Statement by the KOSHH (Keep Our St Helier Hospital and Keep Our Epsom Hospital Campaign) to

"Improving Healthcare Together 2020 to 2030" Committees in Common 3rd July 2020

Please note. Quotes by IHT will be printed in Blue.
Questions by KOSHH will be preceded by a bullet and printed in bold.
We will require answers to our questions, preferably during the meeting as would be expected at a public meeting were it not for the current restrictions due to Covid-19

The KOSHH (Keep Our St Helier Hospital and Keep Our Epsom Hospital) Campaign opposes the plan to close or downgrade Epsom Hospital or St Helier Hospital or both hospitals.
There have been too many such plans over the years and they have cost the public a huge amount of wasted money.

IHT spent a significant amount of time and public money promoting their proposals. Glossy broachers were produced in huge numbers, newspaper adverts were paid for by IHT and many press articles were published,
Public and private promotional meetings in expensive venues were paid for and Consultants were employed.

- **How much has this exercise cost IHT so far?**

We demand that both Epsom and St Helier remain as major acute hospitals in the communities they were built to serve.

There has been no evidence of any medical or financial improvement to be gained from consolidating all acute services on a third site.

The plan is financially and medically flawed.

Any suggestion that the Consultation has yielded broad support for the IHT (Improving healthcare Together) plan is un-evidenced and unwarranted.

KOSHH on the other hand has a many thousands of signatures unequivocally opposing the plans and they continue to increase.

Recent events have thrown the pre existing shortages in the NHS, locally and nationally, into sharp relief. It has become even more evident that we need more hospital services, more beds and more staff.

We do not need more cuts, more closures, more downgrades or more privatisation of our NHS.

Background

The so called "Improving healthcare Together" plan evolved from one devised by the Epsom and St Helier in response to the STP (Sustainability and Transformation Plan) in 2016.
see https://www.swlondon.nhs.uk/our-plan/our-plan-for-south-west-london/

The 2012 Health and Social Care Act removed from the Sec of State for Health the legal duty to provide an NHS. This responsibility was passed onto a QUANGO called NHS England.
In 2015 Simon Stevens, head of the NHSE, divided England into 44 Footprints or areas. Within each area, Hospital Trusts, CCGs (Clinical Commissioning Groups or chief local NHS budget holders) and local Councils were instructed to work together and devise cuts in NHS spending.
Nationally cuts of £23 billion were required.
The SW London Footprint was ordered to cut a massive £1 billion in local NHS spending.
Many cuts in treatments and medications have already been made but the major proposed cut in SW London was to reduce the number of Major Acute hospitals from five to four or three.
St Helier and Epsom were identified as the first most likely casualties, Kingston and Croydon were at some risk and St Georges was stated to be the "only fixed point".

An acute hospital was defined as one which provides major A&E, Maternity, Peadiatrics, Emergency Medicine, Emergency Surgery, Cancer Care and Corinary Care,

The Epsom and St Helier Trust under its new CE Daniel Elkeles, - not the CCGs who denied any responsibility for the plan and not the councils who jointly rejected the plan - put forward their plan to remove all acute services from Epsom and St Helier and offered did they? a single, smaller, more distant substitute facility in their place. This plan proposed fewer beds and doctors. An expensive, unproductive "Engagement" exercise was held and then abandoned without explanation.

Three of SW London's six CCGs then put forward what was essentially the same plan, under the euphemistic named "Improving healthcare Together". Far from this plan being the result of joint working between all the Trusts, CCGs and Councils in SW London, the Trusts now disclaimed responsibility for the plan and referred any questions to three of the six CCGs; and the local councils were denied any details of the plan right up to the point where it went to a Public Consultation.

The Consultation

The Consultation was initially planned to be very short, especially considering the importance of the decisions being made.

It was effectively cut short due to the Corona Virus lockdown and all Public Meetings and public questioning ended.

Responses by interested parties were made more difficult by the lockdown.

No general allowances of extra time were offered, although we understand that Merton Council was given an extension.

We believe that the Consultation should have been cancelled and, if necessary, re-run after the lockdown ended AND time was taken for Covid lessons to be learned.

Prior to the Consultation IHT sent their plan to The Clinical Senate for approval but they did not allow the local Councils or the public to see it.

The IHT team claim to want openness and transparency. There can be no justification for this refusal to publish or share details with bodies who should in fact have been party to the planning.

Bizarrely, IHT did publish the Clinical Senate's response to the draft plan, which contained 93 concerns of the Clinical Senate to the Draft Plan.

Among other matters the Clinical Senate expressed concern that the plan was called Improving Healthcare Together 2020 to 2030 but projected bed numbers and population increases were only made up to 2025.
They said that projections really should be made up to 2030, especially given that was actually part of the name of the Plan.

The Senate said that the option to maintain the status quo should be included. i.e. keep Epsom and St Helier Hospital as major acute hospitals.

They were concerned that the draft plan did not make a strong case that improvements in clinical care would be made, or that the newly invented "District Hospital Model" would work effectively.

The plan that was eventually consulted on failed to implement most of the changes recommended by the Clinical Senate.

The detailed plan was not made available to the public or even the local Councils until the start of the Consultation process giving no time to study it before responses were asked for and made.

The local Councils Joint Health Scrutiny Committees, who are responsible for

examining any proposed changes to health provision, asked repeatedly for sight of the detailed plans over many years but they were repeatedly refused.
Despite holding regular separate and joint Council Health Scrutiny meetings over a lengthy period of time, they had no access to the written plan. They only gained access to the plans at the same time as the public at the start of the consultation.

This is surely at odds with the original STP instructions that the plans should be a joint piece of work and it denied local Councils the ability to carry out their legal duty to protect health provision for the public in their constituency.

The Public Consultation was poorly implemented.
The literature and presentations lacked transparency and were deceptive and misleading. The perceived advantages were spelled out in detail and the losses were NOT made clear.
Many people were misled into thinking that a third site would be an additional acute facility, believed that we would gain an additional A&E and that acute services would remain at Epsom and St Helier Hospitals.
People did not understand the difference between and an A&E and an Urgent care centre and it was not made clear that maternity and other acute services would no longer be available at Epsom and/or St Helier.
Bed losses and Consultant cuts were not made clear.
The Easy Reading publication was particularly misleading and disingenuous. None of the proposed loss in services was identified clearly.

The fact that admission to the new facility would be via ambulance or GP referral was obfuscated.

Journey times were totally unrealistic and the impact on patients of longer journey times was not adequately dealt with.

Many opinions regarding the claimed improvements in outcomes were offered but little or no actual evidence to substantiate those claims was provided despite frequent requests by KOSHH and others.

No evidence that fewer beds were required due to modern medical practices was given and this claim is at odds with the evidence of increased A&E 4 hour wait periods, Cancer wait times and ambulance delays that already exist, which and would only be exacerbated by further cuts.

The increased pressure on ambulance services caused by the ruling that admissions would be via ambulance and the vast increase in hospital transfers, especially under the "preferred option" of siting the new unit in the Royal Marsden hospital, was not dealt with.

The intention to discharge patients from a new acute unit after a very few days or transfer them, by ambulance, to a "District" hospital as soon as possible, was not revealed, nor was the fact that patients would need to be transferred back again if

they relapsed. This would mean a huge increase in the number of transfers of the sickest patients.

Transfers of patients between the Royal Marsden and other SW London Hospitals has a very poor track record of bad transfers of care that may have resulted in deaths of children.
The former NHS England medical director for London, Andy Mitchell spoke out about "burial" of major report by NHSE into deaths caused by such transfers.
He said

"There was a pervasive influence from the top that has stifled this report and this issue." But "To be shunted around London in circumstances when children are critically ill is not the best way to manage them."

"The fragmentation of the service as it currently exists does not facilitate the best quality of care in terms of the patient experience. It raises questions as to whether it is sufficiently safe."

The IHT proposal is being packaged as "centralising" and "consolidating" whereas in reality it is "fragmenting" with the very sickest patients to be transferred in scarce ambulances between hospitals as soon as they are out of an "acute" phase. With the possibility of needing to be transferred back if they deteriorate.
The proposed restructuring would require patient transfers of all patients except Royal Marsden patients.

It is evident that the Royal Marsden needs it own acute facilities but that should not come at the expense of provision of all acute services at Epsom and St Helier.

There is the suspicion that the IHT plan is primarily intended to provide acute services for the Marsden and the large number of private patients it serves.
There is also the suggestion that the Marsden, in its quest for increased private income, could choose to become a private hospital, in which case all acute services in the area would be lost to NHS patients

Unanswered questions

There are many questions that have been asked at public events but have never been answered, and many new ones have emerged since the advent of Covid-19.

It would seem appropriate for answers to be supplied at this meeting and taken into account before any decision is made.

- **What legal authority does the three CCGs have as they have been replaced by an integrated Care system which itself has no legal authority?**

- **How many jobs will be lost to fund the extra depreciation costs , interest costs and capital charges associated with the £500m additional investment proposed?**

- **Why has the option of improving the investment in existing buildings and services not been properly considered and or costed?**

- **Local people have been repeatedly told the NHS cannot afford to go on as it was. That view is being rethought in the light of COVID-19, which has exposed the lack of capacity and resilience of the NHS. Why cannot time be granted to rethink these plans until after we have learned the lessons of COVID-19 properly?**

- **If costs change and plans have to be modified, will changes be consulted upon, scrutinised and approved by public and stakeholders or is this intended to be the last decision that will be made at a public body?**

- **How will cutting the numbers of consultant and junior medical staff, qualified nurses and a whole A&E department improve access and quality of local services?**

When the IHT plan was first put forward the public were reassured that 85% of current services would remain at Epsom and St Helier Hospitals.
This was repeated in the glossy literature produced by IHT and at every Public Meeting and Consultation Event.

However, in the IHT plan most of the beds remaining at E&STH (Epsom and St Helier Trust) were said to be for the rehabilitation of patients discharged from the acute centre but not fit enough to be discharged home or into Care. It was said, By Daniel Elkeles, that these would be mainly elderly people.
There would be very limited medical care, no resident consultants and no doctors onsite overnight.

The Seacole Centre, Headley Heath, which is closely linked with E&STH, has recently been developed, at great expense, to offer rehab services.

If there would be less requirement for rehabilitation beds at E&STH, all acute services are removed, Outpatient services are "A thing of the past" as reported by Sarah Blow, and vast amounts of any remaining outpatient interaction will be "delivered virtually"

- **What services make up the 85% of current services that will still be provided at Epsom and St Helier Hospitals?**

- **Or are both hospitals now even more certain to be closed?**

- **What EVIDENCE do you have that consolidating acute services and moving them further away from most people, improves medical outcomes OR saves money? There is much evidence to the contrary.**

- **How can it be safe to place the <u>only</u> acute services in the area into the heart of the Royal Marsden which treats many immune suppressed patients, especially when some acute patients will carry infections, and further infectious diseases, epidemics and pandemics are expected?**

<u>Beds</u>

Simon Stevens CE of NHS England, The BMA, The Royal College of Emergency Medicine, The Kings Fund and many others have said that we need more acute and general hospital beds not less; and that far too many have been closed in recent years.

https://www.theguardian.com/society/2019/jun/19/hospital-bed-cutbacks-have-gone-too-far-nhs-england-boss-simon-stevens-says

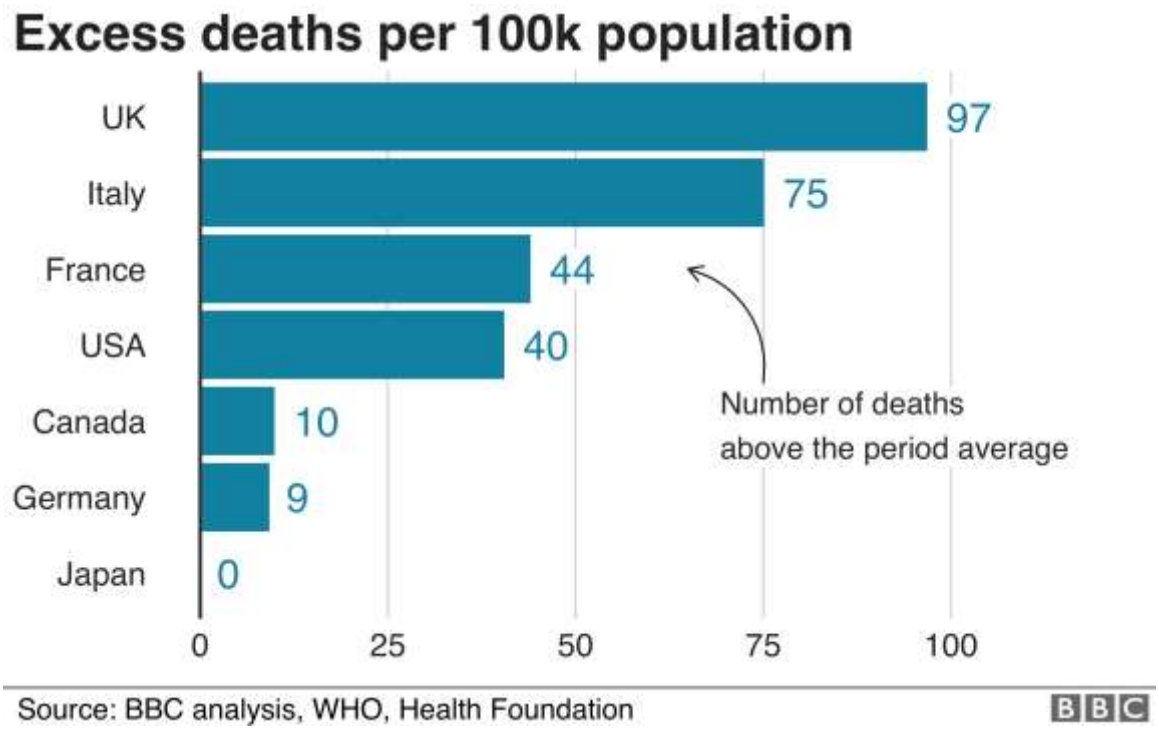
According to the KINGS Fund the number of hospital beds for general and acute care has fallen by 34 per cent since 1987/88.

https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers

We have fewer hospital beds and fewer doctors per capita than most developed countries. We have many fewer Intensive Care and Ventilator beds too. The dire consequences of this chronic shortage have been highlighted by the Corona Virus Crisis.

Great Britain has suffered more deaths from Covid 19 per capita than most other countries in the world.

https://www.bbc.co.uk/news/business-53222182



Thousands have died in care homes and in their own homes, untreated and uncared for having been discharged from hospital or never admitted.

Care home provision was previously problematical and it is certain to decrease as a result of Covid 19. Care workers are likely to be harder to recruit too.

How can it possibly be justified to cut the number of beds from the current 790 acute and critical care beds available at Epsom and St Helier Hospitals to a scandalously low 387 when it is clear to all that this will result in more deaths under normal circumstances and many more in any future emergency.
How can cutting beds be contemplated when even in "normal" circumstances it would certainly mean even longer waits for A&E, even higher bed occupancy levels, an increase in waiting lists, a huge increase in patient harm and many more than the already routinely high number of excess avoidable deaths?

One of the chief justifications for the consolidation of services onto one site instead of the current two was the lack of Consultants.

Daniel Elkeles CE of E&ST told KOSHH that Consultant recruitment was no longer a problem. That had been resolved. It was now middle grade doctors that were hard to recruit.

- **Which of the above statements is true?**

- **How much substantive effort has been made to recruit Consultants and/or middle grade doctors?**

KOSHH comments on the document

Improving Healthcare Together 2020 to 2030
Review of the impact of COVID-19 on the clinical model
Emerging Findings
10 June 2020

https://improvinghealthcaretogether.org.uk/wp-content/uploads/2020/06/COVID-briefing_10.06.20_FINAL.pdf

Quotes in blue italics
KOSHH questions in bold

1. Aim of the paper

"The Trust and Clinical Commissioning Groups are continuing to reflect upon the impact of
COVID 19 in terms of operational performance, patient care and experience, and they will continue to review the likely impact of COVID-19 as further local, regional and national evidence becomes clearer"

KOSHH think that there are many lessons that need to be learned from the Covid crisis.

We think that the whole IHT plan should be abandoned in light of the chronic under provision of the local and the national NHS which has been brought into sharp focus by the crisis. It is unlikely that this will be the last such crisis. The cuts envisaged were never a good idea but it is now inescapably apparent their implementation would cause predictable harm and deaths, and that it would be reckless to proceed with them.

It is evident to us that this recent experience should cause such major rethinking that adherence to any part of the current plan would be unjustified.

If major reorganisation is needed a whole set of new proposals that increase provision should be developed and consulted upon.

2. Context: Improving Healthcare Together 2020 to 2030

"integrating services across the combined geographies via Health and Care models and out of hospital initiatives"

Failures and shortages in Social Care provision have long been evident. They have been increasingly under funded and are largely privatised. Many care homes are likely to cease to exist after Covid-19.

There is no evidence that Social Care will be able to fill the gap left if even more hospital services are cut.

- *"developing and enhancing district hospital services at Epsom and St Helier Hospitals;"*

The proposals are that all acute services be removed from Epsom and St Helier, that A&Es should be replaced by GP or Nurse run Urgent Care Centres, that no Consultants should be resident at either hospital, no doctor cover should be provided overnight, that Outpatient Clinics should be increasingly "virtual" and now it seems likely that the remaining inpatient (rehab) beds will no longer required given the development of the Seacole rehab Centre.

- **In precisely what ways would Epsom and St Helier be developed and enhanced as a "District Hospital"?**

"consolidating Epsom & St Helier University Hospitals NHS Trust (ESTH) major acute services to enable clinical standards to be met."

The Clinical Standards referred to are comparatively new and are in regard to Consultant numbers. We ask again

- **Is there still a shortage of Consultants or is it more junior doctors that are hard to find?**

- **How much substantive efforts have been made to recruit Consultants and/or middle grade doctors?**

"This model was developed and detailed through 2018-19, including refinements in response to feedback from patients, clinicians and regulators (including the London and South East Clinical Senates).

This was reflected in the pre-consultation business case, published in January 2020"

The Clinical Senates made 93 recommendations, the most important of which were not complied with.
IHT failed to include the option to maintain the two current hospitals in the PCBC.
They continued to use population projections up to 2025 in the PCBC and not to the recommended 2030, despite calling them selves IHT 2020 to 2030.
This will have had an impact on the required bed numbers, although that would not have excused to plan to cut already low bed provision by about 50%.

"Since consultation closed in April, Surrey Heartlands and South West London CCGs are considering the feedback from consultation and are developing a decision-making business case (DMBC) which will be considered on July 3 2020"

CCGs had questionable legal authority. The local CCGs ceased to exist earlier this year and have been replaced by Integrated Care Systems. They too have no legal status.

- **How is it possible for an organisation which no longer exists, and which never had any legal status, to make such a critical decision affecting the health and lives of so many people?**

3. Context: COVID-19

"Since this model was developed, the NHS has had to radically change to respond to the global COVID-19 pandemic.
Nationally, this has included:
creation of emergency capacity (e.g., NHS Seacole Hospital and NHS Nightingale Hospitals)"

Nightingale Ward configurations were deemed an efficient way of dealing with large numbers of (infectious) patients with low numbers of staff.

IHT claim that they have too few medical staff but they want to provide more single or private rooms.

- **With too few staff, not enough funding and too few beds how can single rooms solve the problem?**

The Nightingale Hospitals were hardly used, and we are told that the NHS was not overwhelmed.

- **Why then were patients discharged home or to Care Homes to then die of Covid with little or no medical care and others with Covid symptoms were never admitted and died at home?**

- **If the NHS was not overwhelmed, why were so many time-critical diagnostic services and clinical treatments deferred?**

The Seacole Centre at Headley Health has been created very quickly and a great expense to the public, even requiring the re installation of basic services.
It is apparently intended to be a rehab facility.

- **Who is responsible for running the Seacole Centre and who holds the budget?**

The Seacole Centre can deal with a huge number of patients in need of rehab.

- **Is it intended that the Seacole Centre obviates the need for the proposed rehab beds at Epsom and St Helier Hospital if/when acute services are removed?**

- **If so, what percentage of services would remain at E&STH hospitals, would it still be 85% of current services?**

Other changes brought about by Covid *were stated as being*

"Reduction in emergency attendances and cancellation of elective work."

With two major acute hospitals under one management there could be the flexibility in a crisis to temporarily have one Covid hospital and one non Covid hospital that could still deal with most of the A&E and elective work.
Not forgetting of course that we also have Queen Marys Hospital for Children and SWLEOC as additional options in a crisis.

Such flexibility would not be available if we only had one acute facility in the area.
Plans to consolidate must be reconsidered in light of recent experience.

"enhanced discharge -low numbers of medically fit for discharge patients in beds."

- **Covid will cause many Care Homes to close. This will have an impact on the ease of discharge. Has this been considered in the plans?**

"Given the impact of this crisis, we have reflected on whether this will require substantive changes in the proposed clinical model and how we might explore these further as plans evolve."

- **If substantive changes to the plans are required, can they be considered to be substantially the same proposal and, if not, should they not be replaced with different proposals which should be the subject of a new consultation?**

4. Impact of COVID-19 on ESTH

As discussed earlier having two acute hospitals, a children's hospital and SWLEOC all under one Trust provides the opportunity for much more flexibility than if we had just one acute facility.
If the two existing sites had been properly maintained or if they were refurbished or rebuilt then the ageing buildings would not be an ongoing problem.

The "staffing challenges" E&STH faced during the crisis would have been much worse if the massive planned cuts in staff had already been made.

More reasons to abandon the IHT plan.

"The estate cannot adapt to meet the challenges of a pandemic."

"Limited critical care capacity at St Helier Hospital requiring Level 3 critical care to move to Epsom Hospital.
COVID-19 required an increase in Level 3 ITU beds from 7 to 38. This was not possible at St Helier Hospital (the current Level 3 site) due to the layout of the hospital and physical limitations in the oxygen supply.
Therefore, the Level 3 site was moved to Epsom Hospital, requiring the conversion of the standalone South West London Orthopaedic Hospital into a Level 3 unit."

- **Does the IHT para above not prove that having two acute hospitals, a stand alone Orthopaedic hospital and a Stand Alone Childrens Hospital demonstrate that the Trust did have the flexibility to meet the challenges of the pandemic?**

- **Why was Epsom not the current Level 3 critical care site if it is better provided?**

- **When and why did the Trust cease having two level 3 critical care sites?**

- **How were the Trust able to close many wards during the crisis and in addition move the Children's wards into the main hospital if space is at such a premium?**

"Insufficient single rooms meaning potentially infected patients could not be isolated. Less than 20% of the beds at Epsom and St Helier are in single rooms. This was insufficient to isolate an average of 50 suspected COVID-19 patients each day at the height of the recent peak, requiring these patients to be cohorted on wards meaning patients cannot be effectively separated (especially in specialist clinical areas). Moreover,the lack of patient bathrooms and bed spacing also meant the Trust could not meet infection control standards for those patients on wards. The Trust also had to forego gender separation to protect patient safety."

This really is special pleading. In no film of hospitals here or abroad did they show critically sick Covid patients in single rooms.
In all cases they appeared to be cohorted on wards and were not separated. There was clearly not enough staff even in much better provided systems than ours to deal with patients in single rooms.
Most of the very sick patients were in induced comas on ventilators. They needed

no separate toilets or bathrooms. Nor did they need to be separated by sex, they were not mobile and they did not even have visitors.
Staff had very little PPE so infection control was practically non existent anyway.
Looking at the floor plans of the Nightingale hospitals they did not appear to have any toilets at all let alone private rooms.
Single rooms are not staff efficient; most Trusts seem to favour small wards where a nurse can see most patients.
Is the real driver to provide more single rooms for private patients rather than to improve efficient care?

"E&STH's people are stretched and under pressure, leaving limited capacity to respond to a crisis."

A single site with fewer beds and staff would not improve the ability to respond to a crisis or the flexibility required to separate the infectious from those needing other care.

Hospital staff in all hospitals all across the world was, and still are, under extra pressure because of Covid. They all worked above and beyond their normal limits.

E&STH would not have fared better with fewer beds and fewer staff and less flexibility with just one acute centre shared with the Royal Marsden Hospital.

"The model of care can be different with less time in acute hospitals".

This means more risk with the sickest patients being transferred between hospitals. See earlier comments re Marsden poor transfer of care and risks involved.

- Have no lessons been learned despite inquests and suppressed reports on the deaths of children and poor transfers to and from acute hospitals?

"Significant numbers of outpatient appointments can be delivered virtually. *The crisis has forced all acute trusts to rethink outpatient care. ESTH has found multiple ways of delivering clinics differently without face-to-face interaction; it is currently running 500-1000 virtual outpatient appointments a week."*

- ***Does this mean that the promised reassurance of 85% of current services still being provided at E&STH will not be honoured?***

"Patients can be discharged from acute care more quickly*. The crisis has required record numbers of patients to be discharged. This has accelerated significant improvements in patient flow and length of stay, supported by our out of hospital system."*

Discharging patients from hospital with the Covid-19 has spread the infection into Care Homes and caused extra deaths from the disease.

Patients discharged too early from acute care are likely to be re admitted and sicker than previously.

Out of hospital care is likely to be seriously negatively affected by the Covid crisis, Staff will have left and funding is unlikely to improve.

5. Implications for the clinical model

"The clinical model focused on care in 2025 onwards whereas it may take several years before the policy is firmly established around meeting future pandemics and future requirements."

Given that IHT choose the name IHT 2020 to 2030 it should have been focused on care until at least 2030, and you were advised to do that by the Clinical Senate who need to approve your plans.
This is a shameful failure where you do not to plan beyond the expected START of your proposals.

"However, a joint letter from The Health Foundation, The King's Fund and the Nuffield Trust to the Health and Social Care Select Committee1 discussed five main challenges:

- *appropriate infection prevention and control measures will need to be available;*
- *we need to understand the full extent of unmet need;*
- *The public fear of using NHS and Social care needs to be reduced;*
- *looking after and growing the workforce; and*
- *wider reconfiguration and improvement of the health and social care system."*

These all seem like worthwhile objectives that can be best met by retaining the two major acute hospitals we have now. Improving the buildings where required. Having more investment in a fully publicly provided NHS, more hospitals not fewer, better funding for maintenance and rebuilding if required, providing more beds not cutting them, more well paid and respected staff with proper PPE. We also obviously need more investment in a publicly provided Social Care system with properly paid and respected staff.

"More staff are needed in key areas. The shortcomings exposed, especially in ITU, demonstrate a need for more medical staff in each unit. This would be eased by consolidating services to create critical mass and greater staffing resilience, with greater scale enabling better staff-to-patient ratios."

There is no evidence that reducing the number of acute hospitals, cutting the number of beds and employing fewer staff whilst serving a fast growing and ageing population will "Improve" anything medically or financially.
It defies logic to suggest such an option.
A far better solution would be to refurbish the two hospitals we have now and to make concerted efforts to recruit the staff needed. Train up and promote more junior doctors to fill any vacancies and increase bed provision to ease demand for beds required by A&E.
Two sites must be cheaper to maintain and staff than three and people can continue to reach emergency and maternity services in a safe and timely way.

"The district and out of hospital models needs to work more closely together.
COVID-19 demonstrated that the @Home service and Health and Care services can do more to support the district hospital model. In the PCBC, we expected this to be developed over the next five years COVID-19 has accelerated a lot of this work and we are now working in a more integrated way"

It is becoming more and more evident that the proposed new model of care will not be up and running until at least 2025. It is lamentable that population and bed projections were only made up to that expected start date. This is extremely short term planning of an essential, life critical service.
We believe that it is foolhardy in the extreme to make substantial cuts in hospital provision BEFORE out of hospital systems are fully up and running and proven to be ready to fill any gaps. This is clearly not going to happen before 2025.

6. Implications for future capacity

"In response to feedback from consultation, we had already planned to extend the planning horizon for IHT to 2029/30. Extending the bed modelling to this date means we required c.14 more beds than were included in the PCBC. This increase will be included in the DMBC".

As we previously stated the Clinical Senate advised that IHT needed to make its projections and bed modelling to 2030 in accordance with its name.
IHT chose to ignore this and proceeded to Consultation with modelling on beds and population growth to 2025,
Projection to 2030 should have been incorporated in the plan, as required by the Clinical Senate, before launching the Consultation
We already have extraordinarily low bed numbers per capita, among the lowest in the developed world. This and the low numbers of doctors per capita has proved to be disastrous in the Covid 19 crisis. More people per capita have died of Covid in England than in any G7 country and possibly more than in any country at all.
Our normal provision in this, the sixth richest country in the world, falls woefully short of what we need and have a right to expect. Given the impact of the pandemic on the economy, it is now obvious that we cannot afford not to expand and improve NHS provision.

The fact that even Simon Stevens, CE of NHS England, now says we need more beds not fewer and
that the local population is predicted to increase by 20 to 25% by 2035 it seems extraordinary that even now you are only proposing increasing the number of beds you plan to provide by 14 in the proposed DMBC.

This would still result in a significant cut in bed numbers!

This is a shameful and dangerous suggestion.

10s of thousands of excess deaths have occurred in England, in part due to lack of beds, staff, and PPE. Have no lessons been learned?

In a quite extraordinary leap you then go on to say that

"We are currently exploring scenarios where c. 20% additional capacity is required and confirming whether all three potential SECH sites could accommodate this if emergency response was needed. This would be on the basis of further crisis response requiring additional capacity over and above the capacity needed for the clinical model; this would therefore need separate funding if it was needed. The outcome and implications of this review will be included in the DMBC.

This will all continue to be reviewed as part of any subsequent business cases which will revisit capacity requirements and the lessons from COVID-19."

Suddenly you are talking about a 20% increase for which you would need more money!

This is surely another major deviation from the case as Consulted on.

7. Implications for the design of hospital buildings
"COVID-19 has given us lots of insights into how hospital buildings need to be
designed to make them better able to cope with diseases like this in the future.

- ***Buildings need to be designed to be flexible****. To respond to future pandemics and/orchanges in demand, healthcare buildings need to be designed so they can be used in different ways, including providing more ITU and/or ventilated capacity when needed.*

- ***Where possible, access and clinical spaces should be separate/segregated****.*

Planned spaces should, where possible, be separate from emergency spaces, to support separation of patients- and this would be supported by the split of the SECH from the district hospital sites (meaning we could offer COVID-protected environments)

Emergency spaces should also be designed to enable segregation when necessary (e.g., segregating emergency departments in COVID and non-COVID spaces). Departments should, as much as possible, have dual access and egress routes"

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- ***We need greater capacity and staffing resilience to support planned care**. In futurepandemics, we would want to continue more planned care than during COVID-19. Thisrequires better facilities and more resilient staffing, supported by consolidation. The greater separation of planned and emergency care offered by the clinical model would mean we are more able to offer COVID-protected planned care facilities in the future.*

All of these requirements could be met by maintaining the status quo and temporarily reconfiguring services in emergencies. It would have the advantage of being considerably cheaper and safer.

- ***Digital needs to be embedded in the hospital**. To maintain the shift to virtual care,dedicated facilities and systems will be needed alongside clinic rooms for face-to-face care- including the ability to review outpatient/ambulatory patients virtually and for staff to work remotely. Moreover, the facility should maximise the opportunity offered by digital."*

Retaining two acute sites and retaining Queen Mary's Children's Hospital and the Orthopaedic Centre would clearly provide more scope and flexibility to cope with future pandemics and increases in demand.
A single acute site would make provision of a Covid and a separate Covid -free facility much more problematical.
This would be exacerbated by the fact that the Marsden would normally have numbers of immune suppressed patients.
Reducing the number of staff would not improve staffing resilience.
Cutting the number of beds would not improve resilience.
Selling NHS land would significantly reduce the Trust's ability to expand to meet future needs yet this still appears to be planned.
The shift to virtual care is not universally welcomed by many, patients and staff alike.
There is however no reason why investment in IT should not be made in the existing sites.

These areas will be explored further through the business case process as plans develop into more detailed pathway and building designs.
These changes may create a pressure on the cost of any new hospital development, which may require a further case to be made to HM Treasury and the Department of Health and Social Care to ensure ESTH is equipped to respond to future pandemics.

This proposal is moving further and further away from the original proposal and even more expensive than the option to maintain and improve the current hospitals.

8 Conclusion

Our analysis of the impact of COVID-19 on the proposals in the Improving Healthcare Together programme has two conclusions.
Firstly, the need to consolidate acute services in a modern fit for purpose SECH is even more important to do now and remains a pressing priority.

This case has not been made. In fact it is weaker now than ever.

Secondly, we may need to alter the design of both the SECH and the district hospitals to reflect the learning from COVID-19 and we will be requiring ESTH to do this as part of the outline business case that it will submit following our decision on the location of the SECH.
The Trust and Clinical Commissioning Groups will continue to review the likely impact of COVID 19 as further local, regional and national evidence arises. This interim assessment paper will be used as one of the pieces of evidence that CCG Governing Bodies will consider as part of their decision-making process.

The proposal has now moved so far from the original as to be almost unrecognisable. The only real constant is the intention to follow the STP and reduce the number of acute hospitals in SW London from five (Epsom, St Helier which includes Queen Marys Childrens Hospital, Kingston, Croydon and St Georges) to four or three.
This requirement fits neatly with Sir Bruce Keoghs plan to reduce the number of acute hospitals in England from more than 200 to between 40 and 70. This would leave approximately just one per Footprint or STP area. This plan was only parked for fear of a political backlash just before an election
https://www.theguardian.com/society/2014/nov/30/accident-emergency-overhaul-shelved-warning-political-backlash

The original IHT plan was presented to the Clinical Senate, was the subject of a formal Consultation. Many members of the public read the plans and attended Public Meetings.
KOSHH and others held public meetings in response.

The proposals were responded to by Councils, Medical Consultants, members of the public, several unions, Trades Council, political parties, numerous other organisations and KOSHH.

These proposals have now moved very far from those presented to the Councils and the public. So far in fact that they are no longer the same plan at all.

The Consultation was based on proposals, a model and costings that are now subject to fundamental change. Hence it is now rendered invalid.

The CCGs that made these proposals had no legal status and now no longer exist.

It was always financially and medically flawed and the Covid-19 crisis has served to throw these failures into sharp relief.

We rely on our NHS leadership to act in the interests of patients and to insist that se5rvices meet patients' needs. The so-called "Improving Healthcare Together" Plan will halve many services, rely on community healthcare initiatives which are not yet established nor proven to work in other areas and is essentially the same as the proposals made by Daniel Elkeles in 2017 which he chose not to pursue..

It would be reasonable now, for a line to be drawn under this failed project and the IHT plan to be withdrawn in its entirety

We call on you to do this and stop the waste of any more public money