

Why has this not been done? Is this a valid Consultation without that option?

The plan clearly states that the existing two hospitals will be refurbished and used for 85% of patient interactions. The option to refurbish and extend the current sites as required has not been costed or considered.

Plans to significantly extend St Helier were advanced, architect's drawings were made, the project costed at £219m and presented to the public in 2009. After an election in 2010 the incoming Government gave assurances that the money would still be available. The whole scheme was then mysteriously withdrawn.

KOSHH believe that a similar project could be a cost effective solution to estate problems at both Epsom and St Helier.

Financial savings could be made by avoiding the additional costs of planning and building a whole brand new major hospital.

The costs of any new building always rise significantly above the original estimate, they can even double as can be seen at Canterbury Hospital.
https://www.hsj.co.uk/finance-and-efficiency/cost-of-hospital-building-project-doubles-in-18-months/7026896.article

New builds can be devilled by unforeseen costs and teething problems, thus increasing costs There is a danger that costs could increase to such an extent that a new acute hospital could be started but not be completed or that the Trust could not afford to staff it. It would not be the first instance of such a disaster for the population and the NHS.

A main element of the clinical case is lack of available Consultants, or so called "Specialist doctors". It costs £250,000 to train a doctor. It would cost £5.5 million to train 22 doctors. Considerably less than the £511m that the IHT proposes to spend. Fast tracking junior doctors to consultant posts could solve the Consultant staffing levels much more cheaply than building a third facility.

Many of the savings claimed seem spurious.

Savings from new technology are claimed despite these savings being available if on existing sites if the investment were to be made.

Savings are claimed based on existing staffing levels not on the cost of full establishment.

Other cost disadvantages not attended to in the PCBC include:

- increased estate required to be maintained
- diseconomies of scale in co-ordinating care over three sites instead of two
- additional costs and inconvenience to staff, patients and visitors
- changes needed to public transport arrangements

The Trust now runs its own patient transfer operation. In addition the Trust also spends a significant sum on Taxis to move patients; this can not be sound financial model.

With three sites such costs seem likely to increase. There is no evidence that this been costed.

KOSHH/KOEH objections to IHT proposals

As detailed above, the NHS was found not to be meeting statutory requirements for Emergency Preparedness Resilience and Response (EPRR) as many as four years ago. Cuts implemented since 2016 have further degraded the ability of the NHS to cope with any epidemic like the current COVID-19 pandemic.

The implementation of **any** of the IHT proposals can only make matters even worse.

It is astounding, and perhaps speaks volumes about the real motivation of those pushing this pernicious plan through, that given the evidence of COVID-19, the biggest crisis the NHS has ever faced, that the IHT Consultation **has not already been terminated and its plans permanently scrapped.**

Implementation of the IHT plans would not be acceptable even if the risk of pandemic didn't exist, as evidenced by the following assessments, published well before the discovery of the Covid-19 virus.

The Kings Fund report on STPs in London says these *STPs:*

> "**include plans to reduce hospital use and in some cases the number of acute hospital beds. Our analysis suggests that reductions in hospital use on the scale proposed in London's STPs are not credible".**

Recent analysis by the Royal College of Emergency Medicine – looking at hospital use right across the UK – also suggests that **the NHS is likely to require additional beds this year to achieve safe bed-occupancy levels and hit waiting time targets.**

The King's Fund report also says:

> **"Recent reductions in beds appear to have been made at the expense of increases in bed-occupancy levels** (the proportion of hospital beds filled) both nationally and in London (see Table A2 in Appendix A). Bed-occupancy levels in London have been at 87 per cent or above since 2005/6. The **current level of bed occupancy in London – at around 90 per cent – is unlikely to be sustainable and leaves the health system vulnerable to fluctuations in demand, with a knock-on effect on its ability to handle emergency admissions and discharge patients** (**Department of Health 2000).** Patients face increasing risks once bed- 45 occupancy rates exceed 85 per cent, including risk of acquiring health care acquired infections (Kaier et al 2012; Bagust et al 1999)."
>
> **"There is little evidence to suggest that efforts to date to shift care into the community have significantly reduced costs of care – and in some cases the evidence suggests that community-based care can increase costs (Imison et al 2017; Nolte and Pitchforth 2014)."**
>
> **"…reductions in hospital use on the scale proposed are not credible. Heroic efforts will be needed simply to manage rising demand with existing hospital capacity"**
> "At 85 per cent bed occupancy, our analysis suggests that **London may need 1,600 additional acute and general hospital beds by 2021 to keep up with demographic changes alone."**

Summary

The Public Consultation on the "Improving Health Together" programme presents three Issues as creating a case for change and proposals that its proponents (Sutton, Merton and Surrey Downs CCG Governing Bodies) claim will address those issues in such a way as to "Improve Healthcare" for the local population.

The effect of implementation of any of the proposed three options for change would be to reduce the number of Major Acute Hospitals in SW London from 5 to 4 or 3.

This is a terrifying proposal given the inability of the NHS to meet its key targets, let alone the fact that we are experiencing the catastrophic COVID-19 pandemic.

Such a reduction in capacity is a major change to services and should have been the subject of a formal Public Consultation as a mandatory pre-requisite to any Consultation on how to reconfigure the remaining services.

The "Improving Healthcare Together" Consultation imposes that reduction in Major Acute Hospitals as a fait accompli.

The Clinical Senate's report on the Pre-Consultation Business Case raised many criticisms, very few, if any of which seem to have been acted upon. Additionally, the PCBC document which was not published at the time that the Clinical Senates wrote their report, DID contain an additional option which would have kept acute services at BOTH existing sites – therefore the Clinical Senates' report was based on an inaccurate version of the Pre-Consultation Business Case which was later presented.

A preferred option was declared before the start of the Consultation, signalling that the outcome of the Consultation has been pre-determined.

Attendees at so called listening events were repeatedly told that the Consultation was "not a referendum", reinforcing the impression that the outcome had been predetermined.

It is claimed that any of the three options on offer will improve healthcare, but no independent peer-reviewed evidence has been adduced to substantiate such a claim, despite the fact that KOSHH has requested its provision by the Trust Board and by the CCGs from the very start of the plan's development.

The "Issues" that are claimed to necessitate the proposed changes are defined as relating to "Estates", "Clinical" and "Financial".

Estates:

The proposed options are completely at odds with the "Estates" case for change.

It is claimed that the age and condition of the Trust's buildings are too expensive sustainably to maintain, and yet all three options propose their continued use for 85% of the current patient interactions.

The "Estates" case for change is therefore completely unsustainable.

Clinical:

The "Clinical" case for change rests on an assertion that they cannot recruit enough consultants to provide fully staffed services at both sites.

Information provided in the "Issues Paper" (table on page 15) shows that the single-site proposals would lead to a **reduction** in the number of consultants employed of between 15 and 27.

If the dependent population cannot be adequately served with 94 consultants, it is not credible to claim that healthcare can be "improved" with significantly fewer consultants.

A shortage of consultants has been declared for many years. It was identified as an issue in 2012 when BSBV was being proposed, and yet action to train and promote doctors in the understaffed specialisms could and should have been in train when it was first identified.

Such action would not only resolve the shortage, it would also improve recruitment and retention.

Reducing the number of consultant posts will have the opposite effect.

It will also degrade, not improve, healthcare.

Financial:

From the very start of the plan's development KOSHH has asked repeatedly for an independent appraisal and costing of all work needed to make the Trust's existing premises fit for purpose, and indeed such a promise was made at a public meeting, by Daniel Elkeles, the Chief Executive of the Epsom and St Helier Trust at their so-called "estates event" on the 19th of march 2016.

No such appraisal and costings have ever been presented.

The decision to exclude the possibility of continuing to provide all current services at all the current 5 major acute hospitals cannot be justified without that information.

To assert that any option other than the status quo will help resolve financial issues without providing any kind of comparative data to back it up is clearly indefensible and unsustainable.

Other Issues:

It is necessary to point up other problems with the proposals and the way the Consultation has been conducted. These are: Flawed Process, Population Growth, Bed Provision, Health Inequality, and Travel Times.

Flawed Process:

Insufficient time was permitted for the examination and consideration of the proposals and the detailed case for change prior to the launch of the Formal Consultation.

The Pre-Consultation Business Case was not made available to the public, or to inform any of the individual Council and joint Health and Overview Scrutiny Committee until two days prior to the launch of the Consultation.

The start date of the Consultation was announced only 2 days in advance.

Published information and public presentations and consultation documents were designed to encourage enthusiasm for a shiny new facility, while failing to highlight adequately the fact that the number of major acute hospitals and the number of employed Consultant doctors would be cut.

The unwarranted exclusion of an option to retain all services at all 5 major acute hospitals was an abuse of process.

The Consultation Questionnaire avoided any mention of a possibility to retain all services at all the hospitals, and did not mention Queen Marys Hospital for Children at all.

The "Easy Read" Questionnaire included no mention of the proposed removal of all Acute services from Epsom and/or St Helier Hospital.

At the public "Listening" events the responses to questions from the public were routinely evasive, disingenuous and failed to provide any specific answer to the thrust of the many challenging queries raised.

On several occasions, when attention was drawn to major flaws in their arguments and gaps in their information, they retreated by saying the plan was a work in progress.

The Consultation should not have been launched until all the necessary work had been done.

Population Growth:

IHT claim to have catered for population growth up to 2025/6, whereas the new facility is highly unlikely to open before then, and the name of the review is Improving Healthcare Together **2020-2030.**

As pointed out in the Clinical Senate Report, the IHT plan is presented as covering 2020 to 2030.

The claim that an increase in the number of beds from 1048 to 1052, i.e. 4, would be sufficient to meet the population's needs after the next 5 years of population growth is laughable, and they do not propose to provide that many REAL beds in any case.

The local population is forecast to rise from 2016 to 2039 by 24%.

It is self-evident that capital expenditure of ~£500 million should provide sufficient capacity for much more than 10 years, let alone just 5.

Bed Provision:

An increase of 4 beds is patently inadequate to meet the needs of the growing population over the coming decade and beyond, even if the "phantom beds" they suggest would be provided by other, already struggling hospitals in the surrounding area were a viable possibility.

There is in fact a reduction, not an increase in the number beds the plan proposes to provide.

If the proposed facility were to be built at the Royal Marsden, bed numbers would reduce by 50.

If built at St Helier the reduction would be 81 beds

If built at Epsom the reduction would be 205 beds

Those missing beds will allegedly be provided by other Trusts who are already unable to provide sufficient beds to meet their own dependent population's needs.

Even before the COVID-19 pandemic NHS bed occupancy levels were well above safe levels, and any reduction in beds will clearly lead to increased hospital acquired infections, delayed admissions and deaths.

Health Inequality:

Epsom and St Helier Hospitals were sited to serve specific populations.

Epsom Hospital serves an area with a higher average age than does St Helier.

Removal of acute services from Epsom Hospital will cause its older population difficulty and delays in travelling when they require acute services, as they frequently do.

St Helier Hospital serves a poorer, less healthy and relatively disadvantaged population.

They rely on having easy, fast, and affordable access to their local hospital.

Under the preferred option, the acute facility would be closest to a population which is wealthier, and which enjoys longer life expectancy than most of those who rely on Epsom and especially St Helier.

It is self-evident that implementation of any of the options on offer would increase health inequality.

Travel Times:

IHT have claimed that, wherever it may be built, over 99% of the population served by the Trust will be able to reach the proposed facility within 30 minutes if they travel by ambulance or car on a Tuesday morning between 7am and 9am.

This is demonstrably untrue. Even without delays caused by accidents, roadwork's, burst water mains etc such journey times will hardly ever be as short as 30 minutes for most people and would frequently be significantly longer.

For example, travel from St Helier to Epsom Hospital to attend Trust Board Meetings starting at 9:30 has almost always taken much longer than 30 Minutes. The same is true for journeys in the opposite direction.

IHT also claim that the journeys of at least 49.1% of people travelling by public transport to any of the proposed sites will take 30 minutes or less – this is patent nonsense as any local resident who uses public transport will attest.

Many people are at least 10 minutes walk from a station or bus stop, especially the older members of the population. On top of that there is typically at least a 10 minute wait between buses, longer out of business hours, and it is often necessary to wait longer when buses are full such as during the rush hour.

On top of all this is the disgraceful claim that it is acceptable for up to 18.8% of the population relying on public transport to have to wait even longer than they do at present with both hospitals continuing to provide all services.

In any case, what matters in the case of an emergency is not the average journey time, it's the likely longest journey time, such as at 8:15 on a busy Monday morning.

CONCLUSIONS

The IHT proposals should be rejected in their entirety because:

- Their claim that concentrating the acute services of two existing major acute hospitals, onto a single site will improve healthcare, is unsupported by **any** independent peer reviewed evidence
- IHT claim that continuing to use their current premises is unsustainable and yet say they will continue to use them for 85% of their current activity
- They plead a shortage of Consultants while proposing to **reduce rather than increase** the number employed, having failed to take remedial actions since at least as long ago as 2012
- They claim to be increasing, albeit by a negligible number, the number of beds to be provided – while a significant number of those beds will allegedly be provided by other Trusts who are already unable to provide sufficient beds to meet their own dependent population's needs
- They have not properly addressed health inequality issues
- They have presented false information on the impact on travel times
- They have issued dangerously misleading information to the public about their proposals
- The Consultation documents and the IHT Presentations failed to clearly outline the serious dis-benefits of the proposals
- They have not included the option of maintaining and improving the status quo
- They have not provided a comparative analysis of the costs and benefits of the status quo versus their 3 allowed options
- Implementation of any of their proposals would cause harm and excess deaths
- Implementation of any of their proposals will exacerbate the current inability of the local NHS to cope with an epidemic such as the current COVID-19 pandemic, or indeed whichever crisis may strike next.
- **It is scandalous that the Consultation has not been cancelled given the current COVID-19 pandemic.**

KOSHH call on the IHT Programme Board, all involved CCGs, Councils, MPs, NHS England, The Secretary of State for Health and Social Care, and the Government to:

- **Abandon permanently all plans to downgrade Epsom Hospital, St Helier Hospital, or both of them, by removing their essential acute services.**
- **Keep all A&E, Maternity, Paediatric, Intensive Care, Emergency Medicine, Emergency Surgery, Coronary Care and Cancer Care on all current sites**
- **Cease all NHS land sales**

We call on them to protect, maintain and improve all existing services at St Helier, Epsom, Croydon, Kingston and St Georges and retain all five Major Acute Hospitals we now have in South West London.

To proceed with a dangerous plan such as this, despite the overwhelming evidence available that this will cost lives is reckless and dangerous in the extreme, and those responsible can, and will be held to account for their actions.

Report prepared by and on behalf of the Keep Our St Helier Hospital (KOSHH) and Keep Our Epsom Hospital (KOEH) Campaign – an organisation of volunteers who are dedicated to protecting the vital services on which we all rely in this part of South West London and Surrey.

Keep Our Epsom Hospital *

koeh.co.uk

Keep Our St Helier Hospital *

koshh.org