Save Whipps Cross hospital campaign Response to 'Healthcare for London Consultation

- **Acute care configuration**
- In our area debate on elements of the proposals have already been rehearsed in a 'fit for the future' proposed reconfiguration. People have demonstrated how profoundly important having a fully functioning acute and general hospital situated within their community is to them. The campaign that sprang up when the future of Whipps Cross as a DGH was threatened had well informed support across the board. This has been reflected in similar responses to the threat to other hospitals. The evidence has underpinned the need for Whipps as a full acute hospital. Any downgrading towards a 'local hospital' configuration would be unlikely to meet the health needs of the community, be unacceptable and in our view unsafe.
- The 'local hospital' model where patients are admitted as emergencies but only lower risk less complex cases, without intensive care or more complex surgery presents a clear risk to patients whose condition deteriorates, or proves different to initial assessment. Similarly with 'lower risk' births, more intensive care back up facilities are needed.
- The proposal to reduce hospital beds in London by up to 2,235 or 12% despite a growing population is very likely to be unsafe. We say this based on our own experience where hospital beds have been reduced over the last 18 months by something like this percentage. We now have a severe mismatch between hospital capacity and population need. Throughout the winter the hospital has been on red alert, and bed occupancy reaching 95% – 100 % on a regular basis. A&E has even had to close its doors briefly to further patients. Community management of long term conditions has not translated into reduced 'emergency occupied bed days'. Other local hospitals have experienced similar pressures. If either our neighbouring hospital, King George's, or Whipps had lost its full A&E the situation would have been even more critical.
- Any changes downwards to bed numbers need to reflect actual, demonstrated, change in patient need, not be based on untested theories and wishful thinking, nor to be used as a forcing function to reduce access to care or divert it to the private sector.
- Specialist care centres: We welcome the increase of severe injury centres from one to 3 for London. Specialist care for stroke and heart attack sufferers does improve outcomes, however this specialist care needs to be far more widely established, available and quickly accessible than in just 7 hospitals in London. The initial scan and medical treatment decision for a stroke patient is only one brief (though critical) element of specialist care, the on-going specialist nursing, therapy and medical intervention through acute and rehabilitation phase forms the bulk. Many patients have co-morbities not just one isolated condition, will they then loose out on specialist care? Will older people who are more likely to have multiple conditions then find inequitable access to this specialist care?

- Majority of people needing in patient care don't fall into highly specialised care categories but have multiple pathologies. Links to local social services are also vital.
- Access to hospital for relatives, friends, family is important, and can have a significant impact on patient recovery. To move specialist care for conditions which affect such a large number of people seems to be moving in the opposite direction to 'closer to home'.
- In our experience an urgent care model can work well where it is at the 'front door' of a hospital adjacent to an A&E with seamless access to more specialist or higher level care where needed, to ensure clinical safety.
- If routine surgery is removed from NHS hospitals and handed to separate planned care centres such as ISTCs how will NHS clinical staff gain experience necessary to develop the skill and expertise on which complex work will rest? One rationale given is to reduce the risks of cancellations and cross infection. A more coherent way to mange this would be to get the bed base and capacity of the hospital right, with some flexibility for seasonal pressures, and suitable infection control arrangements.
- **Poly clinics and care in the home**
- If local GP surgeries are centralise into a few polyclinics this will seriously reduce their accessibility to those with difficulty getting about whether this is due to frailty, reduced mobility or small children, i.e. the most frequent users and the most vulnerable. The localness of GP surgeries, chiropody, baby clinics and other facilities currently provided in health centres is critical.
- The cost benefit of replicating capital intensive specialist equipment in polyclinics with a much lower volume of usage than in a hospital is questionable. Scarce resources could be better invested in improving existing facilities and staffing to reduce waits.
- Clinical safety and governance arrangements covering procedures carried out in these settings is unclear.
- The continuity of care by family doctors and their knowledge of their community and individual families may well be lost with large scale polyclinics. The particular danger is that these will be taken over by some large private enterprise employing temporary doctors and the close identity with and knowledge of the community served will be lost with very negative impact on quality of patient care.
- Similarly the increased capital costs in setting up polyclinics could be better invested in increasing staff to provide the care. Our experience of PCT estate being sold off and buildings transferred to private providers is that these have been unreliable, costly to lease, with a very poor record of maintenance and servicing.
- The principle of prevention and care close to home where this is appropriate is fully supported. But the reality in our experience in Waltham Forest is that the very staff in position to deliver care at home such as community nurses, and to deliver effective preventive care and health

promotion such as health visitors and school nurses are being drastically cut, and specialist high skilled are being diluted to unsafe levels.

- The most vulnerable sectors of the community especially with high levels of deprivation are less likely to have suitable accommodation for care at home, which will need to be recognised in local service configurations
- Delivering treatment and care at home has an increased cost in terms of staff time, individualised equipment, and different sets of staff skills. But no extra money has been identified. The treatment session times of up to 15 minutes that appear to be used for calculation bear no relation to, for example, a therapy treatment session or complex home nursing or home care sessions.
- **Access to specialists**
- The concept of moving specialist out patient care out of hospital: Increasing access to specialists by running outreach clinics in different locations is logical, but moving them out of hospitals is not. Hospitals like ours are part of the community and very local to those who live near with good bus access. The most important issue is that patients' right to be seen in a timely manner by a specialist when required is maintained and enhanced. This in itself is crucial to preventive care. Specialist departments within hospitals already run nurse practitioner led clinics, therapist practitioner clinics, but which clinic to attend is decided on a clinical basis. There is back up from colleagues if needed.
- Formal and informal liaison networks are critical to effective and efficient progress of patients through care pathways and to clinical safety. Our experience is these are already being disrupted by fragmentation and multiplicity of providers.
- **Use of taxpayers money**
- Use of private sector providers is shown to be poor value, as evidenced by the huge costs of PFI projects, the ISTCs and now use of off-shore tax havens by PFI consortiums. Their use introduces a lack of financial transparency and openness ('commercial confidentiality'). We have already experienced locally how the costs of a PFI hospital in the region threatens to distort decision making health provision with drive to run down Whipps Cross and make patients travel 11 miles to the PFI hospital.
- The NHS is not a service for private profit and handing tax payers money for this purpose is not sound use. Assessing additional costs of private provision, and redirecting this money into directly provided NHS services would enable these services to be expanded to meet objectives of prevention and increased access to care.
- **Reducing health inequalities:**
- The framework document and the initial framework for action document clearly identify the reduction in life expectancy and other health outcomes as for example you move further out to east of London. No remedial measures are identified in terms of funding. The market forces factor in funding allocation continues as it has done for many years to deprive some of the most social and health deprived communities of resources.

This has to be addressed for any shape of health service to be able to deliver a reduction in health inequalities.

- Improvement in the standard of living and ending poverty is fundamental to reducing health inequalities, but this is not identified or addressed within the proposals.

- **Travel and environmental impact** – what environmental impact assessment has been carried out on these proposals? They would appear involve a significant increase in travelling distances within London.
- Increased travel, individual and ambulance journey time are major concerns. These need to be fully assessed and plans that will involve significant increases be rejected.

- **Consultation process**
- Vulnerable groups within the population who will be the most impacted by these proposals are the least likely to have been consulted. They will not have access internet, or be aware of this consultation. The very people who need to use the health service most are the least consulted and informed. In our experience even many social care and health workers are unaware of the consultation.
- Finally the question is who should be deciding on our health services future and who is best placed to do so – those at front line of delivering care, of working to improve the health of the population, and those using it.

Save Whipps Cross Hospital Campaign

07.03.2008