Submission to Independent Reconfiguration Panel, August 2013

Shaping a healthier future – a Summary of False and Misleading NHS North West London Documentation, 2012-13
Prepared by Colin Standfield, 14 August 2013

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Introduction

As Chair of Ealing Hospital SOS, I became concerned by the *SaHF* process even before the JCPCT meeting of 25 June 2012. A press release issued on 18 June 2012 included:

Members of the public are asked to note that the North West London JCPCT will hold a 'meeting in public' on Monday 25 June at 2.30pm to discuss arrangements for health services across the area it serves.

The Agenda and papers for the meeting will be uploaded onto the NHS North West London website www.northwestlondon.nhs.uk on 21 June 2012.

That is, any interested member of the public had from Thursday to Monday to read 1,156 pages of dense NHS verbiage. Despite there having been some staged 'consultation events', it was clear from this that NHS NWL's desire for engagement was limited.

The compression of activity was absurd – the Board ratified the decision on 28 June and the public consultation, starting on the following Monday, was rushed through during the summer holiday months, including the Olympic Games, with the meagre sop of an additional 2 weeks on top of what was said to be the usual 12. Even the Consultation Institute, whose services were belatedly secured only in the week beginning 6 August at a cost of £8,492.50, advised a 6-week further extension but this was not proceeded with.

The process was so poorly co-ordinated that the Risk Register, when it fell accidentally into the public domain, was still being haphazardly managed more than two months into the 'consultation' period, as shown on pages 83 and 84 hereof.

Document Problems

Anne Rainsberry wrote to London Assembly Members on 2 July, including: 'the full Consultation Document outlining our vision and proposals in detail is available as a printed version and online and will be widely available in local GP surgeries, hospitals and libraries throughout North West London and neighbouring areas.'

This was clearly untrue, since the printed document was not then available, save for 80 advance copies costing £17.50 each. In fact, it did not reach libraries in volume until the afternoon of 23 July, more than 3 weeks into the 'consultation' period.

The online version of the public document, posted on that Monday, 2 July, stated that 'This document is also available in other languages'; this was another lie. NHS NWL admitted that no translations were done until August, and then only on the basis of 'demand'. The earliest I can trace a proper translation of the Document is 24 August, nearly 8 weeks into a 14-week period.

This demonstrates that any commitment to equality of engagement for those without English as a first language was severely limited. Indeed, it displays a contempt for non-speakers of English.

The failure to enable a proper consultation because of a failure to deliver timely and appropriate materials is documented in the section 'Consultation Failure – Absence of Documents' on page 16.

Reasons for Lack of Engagement

NHS NWL have demonstrated a lack of honesty and transparency throughout, even when probed under the Freedom of Information Act – indeed, it appeared to be their policy to obfuscate and delay any process of exchanging information with us. Most FoI responses came either on the 20-day deadline or some time afterwards, with many responses, both under the Act and generally, beginning with an apology for lateness – examples in this document alone can be found on pages 37, 47, 51, 67, 76, 79 and 92/3.

This gave rise to a suspicion, not easily dismissed, that their entire approach was dishonest. Our reaction would have been different if they had said from the beginning that this was all about saving money; clearly this would not have reflected well on them – they are the people who have been running health services in this area for years – but at least it would have allowed us to engage with them on the best ways to retrieve a poor situation.

Instead, they decided to promote their hospital closure scheme as 'improvements in patient care' and thereby failed to carry the population with them: it just does not look like an improvement to have to travel further for hospital treatment, especially for the A&E services which are the ones most people have in mind when they think of hospital provisions – the ones they would be likely to need in an emergency. It is no improvement in maternity care to have to travel to a different Borough to have a baby.

Even when they did acknowledge, as they had to somewhere along the line, that they had to save money, they presented the £1 billion savings they needed to achieve as 'at least 4%' (Consultation Document, page 17) whereas it is actually an even more frightening 8% a year.

Attempts to Influence the Consultation

It was unfortunate (page 85) that Chelsea & Westminster and West Middlesex Hospitals were allowed to engage in their own campaigns to save themselves and to close their 'opposed' hospitals, and the mysterious absence of campaigns from Charing Cross and Ealing gave rise to some perhaps unnecessary suspicions. If the results of these single-question campaigns had been reserved to a separate section of the Ipsos MORI results, as had been planned, the unfair influence would not have mattered. (Page 8)

It was unfortunate, too, that the Medical Director allowed himself to be quoted in the local and London press with statements that could not be justified at the time and have not been since, despite assiduous and repeated questioning. (Pages 40, 73)

Lack of Evidence

It would have helped if NHS NWL had cited more evidence throughout, and used such evidence as they did have accurately and in its entirety. The sections on 'Virtual wards' (page 14) and Home Birth (page 54) are examples.

It is astonishing to read the 8 May 2013 letter from Mr Elkeles to the Leader of Ealing Council (page 11), in which he says ' I know you have stated that there is no evidential basis for an over-provision of A&E and that our decision leads to an under-provision of A&Es in NW London compared to the national average. For clarity, *we did not argue that there was an over-provision of A&E services*...' [My italics]

That was just one of the areas where we felt that the 'consultation' document should have had some evidence, saying as it did: 'At the same time, *NW London has more A&E departments per person than other parts of the country*', an assertion that we disproved, using proper evidence.

For Mr Elkeles not to know the contents of his own document is yet another worrying sign of a process which has gone out of the control of its progenitors.

We believe, given this catalogue of 'visions', aspirations, half-truths and outright deceptions passing themselves off as a business case, that there is no option but for NHS NWL's successors to begin again; and this time they should use some honesty and transparency about the real nature of the required actions so that any resulting proposals stand a chance of carrying the broader clinical community and the public with them.

Some honesty and transparency in dealing with challenges, rather than patronisation and shiftiness, would have helped to convince us that genuine attempts to improve patient care were under way, rather than a wholesale evisceration of services to meet monetary targets and prepare the way for private medical services.

Colin Standfield
14 August 2013

NHS NWL Deception – 'Voting' at JCPCT Meeting, 25 June 2012

6 Resolutions were required to be passed at the JCPT Meeting of 25 June 2012 as part of the *SaHF* process. In the event, these were nodded through without any vote.

I asked on 28 June, under the FoI Act, what the votes were for each of these Resolutions:

Subject: **FoI Request – Voting at JCPCT Meeting**
Date: 28/06/2012 22:08:55 GMT Summer Time
From: ColinStandfield@aol.com
To: foi@nw.london.nhs.uk

At the Joint Committee of Primary Care Trusts meeting on 25 June 2012 at Westminster City Hall, 6 Resolutions were on the Agenda for the Committee's attention. (Agenda items 8.1, 8.2, 8.3, 8.4, 9.1 and 9.2)

Under the terms of the Freedom of Information Act, will you, please, let me know in detail the votes cast for each Resolution: those for, those against and those abstaining? I am certain that an accurate record will have been kept for such an important series of decisions.

The response was:

Subject: **NW399 – Voting at JCPCT Meeting**
Date: 17/07/2012 15:56:23 GMT Standard Time
From: foi@nw.london.nhs.uk
To: ColinStandfield@aol.com, foi@nw.london.nhs.uk

In response to your request below I can confirm that all the resolutions were passed unanimously.

I complained on 20 July:

Subject: **Re: NW399 – Voting at JCPCT Meeting – Complaint**
Date: 20/07/2012 16:37:19 GMT Summer Time
From: ColinStandfield@aol.com
To: foi@nw.london.nhs.uk

Thank you for your answer to my questions. I have to make a formal complaint about its accuracy since the very best that could be said of the voting is that it was *nemine contradicente*; I have had this confirmed by someone else who was there. There was no show of hands or even an acclamation; no-one was given the opportunity to vote against or to abstain. I have some video of the voting*, and some members do not even move when asked to confirm.

The implications are either that your information was less than fully accurate or that the decisions had already been made.

Given the significance of the votes for these options, it is astonishing to see the indifference displayed by the Committee members, unless it was already a done deal and this was just a public show.

Perhaps you could investigate and tell me where the word 'unanimously' came from and on what it was based.

* I had inadvertently made 2 video recordings of some of the 'voting' – I had expected there to have been some protest at the vote and left my camera running on the seat next to me. The videos accidentally capture some of the Committee – had I been aware of what was going to happen, I should have ensured that all the

members were visibly not voting. The relevant transcripts, with the number of members barely nodding, are:

a. Mr Zitron: '...*preferred Option A... is the Committee content to approve that*?' [one nod out of 5]. Interjection from floor: *'It's unconstitutional (to consult while giving a preference.*')
Mr Zitron: '*... we've had advice, so what we're doing is quite* [indistinct] *... we'll move on now to the next item, which is, on the basis of what the Committee has just agreed, we are being asked to confirm we are content to commence public consultation on the proposed service changes. Is the Committee content to approve that? Thank you*.' [2 nods *after* 'Thank you.']

b. Mr Zitron: '*So the first Resolution is to approve the plans for public consultation that includes a consultation start date of 2nd July* [indistinct] *...approve that?*' [3 nods out of 9].

'And the second is to delegate signing off of the Consultation document to Anne and myself [indistinct] *...thank you.* [1 nod] *OK?*'

For such important decisions, I think that the lack of proper voting vitiates the process; either there was no vote or it had all been agreed in advance.

The video a) of the 'vote' on Option A can be found at: http://www.youtube.com/watch?v=EHGYlejHVYw ; that for consulting and delegating, b), is at http://www.youtube.com/watch?v=lqyuivEyWbA .

The Information Commissioner's Office was powerless to act because the initial response came from the public record – the Minutes. Sadly, the public record is wrong, as the videos mostly show. Whatever it was, it was not 'unanimous'.

If the due process of *SaHF*, with all its serious implications for the people of North West London, was that a vote was required, then there should have been a proper vote. The absence of such a vote suggests one of two things:

The decisions had already been made in secret, and this was just a public show;

There was a determination to brook no internal dissent, so no members of the Committee were given the opportunity to vote against, or even abstain.

Either way, it was an abuse of process.

NHS NWL Deception – 17,022 Responses Claimed

NHS NWL are desperate to magnify as far as possible the response to their flawed 'consultation' and have persistently claimed 17,022, despite the orally-delivered Ipsos MORI figure of 8,000 at the JCPCT Meeting of 6 December 2012. I immediately challenged that figure, as I had already calculated the true response to be around 4,550, a figure with which the Chair, Jeff Zitron, agreed at the meeting.

IM subsequently adjusted the figure to 7,000 in their response to the JCPCT:

'If these **9,927** responses [their best estimate of the £8,000 Chelsea & Westminster campaign] are excluded from the total, this gives us a figure of **6,843** responses submitted via the official paper and online response forms. Including the 252 responses received via other channels, **this gives a total of 7,095 responses to the consultation**.' (My emboldening)

Even that is an overstatement, since many more should have been deducted. The C&W website on 1 December 2012 stated: **'More than 11,000 people completed a 'Safe in our hands' postcard** and more than 6,500 people signed the Council of Governors petition.' (My emboldening) In fact, if the 11,263 postcards recorded by Ipsos MORI on page 8 of their 28 November Final Report are deducted, rather than 9,927, the **total figure reduces to just 5,759**, still an overestimate (see below).

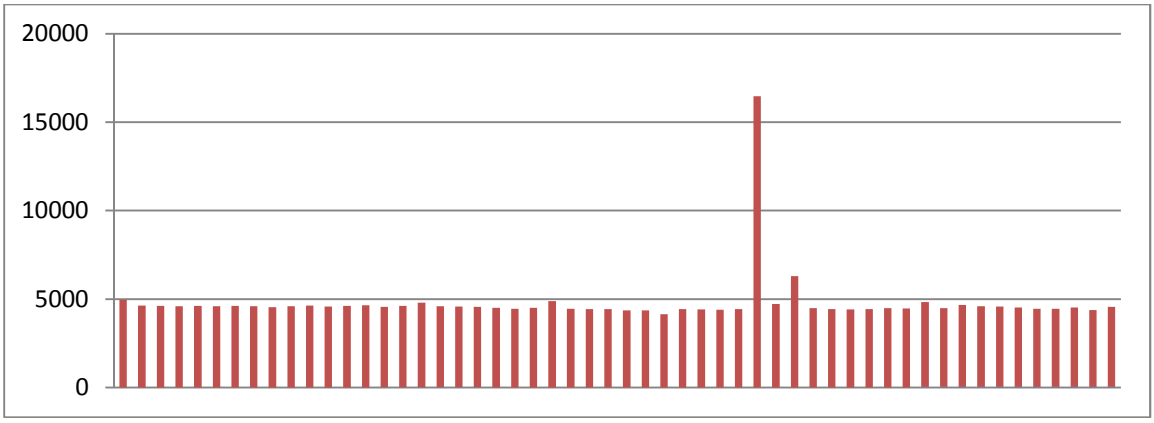
Unexplained Change of Policy

There was an unexplained change of policy on Campaigns and Postcards, a policy originally specified in an e-mail exchange of 26 July. It was clearly stated by Juliet Johnson from Ipsos MORI that 'Essentially, as the postcard does not contain the question from the official response form, we would collate the responses and include them in the report as a separate section, but they would not be merged with the other responses for Q24a.'

And Kate Woolland, Programme Manager, *SaHF*, confirmed: 'However, feedback received in anything other than the online / official paper response form will not be included in their analysis of responses to the consultation questions.'

In the event, all the C&W 'bought' votes (and, indeed, C&W identified them as 'votes': 'Tick this box to *vote* Option A') *were* incorporated misleadingly into the total results, and not as a separate section. Since the only option on their postcard was to vote 'yes' to Option A this clearly skewed the result. This was an abuse of process.

I have asked for a reason for the change in policy, with no response. I have already shown the IRP this graph of responses by question – the huge spike is Q24a, Option A, which was bought by the C&W campaign; the smaller peak was the result of the smaller campaign run by West Middlesex Hospital against Option C:



Clearly, the average response to any question is just below 5,000, and the median question response is below this. **Not one question**, apart from 24a and 26a, **receives 5,000 responses**.

To be exact, the *median* response is Q28a at 4,541, close to the *average* response I have calculated in 3 ways as around 4,550. (And nowhere near 17,022.)

There is an even worse problem for NHS NWL if Borough responses are analysed, as the 8 Boroughs in the sector returned a negative response to all options.

Negative Net Support

The figures on p65 of the Ipsos MORI Report are revealing when you do this further analysis. If you take the responses from just the 8 Boroughs, all 3 Options have a net 'support' expressed as a minus: -95 for A, -1,354 for B and -466 for C. It is only when the non-NWL votes are counted that Option A goes positive, but by just 295 responses. The effect of this is that, far from having made a convincing case to the population of the 8 Boroughs, which we were emphasising throughout, NHS NWL have received a grudging assent to the 'least worst' option.

The entire 'consultation' was skewed deliberately by NHS NWL from the beginning once they had removed Hammersmith and Central Middlesex from the options available and once they had promoted their preference for *their* choice of 5 'Major' Hospitals.

Respondents were herded into agreeing with successive arguments: 'Over the last 10 years it has become increasingly clear that the health system locally needs to change – and not just a little bit.' (Dr Spencer, Consultation document, page 6.) 'Delivering this vision will not be easy. It will mean changes to the way in which people work, where money is invested and the settings (places) in which healthcare is delivered.' (Summary, page 9.) 'NW London has more A&E departments per person than other parts of the country.' (The Challenges, Page 15.) 'Unless things change, we predict that most of the hospitals in NW London will end up in financial difficulties.' (Ib, Page 17.) Question, in essence: do you agree that the status quo is not an option? (Q1, page 19.) How could you disagree?

And so it continues, until the reader is forced to agree with '5 Major Hospitals' and the downgrading of 4 others. This is unfair and unscientific.

Vector of Preferences and Inclusion of Non-Residents

Once Central Middlesex and to a lesser effect Hammersmith had been perversely taken out of these options, the natural vector of preferences *even for NWL residents* would be to the outer ring of Option A hospitals, especially with Northwick Park so close to Central Mid. For *non-residents* (whose responses should not have been included in the tabulations), the natural vote would go to Option A hospitals, as Ealing is effectively buffered by the surrounding Boroughs – Ealing Hospital would always have less relevance for someone living in Hertfordshire or Camden than Northwick Park or St Mary's. Charing Cross suffers likewise.

We have been stressing these distortions from the beginning, along with our concerns that, in what should be a balanced, neutral process, NHS NWL have not just indicated but promoted a 'preferred option'. The corrupting effect of this was predictable and we predicted it: there was, unfairly and perversely, no general option to vote for the overall status quo, but for many residents towards the outer edges of the area and probably all non-residents (those in contingents Boroughs) Option A effectively represents the status quo for those locations and therefore, and as predicted, attracted the vote.

Lack of Engagement

Clearly there was something wrong with the reach and engagement of the 'consultation' if NWL have had to massage the result to portray it as bigger than it really was. Even 17,022 out of an adult population of, say, 1.6 million is just 1.06% – a Ward by-election on a rainy day in February would poll 10 times that figure. This pathetic result shrinks even further if the populations of contingent Boroughs are excluded.

And, of course, it almost vanishes to a 0.28% figure if the true response of 4,550 is used, giving no mandate at all for the wholesale disruption of the health estate in the area.

In many cases, response to questions analysed by Borough (page 65 of the IM Report) are too small to be reliable. In fact, 14 out of 33 values in the analysis of responses for Options A, B and C indicate 'small base size and where caution is due in interpreting this data'. (Or 'these data', correctly.)

I can see the imperative for this dishonesty – NHS NWL were desperate to disguise the poverty of their engagement and the meagre results from their £7 million expenditure, not to mention the, at best, equivocal nature of the result once the separate campaigns from two of their favoured Hospitals are stripped out. But the *SaHF* 'consultation' results cannot be allowed to stand as a credible analysis of the public mood in North West London.

Broken Agreement not to Run Campaigns

The Minutes of the Communications & Engagement Working Group meeting held on 6 September 2012 state: 'There have been issues with some Providers websites

providing a campaign or voting system with regard to SaHF. DN [Don Neame] advised that he has asked for these to be taken down.'

The unilateral activities of C&W and West Middlesex were clearly 'campaigns', each aimed at a vote on a single question. If the websites were required to be taken down, why were the results of these campaigns allowed to remain among the spurious 17,022 responses?

Unfair Inclusion of a 'Petition' as 'Responses'

The Ipsos MORI presentation of 28 November 2012 includes on Slide 27, *Petitions – II*, the details of the C&W promotion as a *petition:* 'Chelsea and Westminster Hospital 'Safe in Our Hands' campaign. Postcard and online postcards in support of Option A, calling for Chelsea and Westminster Hospital to be a major hospital with a full A&E - 11,263 (9,927 of these also submitted in the online form)'

These are the numbers unfairly reclassified as bona fide consultation responses, yet just below are the 25,193 Ealing petition responses, which are subsequently disregarded ('Petition calling for Ealing, Central Middlesex, Charing Cross and Hammersmith Hospitals to retain their status and keep all existing services, from Ealing Council').

The 2,613 petition signatories in favour of Hammersmith Hospital and the 9,388 for Charing Cross have been similarly dismissed.

This is clearly unfair, and a grotesque distortion of the response to *SaHF*, deliberately engineered to try to justify NHS NWL's untenable position.

It would seem that the only way to ensure that a petition is considered is if its author also has a position of influence within *SaHF*, such as a Medical Director.

Lack of Faith

We therefore have no faith in the results of the 'consultation'.

NHS NWL Deception - Number of A&E Departments per Unit of Population

One of the reasons advanced for the closure of 4 A&Es in North West London is that we have too many already. This is nonsense.

NHS NWL Claim

The 'consultation' document states at page 15: *'At the same time, NW London has more A&E departments per person than other parts of the country*'. No evidence is given for this. It is not clear whether these 'other parts' are, say, Lincolnshire or the Western Isles. It would be expected that a London Hospital might serve a smaller, more densely packed catchment area, but some appropriate data would have helped.

This is not an isolated claim: 'We have more A&E departments per head of population than other parts of the country and this makes it harder to ensure enough senior staff are available. (Paper-3-1-shaping-a-healthier-future-case-for-change-9-feb-2012, p25)

The Data
In fact, the UK has 249,048 people per A&E; in NWL it is 247,150, an 'advantage' of only 0.77% – that is, NWL is virtually the same as the national average. This is based on the 8 Type 1 A&Es in the area, Central Middlesex being open only 12 hours a day. If you include Central Middlesex, the NWL figure falls to 219,689 – a 13% 'advantage' to NWL. If you include a part-time Central Middlesex, the 'advantage' is just 7% (232,612 per A&E).

After losing 3 more A&Es, in NWL there will be 395,440 people per A&E, a 'disadvantage' of 52% – a massive over-compensation.

Sources
UK population: 62,262,000 ONS Mid-year Estimate 2010[1]
NWL population 1,977,200[2]
A&Es in UK: est. 250, supplied by College of Emergency Medicine[3] (on next page)

[1]http://www.direct.gov.uk/en/governmentcitizensandrights/livingintheuk/dg_10012517 Document: onsmidyrestimates201_tcm77-233025-2)

[2]Based on Borough data, 2011 Census:

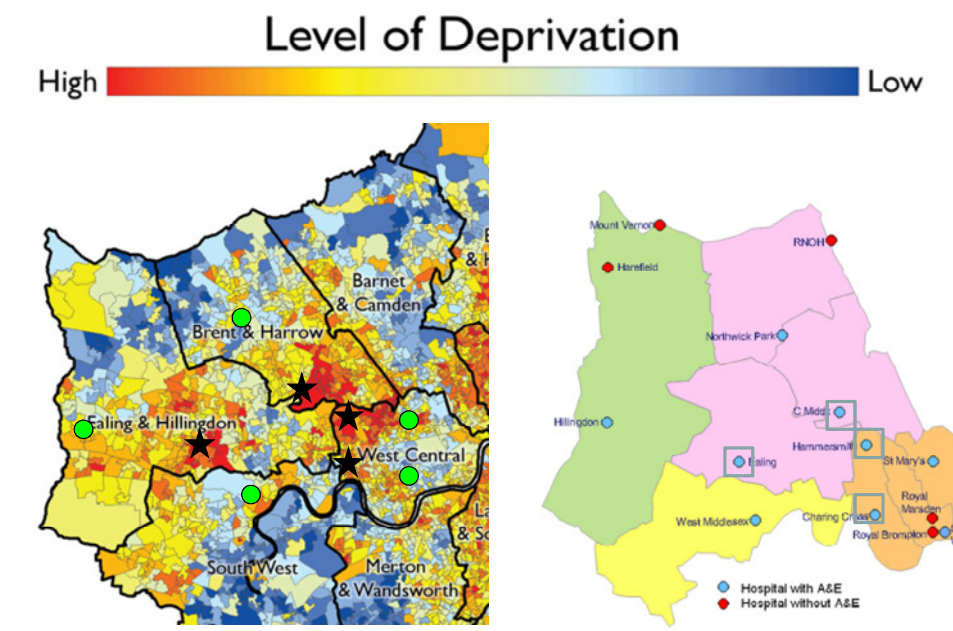
Brent	311,200
Ealing	338,400
Hammersmith & Fulham	182,500
Harrow	239,100
Hillingdon	273,900
Hounslow	254,000
Kensington & Chelsea	158,700
Westminster	219,400
	1,977,200

[3] 'I can confirm that there are 250 Type 1 Emergency Departments in the UK (which includes Northern Ireland)' - e-mail from @collemergencymed.ac.uk .

NW London is a significantly more ethnically-diverse area than the national average and it has very high incidences of diseases like TB, COPD and HIV. Ealing is the fourth most ethnically-diverse Borough in the country

Even though the GP lists for the Ealing CCG area total 390,000 for a Borough with a census population of 338,400 (*Our three-year strategy for coordinated, high quality care out of hospital* 2012 – 2015, V0.3 – 17.05.2012, Exhibit 11, page 21) it is believed that many of the less advantaged in the area do not use primary care and depend more on A&E.

It is also clear that the planned A&E closures are in the areas of highest deprivation:



● Emergency Department Open

★ / □ Emergency Department Closed under SaHF

The impact on the more deprived areas of Ealing have been under-researched and underestimated: the *Equality Impacts – Strategic Review*, Shaping a Healthier Future, June 2012 never even mentions two of the most significant groups in Southall, Sikhs and Muslims; nor do other minority groups such as Travellers feature in the report, which must be considered defective.

Retreat from an Absurd Position

It is now becoming clear that the remains of NHS NWL have become embarrassed by this absurd contention about over-provision of A&E Departments – in direct contradiction to the statement on page 15 of the 'consultation' document, Daniel

Elkeles sought to convince Cllr Bell that this had *not* been part of the thinking: 'I know you have stated that there is no evidential basis for an over-provision of A&E and that our decision leads to an under-provision of A&Es in NW London compared to the national average. For clarity, *we did not argue that there was an over-provision of A&E services*...' [my italics; cf '*NW London has more A&E departments per person than other parts of the country'.]* (Letter from Daniel Elkeles, SRO Shaping a healthier future, Chief Officer CWHH CCGs, 8 May 2013)

It must always be considered dangerous when an organisation which has failed to develop and promulgate a coherent case resorts to shifting the grounds of argument when challenged.

I believe that, despite the millions spent on the *SaHF* proposals, and especially the very expensive hired 'expertise', NHS NWL have not been capable of producing a health strategy that either meets the needs of the local population or satisfies the judgment of common sense.

It would be a matter of honour and honesty for them to agree now that they have failed in many instances, such as A&E provision, to produce any credible evidence for many of their assertions and to admit that they have entirely failed to carry with them the affected populations of North West London.

But I accept that this is not in the DNA of an organisation which prefers to shut its ears to reasoned criticism and to rely instead on unattributable generalities. When Mr Elkeles says in his letter to Cllr Bell 'I cannot stress how passionately doctors and clinicians across NW London believe this,' he should realise that he would not need to stress it if he could provide some unbiased evidence of it.

NHS NWL Deception – Virtual Wards

Since their appearance in the PCBC, I have been trying to obtain robust information on the safety and efficacy of 'virtual wards'. I made the following request under the Freedom of Information Act:

From: ColinStandfield@aol.com [mailto:ColinStandfield@aol.com]
Sent: 25 July 2012 12:47
To: FOI NWL
Subject: Virtual Wards

Dear Sirs,

The Pre-Consultation Business Case for *Shaping a healthier future* alludes to 'virtual wards' in Hammersmith and Fulham and 'virtual teams' in Hillingdon and elsewhere (Vol 2, p12 et seq; Vol 12, p3 et seq).

Under the terms of the Freedom of Information Act, please tell me:

a) where in the UK have such virtual wards been in operation?

b) what are the typical costs of running a virtual ward in terms of:

i. IT capital expenditure;
ii. IT recurrent costs;
iii. staff training;
iv. GPs' time
v. the 'management centre'
vi. office space for co-location?
c) what measures have been introduced to measure their clinical effectiveness and where have the results been published?
d) what levels of patient satisfaction have been recorded for the use of such virtual wards?

Thank you,

Colin Standfield

The reply was:

Subject: **Our reference NW466 – Virtual Wards**
Date: 27/07/2012 11:04:35 GMT Standard Time
From: foi@nw.london.nhs.uk
To: ColinStandfield@aol.com

Dear Sir

In respect of your request I must advise you that **NHS North West London does not hold the data you have requested**. As you are asking for data for the whole of the UK you will need to contact the Department of Health. The FOI team can be contacted via their web page at http://transparency.dh.gov.uk/category/foi/

Yours sincerely,

Brian Coleman

The answer to the same questions from the DoH was:

DE00000717312:

The Department does not hold any of the information requested on virtual wards. Any virtual ward pilots are being run by local NHS organisations.

I was therefore surprised to see this claim later made in the DMBC:

'Virtual wards'[134] and 'Hospital at Home'[135] schemes have been shown to be successful. The Cochrane review showed that patient satisfaction was higher, mortality was lower and bowel and urinary complications were fewer. (Vol 3 p 212 of pdf)

'[134] e.g. Wandsworth CCG in C Ham et al. Avoiding Hospital Admissions. Kings Fund 2010'

The Conclusion from Ham et al in *Avoiding Hospital Admissions*, Kings Fund 2010, includes:

The *use of virtual wards holds promise* as an admission avoidance strategy, as evidenced by Wandsworth, but more evidence is needed to assess their impact and cost-effectiveness. (Summary, p3)

There are four virtual wards, each with approximately 30 patients, serving a total catchment population of about 254,000. Each ward has an estimated maximum capacity of 100 patients, and in the first 10 months of operation, the wards have admitted 173 patients. *Potential problems include* the GP in the virtual ward team playing more of a managerial than a clinical role, and the possibility that the system may be paying practice based GPs and virtual ward GPs to do the same job. *Long-term capacity may also be an issue*, as to date, the wards have been admitting more patients than they have been discharging.

It was anticipated that savings from reduced hospital admissions would cover the costs of the virtual ward. Initial evaluation shows that the wards *have the potential to be cost-effective*, but *there needs to be a more robust analysis*, including the impact on wider system costs over a longer period of operation, to confirm this. (p 14) (My italics throughout)

I sought to raise this at the February JCPCT Meeting but was not allowed to complete my question; I had asked how many of the Committee had read both the papers referenced and only one hand was raised, Dr Mark Spencer's.

If they had bothered to read these supporting papers, they may have been as concerned as I was that the 'success' of virtual wards included the possible payment to two doctors for doing the same job; and that this endorsement of 'success' still required more evidence and robust analysis.

It is of concern that they were relying on a 2010 paper, yet feigned to have no knowledge of it when I enquired in July 2012. I am forced to the conclusion that this would have been damaging to them as the 'consultation' was still in progress and

they were desperate not to allow the truth or any form of real evidence to intrude into their comforting fable about the provision of care in out-of-hospital settings.

This constitutes an abuse of process.

Consultation Failure – Absence of Documents

The *SaHF* plans were severely affected by the non-availability of the consultation document in the crucial early weeks, other than an online version which thereby discriminated against the less advantaged communities across NW London.

Partly this was a result of chaotic management, which calls into question the competence of the NWL leadership as a whole; it would not have been necessary to start the 'consultation' period without hard copies of the document if sensible planning had been involved. And partly it was to do with the apparent desire of NHS NWL to drive their programme through without considering any opposition.

The e-mail exchanges reproduced below indicates the lengths to which NHS NWL were prepared to go to cover their inability to organise a proper schedule of consultation. To receive two conflicting e-mails on 11 July from the same team showed me how badly things were going. The following day I telephoned Mr Thirunesan, who told me that the reason for the scarcity was that 2,000 had been ordered by the Tri-Borough library service including Hammersmith & Fulham; the following day the central receiving library, Fulham, confirmed that they had been told by NWL that 'they are waiting for print runs to begin'. And only 50 were going to be sent to them, not 2,000.

They received their copies on 23 July, over a week later.

Some of the answers I received were, frankly, deceptive if they were not the product of irresponsible ignorance. I was told that the reason for the delay was that they could go to print only after approval by the JCPCT and the Board and that in the past 'the NHS has been criticised for making a decision to launch consultations of potentially great interest to the local public and then there being a hiatus before formal consultation launch'. I did not believe that, and it proved to be a ridiculous deception:

'Unfortunately I am struggling to find independent evidence of my assertion that the NHS has been criticised for the delay between making a decision to launch consultation and the start date for the consultation itself. Rightly or wrongly it was in our minds at the time and is the reason why the consultation was launched so soon after the JCPCT and NHS London Board. I will continue to look for the evidence.'

'It was in our minds at the time' is no justification for committing a convenient lie to print. Of course, the 'evidence' never arrived.

It was just an expedient but lame excuse for appalling management.

The case remains that the failure to deliver documents on time and the failure to deliver documents in languages other than English, despite assurances to the contrary, severely vitiated the *SaHF* process.

From: ColinStandfield@aol.com [mailto:ColinStandfield@aol.com]
Sent: 06 July 2012 16:09
To: Communications NWL
Subject: 'Shaping a healthier future' Consultation Document.

Dear Sirs,

Please will you send a copy of the Consultation document and questionnaire to me?

My address is: 20 Balfour Avenue, Hanwell, London W7 3HS.

Thank you,

Colin Standfield

Subject: **RE: 'Shaping a healthier future' Consultation Document.**
Date: 09/07/2012 12:33:16 GMT Daylight Time
From: consultation@nw.london.nhs.uk
To: ColinStandfield@aol.com

Thank you for your email and we will get back to you shortly. For further information please see our website **www.healthiernorthwestlondon.nhs.uk**

The Consultation Team
Communications Response Unit
(Shaping a Healthier Future Programme)

NHS North West London
15 Marylebone Road,
London, NW1 5JD
Tel: 0800 881 5209
Email: consultation@nw.london.nhs.uk

From: ColinStandfield@aol.com [mailto:ColinStandfield@aol.com]
Sent: 06 July 2012 19:42
To: consultation
Subject: Consultation Document

Please send a copy of the 'Shaping a healthier future' Consultation Document to:

Colin Standfield, 20 Balfour Avenue, Hanwell W7 3HS.

Thank you,

Colin Standfield

Subject: **RE: Consultation Document**
Date: 09/07/2012 09:47:45 GMT Daylight Time
From: consultation@nw.london.nhs.uk
To: ColinStandfield@aol.com

"Thank you for your email and we will get back to you shortly. For further information please see our website **www.healthiernorthwestlondon.nhs.uk**"

The Consultation Team
Communications Response Unit
(Shaping a Healthier Future Programme)

From: ColinStandfield@aol.com [ColinStandfield@aol.com]
Sent: 10 July 2012 18:19
To: Zitron Jeff (NHS NORTH WEST LONDON)
Subject: Consultation Document

Dear Mr Zitron,

I have been trying without success to obtain a hard copy of the Consultation Document for the NHS NWL reconfiguration. It is now over a week since the 'consultation' started and those without internet access - which will include many of the disadvantaged people the Ealing Hospital SOS campaign is particularly concerned for - will not have had the chance to understand the complex arguments you are putting forward.

I went to the Central Library in Ealing this afternoon and not only did they have no copies, they were completely unaware of its existence. My GP does not have copies.
Your website says, at http://www.healthiernorthwestlondon.nhs.uk/have-your-say, 'This is available in local GP surgeries, libraries, xxxxxx and xxxxxxx...' Whatever the 'X' stands for, it is a symptom of the incompetence attending this exercise. If you can fail to deliver the vital documentation or even a simple web page, what hope should we invest in your promise of 'Delivering the vision' (p32 of *Shaping a healthier future*')?

The consultation period will now presumably extend beyond 8 October.

Colin Standfield
Chair, Ealing Hospital SOS

Subject: **Consultation Document**
Date: 10/07/2012 20:52:46 GMT Daylight Time
From: jeff.zitron@nhs.net
To: ColinStandfield@aol.com
CC: consultation@nw.london.nhs.uk

Dear Mr Standfield,

Thanks for your e-mail. Our Consultation Unit is overseeing the process so I have copied this to them so that they can send you a copy of the Consultation Document to the address on your e-mail, 20 Balfour Avenue, Hanwell, London W7 3HS.

Jeff Zitron
Chairman, NHS North West London
Jeff.Zitron@nhs.net

Subject: **RE: Consultation Document**
Date: 11/07/2012 09:35:09 GMT Daylight Time
From: consultation@nw.london.nhs.uk
To: ColinStandfield@aol.com

Thank you for contacting the 'Shaping a healthier future' consultation team.

A copy of the full consultation document, which details our proposals for improving health services in North West London, will be sent to you once it is available.

We are currently waiting for delivery of the document and we expect to receive this within the next 10 days. We will send you an email to let you know when your copy is in the post.

In the coming weeks the consultation document will also be available in local GP surgeries, hospitals and libraries throughout North West London and neighbouring areas.

Over the next few months we are holding a series of road shows where you can learn more about the proposals ask questions and give your views. More information about when and where these are taking place can be found on the website.

In the meantime you can view the document online, as well as learn more about our proposals and how you can have your say by visiting our website www.healthiernorthwestlondon.nhs.uk.

Thank you again for taking the time to contact us.

The Consultation Team
Communications Response Unit
(Shaping a Healthier Future Programme)

Subject: **RE: Consultation Document**
Date: 11/07/2012 17:02:39 GMT Daylight Time
From: consultation@nw.london.nhs.uk
To: ColinStandfield@aol.com

Dear Mr Standfield,

Thank you for contacting the "Shaping a healthier future" consultation team.

We write to you with reference to a recent correspondence from our Chairman Jeff Zitron dated 11/07/2012 sent to you earlier today via email. We can now confirm that a hardcopy of the consultation document has been sent via special delivery to your home address today as outlined in your email.

May we take this opportunity to apologise for any inconveniences caused in relation to you being unable to obtain a hardcopy version of our consultation document as we have seen an unprecedented demand which had resulted in, a shortage of copies. We can assure you that this has since been addressed and we have received a large batch from our printers today ready for dispatch into our local community.

If you have any further questions or queries, please feel free to contact us.

Yours sincerely,
The Consultation Team
Communications Response Unit
(Shaping a Healthier Future Programme)

Subject: **RE: Attn Nesan Thirunesan - Consultation Document not at Hammersmith**
Date: 12/07/2012 14:42:34 GMT Daylight Time
From: consultation@nw.london.nhs.uk
To: ColinStandfield@aol.com

Thank you for contacting the 'Shaping a healthier future' consultation team.

Your query is very important to us and a member of our team will reply to you as quickly as possible.

We may not be able to respond immediately. In the meantime, if you would like to find out more about our proposals for improving NHS services in North West London you can also:

• visit www.healthiernorthwestlondon.nhs.uk

• call 0800 881 5209

We want to hear from as many people as possible about what you think of our vision and the changes proposed.

Over the next few months we are holding a series of road shows across North West London and the surrounding areas where you can learn more about the proposals ask questions and give your views. More information about when and where these are taking place can be found on the website.

Thank you again for taking the time to contact us.

The Consultation Team
Communications Response Unit
(Shaping a Healthier Future Programme)

NHS North West London
15 Marylebone Road,
London, NW1 5JD
Tel: 0800 881 5209
Email: consultation@nw.london.nhs.uk

From: ColinStandfield@aol.com [mailto:ColinStandfield@aol.com]
Sent: 12 July 2012 14:35
To: consultation
Cc: Jeff Zitron
Subject: Attn Nesan Thirunesan - Consultation Document not at Hammersmith

Dear Mr Thirunesan,

You said this morning that 2,000 of the documents had been requested by the libraries including Hammersmith - I believe they are called 'Tri-Borough' - which was the reason for their scarcity.

It is 2.30 pm. I can report that I have just spoken to Hammersmith Library and the Reference Section at Fulham Library and neither location has any copies. Fulham are making enquiries on my behalf.

Has the document been printed and delivered or not?

Colin Standfield

[The promised confirmation of that morning's phone call never arrived.]

Subject: **Shaping a healthier future for North West London consultation document**
Date: 12/07/2012 14:48:08 GMT Daylight Time
From: @lbhf.gov.uk
To: colinstandfield@aol.com

Hello Colin
Re: Shaping a healthier future for North West London consultation document - telephone enquiry to Fulham Reference Library.
I have spoken to the NHS department responsible for this particular document and they are waiting for print runs to begin and will send me 50 copies once available. I will let you know as soon as I get any copies and send copies for you to pick up from Hammersmith Library.
I have also emailed our local NHS trust in Fulham and await their reply.
Kind regards
[name]

Fulham Reference Library
Leaflets Information Collection

From: ColinStandfield@aol.com [mailto:ColinStandfield@aol.com]
Sent: 19 July 2012 13:20
To: [name]@lbhf.gov.uk
Subject: Re: Shaping a healthier future for North West London consultation document

Dear [name],

Just out of interest, is there any sign of the NHS NWL document 'Shaping a healthier future'? There are some printed copies around, but none in the libraries here in Ealing.

Thanks for your help so far.

Regards,

Colin

Subject: **RE: Shaping a healthier future for North West London consultation document**
Date: 19/07/2012 17:50:31 GMT Daylight Time
From: [name]. @lbhf.gov.uk
To: ColinStandfield@aol.com

Hello Colin

I am afraid I have not received any yet, but I will let you know when I receive them.

Kind regards

[name]
RSD - Libraries, Leisure and Fleet Transport

Tel:02087533875/ 3877
Email: [name].@lbhf.gov.uk

Subject: **RE: Shaping a healthier future - Thanks**
Date: 22/07/2012 11:51:28 GMT Daylight Time
From: [name].@lbhf.gov.uk
To: ColinStandfield@aol.com

Hello Colin

The NHS has sent the Library a couple of posters and postcards for the consultation, no document as yet. However, they highlight **"Shaping a healthier Future" road show at Hammersmith Town Hall (King Street, London W6 9JU) on the 28th July 2012 between 9.00am and 2.30pm**, where you might be able to pick a consultation document in printed format. In the meantime, if does arrive here, I will let you know.

Kind regards

[name]

Subject: **RE: Shaping a healthier future - Thanks**
Date: 23/07/2012 15:52:08 GMT Daylight Time
From: [name].@lbhf.gov.uk
To: ColinStandfield@aol.com

Hello Colin

We received the consultation document this afternoon. I will send copies to all the Libraries including Hammersmith Library with your name on it. Hopefully you can pick up the document on Wednesday or Thursday this week.

Kind regards

[name]

Subject: **RE: Consultation document**
Date: 01/08/2012 18:02:12 GMT Daylight Time
From: David.Mallett@nw.london.nhs.uk
To: ColinStandfield@aol.com

Dear Mr Standfield

Thankyou for your e-mail below. I will attempt to deal with your points in the same order.

We are aware of criticism that the consultation document has not been widely distributed but as this is not the case it is useful to use the website to put on record the facts of the situation. At the time of writing (4.00 pm 1 August) I am advised that 34,000 copies have been sent out.

Regarding the availability of documents at the commencement of consultation, this is a problematic issue which all NHS consultations of this type face. The problem is this. As you know, the North West London consultation was approved for launch by the JCPCT on 25 June and by the NHS London Board on 28 June. Printing documents takes time and has a

cost to the taxpayer. In North West London's case, the full print run of consultation documents is 100,000, which took 12 days and the printing cost was approximately £58,000.

We could have arranged for all the documents to have been printed ready for the launch on 2 July. However this would have required beginning the print run before the two meetings and ran a risk that issues could have been raised at those meetings which would have required significant changes to the consultation document. Had this occurred we would have had to undertake another £58,000 print run.

A possible solution to this issue is to build in a delay to the launch of consultation after approval meetings to allow for printing. Where this has been done elsewhere, the NHS has been criticised for making a decision to launch consultations of potentially great interest to the local public and then there being a hiatus before formal consultation launch.

In view of the above, NHS service change consultations that I am aware of have adopted the approach undertaken in North West London which was to place the consultation document on the web-site, undertake a small print run to satisfy immediate demand while the full print run progressed. In our case the first small print run was of 80 documents at a cost of over £1400. This approach is not perfect but it's the best way I am aware of that matches the demands of timing and value for money.

We will make the document available in other languages and formats on the basis of demand. Again this is an issue of value for money. It is very difficult to predict demand in other languages before consultations are launched. We have discussed this issue with Community Interpreting Translation and Access Services (CITAS) and their advice was "CITAS does not recommend the translation of the full 74-page document,: research shows that translations of large documents are not the preferred method to speakers of other languages, who may not be able to read due to visual impairment or illiteracy in the mother-tongue. In this case, language-specific, bi-lingual support is advised, as part of a reading group dynamic. Summary documents are more effective in getting targeted messages across and are, in general, a more cost-effective solution, as they can be made available in more languages".

On the basis of demand to date, we have decided to undertake small print runs of the full document, summary and response form in Arabic, Bengali, Hindi, Polish, Punjabi (Ghurmuki), Somali, Swahili, Tamil and Urdu and these will be available on the web-site by 24 August and in hard copy for distribution shortly after. We are currently considering further translations into Simplified Chinese, Farsi, French, Tigrina and Pashto. We already have Braille copies, 5 of which have been sent out. We have also discussed this issue with Ealing Supported Living Project and agreed with them the development and printing of an "easy-read" version of the summary. Our Consultation Response Unit (CRU) will post the Polish version to you as soon as it is available or, if it is helpful, we can post it direct if you can provide the CRU with your neighbour's address.

Finally, I am aware that you have submitted Freedom of Information Act (FoI) requests that also cover some of the issues above. In line with the Act and related guidance you will be receiving a separate response to those submissions.

Kind regards,

David Mallett

SRO *SaHF* Programme Delivery

From: ColinStandfield@aol.com [mailto:ColinStandfield@aol.com]
Sent: 01 August 2012 12:02
To: David Mallett
Cc: andy.slaughter.mp@parliament.uk; onkar.sahota@london.gov.uk; eveturner@btinternet.com; olivernew@btinternet.com
Subject: Consultation document

Dear Mr Mallett,

I wonder what is the purpose of having this on your website today

July 26, 2012

The distribution team on the 'Shaping a healthier future' programme has, as of 26 July, now sent out over 28,000 copies of the consultation document and response form, including tens of thousands of copies sent to all eight of the key NW London boroughs and also to the three boroughs potentially affected by the proposals - Camden, Wandsworth and Richmond.

[http://www.healthiernorthwestlondon.nhs.uk/news/over-28000-consultation-documents-now-distributed-and-more-come]

'Tens of thousands' sounds like lot, but merely 3 'tens of thousands' is more than you have sent out altogether.

It then says:

This first wave of distribution, which has been taking place ever since consultation was launched on 2 July, has seen documents being sent to GP surgeries, libraries, hospitals, and other key venues.

Did it not occur to anyone that it might have been helpful, if a little utilitarian, to have had the documents available in hard copy before the consultation began, rather than over 3 weeks later?

And could you put in the post for me today, just by way of example, a copy in Polish that I could show to a neighbour? It says that it 'is available' on the inside back cover.

Thank you,

Colin Standfield

From: ColinStandfield@aol.com [mailto:ColinStandfield@aol.com]
Sent: 02 August 2012 15:01
To: David Mallett
Subject: Fwd: Out of Office: Consultation document - Facts and Errors

Dear Mr Mallett,

Thank you for your reply, which is worthy of Sir Humphrey but without the wit. It will provide valuable evidence.

Let me take your points in order.

The criticism is not that the documents were not widely distributed but rather that they were not distributed *at all* at the beginning of the consultation - I am surprise that my spell check does not encourage me to put quotation marks around that word. Andy Slaughter MP thought he had been sent one by 10 July until I pointed out in the Palace of Westminster that he had a ring-bound photocopy - was this one of the 80 costing £17.50 each? Your web page clearly states that the first wave of the documents were being sent out from 2 July - to whom among the 4 categories listed were they sent on that day? Please check very carefully, before you answer, that they correspond with the detail in the web article - that is, properly printed and bound editions analogous to those referred to in the first paragraph.

In what way does 28,000 or even 34,000 sustain a reasonable interpretation of the phrase 'tens of thousands'? Admittedly, it is more than one ten of thousands but people I have spoken to have suggested variously that it suggests at least 50,000 - and you call that phrase 'a fact'.

Your paragraph about the timing betrays the unseemly haste you have engineered for yourselves and it is no-one's fault but your own. Clearly there is an agenda you do not wish to reveal that requires a document to be on a Minister's desk by early February - this is why your Medical Director was anxious in his *Evening Standard* article to avoid political delays and not because it would save 200 lives - a figure which, incidentally, I have challenged. I have experience at Board level in advertising and marketing and know how to programme activity, including all collateral material, to achieve a result within a deadline.

Here is what should happen in a well-ordered campaign:

1 The deadline and intermediate timings are established, taking in to account production timings.

2 Decision points are agreed, allowing sufficient time for discussion and amendment.

3 Simultaneously, the strategy, background evidence and operational plans are worked out.

4 A decision is made to proceed and materials are produced and delivered to pre-planned locations and according to the available distribution mechanisms - the number of libraries and GP surgeries, for example, and other 'key venues'.

What you have done is to set a deadline and hope that you could compress everything into the remaining period. That is why the JCPCT papers were not available online until 21 June for a meeting on 25 June - under 4 days, including the weekend, to digest over 800 pages. It was clear to me that the panel had not read them - otherwise they would have picked up at least one glaring error. It was clear to me and others that they did not 'vote' on them, so there was no danger of any alteration to the document. I was not there, but I assume the NHS London Board was a similar rubber stamp.

It is absurd to imagine that you thought there might be any changes after the Board date, as you would have had just one working day to implement them before the 'consultation' began on the following Monday. So why pretend? If anyone had asked, for example, for the evidence from anywhere in the UK to support the clinical efficacy of GP networks, you could not have got it in time because NHS NWL have told me you do not have it.

Likewise, the Extraordinary Ealing CCG meeting on Friday 25 May was told its Chair would be asked to sign a letter of support (identical, as it happens, to all the other 7), which she duly did on the following Tuesday. There was no suggestion of any alteration and they did what they were told.

NHS Ealing admitted that the documents were not available on 13 July - nearly 2 weeks into the process - and I have been monitoring their progress as much as I can; Fulham Reference Library e-mailed me to say that they received theirs on the afternoon of 23 July - 3 weeks in. Please don't tell me the document was on the website: as we have repeatedly said, many in this Borough do not have

internet access or skills. And, for those whose first language is not English, the 'Select Language' tab on the healthiernorthwestlondon page is still showing nothing today, over 4 weeks into the process.

Incidentally, the NHS Ealing e-mail was sent three days after your 'have-your-say' web page said that the documents were actually available in libraries. Consistent, however, with your customary ineptitude the paragraph actually reads: 'This is available in local GP surgeries, libraries, xxxxxx and xxxxxxx and a summary version of the document is being distributed in local papers throughout the NHS NW London area.'

Please tell me where in the past the NHS has been *reasonably* criticised for making a decision which needed consultation and for then allowing a responsible period to produce the appropriate material. It truly beggars belief that you are happy to reverse the sensible order of things. I am utterly convinced that you would not have been upbraided for announcing the conclusions of the Board Meeting and the intermediate deliberations of the JCPCT, and declaring that the consultation would begin on a certain date consistent with the reasonable expectation of print delivery. What you are saying is 'We'll give smart folk with the internet a head start on this; the rest can wait 3 weeks or more and over 7 weeks if they want a foreign language.' I find that contemptible, as is the insinuation that people without English as a first language are any more unlikely to 'be able to read due to visual impairment or illiteracy in the mother-tongue.' I am surprised that CITAS said that, but I defer to their expertise in literacy and ocular health.

The Consultation Document says clearly on the inside back cover 'This document is also available in other languages.' Clearly that is not true as you have confirmed. The earliest you say any translation will be generally available is 24 August. Does the despatch of 5 copies in Braille satisfy the "reasonable adjustments" demanded by the Equality Act 2010?

Please do not imply a complaint to me about the costs of printing - they should have been an expected part of the process your organisation has sought to undertake and are probably dwarfed by the money you have spent on advisers and London Agencies.

And please do not advise me to pass on details of my neighbours to you - I shall ask them to make their own arrangements if they wish as I was trying only to be helpful.

If I seem obsessed with the documents' non-delivery, it is only partly because they form a vital part of the process of helping people of all backgrounds, cultures and levels of ability to understand what is being proposed and what services they will lose. But it is also because this shambles is reasonably representative of the whole wider process of taking away important elements of local healthcare and replacing them with wholly untried 'community models' which have no evidential accreditation, or, at least, none that your FoI team are able to present.

If I can agree with just one thing Dr Spencer has had to say, it is that we are 'currently wedded to mediocre services', that is, the services of the *Shaping a healthier future* team, who seem unable or unwilling to engage appropriately or in a timely manner with the people of this Borough and, I guess, of all 8 Boroughs in the area.

Regards,

Colin Standfield

Subject: **RE: Out of Office: Consultation document - Facts and Errors**
Date: 03/08/2012 18:15:27 GMT Daylight Time
From: David.Mallett@nw.london.nhs.uk
To: ColinStandfield@aol.com

Dear Mr Standfield

It's going to take another day to prepare a fuller response to your e-mail below and unfortunately I am on leave on Monday (6th). Please accept my apologies, I will write to you on Tuesday.

One point I can confirm. You asked "*Andy Slaughter MP thought he had been sent one by 10 July until I pointed out in the Palace of Westminster that he had a ring-bound photocopy - was this one of the 80 costing £17.50 each?* ". To which the answer is yes, we sent him 20 spiral bound printed copies. Definitely printed, not photocopied but presumably not conforming to your definition of "properly printed and bound editions analogous to those referred to in the first paragraph " if by that you mean, bound identically to the 100,000 copies in the full print run.

Regards

David Mallett

SRO *SaHF* Programme Delivery

NHS North West London

Subject: **Re: Out of Office: Consultation document - Facts and Errors**
Date: 03/08/2012
To: David.Mallett@nw.london.nhs.uk

Dear Mr Mallett,

You are quite perceptive - a spiral bound lash-up does not conform to the detailed description I gave, nor to any reasonable interpretation of a document required for such an important purpose. An ISBN, a Printer's name and a Publisher might have added a little dignity, but we should be pleased to see it at all.

Colin Standfield

Subject: **RE: Out of Office: Consultation document - Facts and Errors**
Date: 07/08/2012 20:21:26 GMT Daylight Time
From: David.Mallett@nw.london.nhs.uk
To: ColinStandfield@aol.com

Dear Mr Standfield

Thank you for your e-mail below. [Re 'Sir Humphrey' of 2 August, above] I will attempt to address your points in the same order.

Regarding the first round of consultation documents, in my e-mail of Friday 3 August I confirmed "You asked "*Andy Slaughter MP thought he had been sent one by 10 July until I pointed out in the Palace of Westminster that he had a ring-bound photocopy - was this one of the 80 costing £17.50 each?* ". To which the answer is yes, we sent him 20 spiral bound printed copies. Definitely printed, not photocopied but presumably not conforming to your definition of "properly printed and bound editions analogous to those referred to in the first paragraph " if by that you mean, bound identically to the 100,000 copies in the full print run. "

I understand what you are saying about the phrase "tens of thousands", I do not think I can offer you further useful comment.

Regarding the suggestion that there is 'an agenda' to get this 'on a Minister's desk by early February', the matters under consultation are for the local NHS to make a decision on, not a minister. The SaHF programme is not working to any externally imposed timetable. The only way our proposals could end up on the government's 'desks' would be if the consultation and/or final decision were referred to the Secretary of State by the JHOSC or one of the OSCs. Currently we are aiming to make a final decision in early 2013. Currently there is no time limit on JHOSC/OSC referral but normally, if they refer, it is not long after the local NHS has made its decision. Were they to do so, the Secretary of State would ask the Independent Reconfiguration Panel (IRP) [www.irpanel.org.uk] to advise whether a full review is required and, on their advice, request a full review. If the JHOSC/OSC referred in, say, March 2013, the IRP's final report might be back to the Secretary of State in September 2013. I should stress this is speculation on my part and would depend on the timing of any referral, how quickly it is dealt with by Secretary of State and how long the IRP require to take their work.

It is hard for me to comment on your suggestion that 'It is absurd to imagine that you thought there might be any changes after the Board date ' . As described in my previous e-mail, a factor in the timing of the availability of consultation documents was the possibility of changes being necessary in light of the JCPCT's decision. There were 3 working days available to make changes after the JCPCT meeting, 1 after the NHS London Board. The JCPCT meeting in particular had potential to require changes and, if necessary, we would have postponed the consultation launch date to accommodate them.

I have just (7 August) checked on the web-site and the drop down menu offers a translation into 64 languages and I have seen that function working previously. You'll appreciate it is only a 'Google translate' function, we have not written separate text on the web-site pages in other languages.

I can't comment on whether elsewhere the NHS was "reasonably" criticised for the length of time between the decision to launch and the formal consultation launch date. I understand that this is a criticism that has been levied and the plan adopted in NHS NWL, to put the document on the internet and undertake a quick print run of a small number of documents while awaiting the much larger print run has also been an approach adopted elsewhere to deal with that issue.

As far as I know we have met the needs of the Equality Act to date. We will be undertaking a further review of compliance against the Act.

I was not implying a complaint about the cost of printing. I foresaw that if I suggested to you cost was a factor, you would ask what that cost was. As you say, the amount concerned is relatively small compared with other programme costs, nevertheless, printing costs were a factor in the decision regarding the sequence and timing of the consultation materials.

Regarding your neighbour, I also was only trying to be helpful.

Finally, I am surprised if our FoI team was unable to furnish you with information about the evidence base for the proposals. I have asked them to provide me with your original request and their answer.

David Mallett
SRO *SaHF* Programme Delivery
NHS North West London

Subject: **RE: London Mela Disgrace**
Date: 24/08/2012 19:19:05 GMT Daylight Time
From: David.Mallett@nw.london.nhs.uk
To: ColinStandfield@aol.com

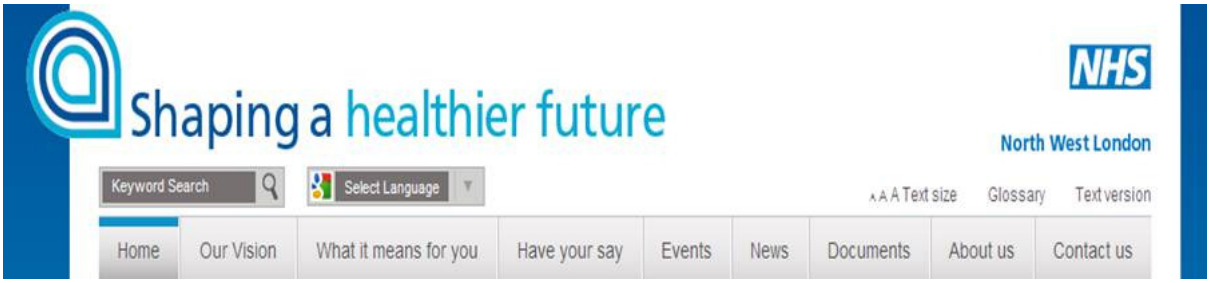
Dear Mr Standfield

Thank you for the e-mail below.

I will try to address your points in the order you raise them. Before I do, can I draw your attention to the e-mail I sent you on 23 August regarding the proposed public debates. As I mention in that e-mail, I am on leave next week. When it is convenient, If you were able to 'reply all' with your comments on that e-mail the team will pick them up.

As I explained in a previous e-mail, electronic translated documents were provided to us today and are being uploaded to the web-site. Distribution of hard copies will begin next week. I think the person who you say said 'None had been asked for' was my colleague Abbas Mirza who is leading on this part of our engagement. Abbas' memory of the conversation is that he told you that no one had asked at the stall for translated documents, not that none had ever been asked for.

I am sorry you are having difficulties with the web-site. I have checked again today at: http://www.healthiernorthwestlondon.nhs.uk/. This is a screen grab of the home page:



It is the 'select language' drop down I was referring to previously. In my previous e-mail I said "*I have just (7 August) checked on the web-site and the drop down menu offers a translation into 64 languages and I have seen that function working previously. You'll appreciate it is only a 'Google translate' function, we have not written separate text on the web-site pages in other languages.* " I did not mean for you to draw the inference that I was referring to a translation of the consultation document itself as the e-mail explained that translations were not available. The drop down menu creates a google translation of the web-page only.

Sadly, regarding timetable, if not "argue", I am going to have to clarify my interpretation of "the definitions of 'externally', 'imposed' and 'timetable' " in the previous e-mail exchange. The NCAT report is correct in saying that the NHS transition was a factor regarding the programme timetable. In your previous e-mail you suggested "Clearly there is an agenda you do not wish to reveal that requires a document to be on a Minister's desk by early February " which I interpreted as what you meant by external.

Unfortunately I am struggling to find independent evidence of my assertion that the NHS has been criticised for the delay between making a decision to launch consultation and the start date for the consultation itself. Rightly or wrongly it was in our minds at the time and is the reason why the consultation was launched so soon after the JCPCT and NHS London Board. I will continue to look for the evidence.

As described above, I am on leave next week although my e-mails are being monitored.

David Mallett

SRO *SaHF* Programme Delivery

NHS North West London

From: ColinStandfield@aol.com [mailto:ColinStandfield@aol.com]
Sent: 19 August 2012 22:49
To: David Mallett
Subject: London Mela Disgrace

Dear Mr Mallett,

I have just come back from the London Mela, where your team had a stall. I found it outrageous that it did not contain a single document of any description in a language other than English. Was this a calculated insult to the thousands of Ealing residents and others who were there from our widely diverse ethnic and cultural backgrounds? Or just another example of the complacent and sloppy process that has been the hallmark of this 'consultation'?

I shall be interested to see what the BBC make of it.

The person who told me that 'None had been asked for' had actually had a conversation with one of our team nearly two weeks ago about the availability in a number of languages. As it was a hot day and as I am now accustomed to your organisation's nodding acquaintance with the truth, I let it go. The documents they were handing out contain the words: 'This document is also available in other languages, in large print, and in audio format.' Clearly that is not true, so far from the truth indeed that I think it deserves a public apology.

You wrote to me on 7 August: 'I have just (7 August) checked on the web-site and the drop down menu offers a translation into 64 languages and I have seen that function working previously.' Would you, please, send me the url of that page because I have been trying, without success, to glean information from http://www.healthiernorthwestlondon.nhs.uk/document/shaping-healthier-future-consultation-document-2-august-2012 , where there is a drop-down menu, reproduced here,

Search form

Search [ ]

Select Language ▼

where the language option does nothing.

In that same e-mail, you say that; 'The SaHF programme is not working to any externally imposed timetable.' Yet the NCAT Report says: 'The leaders of the program are obviously keen to move to consultation in June 2012, especially as there is another major organisational change happening in the NHS. The abolition of NHS London and the PCTs is driving the pace for the consultation.' Have they been misled? Or are you simply going to argue over the definitions of 'externally', 'imposed' and 'timetable'? Your answers so far have been anything but convincing.

For example, you also say in that e-mail: 'I can't comment on whether elsewhere the NHS was “reasonably” criticised for the length of time between the decision to launch and the formal consultation launch date. I understand that this is a criticism that has been levied.' All I am asking is:

where has this criticism been levied? Just a couple of examples would do. Otherwise I believe this is just another fantasy, like 'virtual wards', designed to cover your embarrassment.

Please reply when you have something sensible to say so that we can continue our preparation. This *SaHF* operation is becoming more and more evidently flawed.

Regards,

Colin Standfield

Chair, Ealing Hospital SOS

NHS NWL Deception – Demolition of Ealing Hospital

Whereas there is a notional figure for demolition of hospital buildings in the PCBC, there was no suggestion in that document nor in the public consultation document, that there were advanced plans to demolish Ealing Hospital and replace it by what is effectively a polyclinic, occupying just 4% of the current site (DMBC, Volume 2, page 599), and selling the remainder for private development.

There is a mention, just once in the PCBC and then only as a footnote to a chart, of residential development on the site:

'Figure 16.14: Summary of assessment of Option C for Ealing

‘Fits in with the development of the Uxbridge Road frontage for residential purposes, raising the value of the land at the front of the site’. (PCBC Vol 4, p14)

This was a sneaky way to foreshadow an intention to hive off NHS land for private gain, so I asked NHS London the following under the FoI Act on 28 June 2012, 3 days after the JCPCT meeting where the PCBC was agreed and the plans nodded through:

'Under the terms of the Freedom of Information Act, will you, please, let me have details of any plans at any stage considered by NHS London or NHS North West London concerning the development of land at the Ealing Hospital site for residential purposes?

'Please let me have any projected or estimated costs or income from such activity.'

Two days after the Act's 20-day deadline, I received a reply of which the first 2 paragraphs are: 'Thank you for your Freedom of Information (FOI) request concerning the development of land at the Ealing Hospital site for residential purposes.

'West London Mental Health Trust have submitted an Outline Business Case (OBC) to NHS London for the approval to invest £61m including reinvestment from land sale proceeds in the development of an 80 bed medium secure unit on their St Bernard’s site in Ealing.'

It directed me to a website for WLMHT, but completely sidestepped any reference to Ealing Hospital and the plans under *SaHF*. It could reasonably be inferred that there no such plans for the EHT part of the site.

In fact, having been asked a direct question under the FoI Act it would have been more honest to confirm what was to appear in the DMBC 7 months later. Their reluctance to do so taints the 'consultation' because for the whole period of it up to October, and beyond, this silence was continued.

The PCBC was deceptive in not expanding on the footnote to Figure 16.14, and the public consultation document was deceptive in not mentioning the demolition of Ealing and Charing Cross **at all**; indeed, it says only: 'It [any 'Local' Hospital]

basically provides the kinds of services that most people going to hospital in NW London currently go there for.' (Consultation document, page 34)

And: 'Under this option, around 91% of services would not be affected by the proposed changes.' (Consultation document, page 57) It is hard to see how that will apply when two significant buildings disappear to be replaced by clinics.

Pages 600 and 601 of Volume 2 of the DMBC introduce, for the first time in public, the previously undisclosed fact of the demolition of Ealing Hospital and the reduction of the Ealing estate. This was **not** part of the public consultation, which is thereby vitiated.

Even now, people in Ealing are unaware that their Hospital will be demolished.

This is deceitful.

NHS NWL Freedom of Information Deception – UCC Exclusion List

At a public meeting in Wembley on 15 May 2012 a member of the audience showed a paper referred to as the 'black list' of conditions the Urgent Care Centre at Ealing Hospital would not treat. From a brief glimpse, I thought it included a condition of mine and asked two of the Clinical Leads at the meeting, among other things, for a copy:

Subject: **Ealing Hospital – Tuesday's Consultation Event**
Date: 17/05/2012 12:06:31 GMT Summer Time
From: ColinStandfield@aol.com
To: Susan.LaBrooy@thh.nhs.uk, mark.spencer@nhs.net

Dear Dr LaBrooy and Dr Spencer,

I am writing as a follow-up to the meeting on Tuesday 15th, at which I managed to raise a couple of issues, even though the majority of the format was against it.
.....

It was claimed at the meeting that there is some kind of 'black list' of cases which the Urgent Care Centre at Ealing will not deal with. I have not actually read this list but I gather that one of my conditions is on it – is it in the public domain, and may I have a copy, please?

The reply on 13 June 2012, Ref no: NW367, included:

'There is no such list of conditions which are allegedly not treated at Ealing Hospital's Urgent Care Centre (UCC). [My italics] The UCC's contract states that the UCC should see all minor injuries and illnesses in line with what a reasonable GP practice would see. There are live working documents (not in the public domain) which are used to co-ordinate which conditions are seen by the UCC and which by other specialist departments not based at Ealing Hospital (such as for example plastic surgery or serious emergency eye care). This is not a prohibitive list as such but a practical document used to ensure care is properly co-ordinated between clinical units." ' (The double quotation marks at the end are not mine, the single one is.)

I maintain that the *Urgent Care Centre Exclusion List*, which had by then been sent to me by someone unknown, was *precisely* a 'list of conditions which are not treated at Ealing Hospital's Urgent Care Centre (UCC)'. I could not see why there was any need for deception then, and cannot now – except that, with the 'consultation' about to start, this was not news that NHS NWL wanted in the public domain.

It is perhaps of note that NHS NWL managed to stave off revealing the document until after the 'consultation' had closed.

I had complained to them on 26 June[1] (on next page) after receiving the dishonest response above, and the revelation occurred only after the intervention of the Information Commissioner's Office[2] – NHS NWL regularly and unnecessarily broke the rules by delaying FoI responses beyond the 20 days, but 17 May to 9 October is

both absurd and deeply troubling. My e-mail of complaint specifically mentioned that the information was 'highly pertinent to an adequate public assessment of the impact of the changes' – this warning was before the 'consultation' period began, the limp response was only after it had closed.

In fact, I hope it was only by coincidence that this late response[3] on 9 October came precisely *the day after* the 'consultation' closed on Monday 8 October. A nagging doubt suggests it was not.

[1] UCC Excl List FoI Complaint

Subject: **FoI Request – Your Ref no: NW367 of 13 June 2012**
Date: 26/06/2012
To: foi@nw.london.nhs.uk

I wish to complain formally about your response to my request of 17 May regarding the list of conditions which the UCC at Ealing Hospital will not treat. I asked specifically for the list which had been produced at the Sattavis Patidar Centre on 15 May and which I had briefly seen; it appeared to contain a condition of mine.

In your answer you say: 'There is no such list of conditions which are allegedly not treated at Ealing Hospital's Urgent Care Centre (UCC).' I am attaching a document entitled 'Urgent Care Centre Exclusion List' which has since been sent to me by someone and which looks very much like the list I had seen; it does contain a condition related to me. I have no reason to doubt its authenticity.

In the papers for the Joint Committee of Primary Care Trusts which were made available last Thursday 21 June is a document '04NCATreportonemergencyandurgentcareJune2012' – the report from the National Clinical Advisory Team – which contains inter alia this recommendation on page 10: '*6. The public are not interested in the number of doctors and the quality of doctors, they want to know what can be treated in each of the sites and what cannot be treated.'*

Therefore, the information I asked for is also required by the National Clinical Advisory Team to be in the public domain.

Will you, please, formally send me the information I asked for and any further information on '*what can be treated in each of the sites and what cannot be treated'* at each Hospital in the NWL area?

I need hardly add that this information is highly pertinent to an adequate public assessment of the impact of the changes to healthcare in this area proposed in *Shaping a healthier future,* as NCAT has stated.

[2]Information Commissioner's Acknowledgment

Subject: **Letter to Mr Standfield – Case Reference Number FS50466668 [Ref. FS50466668]**
Date: 02/10/2012 10:41:06 GMT Daylight Time
From: casework@ico.gsi.gov.uk
To: ColinStandfield@aol.com

02 October 2012

Case Reference Number FS50466668 and FS50458156

Information request to NHS North West London – Reference NW367

Thank you for your correspondence dated 13 September 2012 in which you complain about the time taken for NHS North West London to carry out an internal review that you requested on 26 June 2012. Please find attached a document describing how we deal with Freedom of Information complaints.

You will notice that there are two reference numbers at the top of this page. To explain why, **FS50458156** relate to the original documents you sent to us on 26 July 2012. **FS50466668** is a new reference number, which relates to the further information you have sent us in order to progress your complaint further.
.....

I have written to NHS North West London to recommend that they issue you with an internal review decision within 20 working days from the date of receipt of our letter. I enclose a copy for your information.

Subject: **Re: Letter to Mr Standfield – Case Reference Number FS50466668 [Ref. FS504666...**
Date: 02/10/2012
To: casework@ico.gsi.gov.uk
CC: foi@nw.london.nhs.uk

Thank you for this reply. I am happy for NHS NWL to respond to my complaint by 23 October, that being 21 rather than 20 days from today.

The document 'Urgent Care Centre Exclusion List' should never, I believe, have been outwith the public domain once the UCC became operational, but to state under the FoI that it did not exist at all demands an explanation. I am sure there is a ready answer and I shall let you know when I receive it.

[3]NHS NWL Final, Overdue Response

Subject: **IR11/NW367 FoI Request – Your Ref no: NW367 of 13 June 2012**
Date: 09/10/2012 14:01:18 GMT Daylight Time
From: foi@nw.london.nhs.uk
To: ColinStandfield@aol.com, foi@nw.london.nhs.uk, casework@ico.gsi.gov.uk

Ref: IR11/NW367 ICO FS50466668

Further to your Freedom of Information request, request for an internal review and your subsequent complaint to the Information Commissioner. I apologise for the unacceptable delay in responding to your request. The Director reviewed the case on 24 August 2012 and concluded that he would have to be reassured Ealing PCT through its contract with Care UK did not have a copy of the list that you refer to. I have been liaising with Ealing on this matter. I can now respond.

Ian Jackson, Head of Locality Development and Support, Ealing has provided an explanation to the list that you refer to:

"I can confirm that there is no black list of conditions which Care UK will not treat. There are a number of treatment pathways, agreed between clinicians at Care UK and Ealing Hospital Emergency Department which are followed in all cases. The attached list of conditions refers to those who would be sent directly to the Emergency Department within the hospital rather than have Care UK attempt treatment as these conditions are all severe enough to require immediate emergency treatment."

Our previous response stated that the list did not exist. A black list of conditions does not exist. However, the list that you provided in a subsequent email is a list of conditions that will be dealt

with by the Emergency Department rather than the UCC. I apologise for the misunderstanding. The list you refer to is part of the treatment and transfer pathways. I attach a copy of the list that you already have.

It is impossible to tell whether the writer is simply cavilling at the adjective 'black'. It is clear, though, that the sentences I have highlighted in red (from 'A black list' to 'misunderstanding') are an astonishing piece of legal sophistry. I cannot tell when a list clearly headed *Urgent Care Centre Exclusion List* became 'UCC Transfer List' – my only construction on all of this is that it was a deliberate and sustained attempt to deceive.

If NHS NWL cannot be trusted to deliver a simple document on time and honestly, they cannot be trusted to devise and implement a complex reorganisation of health care requiring, for many residents, a deterioration rather than improvement in the quality of and access to emergency treatment.

URGENT CARE CENTRE EXCLUSION LIST

ACS/MI
Acute anaphylaxis
Actively suicidal/deliberate self harm (not suicidal ideation)
Acute confusion
Alcohol or drug intoxication (likely to need obs)
Alleged rape (with major injury)
Children with complex fracture of upper or lower limb likely to require manipulation
Complex fractures/pelvic fractures/hip or long bone fractures
Colles fracture
Collapse state
Currently having seizure
CVA/TIA (separate pathway)
Dental injury (Northwick Park maxfax)
Dvt or suspected Dvt
Extensive burns
Fever with oncology
Hematuria post abdominal injury
Inhalation of smoke or fumes
Mandible dislocation
Major Head injury
Meningitis or suspected meningitis
Multiple injury/trauma
Needle stick injury
Penetrating eye injury
Pregnancy with persistent vomiting
Psychosis
PV bleeding (heavy)(pregnancy less than 20 weeks to ED and more than 20 weeks to obstetrics)
Pregnant with abdominal trauma
Paediatric white card holders (will directly go to paediatrics)
Patients with gp referral letter to go to speciality direct
Renal colic (blood positive on urine dipstick)
Severe pain (requiring parental analgesia)
Severe breathing difficulties
Shoulder dislocation
Sickle cell crisis
Significant epistaxis
Significant haemoptysis/heamatemisis
Gunshot injury
Significant stab wound
Unconscious
Uncontrollable haemorrhage
Unresponsive floppy child

NHS NWL Deception – '200 people are being killed'

On 11 July 2012, just after the public consultation on *Shaping a healthier future* began, its Medical Director, Dr Mark Spencer, was quoted in an article in *The Evening Standard* under the headline: 'Delaying casualty unit shake-up will cost lives of 200 patients a year'.

In it Dr Spencer said: 'If it's bogged down in a judicial review, politicians are killing 200 people a year.' He has never claimed that he was misquoted. His use of the present indicative rather than a highly qualified conditional was astonishing.

Two days later, after a letter was sent to Ealing GPs from Sharon Hodson, Business Manager at NHS Ealing (but I understand with Dr Spencer's guidance, and my information was not gainsaid) which mentioned anxiety raised by press coverage, I could not stand the hypocrisy and wrote to the Chair and CE of NHS NW London:

Subject: **Dr Mark Spencer's Comments in The Evening Standard**
Date: 13/07/2012
To: jeff.zitron@nhs.net, anne.rainsberry@nhs.net

Dear Dr Rainsberry and Mr Zitron,

It was ill-advised for your Medical Director to write to GPs today saying: 'The programme has recently attracted increasing press coverage and patients are starting to become anxious.' This is the programme described in Parliament on Wednesday as 'an evisceration, an amputation without anaesthetic and a destruction of what we in north-west London hold so dear,' with no specific counter from the Minister of State, Simon Burns.

This is also the week in which Dr Spencer made his own attempt at stirring up anxiety by being quoted in *The Evening Standard* thus: 'If it's bogged down in a judicial review, politicians are killing 200 people a year'. I have seen nothing in the paperwork which *guarantees* that the remaining A&E units after the reconfiguration will meet the standards of the Chelsea and Westminster and the trust running St Mary's. Dr Spencer must be invited either to withdraw or substantiate his remarks, which can readily be construed as a deliberate attempt to influence the public consultation. In that respect his comments have been carefully noted.

He also makes scurrilous, unprovable and unchallengeable allegations about Councillors, alleging that they confide one thing to him in private and say another in public so as to 'be seen to fight for their local hospital'. I have today asked all Councillors in Ealing, where Dr Spencer is a part-time GP, to confirm as anonymously as they prefer any such private briefing. I have received so far flat denials from two of the main parties that any of their Councillors has engaged in any such activity. I expect the same from the third.

For example, and unprompted by me:

'I confirm that neither I nor any of the council group have had any private conversations with Dr Spencer where we indicated any support for his proposals

On behalf of the group I would also like to reaffirm that we are fully committed to retaining a District General Hospital at Ealing Hospital with an A&E and all its current services, and furthermore that we are opposed to the loss of the A&E at Central Middlesex, Charing Cross and Hammersmith hospitals.'

Again, it would be honourable for Dr Spencer to be invited to substantiate or withdraw the remarks, which accuse unspecified Councillors across the NWL area of double-dealing. He has already had to retract, in a letter to *The Ealing Gazette* today, remarks attributed to him last week.

We are trying to conduct a fair and transparent campaign, engaging appropriately with the public, and will challenge any attempt at subversion through misleading answers to FoI requests or unsubstantiated comments from your officers.

Regards,

Colin Standfield
Chair, Ealing Hospital SOS and Secretary of the Ealing Campaign Steering Group

Subject: **Dr Mark Spencer's Comments in The Evening Standard**
Date: 17/07/2012 10:38:28 GMT Daylight Time
From: Anne.Rainsberry@london.nhs.uk
To: ColinStandfield@aol.com
CC: jeff.zitron@nhs.net

Dear Mr Standfield,

Thank you for your letter, which we have discussed with Dr Spencer.

We are content that the case for savings lives is explained in more detail in the pre-consultation business case. The remarks made by councillors have been made in public and witnessed by others and so Dr Spencer's comments remain on record. The potential for saving 200 lives a year is a very conservative estimate.

There was no retraction in the Gazette this week – we merely needed to point out that the journalist had curtailed Dr Spencer's comments when asked about petitions he went on to say that the consultation was asking for reasons and suggestions to improve the proposals rather than signed petitions. [No reply on Councillor accusations.]

We look forward to your continued involvement in this consultation.

With best wishes.

Anne Rainsberry

Subject: **'200 Lives' and Public Opinion**
Date: 26/08/2012 23:53:54 GMT Summer Time
From: ColinStandfield@aol.com
To: anne.rainsberry@london.nhs.uk

Dear Dr Rainsberry,

On 17th July I asked you to justify the figure of 200 lives that would be lost if politicians delayed the *SaHF* plans. Dr Spencer's exact words in *The Evening Standard* had been: 'If it's bogged down in a judicial review, politicians are killing 200 people a year.' You wrote to me earlier on 17th to say that 'the case for savings lives [sic] is explained in more detail in the pre-consultation business case.'

I asked you to identify exactly where, as I had been through the entire document and PCBC and could find no reference to any saving of 200 lives, or any projection that a political delay would kill that many. So far you have failed to do so.

I think it is fundamentally important that your Medical Director should not intervene during the consultation process with allegations that cannot be substantiated – this can be readily construed as an attempt to influence the course of that process and it therefore vitiates it.

In that same e-mail, you sought to explain Dr Spencer's comments in The Ealing Gazette, in which he was asked if petitions or campaigns could make a difference. He allegedly replied: 'No. People are currently wedded to mediocre services.'

You say that his answer was 'curtailed' and that he had gone on to say that the consultation was asking for reasons and suggestions. My simple question remains: did he or did he not answer 'No' to that question, knowing it was likely to be published? [No reply ever given.]

This exchange in the press has clearly created confusion, as I have today received a complaint which stems from that comment.

I have been more than necessarily patient in awaiting responses from NHS NWL but time is now pressing and I should appreciate the courtesy of an early reply.

Colin Standfield

Chair, Ealing Hospital SOS

Subject: **RE: '200 Lives' and Public Opinion**
Date: 30/08/2012 09:30:23 GMT Standard Time
From: Anne.Rainsberry@london.nhs.uk
To: ColinStandfield@aol.com

Good morning Colin,

Thank you for your email. This has been forwarded to the relevant team and they will respond to you in due course.

Kind regards

Elaine

Elaine Turner
on behalf of Anne Rainsberry

Subject: **Re: '200 Lives' and Public Opinion**
Date: 30/08/2012 10:44:21 GMT Summer Time
From: ColinStandfield@aol.com
To: Anne.Rainsberry@london.nhs.uk

Dear Elaine,

Thank you. Since Dr Rainsberry wrote to me that 'the case for savings lives is explained in more detail in the pre-consultation business case' and since she is the Senior Responsible Officer, I assumed she knew.

I trust it will not be long before that figure of 200 is identified.

Regards,

Colin Standfield

Subject: **'Politicians are killing 200 people a year' – Dr Mark Spencer**
Date: 08/10/2012 10:39:02 GMT Summer Time
From: ColinStandfield@aol.com
To: anne.rainsberry@london.nhs.uk

Dear Dr Rainsberry,

I refer to my e-mails of 17 July and 26 August, in which I sought substantiation of Dr Spencer's comment about any political challenge to *SaHF* in *The Evening Standard*: 'If it's bogged down in a judicial review, politicians are killing 200 people a year.'

You had asserted on 17 July that this figure was justified: 'the case for savings lives [sic] is explained in more detail in the pre-consultation business case.'

I asked where the figure was to be found and your office advised me on 30 August that 'the relevant team' would respond to me in due course.

Due course has now run and I can trace no answer.

We are now being assured that no changes to hospitals will occur for three years, while the changes to UCCs are made and the Out-of Hospital strategy is developed; there is no reason why Judicial Review should not happen simultaneously, and it will take probably no more than 6 months if lives are at stake, in which case NHS NWL will be responsible for 200 deaths a year. Who is currently answerable for those deaths?

Please treat this as a request under the Freedom of Information Act, and you may answer by e-mail:

1. What are the data which show that a Judicial Review will result in the deaths of 200 people a year?

2. When is it estimated that such a Review will begin?

3. What estimate is made of the length of time such a Review will take?

4. To what extent is it calculated that any Review will realistically delay or vitiate the completion of the Commissioning Strategy Plan 2012 – 15 or the *SaHF* timetable?

My concern, I repeat, is that Dr Spencer's remarks were an attempt to influence the consultation, being published just over a week after it began. This would make a JR not only more likely, but more likely to succeed.

Colin Standfield

Subject: **RE: 'Politicians are killing 200 people a year' – Dr Mark Spencer**
Date: 09/10/2012 14:04:37 GMT Standard Time
From: Anne.Rainsberry@london.nhs.uk
To: ColinStandfield@aol.com

Dear Colin,

Thank you for your email, we will be in contact shortly.

Kind regards

Anne Rainsberry

Subject: **NW598 RE: 'Politicians are killing 200 people a year' – Dr Mark Spencer**
Date: 26/10/2012 17:00:09 GMT Summer Time
From: foi@nw.london.nhs.uk
To: ColinStandfield@aol.com
CC: foi@nw.london.nhs.uk, Anne.Rainsberry@london.nhs.uk

Dear Mr Standfield,

Further to your enquiry and Freedom of Information request sent to Dr Anne Rainsberry on the 8 October. I can now provide a response on behalf of the Shaping a Healthier Future team.

I attach a letter and appendix which responds to your queries.

Regards

Dominic Mallinder
FOI Lead
NHS North West London

The salient extract from Mr Mallinder's letter (26 October 2012, Ref no: NW598) is:

The response to your request is:

1. What are the data which show that a Judicial Review will result in the deaths of 200 people a year?
I attach a letter from Mr Mallett regarding evidence to support Dr Spencer's contention that the SaHF proposals when fully implemented will save at least an additional 200 lives per year.

The view is that any delay in implementation, from whatever cause, would lead to these lives not being saved.

2. When is it estimated that such a Review will begin?
No estimate has been made of when a Judicial Review might begin.

3. What estimate is made of the length of time such a Review will take?
No estimate has been made of how long a review might take.

4. To what extent is it calculated that any Review will realistically delay or vitiate the completion of the Commissioning Strategy Plan 2012 – 15 or the SaHF timetable?
No calculation of this type, beyond the general point that any delay would lead to lives not being saved, has been made.

The Mallett letter, appended below, begins with what became a customary apology and Dr Spencer's version of 'the dog ate my homework':

'Firstly can I offer my apologies for the long delay in responding to your enquiries regarding the justification for Dr Mark Spencer's assertions about the number of additional lives that could be saved by implementation of our proposals as originally quoted in The Evening Standard. Mark thought he had replied to your original e-mail but searching his e-mail account can find no record of a reply.' Oddly, nor can I.

The paragraph on which they mostly depend, No 1, provides a wealth of mathematics, agreeing with me as it happens on the multifactorial nature of the alleged 'weekend effect', but ends in a mere expectation: 'By implementing the proposals within 'Shaping a Healthier Future' we *expect* to substantially reduce the weekday versus weekend difference saving these 130 lives.' By the final paragraph Mr Mallett notes that 'only the 130 excess deaths figure has significant analysis to support it.' 'Analysis' note, not 'evidence' – it is a calculation on a calculation leading to an expectation.

Paragraph 2 is Panglossian in its desperation to find some lives to be saved – 'if every hospital were as good as the best', in effect, 'some lives might be saved'. This

is simply a management issue, not one that requires the closure of 4 A&Es and concomitant services. It is an embarrassing irrelevance.

It is also a statistical deception: the Hospital Standardised Mortality Rate is a statistical estimate and so cannot be used to determine precise numbers of deaths that may have occurred or that could have been avoided. It is much better suited to an examination of the same organisation over time, in my opinion. Indeed, as the authors of the referenced Nuffield study acknowledge: 'As a consequence, it seems likely that, in the 21st century, the ability to compare health system performance using mortality data at the aggregate level is likely to be limited, simply because the differences will be relatively small.'

It is not even clear whether Mr Mallett is referring to HSMRs or SHMIs when he mentions 'SHMRs'. Nor is it clear what part of the East Midlands dataset is being referred to in footnote 8. In fact, the whole of that paragraph disappears into statistical irrelevance, just to save the blushes of a Medical Director.

Paragraph 3 is even less relevant, even if Mr Mallett had correctly identified the author of the 'Volume of Procedures and Outcome of Treatment' study as Soljak rather than Seljak. Soljak qualifies his general thesis throughout, taking much of his data from research on a limited number of conditions. Much of the paper is equivocal and one of his sources, dating from 1996, states: 'The best research suggests that there is no general relationship between volume and quality. However, in some specialities there appear to be quality gains associated with increased hospital or clinician volume.' (*Effective Health Care* bulletin, Vol 2 No 8)

But it adds: 'In some cases, the indicated thresholds are relatively low, and could be reached through specialisation of tasks within a hospital rather than an increase in the size of the provider.'

The EHC paper concludes: 'The literature on links between volume of activity and clinical outcomes suggests that for some procedures or specialities there may be some quality gains as hospital or clinician volume increases. In other areas the research suggests an absence of significant volume gains. Generalisation is clearly not possible on the basis of these results. Hence it would not be warranted to extrapolate the findings, whether positive or negative, outside the sample ranges, or for the many procedures where the research evidence is too poor to suggest any conclusion.

'Where volume is associated with quality, the direction of causation is not established and there is no good evidence to indicate that increasing volume will actually result in an improvement in health care outcomes.'

It is not for me to make a judgment on the age or quality of the research presented to me by NHS NWL. What is apparent and undeniable is that there is nothing in that paragraph of Mr Mallett's, and still less in its footnote references, which does anything to support NHS NWL's desperate defence of Dr Spencer.

It is an appalling state of affairs – that the might of NHS NWL's team can muster, after 15 weeks of procrastination and denial, just this limp observation by way of

'evidence': 'I know Mark's feeling is that a reduction in excess of mortality of 200 lives per annum is a reasonable assumption'.

I believe Spencer saw an opportunity to influence public opinion at the very start of the 'consultation', and took it. Blaming 'politicians' for non-existent or merely extrapolated deaths was a disgraceful intervention by the Medical Director of an organisation which was clearly incapable of preparing a coherent case for the public, relying instead on hysterical shroud-waving.

I am not a politician, but am implacably opposed, as are thousands in Ealing, across North West London and beyond, to the wholesale and unjustified cuts in services which will lead to very few improvements in health care.

North West London

NHS North West London
15 Marylebone Road
London, NW1 5JD

Tel: 020 3350 8000

26 October 2012

Dear Mr Standfield,

Firstly can I offer my apologies for the long delay in responding to your enquiries regarding the justification for Dr Mark Spencer's assertions about the number of additional lives that could be saved by implementation of our proposals as originally quoted in The Evening Standard. Mark thought he had replied to your original e-mail but searching his e-mail account can find no record of a reply.

Mark's claim rests on four potential benefits from the proposed changes:

1. There have been many studies showing excess deaths from admissions at weekends and at night published in the last 15 years[123]. Imperial College published the largest study showing this effect in 2010[4]. This confirmed an excess death rate of 10% for weekend admissions. Following this Prof Aylin was asked to do a specific analysis for London. The study calculated 'excess' deaths across London at 500 per annum (in keeping with the national 10% – the actual London The probability ratio is 1.12 (95% CI from 1.08 to 1.15), P value = <0.001). The calculation is not statistically robust at individual site level however we calculate NWL's proportion of these deaths to be around 130. As you will be aware, one of the key deliverables of any of the Shaping a Healthier Future (SaHF) options is improving weekend cover by a better distribution of our limited consultant resource and support services. The 'weekend effect' is multifactorial, but importantly studies have also shown that, for example, where stroke centres have been implemented with improved senior clinician and diagnostic access the effect is removed[5]. Dr Foster have just released a review of this study, prior to full publication in this year's hospital guide, again showing the 10% excess, but highlighting that this is much greater for some conditions[6]. By implementing the proposals within 'Shaping a Healthier Future' we expect to substantially reduce the weekday versus weekend difference saving these 130 lives.

2. As you know, Hospital Standardised Mortality Rates (HSMR) of NWL providers are relatively low in North West London but there are significant differences between them. I'm sure you know that HSMR is weighted for deprivation (amongst other things) so that this doesn't explain the variation. If all NWL providers achieved the same HSMR as the best Trusts in inner NW London, this would equate to approximately 800 lives per annum. Again, by adoption of the consistent high standards that all SaHF options deliver, we expect a significant reduction in the variation

[1] Bell, M. D., Redelmeier, D. A. (2001). Mortality among patients admitted to hospitals on weekends compared with weekdays The New England Journal of Medicine 345: 9
[2]Barba, R., Losa, J. E., Velasco, M., Guijarro, C., Garcia de Casasola, G. & Zapatero, A. (2006). Mortality among adult patients admitted to the hospital on weekends The European Journal of Internal Medicine 17: 322-324
[3] Riciardi, P. (2011) Mortality rate after non-elective hospital admission. Arch. Surg. 2011; 146(5): 545-551
[4] Aylin P et al: "Weekend Mortality for emergency admissions: a large multicentre study"; Qual Saf Health Care 2010;**19**:213-217
[5] Cerebrovasc Dis 2009;27:107-113
[6] http://www.guardian.co.uk/society/2012/oct/15/weekend-hospital-admissions-stroke-kidney?newsfeed=true

towards the low HSMR's achieved by the best. It should be noted that if SHMR for conditions amenable to health care[7] are considered we do less well in North West London and greater opportunity to save lives by improved care is suggested[8].

3. You will be aware of research suggesting a correlation between increased patient volume and quality. This is well-recognised in some specialties, for example, major trauma and vascular surgery[9]. A paper by Seljak[10] set out the case for a more general application of this principle although this application is definitely contentious.

4. Finally, you will be aware that the SaHF proposals include reinvestment of savings made in the secondary care sector into primary care and community services. We expect this to lead to many improvements for patients including better care for those suffering from long term conditions (LTC) such as diabetes. Patients with LTC account for 60% of all hospital bed days[11]. The National Diabetic Audit[12] showed that there were 24,000 excess deaths each year in England. London's care is better than elsewhere in the country and "only" about 750 excess deaths occur in North West London (from this one condition. Investment in secondary prevention and improved community care has been shown to reduce mortality[13]. Simple measures such as telehealth is being implemented as part of the Out of Hospital work, have been shown to reduce mortality at 1 year after acute admission by almost 50% (from 8.3% to 4.6%)[14]. Similar evidence is available across the range of Long Term Conditions that will be positively impacted by the investments in Primary Care Services.

For clarity, we recognise the first 3 points above probably overlap and that only the 130 excess deaths figure has significant analysis to support it. The scale of potential benefit from the improvement in primary care is however much greater. However, taken together, I know Mark's feeling is that a reduction in excess of mortality of 200 lives per annum is a reasonable assumption. Indeed a very conservative one.

I trust you find this reply helpful and please can I reiterate my apology for the delay in responding.

Yours sincerely,

David Mallett
NHS NWL SRO Programme Delivery

[7] http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/does-healthcare-save-lives-mar04.pdf
[8] http://www.emqo.eastmidlands.nhs.uk
[9] http://www.ncbi.nlm.nih.gov/pubmed/20557176 'Volume-outcome relationships in vascular surgery: the current status'
[10] Seljak, M: 'Volume of Procedures and Outcome of Treatment'; BMJ 2002;325;787-788
[11] http://library.nhsggc.org.uk/mediaAssets/library/nhsggc_ltc_strategic_framework.pdf
[12] http://www.ic.nhs.uk/webfiles/Services/NCASP/Diabetes/200910%20annual%20report%20documents/NHS_Diabetes_Audit_Mortality_Report_2011_Final.pdf
[13] **Diabetes Care Jun 2012;35(6):1279-1284**
[14] BMJ 2012;344:e3874

NHS NWL Deception – Out-of-Hospital Services

General

The implementation of the *SaHF* plans relies on heroic and unsubstantiated assumptions about the availability and effectiveness of 'out-of-hospital services' to cope with much of the displaced A&E demand. The people who have drawn up *SaHF* are the same as those who have been trying for 10 years to reduce the A&E burden by utilising more community-based care: Dr Spencer and I were both on the Ealing PCT Board in 2004 when this was a live issue and he and his colleagues have achieved nothing since. There has been no appreciable effect on Ealing's A&E attendances and, indeed, they rose by 2.75 % last year. ('A&E activity for the full year was 41,645 attendances, which represented an increase in 1,115 attendances from 2011/12 and UCC attendances were marginally (439) down on 2011/12.' ECG *Paper 8a Ealing AE Improvement Plan v13 FINAL 19 6*, July 2013)

The lack of clarity about OOH provision, beyond promises and aspirations, means that the public have been deceived into believing that there is a robust and costed plan to provide safe and accessible services once the Hospital has closed. (And closed is what it will be – some out-patients and diagnostics with an 'Urgent' Care Centre do not comprise a hospital.)

NCAT

The National Clinical Advisory Team expressed reservations about the OOH plans before the PCBC, and reiterated those concerns in their second report. One of their team paid a visit to Ealing and became convinced, on the strength only of a 'commitment' from NHS NWL: 'a commitment to work with the Health and Wellbeing Boards to collect a matrix of information on OOH provision before initiating the hospital reconfiguration.' Very reassuring.

His main point of enquiry seemed to be whether Ealing was unique rather than whether it had a valid claim to the retention of its full DGH services.

Sadly, NHS NWL have decided to put up only the first 3 pages of his letter, at: http://www.healthiernorthwestlondon.nhs.uk/sites/default/files/documents/NW%20London%20final%20report%20%2018-2-13.pdf .

PCBC

I did point out to NHS NWL that there was a major error in the PCBC at Vol 11 – the alleged Ealing Out-of-Hospital strategy, uniquely among the 8 CCG documents, was Ealing-based up to page 6, returning to Ealing only on page 26; for the rest it is NWL generic, whether through laziness, incoherence or simply blundering. This made it difficult, if not impossible, for any interested Ealing resident to gauge what resources were going in to the A&E replacement activity.

We would be within our rights in Ealing to expect the £105 – £120 million promised in the chart on page 23. But we would be deceived, as these are the *sector* figures.

Given the resources devoted to *SaHF*, I cannot see how this blunder occurred and still have not had an explanation for this error, more than a year later.

PROVIDER DOUBTS

Even the Board of one of the favoured hospitals, Chelsea & Westminster, was expressing doubts about the out-of-hospital strategy (if it can be called that) as late as 28 May 2012: 'It was agreed that we should be expressing concern that **the out of hospital model has no evidence or financial evaluation**.' (Minutes of Board Meeting 3.4) [My emboldening]

This echoes precisely what we have been saying; this was just over a month before the consultation was due to begin, and shortly afterwards the same Minutes record: 'The Board remains unclear of Imperial Healthcare's strategy should Charing Cross Hospital A&E close.' This belies the constant claims made by NHS NWL that there is some sort of unanimity of thought among clinicians.

Given that one of the *SaHF* Medical Directors also sits on that Board, it is doubly surprising that such chaotic thinking existed at such a crucial time. Perhaps he had absented himself as having a conflict of interest, although this is not recorded.

DMBC

I had hoped that the *Decision-Making* Business Case would have had proper and more defined evidence. I found, however, on reading the documents before their presentation to the JCPCT on 19 February, that the 'plans' were as nebulous as ever, and prepared a short paper, appended as 'Incomplete DMBC and vague promises' which analysed sequentially the promises of detail and the reneging on those promises, all in the same Volume. The red highlighting in it is mine.

Some extracts are:

'The main area for development highlighted by individuals and organisations responding to the consultation was the need for **confidence in the capacity of services to deliver out of hospital strategies.'** (Vol 1, p 219, NWL's emboldening)

'We recognise that the development of primary care is crucial to the success of the eight CCGs' out of hospital strategies... Details of this programme can be found in Chapter 8b.' (Vol 1, p 226)

But 8b, at 8.6, says, for example, only words such as 'In the future, residents in NW London will experience a coordinated and integrated health and social care service using evidence-based pathways, case management and personalised care planning.' Or 'There are a number of areas in which practices have already started to work in new ways and to inform further developments NHS NW London has completed a significant research programme....'

Or 'This programme will run throughout the implementation out of hospital strategies [sic]'

But no 'details' at all.

And, under 'Estates' at 8c, there are again vague references and promises: 'These are indicative estimates: in the coming months, more detailed work will be carried out to deliver outline business cases for the investment in these sites, including detailed work on affordability.' Note that: in the months *after* the DMBC was nodded through by the JCPCT on 19 February, 'detailed work' will be done to produce *'outline'* business cases. (Vol 1, page 247)

NHS NWL have already confirmed that at least one community health centre in Ealing is full: 'You are right to say that Jubilee Gardens is working to capacity, we think it's right that we use expensive NHS facility as efficiently as possible.' (Letter of 18 July 2012 from Mr Rob Larkman in response to my questions of 16 July to Mr Jeff Zitron, including: What guarantee is there that adequate community facilities will be in place when you downgrade Ealing Hospital?)

'Virtual Beds'

The concept of 'virtual beds' in Ealing did not feature in the PCBC nor the public consultation. After it appeared in the DMBC I wrote to Dr Rainsberry on 9 March, 'What is a 'virtual bed'?'

The reply from Dr Spencer in what can only be described as a petulant e-mail reads:

' Apologies, I thought this had gone to you earlier.

'I'm afraid we all have work to do – so while you will have replies, they are not top of our priorities whilst we continue to seek to improve health care.

'... A virtual bed is a co-ordinated care package given to an indivual [sic] highlighted as being at risk of deterioration using one of a variety of risk assessment tools.'

I think that the people of Ealing deserve a more honest approach than this – not to have had a chance to raise questions on it until after the consultation means they were misled. It suggests another act of desperation, trying to convince us that there is credible provision in community settings, whereas it is an unproven notion – as the C&W Board (including Dr Anderson) agrees. No evidence has been provided to assure us of its safety or efficacy.

Summary

Care outside of hospitals is undeveloped, both in practice and in the two Business Cases. Existing community centres are at capacity and the rest of the current community provision is challenged as GPs are unable to take up the slack: 'Demand on general practice is already high, and in order to achieve our vision for out of hospital care practices we will need to work both collaboratively and innovatively.' (DMBC Vol 1, page 233) And the 'detail' that is supposed to be reassuring us is nothing more than commitments and aspirations; or, for those of us desperately seeking real reassurance, mere fantasies.

Appendix – Incomplete DMBC and vague promises: sequential extracts from Vol 1

The main area for development highlighted by individuals and organisations responding to the consultation was the need for **confidence in the capacity of services to deliver out of hospital strategies.** (Vol 1, p 219)

8.4.3. Developments since consultation
Figure 8.3 summarises the key themes across all the feedback we received from the consultation process, together with reference to where further details about the development of our plans can be found. (Vol 1, p 222)

Primary care development is a crucial strand of our out of hospital work, and we have conducted further work to develop a programme (see Chapter 8, Section 8.5.1) (Vol 1, p 222)

8.5.1. Primary care development
We recognise that the development of primary care is crucial to the success of the eight CCGs" out of hospital strategies and a vital means to ensuring patients have access to the right care when they need it.
To further understand patients" priorities for primary care, we have conducted a major research programme – including a survey of over 1,000 patients – to understand priorities for primary care. From this, we have developed a programme of activity that will support primary care across the right CCGs to work together and support each other, thus realising the ambition of delivering better care closer to home.
Details of this programme can be found in Chapter 8b. (Vol 1, p 226)

8b. Primary care development
8.6. Supporting primary care across NW London

GP practices will continue to offer core primary care services, and as GP networks and other integrated ways of working develop, these local networks will be able to offer additional expertise and capacity for more appointments..... ...Finally, all patients will have access to urgent care 24 hours a day, seven days a week at their local hospital through urgent care centres. In the future, residents in NW London will experience a coordinated and integrated health and social care service using evidence-based pathways, case management and personalised care planning.

Demand on general practice is already high, and in order to achieve our vision for out of hospital care practices we will need to work both collaboratively and innovatively. There are a number of areas in which practices have already started to work in new ways and to inform further developments NHS NW London has completed a significant research programme....

A programme of activity has been agreed between all CCG chairs in NW London which will enable them to work together to support over 400 practices in the area to realise the ambition of delivering better care closer to home. This programme will run throughout the implementation out of hospital strategies [sic] to ensure that primary care is prepared for the activity shift resulting from these strategies. (Vol 1, p 233)

8.10. Next steps
We are developing a programme of primary care development [sic] to support the 400 practices across NW London...

It is expected that this programme will be focused on developing primary care by encouraging innovation and entrepreneurship...

This change will be led by the CCGs, and we will work with the CCG chairs, NHS Commissioning Board, patients and other key partners to develop the programme further and agree actions for 2013/14. (Vol 1, p237)

8c. Out of hospital estates
8.11. Delivering the estate we need for out of hospital

....Delivering these hubs/health centres is expected to require investment of £6 million for the minimum needed for *Shaping a healthier future* and £60–112 million for the range of enhanced services to offer a fuller clinical service at each site. These are indicative estimates: in the coming months, more detailed work will be carried out to deliver outline business cases for the investment in these sites, including detailed work on affordability.

Initial assessments of revenue affordability for individual proposed hubs suggest 58% of them would be affordable under current assumptions and affordability is most challenging for new-build hubs. Further work is required in this area and investments for each individual site will require an outline business case including detailed analysis of revenue affordability in the next phase of this process. (Vol 1, p247)

It is entirely unprofessional to have spent so much time and money yet to have in the **Decision-Making** Business Case so many 'expectations' and works in progress.

It is also a grotesque injustice for the people of North West London, who deserve some semblance of certainty about what services they will have when this flawed process crawls to its conclusion. If NHS NWL and the CCGs do not know yet, they should not be permitted to continue, especially when the crisis in A&E nationally has become so apparent.

NHS NWL Deception – Home Birth

The following sentence occurs 6 times in the Decision-Making Business Case (Vol 1, pp 107, 224, 232, 236, 240 and Vol 2 p 35, of the respective pdfs) and therefore must have more weight attached to it than a mere throwaway line: *'The National evidence demonstrates that homebirth is safe and recommended practice*'. This is entirely unsupported, and insupportable.

It is a lie.

I asked the NHS NWL team at the 4 March Ealing HOSC what this evidence was and was vehemently assured that it existed and would be presented to me. There followed a series of e-mails, reproduced here with apologies for its extent – I am afraid it took that amount of perseverance to extract any information from NHS NWL:

Subject: **Evidence of Recommendations for Home Birth**
Date: 06/03/2013
To: s.labrooy@nhs.net
CC: jeff.zitron@nhs.net, david.mallett@nw.london.nhs.uk, anne.rainsberry@london.nhs.uk, mark.spencer@nhs.net, unwink@ealing.gov.uk, julian.bell@ealing.gov.uk, boothm@ealing.gov.uk, onkar4gla@gmail.com

Dear Dr LaBrooy,

I am re-sending this as you have left HHT. It was copied to jeff.zitron@nhs.net, david.mallett@nw.london.nhs.uk, anne.rainsberry@london.nhs.uk, mark.spencer@nhs.net, unwink@ealing.gov.uk, julian.bell@ealing.gov.uk, boothm@ealing.gov.uk, onkar4gla@gmail.com

At the Scrutiny meeting on Monday I promised to send details of the similarity of the 8 CCG Chair letters, which I did that evening. I won't trouble you with the originals as I'm sure you have them, but I am attaching extracts of them, which differ only in the obvious particular details (except for Central London, which finishes 'given adequate resources').

You promised to supply details of the 'national evidence' which 'recommends' home births, and I have not yet seen it.

I am attaching a paper* I drew up before the meeting detailing all the research I spent the weekend analysing. I can find nothing in any of it which shows that home birth is 'safe and recommended'.

Home birth is 'safe' where it is safe: that is, for 'low-risk' pregnancies (however defined) among multiparous women. Even then, as you will know, 21% of planned 'safe' home deliveries require transfer to obstetrics (rising to 45% among nulliparous mothers) and, under *SaHF*, this will mean transfer to another Borough. Indeed, as far as I can see and except for the residual home births, **no child will ever again be born in Ealing**. How can this possibly be construed as an improvement in clinical standards?

The reason I raised this on Monday – and I do not know why Mr Elkeles was puzzled over it – is that this sentence occurs 5 times in Volume 1 of your DMBC: 'The national evidence demonstrates that home birth is safe and recommended practice.' (pp107, 224, 232, 236, 240) At none of those instances is any evidence cited.

For Mr Elkeles' benefit, if you mention something 5 times in a Business Case, it achieves a certain significance and you may expect questions on it. The alternative, as I said on Monday, is that no-one had read it and therefore no-one spotted the repetition. But I did.

The furious shaking of your head on Monday suggested that this research was readily available – when can I see it, please?

If it does not exist, it is another good reason why the DMBC should be thrown out or referred.

* Paper on Home Birth

Shaping a healthier Future – Home Birth Not Consulted On

Home birth is an option for pregnant women that barely featured in the June 2012 Pre-Consultation Business Case or the July 'consultation' document.

As NHS NWL have tried desperately to exaggerate their commitment to what are currently wholly imaginary 'out-of-hospital services' they have enhanced the role of home births to an extent which is both dangerous and limiting for birth options available to women in Ealing.

Partial and Misleading Claim

This sentence occurs 6 times in the new Decision-Making Business Case: *'The national evidence demonstrates that Homebirth is safe and recommended practice*.' No reference is given, at any of these 6 instances, to this 'national evidence'. 'Safe' is based on a partial understanding of the evidence, 'recommended' is a fantasy.

No competent authority has been cited by NHS NWL as saying that home birth is unreservedly 'safe' – and almost invariably the papers I have reviewed describe home birth as safe for 'low-risk' pregnancies: that is, not first-time pregnancies (*nulliparous* mothers), not women who have had complications in previous pregnancies, not women who have had caesarean sections, and not women who have other complications. To sum up, **home birth is safe where it is safe.**

The National Commissioning Board says: "The continued provision of a home birth service is important so that multiparous women, and some nulliparous women who are *aware of the additional risks to the baby* and the high likelihood of transfer, can plan to have their baby at home.'[1] [My italics]

The Brocklehurst *Birthplace* study does indeed say: 'For multiparous women, there were no significant differences in the primary outcome between birth settings.' But it must be remembered that this was a study of low-risk births and there is no rationale from it to support any unqualified statement about safety, let alone recommendation.

The Possible Need for Urgent Transfer

Several papers and guidelines stress the need to have ready access and transport to specialist obstetric units – but, under *SaHF*, Ealing's maternity unit will close and the 21% of planned home births which require transfer[2] will need to rush to another Borough. Home birth 'is usually a planned event where the woman gives birth at

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[1] *Commissioning Maternity Services : a Resource Pack to support Clinical Commissioning Groups*, (NCB, July 2012) p 9

[2] *Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study*, Brocklehurst, *BMJ 2011;343:d7400* Table 2

home, with care provided by a midwife. Should complications arise, all NHS home birth services are provided within a functioning, swiftly responsive, and well understood local network of emergency services and transfer arrangements.'[3]

The Royal Colleges say: 'A maternity network, which includes births at home, in midwifery units and in obstetric units, should have a common governance structure, including robust systems and clear guidelines for monitoring the safety, quality and performance of the maternity services *and transfer arrangements within the network should problems arise*.'[4] [My italics] And: 'Service guidelines must be customised to account for *their relative proximity to an obstetric unit*.'[4]

NICE says: 'That giving birth is generally very safe for both the woman and her baby.'[5] But 'That if something does go unexpectedly seriously wrong during labour at home or in a midwife-led unit, the outcome for the woman and baby could be worse than if they were in the obstetric unit with access to specialised care.'[5] In Box 2 of page 10 they add 'There should be no barriers to rapid transfer in an emergency.' Our contention is that having the appropriate obstetric care available only in the next Borough is just such a barrier.

Home Birth Not 'Recommended'

Despite the assertion that there is 'national evidence' to support the recommended status of home births, none is cited in the DMBC and this literature review has revealed none.

Even the National Childbirth Trust stops short of 'recommending' home births, although they support and promote them. In *Is a home birth safe?*[6] they say: 'There is often an assumption that home births are not as safe as hospital births when in fact they *can be*, for women having *a straightforward birth*.' [My italics] They do not go on to recommend it, but draw attention to the facts and the research that indicate a near parity between hospital and home delivery for 'low-risk' births. 'The main focus of the study [the Brocklehurst NPEU *Birthplace Study,* 2011] is outcomes for women who are 'low risk', i.e. those who are healthy, with a straightforward pregnancy, no previous obstetric complications that might affect this pregnancy. The study finds that there are *positive reasons for considering planning* to use a birth centre or to have a home birth.' [My italics]

NICE is circumspect about the criteria for considering a home birth in CG55; on

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[3] *Maternity Matters: Choice, access and continuity of care in a safe service* (DoH, April 2007) p 47

[4] *SAFER CHILDBIRTH: Minimum Standards for the Organisation and Delivery of Care in Labour* (October 2007, Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health) pp 1 and 13

[5] NICE *Intrapartum Care* CG55 (September 2007) pp 6,7

[6] http://www.nct.org.uk/birth/home-birth-safe

page 6, it says: 'Women should be offered the choice of planning birth at home, in a midwife-led unit or in an obstetric unit. Women should be informed:

> That giving birth is generally very safe for both the woman and her baby. That the available information on planning place of birth is not of good quality, but suggests that among women who plan to give birth at home or in a midwife-led unit there is a higher likelihood of a normal birth, with less intervention. We do not have enough information about the possible risks to either the woman or her baby relating to planned place of birth. But it adds:
>
> That if something does go unexpectedly seriously wrong during labour at home or in a midwife-led unit, the outcome for the woman and baby could be worse than if they were in the obstetric unit with access to specialised care.'

The primary conclusion from the limited Olsen and Clausen Cochrane Review[7] was 'There is no strong evidence from randomised trials to favour either planned hospital birth or planned home birth for low-risk pregnant women,' before advocating further research. Once again, the focus was on 'the effects of planned hospital birth compared with planned home birth in *selected low-risk women*.' [My italics]

The King's Fund mentions: 'Other reviews have concluded that home birth can be a cost-effective option for low-risk pregnancies when compared to both birth centres and hospital-based care,'[8] but makes no recommendation either way.

The Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists[9] endorse *but do not recommend* home births: they 'support home birth for women with uncomplicated pregnancies.'

They add at 2.5 on page 2: 'A proportion of women who plan a home birth are transferred to hospital... The most serious reasons for transfer are maternal haemorrhage, concerns about fetal [sic] wellbeing and the neonate born in an unexpectedly poor condition. Delay in transfer under these circumstances may have serious consequences.' The section concludes: 'The discussion with women regarding their potential transfer in labour should *include consideration of the distance between birth settings* [my italics] and of other local circumstances which may introduce delay in transfer.'

Conclusion

If there is any evidence to support NHS NWL's assertion that home deliveries are

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[7]Planned hospital birth versus planned home birth. *Cochrane Database of Systematic Reviews* 2012, Issue 9. Art. No.: CD000352. DOI: 10.1002/14651858. CD000352.pub2.

[8]*STAFFING IN MATERNITY UNITS*, Sandall J et al, The King's Fund, 2011

[9]Joint Statement No. 2, RCM and RCOG, April 2007; page 1

recommended, they have not cited it and I have not found it. Home births are a late entry into the proposals, they have formed no part of the 'consultation' and are a desperate attempt to try to portray 'out-of-hospital services' as a reality.

Because the *SaHF* proposals will mean no maternity unit at Ealing, women in the Borough will have much more limited choices of perinatal care. The only reason this contentious passage of the DMBC was passed by the JCPCT is that **none of the JCPCT members had read the Business Case.**

Appendix A

Birth Research Cited by NHS NWL, and other Home Birth Mentions

Quotations from research papers are indented.

In PCBC

Safer Childbirth – Minimum Standards for the Organisation and Delivery of Care in Labour (2007), RCOG (Vol 2 p25) Which says:

> 'Several birth options are available for women. They include planning birth at home, in a midwifery or an obstetric unit. Service guidelines must be customised to account for their relative proximity to an obstetric unit.' (2.2.15, p22)

Safer Childbirth also notes:

> '2.2.20 Women have the right to choose where to give birth. If a woman chooses to give birth at home or in a midwifery unit contrary to advice from midwives and obstetricians, there needs to be clear documentation of the information given. Her understanding should be clarified of the potential impact of managing complications in this setting and the potential consequences of any delay in access to hospital medical care for herself or her baby. (p24)

'The maternity network agreed that they would prefer to invest in co-located midwife led units and improved out of hospital deliveries for home births versus setting up standalone midwifery units, even if their local unit was going to be moved. There was a clear commitment to increasing the number of home births.' (Vol 17 p16)

In '08 Patient Choice and Competition Report'

'*For example, there may be times when a woman is advised against proceeding with her preferred choices because of the risks involved with a more complex pregnancy.' (*p27)

In 'Consultation' document

'Women should be able to choose the option of an out of hospital pathway (home birth and standalone midwife-led unit) if appropriate.' (p28)

'To give women in NW London more choice about where they give birth, the new major hospitals would also have a midwife-led maternity unit... All maternity services will work to support women who choose to have their baby at home.' (p45)

That is to say: there is no mention in the 'Consultation' document of the safety of home birth, no mention of its being 'recommended' and no mention of its needing to be increased to cope with displaced hospital admissions.

The idea of increased numbers of home births has simply not formed part of the 'consultation'.

In DMBC

'The national evidence demonstrates that Homebirth is safe and recommended practice.' (Vol 1 pp107, 224, 232, 236, 240) **No evidence cited at any mention.**

'If expectant mothers are at risk or have a complicated birth they need to have immediate access to supporting services such as emergency surgery, anaesthetics and other services.' (Vol 1 p129)

Safer Childbirth – Minimum Standards for the Organisation and Delivery of Care in Labour (2007), RCOG (Vol 1 p133)

'We will ensure that there is a Midwifery led homebirth community service for all women in NW London.' (Vol 1 p160)

'Source: *Standards for maternity care : report of a working party*. London : RCOG, 2008; *Safer childbirth : minimum standards for the organisation and delivery of care in labour* . London : RCOG, 2007; *Towards better births : a review of maternity services in England*. (2007). Healthcare Commission Maternity Review, National Institute for Health and Clinical Excellence (NICE*). Intrapartum care: care of healthy women and their babies during childbirth*. London: NICE; 2007, *Future Role of Consultant: A working party report* (2005). RCOG' (Vol 1 p166)

'Hillingdon LINk argued that the targets to increase the number of home births are highly ambitious and questioned whether “large maternity units” meet the needs of expectant mothers.' (Vol 1 p214)

'The proposal is for a sector wide collaboration to increase staff and develop a homebirth service in NWL in line with the national evidence. The national evidence demonstrates that Homebirth is safe and recommended practice.' (Vol 1 p224 *et seq* – e.g. p240, Item 4) **No evidence cited.**

'The Royal College of Midwives supported the proposals but criticised the absence of any freestanding midwife-led units in the proposals or discussions on how to facilitate home births.' (Vol 1 p227)

'We will ensure that there is a Midwifery led homebirth community facility for all women in NWL.' (Vol1 p228 *et seq*)

'This will be configured in the NWL midwifery home birth and community model. A comprehensive homebirth service is proposed.' (Vol 1 p229 *et seq*)

'The proposal is for an increase in and the development of a homebirth service in NW London in line with the national evidence.' (Vol 1 p233)

'Additionally, homebirth will be encouraged.' (Vol 2 p28)

'The NHS should also find ways to expand choice in associated service areas where possible, for example in obstetrics, by developing along-side midwife-led units, standalone midwife-led units and measures to support an increase in home births.' (From *NHS London Reconfiguration Guide* (2011), quoted in Vol 2 p29)

[11] Department of Health (April 2007) *Maternity matters: Choice, access and continuity of care in a safe service;* which includes:

> Home birth: This is usually a planned event where the woman gives birth at home, with care provided by a midwife. Should complications arise, all NHS home birth services are provided within a functioning, swiftly responsive, and well understood local network of emergency services and transfer arrangements.' (p47) And:
>
> 'As with home births, all midwifery services must be provided within the safety net of a functioning local network providing prompt emergency transfer when required.' (p48)

'Indeed for low risk second pregnancies home delivery is as safe as a maternity unit, but with lower risk of intervention (but 10% or more of women transfer to obstetric units).[29]' (Vol 3 pp195-196) Footnote [29] refers to: P Brocklehurst *et al*. *Perinatal and Maternal outcomes by planned place of birth for healthy women with low risk pregnancies: The Birthplace in England national prospective cohort study*. British Medical Journal, 2011, 343:bmj.d7400. This concludes:

> **Conclusions** The results support a policy of offering healthy women with low risk pregnancies a choice of birth setting. Women planning birth in a midwifery unit and multiparous women planning birth at home experience fewer interventions than those planning birth in an obstetric unit with no impact on perinatal outcomes. For nulliparous women, planned home births also have fewer interventions but have poorer perinatal outcomes.

'As opposed to routine pregnancy and birth care, which can be safely delivered at home or in a standalone midwifery unit, an obstetric unit (which deals with complex pregnancies which require medical intervention) needs to have co-located acute medicine, critical care, anaesthetics, emergency support services (imaging, transfusion, pathology) and neonatology.' (Vol 3 p199) This refers to the same Brocklehurst paper, with the same caveat.

The Royal College of Midwives supported the proposals but criticised the absence of any freestanding midwife-led units in the proposals or discussions on how to facilitate home births:

The loss of consultant obstetric services at Ealing will have a negative impact on tackling health inequalities in the borough; this could be mitigated – at least for women at low medical risk – if the obstetric service were replaced by a FMU…. we are extremely disappointed that Shaping a healthier future does not include any proposals for the establishment of freestanding midwife-led units (FMUs).

The Royal College of Midwives (DMBC Vol 3, p 115, p 386 of pdf)

'For mothers with less complexity, evidence does suggest that midwife-led care can offer a range of better outcomes for women who are low or medium risk when compared with medically led care and models where different professionals share responsibility for care.[26]' (Vol 7 p165) Footnote [26] refers to: The Kings Fund (2011) *Staffing in maternity units*. This contains:

> 'Other reviews have concluded that home birth can be a cost-effective option for low-risk pregnancies when compared to both birth centres and hospital-based care (eg, Anderson and Anderson 1999; Henderson and Petrou 2008). The cost-effectiveness stems largely from the absence of hotel costs, rather than staffing.' (p28)

Appendix B

Other Research Examined – No Mentions of 'Home Birth Recommended'

Neonatal outcomes associated with intended place of birth: birth centers and home birth compared to hospitals, American Journal of Obstetrics *&* Gynecology Supplement to January 2012 'The risk of cesarean delivery is significantly lower for women who had or intend to have births outside of hospitals; however, the risk of lower 5-minute Apgar score and neonatal seizure was higher for intended home births.'

Planned home birth: the professional responsibility response, American Journal of Obstetrics *&* Gynecology January 2013 'We call on obstetricians, other concerned physicians, midwives and other obstetric providers, and their professional associations not to support planned home birth when there are safe and compassionate hospital-based alternatives and to advocate for a safe home-birth-like experience in the hospital.'

A Refreshed Framework for Maternity Care in Scotland, The Scottish Government, Edinburgh 2011

National Service Framework (NSF) for Children, Young People and Maternity Services, Welsh Assembly, 2006

High Quality Women's Health Care: A proposal for change, RCOG, July 2011

Making sense of commissioning Maternity Services in England – some issues for Clinical Commissioning Groups to consider, NCT, RCM, RCOG not dated (but post-2011)

Continuous support for women during childbirth, Cochrane Review, 2011

Quality and Safety Programme, Maternity services, London Health Programmes, February 2013

Outcomes of planned home birth with registered midwife versus planned hospital birth with midwife or physician, CMAJ 2009. DOI:10.1503/cmaj.081869 'The Society of Obstetricians and Gynaecologists of Canada encourages research into the safety of all birth settings. It does not take a specific stand on home birth.'

*National Guidelines for Maternity Services Liaison Committees (MSLCs),*DH, 2009

Maternity Matters: Choice, access and continuity of care in a safe service, DH, April 2007, 'PbR does not cover all birth settings, as home births are excluded.'

Royal college shelves controversial maternity report, Pulse, 02 March 2013,

'Specialists are to review controversial recommendations on maternity services, after it came under fire for putting ‘unethical' pressure on women to give birth at home and refuse pain relief.'

Birthplace in England – new evidence, NHS Confederation, June 2012, 'This study also provides new insights – namely, the increased risks for the babies of first time mothers in planned home births and greater chances of transfer during labour to hospital for women who plan to have their first baby at home or in a midwifery unit. Transfer rates were high for first-time mothers with almost half of planned home births, to just over a third for those in freestanding midwifery units transferring during labour.' (p3)

'For women having a first baby, a planned home birth increases the risk for the baby and there is a fairly high probability of transfer to hospital during or immediately after labour.'

But: 'For women having a subsequent baby, a planned home birth does not increase risk for the baby, and reduces the risk of interventions for the mother.' (p3)

Maternal and newborn outcomes in planned home birth vs planned hospital births: a metaanalysis, NIHR, 2011, 'Authors' conclusions: Less medical intervention during planned home birth was associated with a tripling of the neonatal mortality rate.' (This study has been criticised.)

Is a home birth right for you? If you've had a trouble-free pregnancy and any previous births have been straightforward, there's no reason why you shouldn't have a home birth. http://www.askamum.co.uk/Birth/Search-Results/Preparing-for-labour/Home-birth/

Where to give birth: the options, NHS Choices – http://www.nhs.uk/conditions/pregnancy-and-baby/pages/where-can-i-give-birth.aspx#close 'Healthy women assessed to be at 'low risk' should be offered a choice of birth setting. If you choose to give birth at home or in a unit run by midwives, you should be given information by your midwife or GP about what would happen if you need to be transferred to hospital during labour, and how long this would take. If something goes seriously wrong during your labour (which is rare) it could be worse for you or your baby than if you were in hospital with access to specialised care.'

Here are some questions you might want to ask:

- How long would it take it I needed to be transferred to hospital?
- Which hospital would I be transferred to?

'The Royal College of Midwives (RCM) and the Royal College of Obstetricians and Gynaecologists (RCOG) support home birth for women with uncomplicated pregnancies.' http://www.homebirth.org.uk/homebirth1.htm

Standards for Maternity Care, RCOG, June 2008

SERVICE STANDARDS FOR HOSPITALS PROVIDING NEONATAL CARE (3rd edition), BAPM, August 2010

Outcomes of planned home births with certified professional midwives: large prospective study in North America, BMJ June 2005; 330 doi: http://dx.doi.org/10.1136/bmj.330.7505.1416

Colin Standfield
3 March 2013

END OF HOME BIRTH PAPER

Subject: **Evidence of Recommendations for Home Birth**
Date: 08/03/2013 10:16:25 GMT Standard Time
From: Duncan.Stroud@nw.london.nhs.uk
To: ColinStandfield@aol.com

Thanks for your recent email to Dr LaBrooy regarding home births.

Someone from the Shaping a Healthier Future programme team will reply next week.

Best wishes

Duncan Stroud, Communication Manager

Brent, Ealing, Harrow, Hillingdon

Subject: **Re: Evidence of Recommendations for Home Birth**
Date: 08/03/2013
To: Duncan.Stroud@nw.london.nhs.uk
CC: susan.labrooy@thh.nhs.uk, jeff.zitron@nhs.net, david.mallett@nw.london.nhs.uk, anne.rainsberry@london.nhs.uk, mark.spencer@nhs.net, unwink@ealing.gov.uk, julian.bell@ealing.gov.uk, boothm@ealing.gov.uk, onkar4gla@gmail.com

Dear Mr Stroud,

Thank you for your temporising reply. Why does it have to take so long? Dr LaBrooy assured the meeting on Monday that the evidence was there; it is mentioned 5 times in the 'Business Case' without ever being cited, but it must exist (presumably).

All I want is the name of at least one competent authority which states that home birth is 'safe and recommended', and the documentary evidence.

My patience is wearing thin. As far as that process may go, it will never achieve the fag-paper sparseness of the Decision-Making Business Case (for all its 2,678 pages). The DMBC has accreted like a shanty town: if I had produced anything so ramshackle I'd have been embarrassed to see it creep into the public arena.

It will be an interesting piece of research if it turns up: home birth is 'safe' for a narrow group of expectant mothers, although most authorities agree that women should be given the option. The 'safe' group includes multiparous women with no previous or current obstetric complications – possibly around a quarter of the total. Of these planned 'safe' multiparous pregnancies, 12% are transferred to obstetrics ('Transfers during labour or immediately after birth among healthy women with low risk pregnancies by their planned place of birth at start of care in labour'). This compares with **45%** of nulliparous women in the same circumstances, according to the Brocklehurst *Birthplace Study* (BMJ November 2011).

If any other lawful activity resulted in 12% of its participants' being transferred to hospital, 'safe and recommended' would not be the epithet that sprang to mind.

G Visser in *Obstetric Care in the Netherlands: Relic or Example?* (J Obstet Gynaecol Can 2012;34(10):971–975) describes the safety trajectory quite well. He paraphrases the RCOG 2007 Joint Statement thus: 'To begin, home delivery should be offered only in a neighbourhood close to a back-up hospital.' This condition will, of course, no longer apply to any of the mothers who would currently use Ealing Hospital.

But no doubt your research will describe it better.

Subject: **Evidence of Recommendations for Home Birth**
Date: 15/03/2013
To: Duncan.Stroud@nw.london.nhs.uk
CC:susan.labrooy@thh.nhs.uk, jeff.zitron@nhs.net, david.mallett@nw.london.nhs.uk, anne.rainsberry@nhs.net, mark.spencer@nhs.net, julian.bell@ealing.gov.uk, boothm@ealing.gov.uk, onkar4gla@gmail.com, unwink@ealing.gov.uk

Dear Mr Stroud,

Why am I not surprised to be writing to you again? A week ago you wrote: 'Someone from the Shaping a Healthier Future programme team will reply next week.' It is now 7.30 on Friday evening and no-one has sent a thing.

All I was asking for was the 'national evidence' which shows that 'home birth is safe and recommended'. This is mentioned, without being detailed, 5 times in your 'Decision-Making Business Case' and your team at the Ealing HOSC appeared irritated that I should have challenged it; Dr LaBrooy promised to send it to me.

Obviously, the reason it has not been sent is that it does not exist, as I knew on 4th, having spent the weekend looking for it. No competent authority would 'recommend' home birth, although many sources quite rightly hold the view that women should be offered the choice (provided that they know the risks and provided that appropriate and timely transfer to hospital is available for the 21% of planned low-risk births that required it, according to *The Birthplace Study* by Brocklehurst et al.)

It should not take the best part of a fortnight to produce such a crucial piece of evidence, and I think it would have been gracious and honest for someone to have admitted on 4th that the document contained a major blunder, if not a falsehood. Not the only one: I am still awaiting responses to my 2 e-mails to Mr Zitron of 18th February in which I pointed out substantial errors and false claims in the documentation.

And I wrote to Dr Rainsberry last Friday asking what a 'virtual bed' was, without – and this is clearly NWL policy in its dying days – the courtesy of a reply, from anybody.

There is no point in going into denial just because NHS NWL is about to close its doors – there are people here who will be grossly affected by this shambles and I think we deserve some honest and timely answers.

Subject: **RE: Evidence of Recommendations for Home Birth**
Date: 18/03/2013 09:40:10 GMT Standard Time
From: Duncan.Stroud@nw.london.nhs.uk
To: ColinStandfield@aol.com
CC:susan.labrooy@thh.nhs.uk, jeff.zitron@nhs.net, David.Mallett@nw.london.nhs.uk, anne.rainsberry@nhs.net, Mark.Spencer@nhs.net, julian.bell@ealing.gov.uk, boothm@ealing.gov.uk, onkar4gla@gmail.com, unwink@ealing.gov.uk

Colin

Thank you for your email. I will chase the response we are preparing for you on home births and send it to you as soon as possible.

Many apologies for the delay.

Duncan Stroud

Subject: **Re: [Evidence of] Recommendations for Home Birth**
Date: 18/03/2013
To: Duncan.Stroud@nw.london.nhs.uk
CC:susan.labrooy@thh.nhs.uk, jeff.zitron@nhs.net, David.Mallett@nw.london.nhs.uk, anne.rainsberry@nhs.net, Mark.Spencer@nhs.net, julian.bell@ealing.gov.uk, boothm@ealing.gov.uk, onkar4gla@gmail.com, unwink@ealing.gov.uk,

Dear Mr Stroud,

Thank you. I was not expecting a 'response prepared for me', especially now that Dr Spencer has made it clear to me that I am already taking up too much time asking damn' fool questions – all I am asking for is a reference to the national research that shows that home birth is 'safe and recommended'. This research is mentioned 5 times in your 'Business Case', and your team at the duly-constituted Ealing HOSC assured the meeting that it existed.

I am sure that they would not have addressed a formal Council Meeting in the manner they did without having exact details of the research in mind and I am only surprised that a note was not passed back to me during the evening with the details.

Please don't apologise for the delay – it has become NHS NWL's *modus operandi*, to the extent that it is almost a *modus vivendi*. I expect the courtesy of a timely reply in the way that the Three Sisters expect to get back to Moscow. If I collated the apologies for delay that I have had from your organisation, they would fill all the pauses in Chekhov.

Subject: **RE: Evidence of Recommendations for Home Birth**
Date: 18/03/2013 10:10:17 GMT Standard Time
From: consultation@nw.london.nhs.uk
To: ColinStandfield@aol.com
CC: Thirza.Sawtell@nw.london.nhs.uk, Mark.Spencer@nhs.net, Kevin.Atkin@nw.london.nhs.uk, Liz.Knight@nw.london.nhs.uk, Anne.Rainsberry2@westminster-pct.nhs.uk, david.mallett@london.nhs.uk, jeff.zitron@nhs.net

Dear Mr Standfield,

Thank you for your email and letter to Dr LaBrooy concerning home births, as they were kindly passed us please find attached our letter of response.

Best wishes

The Consultation Response Team
Shaping a Healthier Future
NHS North West London

0800 881 5209
consultation@nw.london.nhs.uk

Subject: **Re: NO Evidence of Recommendations for Home Birth**
Date: 18/03/2013
To: Duncan.Stroud@nw.london.nhs.uk
CC: Thirza.Sawtell@nw.london.nhs.uk, Mark.Spencer@nhs.net, Kevin.Atkin@nw.london.nhs.uk, Liz.Knight@nw.london.nhs.uk, Anne.Rainsberry2@westminster-pct.nhs.uk, david.mallett@london.nhs.uk, jeff.zitron@nhs.net, s.labrooy@nhs.net, julian.bell@ealing.gov.uk, unwink@ealing.gov.uk, david.millican@ealing.gov.uk, nigel.bakhai@ealing.gov.uk

Dear Mr Stroud,

I am replying to you as I have today received an unsigned letter from the *SaHF* Response Team. I do not see why they should not have the courage and decency to put a name to it and I do not see why I should respond to an anonymous letter.

(At least, I assume it is from the *SaHF* response team: it is on poorly laid out samizdat letterheading.)

As I suspected, almost a fortnight has gone into a desperate attempt to concoct a post-hoc rationale for the claim which cannot be substantiated – let's call it a lie – in your business case about the 'national evidence'. It simply won't wash. There is no 'national evidence' which makes recommendations in the form the DMBC states and as suggested by the *SaHF* team at Ealing's Scrutiny Committee. The letter is arguing against something I haven't said.

I believe the HOSC was misled.

I am sending back the letter with my observations. [Reproduced, starting from the next page] The Committee deserves an apology, as do I.

As this is not the only major error in the 'Business Case', it should be withdrawn.

Colin Standfield's responses to 18 March letter in boxes, sent on 18 March

Dear Mr Standfield

Thank you for submitting the paper on Home Births which prompted your questions at the Ealing Council Overview and Scrutiny Committee on 4 March 2013. I am copying this response to the Chair of the Committee and I hope it will clarify the issue for everybody.

You say in the paper that Home Birth 'barely featured in the Pre-Consultation Business Case' and occurred five times in the new Decision-Making Business Case as 'safe and recommended practice.' You contend that this is a partial and misleading claim because no authority has said that 'home birth is unreservedly safe.'[1] You go on to quote evidence from various research papers about the criteria

[1]No. Get the quotation marks correct: I said "No competent authority has been cited by NHS NWL as saying that home birth is unreservedly 'safe'." Every discussion about safety has been attended by reservations about the likely risk factors: nullips, previous caesareans etc. My claim is that there is no '*national evidence*' that '*demonstrates that Homebirth is safe and recommended practice*.' That claim subsists and is, frankly, unchallengeable.

and evidence of outcomes of home birth. Your conclusion from this is that home birth is not 'unreservedly safe' and therefore cannot be recommended.[2]

[2]No. I have never said that, but am sure that you would advert me to it if I have. My conclusion in that context could not have been clearer, since it is in **bold**: "To sum up, **home birth is safe where it is safe."** Please also read the conclusion under the heading '**Conclusion**' in my paper: **'**If there is any evidence to support NHS NWL's assertion that home deliveries are recommended, they have not cited it and I have not found it.' That assertion subsists.

In response, can I say first of all that the statements about Homebirth featured more frequently in the Decision-Making Business Case because they were part of the report of the Maternity Clinical Implementation Group (pages 194, 202, 206 and 210 in the final DMBC) which had not completed its work at the time of the Pre-Consultation Business Case.[3]

[3]I am not responsible for the haphazard timing of your struggles to compile a case.

In that report, the group of committed senior clinicians from all hospitals in NW London stated that their main purpose was to ensure the delivery of safe and secure maternity services. In the summary of its recommendations, it talks of delivering obstetric-led hospital units, midwifery-led units and home birth services[4] which are all options available to women now.

[4]Of these 3, the only birth setting available to women *in Ealing* will be home birth, under SaHF; the other units will all be out-of-Borough. (DMBC Vol 1, p 210 or 240)

It specifically talks of developing home births across all of NW London so that it becomes a 'true option for women.' The recommendation, therefore, is not to impose home births[5] as an alternative to

[5]Please show me where I said that home births would be 'imposed'. They would certainly be the only option available within the Ealing Borough boundaries.

other services but to offer the service to appropriate women according to the criteria in the research evidence which they use in their report. Women will therefore have a choice. Women will be assessed according to risk criteria and will be advised accordingly before they choose. This is what happens now and will continue to happen.[6]

[6]No-one is arguing that home birth is not or should not be an option, least of all me. I am simply saying that no-one 'recommends' it. I maintain that it should be an option and, indeed, my e-mail of 8 March to Mr Stroud says: "most authorities agree that women should be given the option". I am with them, but am not an authority. They have a choice now.

The reason for the emphasis on Home Births in the Maternity Clinical Implementation Group's report is that NW London has a lower home birth rate than other parts of London and the country and therefore this suggests[7] women have less opportunity to choose that Home Birth option. The group

[7]This suggests no such thing, and a 'suggestion' is hardly clinical evidence. It could be a function of deprivation, culture, language, ethnicity or GP habit as much as of 'opportunity'.

has committed itself (Point 4 under Implementation Issues to be Addressed) as a clinical group to develop it in 'a safe and step-wise way.'

As far as the evidence for the safety of home births is concerned, you have quoted from the research evidence that the Clinical Implementation Group references in its report. These reports support home birth as a safe option for women who fit the appropriate criteria (Brocklehurst 2011 states that for multiparous women there was no significant difference in risk for Home Birth).[8]

[8]Brocklehurst is a comprehensive study only of *planned 'low-risk' births*, so, as I have now already said twice: home birth is safe where it is safe. Even among these safe, planned home births to multiparous women, 12% are transferred to obstetrics (see below).

You yourself quote NICE guidelines which say that women ought to be offered the choice of birth at home and this was the contention of the Maternity group – the Clinical Implementation Group believe that we don't offer enough women a real choice in NW London. It is, however, only one of the types of delivery offered. You also quote NICE as saying that for women giving birth at home there is a 'higher likelihood of a normal birth with less intervention.' The Royal College of Midwives and the Royal College of Obstetricians 'support home birth for women with uncomplicated pregnancies.' Lastly, could I correct your quote from Brocklehurst about the percentage of home births requiring transfer. It's 12%, not 21%.[9]

[9]Please don't try to patronise me: the rate of transfer to obstetrics according to Brocklehurst is 21% for all planned low-risk home births; it is 12% **only** for multiparous women, rising to 45% for nulliparous women. (Table 2) A shabby example of the selective use of statistics. As I said in my 8 March e-mail: "If any other lawful activity resulted in 12% of its participants' being transferred to hospital, 'safe and recommended' would not be the epithet that sprang to mind."

In conclusion, can I reassure you that the group of senior clinicians from all hospitals in NW London carefully considered all the research evidence you yourself reference and in their report recommended developing home birth which is a service that already exists, for a carefully selected group of women[10] where it is considered to be as safe as other options of delivery because it would

[10]Are you aware of how pathetic this sounds? Read it aloud. 'Carefully selected'? Nothing like the same as 'home birth is safe and recommended.'

give women more choice. They intend to oversee the implementation to make sure it produces an improved service.

With best wishes

The Consultation Response Team
Shaping a Healthier Future
NHS North West London

0800 881 5209 consultation@nw.london.nhs.uk

Needless to say, perhaps, there has been no response to my refutation of their farrago of 'evidence'. The trail runs cold and the only reasonable inference is that they have given up trying to justify the unjustifiable.

It is pitiful that they sought to impute words to me that I never used.

One of the most significant areas of deception is the conflation of nulliparous (42.4% of the 'restricted' total) and multiparous mothers (56.8%) – for the latter, the *Birthplace* study does allow that the risks 'generally' are the same as for obstetric unit delivery. But what the DMBC fails to add, and what Brocklehurst et al stress, is that these are all planned, low-risk pregnancies. What the DMBC also fails to add is that the weight of advice is that there should be ready access to obstetrics – given that 12% of 'safe, planned' homebirths *even* among multips end up in obstetrics, this is a crucial omission. For all Ealing women, obstetrics will be in another Borough.

The dangerous, unqualified and untrue assertion about 'safe and recommended practice' was designed, in my view, to bolster the wafer-thin and desperate attempts by NHS NWL to convince the public that there were or would be adequate services in the community once the 4 A&Es were closed, along with services such as, in this case, maternity.

NHS NWL Misleading – Comments in *The Ealing Gazette*

On 3 August 2012, *The Ealing Gazette* ran a Q&A interview with Dr Mark Spencer, Medical Director of NHS NWL, on the subject of the *SaHF* proposals. After some research I wrote to him:

Subject: **Emergency Caesarian Births in Ealing**
Date: 22/08/2012 18:20:43 GMT Summer Time
From: ColinStandfield@aol.com
To: mark.spencer@nhs.net

In your Q&A in *The Ealing Gazette* of 3rd August, you say: 'Ealing hospital's maternity unit is small, has trouble recruiting midwives to manage rotas and has very high emergency caesarean rates.'

Anecdotally, I doubt that Ealing has any more trouble than other parts of London in recruiting midwives, but perhaps you will provide me with the figures before I have to find them. It will probably, of course, have more problems once these statements are in the public domain.

The emergency caesarean rates, however, do not support your allegation. It is true that Ealing is higher than the England average (17.03% vs 14.48%) but it is lower than not only the London average (17.18%) but also the London median (18.96%). You will note that it is also lower than the Chelsea & Westminster's, Hillingdon's and that of North West London Hospitals NHS Trust. To put it another way: of all the hospitals under your control only West Middlesex (by 0.11 percentage points) and Imperial (by 0.75 percentage points) have lower rates of emergency caesarean delivery. Does that justify your comment?

I have summarised the latest data I could find, as attached, from *Maternity data 2010-11* at: http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=1815 There is a separate tabulation of the London data ranked by Emergency Caesarean rate alongside the London SHA data.

I have not discussed this issue with the CE of Ealing Hospital but have copied her in to this e-mail in case she has more up to date data which may support your position.

The key NWL table was:

NWL Only	36 Table D: Delivery method Emergency caesarean	ALL Episodes	Emerg Caes %
Imperial College Healthcare NHS Trust	1,602	9,842	16.28
West Middlesex University Hospital	779	4,603	16.92
Ealing Hospital	520	3,054	17.03
The Hillingdon Hospitals NHS Foundation Trust	724	4,063	17.82
North West London Hospitals NHS Trust	927	5,188	17.87
Chelsea And Westminster Hospital NHS Foundation Trust	1,098	5,646	19.45
	5,650	32,396	17.44

(NHS Maternity Statistics by No. of Births, 2010-11)

The following day I followed up with some further analysis:

Subject: **Unadjusted Rates of Caesarian Section**
Date: 23/08/2012 09:54:53 GMT Summer Time
From: ColinStandfield@aol.com
To: mark.spencer@nhs.net

Further to my e-mail about caesarean sections at Ealing, proving that, although Ealing is above the national average, it is below not only the London average but also the London median, I should point out that it is, of course, below the NWL average (17.03% vs 17.44%).

It is worth also noting (because I like to do the research that others don't bother with) that the BMJ in 2010[1] said: 'Moreover, using unadjusted rates of caesarean section as a quality indicator has been shown to be flawed because failing to account for clinical factors may lead to incorrect conclusions.'[2] Oh dear.

The BMJ continues: 'A first step to improving our understanding of maternity statistics would be to replace publication of unadjusted rates of caesarean section with publication of either rates of caesarean section for women with particular clinical indications or risk adjusted figures.'

It concludes: 'Characteristics of women delivering at NHS trusts differ, and comparing unadjusted rates of caesarean section should be avoided. Adjusted rates of caesarean section still vary considerably and attempts to reduce this variation should examine issues linked to emergency caesarean section.'

I can't find a BMJ recommendation anywhere that says emergency caesarean rates should be a key criterion for closing a maternity unit, but there again, I'm not a doctor. Perhaps that's why I, too, stupidly compared unadjusted rates in the table I appended to my previous e-mail, for which I apologise.

Dr Spencer's reply was patronising, and began:

Subject: **RE: Unadjusted Rates of Caesarian Section**
Date: 23/08/2012 22:21:37 GMT Standard Time
From: mark.spencer@nhs.net
To: ColinStandfield@aol.com

Thank you for your interest Colin, but the figures you are quoting are out of date.

Last year the total CS rate at Ealing was 28.2%. The latest figures I have for this year show 18.2% non-elective section rate with an overall rate of 29.5%.
You are correct in saying that Ealing is not alone in having high CS rates. Non-elective CS rates vary across our trusts from 13.2% to 19.2% in the last month for which I have data. These are all well above the Royal College of Obs and Gynae target of 12%.

This is certainly multifactorial and the CCGs and NHS London have been examining this in a variety of maternity units. Some of Southall's population well have small pelvis making CS more likely, but this is counterbalanced by the fact that Ealing Hospital does not take high risk pregnancies.

It was, of course, some months before I could gain access to anything like those data – somebody sent them to me with the information that an attempt had just been made to recruit one midwife, and 72 had applied – and they showed the following:

Ref	Metric		Actual				Cumulative YTD
			Apr	May	Jun	Jul	
MY16	% of Emergency C/S	Actual	20.5%	20.2%	20.2%	19.1%	20.0%
		Target	12%	12%	12%	12%	12%
MY17	% of Elective / Planned C/S	Actual	7.3%	9.7%	8.2%	6.9%	8.1%
		Target	12%	12%	12%	12%	12%
Totals			27.8	30.1	28.4	26.0	28.1

I cannot explain the discrepancy between my figure of 19.1% and Dr Spencer's 18.2% for what must have been the same period (possibly adjusted/unadjusted). Even if it had been 19.1% Dr Spencer ought to have had the honesty to point out that it was on a reducing trend for the year to date. I believe Ealing's Emergency Caesarean rates are now sustained below the sector norm.

Perhaps of even greater concern was his gratuitous and unfounded comment that 'Ealing Hospital does not take high risk pregnancies.' I later asked him to justify this comment, on 30 August:

What do you mean by "low risk pregnancies'? What criteria are used ? Ealing is dealing with late bookers and high levels of gestational diabetes. We just need to understand the definitions.

I had no answer. Ealing never turns women away on the basis of high risk and has high rates of TB and HIV in pregnancy, as well as gestational diabetes (one of the highest in the country – 24% in July 2012, 14% in August).

The RCOG target of 12% for both elective and emergency caesarean delivery is met by only 15% of the country's hospitals.

Ealing does, and was doing at the time of his comments, much better than Dr Spencer would have the readers of *The Ealing Gazette* believe and the inference from his unfounded comments must be that he chose to take a media opportunity to muddy the waters of the debate during the 'consultation' process and soften up the public for the closure of maternity services at the Hospital.

NHS NWL – McKinsey Costs

A Freedom of Information response from NHS NWL revealed the amounts paid to management consultants McKinsey:

Further to your Freedom of Information request asking:

"Please would you supply us with costs and fees paid to management consultants McKinsey by NHS North West London over each the last four financial years and the first half of this financial year, with regard to the reorganisation of London hospitals."

I apologise for the delay in responding. I am now able to respond with the fees paid to consultants McKinsey. North West London only came into being in September 2009. The fees are:

Year	Company	£ 000
2010/2011	McKinsey	500
2011/2012	McKinsey	2,555
2012/2013 *(up until 30 September 2012)*	McKinsey	440

16 October 2012

Ref no: NW535/SHFP613

McKinsey's name barely features in either of the Business Cases, and it was hard for our campaigners to see any evidence of their input, particularly given the chaotic nature of both sets of documents. We would have expected much more professionalism in presentation as a result of the expenditure on one of the world's leading consultancies (one of the 'Big Three') of £3.5 million in those years alone.

Most remarkably, the figure of £2,555,000 for 2011/12 is exactly divisible by 365, prompting the suspicion that, for whatever reason, McKinsey were paid a flat £7,000 a day for the whole of that year.

I tried to get an idea of what they actually did and how they were appointed, with limited success. The first response was:

From: FOI NWL
Sent: 22 November 2012 17:39
To: 'ColinStandfield@aol.com'
Cc: FOI NWL
Subject: NW640 RE: FoI Request – McKinsey

Dear Mr Standfield,

Further to you Freedom of Information request I can now provide the following response to your questions.

1. What tendering process took place before McKinsey were first awarded a contract to work with NHS NWL?

All tendering processes follow the standing financial instructions of the organisation and comply with EU regulations. NWL follows NHS Westminster's standing financial instructions which state that for tendering exercises between £5k and £50k 3 quotes must be obtained, for exercises between £50k and £100k more formal competitive tendering and anything above £100k must follow the EU regulations. All tendering exercises which resulted in a contract being awarded to McKinsey followed the relevant process.

2. What tendering process took place before McKinsey were awarded the contract for the FY 2011/12 by NHS NW London?

All tendering processes follow the standing financial instructions of the organisation and comply with EU regulations. NWL follows NHS Westminster's standing financial instructions which state that for tendering exercises between £5k and £50k 3 quotes must be obtained, for exercises between £50k and £100k more formal competitive tendering and anything above £100k must follow the EU regulations. All tendering exercises which resulted in a contract being awarded to McKinsey followed the relevant process.

3. What KPIs or other metrics were established and what outputs were recorded for that period from McKinsey?

Each individual project will have different measurements depending on the services being delivered; these can range from stage payment signoff to detailed task completions against either set dates or criteria, which is monitored by the project manager.

4. What formal contract monitoring was in place during that period and who was accountable for ensuring value for money?

The contracts would be monitored in different ways depending on what was being delivered, most commonly a weekly update meeting would be held to establish progress and sign off agreed work to exact dates, value for money would be kept in place by ensuring that delivery of the services required was being monitored closely, the senior responsible officer and the project manager would be responsible for ensuring value for money was maintained.

5. What tendering process took place before the current year's contract was awarded to McKinsey?

All tendering processes follow the standing financial instructions of the organisation and comply with EU regulations. NWL follows NHS Westminster's standing financial instructions which state that for tendering exercises between £5k and £50k 3 quotes must be obtained, for exercises between £50k and £100k more formal competitive tendering and anything above £100k must follow the EU regulations. All tendering exercises which resulted in a contract being awarded to McKinsey followed the relevant process.

6. What KPIs or other metrics have been set, what outputs are required and what have been delivered?

Each individual project will have different measurements depending on the services being delivered; these can range from stage payment signoff to detailed task completions against either set dates or criteria, which is monitored by the project manager.

7. What formal contract monitoring is in place and who is accountable for ensuring value for money?

The contracts would be monitored in different ways depending on what was being delivered, most commonly a weekly update meeting would be held to establish progress and sign off agreed work to exact dates, value for money would be kept in place by ensuring that delivery of the services required was being monitored closely, the senior responsible officer and the project manager would be responsible for ensuring value for money was maintained.

8. What formal audit or Board report has there been at any time of the value delivered by McKinsey?

Only contracts that are over £1m in value need to go to the Board for formal audit and review for VFM.

This did, at least, alert me to a claim that there were several 'projects' or 'contracts', rather than a daily retainer. I was not convinced.

A further FoI request was clearly required, and submitted on 22 November. There being no response within the 20 days, I sent this:

Subject: **Re: NW640 RE: FoI Request – McKinsey. OVERDUE**
Date: 24/12/2012 02:15:18 GMT Summer Time
From: ColinStandfield@aol.com
To: foi@nw.london.nhs.uk
CC: ruth.carnall@london.nhs.uk, jeff.zitron@nhs.net, anne.rainsberry@london.nhs.uk

Dear Mr Mallinder,

This is a formal complaint. Yet again.

Once more you gave failed to respond to a request under the FoI Act within 20 working days. You are simply reinforcing the impression I have that you are deliberately delaying responses in the hope that NHS NWL will have ceased to exist before you have to reveal the truth. NHS NWL will then be able to pass on a toxic legacy to the CCGs.

I asked on 22 November, in a follow-up to your meagre reply to my original enquiry about McKinsey, for further information which I believe you deliberately withheld in your first response.

You have not sent me your original invitation to tender document; you have not told me what other organisations responded; you have not told me why McKinsey were judged to be the better or best.

You have not sent me a list of projects undertaken by McKinsey; you have not told me what measures were applied to the work they supposedly did; you have not told me whether those metrics were satisfied. I have seen not one document 'signed off to exact dates' by a 'senior responsible officer' and a 'project manager'.

You have not given me the results of the audit which must have been instituted, as this contract was for 'over £1 million in value'.

In the absence of any information from you, why should I believe that McKinsey did anything at all for the £2,555,000 (or exactly £7,000 per day) they were paid in the year 2011/12? If there were 'projects', there would have to be a long list, and you have sent me nothing. If there had been, say, fortnightly meetings, they would have cost over £98,000 each in McKinsey time. I believe even a McKinsey Partner costs only £1,500 to £2,000 per hour so you could have had 15 McKinsey Partners at a 3-hour meeting each fortnight for a year, and had plenty of money left over.

I do not believe you had 15 Partners at any meeting. In fact, I am beginning to wonder whether NHS NWL met McKinsey at all – their name appears nowhere in all the documentation.

You have now had over 40 working days to describe what McKinsey are supposed to have delivered for the £2.5 million of public money they received in that year. Your reluctance is becoming significant and your silence is making me suspicious.

I do not see why I should have to spend the Sunday before Christmas trying to wheedle information out NHS NWL that was requested before the clocks went back in October. Someone must have a spreadsheet.

Please urgently send me what evidence you have that there has not, in fact, been a fraudulent use of public money.

The reply was:

Subject: **RE: NW640 RE: FoI Request – McKinsey; Follow-up**
Date: 04/01/2013 18:00:05 GMT Standard Time
From: foi@nw.london.nhs.uk
To: ColinStandfield@aol.com
CC: jeff.zitron@nhs.net, Anne.Rainsberry@london.nhs.uk, foi@nw.london.nhs.uk

Dear Mr Standfield,

Further to your Freedom of Information request and subsequent complaint that the NWL Cluster has failed to provide a satisfactory response. I apologise for the delay and have been seeking the information from colleagues to fulfil your request.

- Firstly, the figure that you quote of £2,555,000 being a contract value with McKinsey is not accurate. A previous separate FOI response stated that the cumulative spend over the period of 2011/2012 to McKinsey was £2,555,000. This was not a single contract value.

The attached document explains all Mckinsey's & NHS NWL contracts and the procurement method used since April 2011. Further details to the Government Procurement Service (GPS) Multidisciplinary Consultancy Framework (RM 353), as referred to in the note, can be found on the Government's Cabinet Office website – http://gps.cabinetoffice.gov.uk/contracts/rm353. This site also contains further information about Public Sector Procurement methods.

The board papers discussing the contract to provide consultancy support service reconfiguration pre-consultation preparation, as referred to in the note, are available from the 4 January 2011 meeting and details are located on the NHS NWL website:
http://www.northwestlondon.nhs.uk/publications/?category=3148-NHS+North+West+London+4+January+Board+Papers-d. *

Regards

Dominic Mallinder

FOI Lead

NHS North West London

*The documents referenced by that hyperlink do not reveal any such discussion on the McKinsey contract, still less on whether it had received Board approval, unless it is meant to be at one of these entries:

The Minutes of North West London (NWL) Cluster Open Board Meeting, Wednesday 9 November 2011show, at 6.9:

DE confirmed a flexible consultation programme was being designed to support elements of engagement at different times to enable local responses. The consultation document will be written as a series of individual proposals, and will be developed **with external support**. [My emboldening]

The Minutes of the Finance & Performance Sub Committee held on 3 November 2011 show, at 6.12:

As part of the 2011/12 Operating Plan, the Cluster Board approved funding of £1m from the 2% Fund to **support the preparation of the OBC and FBC**. [My emboldening] The Programme Board receives financial updates from the Programme Director on expenditure incurred on producing the OBC. At the last Programme Board meeting, expenditure incurred on producing the OBC was estimated at **£2.5m**. The Cluster funding of £1m has been fully spent together with funding received from NHS London (£500,000). The balance of £1.5m has been met by the two Trusts from their own resources.

This, however, is in relation only to the Ealing/NWLHT Merger Outline Business Case, and my emboldening of the figure indicates perhaps just a coincidence.

But the Audit Committee Minutes of 22 November 2011show, at 14.4:

It was noted that the report of the McKinsey assessment of the 2011/12 Contracting Round will be seen by the Cluster Finance Committee. A copy will be sent to Audit Committee Members. It was also noted that the contract with McKinsey for this assessment was incorrectly categorised in the Cluster report on Consultancy Contracts (included in the Month 6 Finance Report); it was shown as "Tendered" when in fact it had been the subject of a tender waiver. The report will be amended.

This 'waiver' is not mentioned in the 22 November response. This is a contradiction, although it may perhaps be inferred from this paragraph:

Since April 2011 NW London has awarded seven contracts over the specified thresholds to McKinsey & Company; six contracts were tendered competitively using the Government Procurement Service (GPS) Multidisciplinary Consultancy framework (RM 353) that was created via an OJEU compliant process.

There was, presumably, a reason not to spell out that one was not tendered.

The bulleted paragraph is disingenuous: nothing in the earlier reply said, or even hinted, that this was a cumulative figure. The corollary must be that it was the sum of a number of different projects or contracts, which their attachment detailed:

Contract 1: Contract for the provision of Consultancy solutions for the establishment of A Framework for integrated care.

Contract 2: The provision of Consultancy solutions services for Ealing Commissioning Group Out of Hospital Strategy Development – Mobilisation and further refinement of the strategy.

Contract 3: Call off arrangements for North West London Commissioning Development.

(No documented outputs in the contract)

Contract 4: Consultancy Services for the provision of external consultancy support to assist the NW London Out of Hospital Programme – Determining local hospital models and services and resulting estates plans.

Contract 5: Consultancy support for service reconfiguration pre-consultation preparation
Contract 6: The provision of NHS North West London Commissioning Support Development

Contract 7: External Consultancy Support to develop community workforce requirements to deliver the NW London out of hospital strategy.

Each of these headings was followed by details of the supposed, contracted outputs. As a result, NHS NWL are seeking to show that the £2.555 million spent that year was the sum of a series of activities. If this total should then be divisible precisely by 365 to produce a daily cost of exactly £7,000, it would be frankly an unbelievable coincidence. And I do not believe it.

NHS NWL – Incoherent Presentation and Poor Risk Management

Gross Errors in PCBC

E-mail sent following presentation of the Ipsos MORI results on 28 November 2012

Subject: **Stakeholder Responses, and Other Errors**
Date: 30/11/2012 00:59:13 GMT Summer Time
From: ColinStandfield@aol.com
To: mark.spencer@nhs.net, jeff.zitron@nhs.net, anne.rainsberry@london.nhs.uk, ruth.carnall@london.nhs.uk

Dear NHS NWL,

Does nobody check anything in your organisation? Trying to take a measure of the Stakeholder responses recently posted on your website, I find that the first two pages of the Brent Link letter are missing (the clue is in a file size of 0Mb) and that the response from the Royal College of Midwives is missing, having been supplanted by an identical copy of that from the Royal College of Paediatrics and Child Health with just a change of title. (The clue is in the consecutive identical file sizes.)

Small details perhaps (though perhaps not so if you were a member of one of these organisations) but typical of the sloppy and cavalier attitude of the whole *SaHF* process. I pointed out to you back in July that the Ealing Out of Hospital Strategy (Vol 11 of the PCBC) was deficient – from p7 to p25 it ceases to be Ealing and becomes generic NWL, except for a brief allusion to 'the Borough' at the top of p10 (but this could be any Borough).

This essential element of the *SaHF* proposals, nodded through without a vote at the JCPCT Meeting of 25 June, is a ham-fisted cut-and-paste job: the line 'We have identified five key enablers to support the change for better care, closer to home in Central London, as set out in figure 24' is stolen from Vol 10 and reproduced as 'We have identified five key enablers to support the change for better care, closer to home in Central London, as set out in Figure 19'. The Figure number has changed but, sadly and stupidly, not the CCG name.

This slapdash approach probably also explains the parenthesis '(Optional intro –May be in case for change section)' under Figure 1 on p7 – obviously nobody checked for running notes – and the fact that the Table of Contents appears on p6. It would also account for the ramshackle changes of typestyle and weight. And, of course, the apparent absurdity of the line on p20 'Each of the CCGs have their own individual plans that they have created to meet their population's needs (see appendix)' becomes (only slightly) less absurd when you realise that THIS IS A PART OF THE APPENDIX REFERRED TO!

Ealing's OOH Strategy does not have a budget breakdown, unlike the other 7 – the sort of detail to be found at p34 of Vol 12 or p28 of Vol 14, for example. I pointed this out in a response to your 'consultation' website on 14 July and have not had an answer; last night on Table 4 I raised the same point with Dr Parmar and she had no idea of what I was asking or that her CCG Strategy had no budget (had she read it?) Without this detail it is even more impossible to make sense of the fantasy figure of £120 million to be spent across the area. Someone should do what I did, and try to reconcile the sum of the individual Borough budgets, with an interpolation for Ealing.

I could go on, but it is getting late and I have devoted enough of my time to the grotesque farrago that passes itself off as a considered business case benefiting somehow from the £3.5 million of taxpayers' money trousered by McKinsey. I suggest that a tiny proportion of that could have been wisely spent on a competent proof-reader.

Colin Standfield

No Reply. The Royal College files on the website were subsequently corrected.

Poor Risk Management

The OGC Gateway Review issued to the SRO on 4 May 2012, just 2 months before the start of the 'consultation', rather alarmingly noted:

4: Risk management
The Programme has a risk management framework with a clear process for capture, reporting and escalation although *this stated process does not appear to be followed*. [my italics]

The RT observed that the Risk Register has relatively few entries for such a large programme. Those entries that are captured do not cover all the risks discussed with the RT. Although stakeholders reported that risks were discussed as part of Board agenda items there was no specific discussion of the top risks for the programme, although these are discussed at the weekly Programme Executive meetings. The Register and summary do not contain any listing of reviews and reporting of actions or mitigation taken so there is no audit trail to evidence active risk management.

The RT notes a number of risks recognised by stakeholders but not recorded, including:

- availability of sufficient resource to manage consultation and next steps,
- the lack of time allowed for review and reflection during the tight timetable to detect and correct inconsistencies in the consultation material and plans,
- the immaturity of workforce planning for transition and future service delivery.
- In particular any miss-match between desired and available skill and seniority mix,
- the real potential for services to fall over, as they fail to meet quality and safety requirements, if there is delay.
- delay due to Independent Reconfiguration Panel (IRP)/Sec of State (SoS) intervention,
- potential challenge regarding the different approach being taken for the reconfiguration in SW London,
- inconsistency in communication due to the lack of fully integrated messaging, particularly with Providers.

The programme must refresh the register and review its compliance with the stated risk process.

The confidential Risk Register was left behind at a Cluster Meeting in September 2012 and found by a member of the public. On page 3 it notes:

'NWL CA040 – New Risk identified for NWL BAF from Quality & Clinical Risk Register (August – mitigating actions awaited)

'Risk: Implementation of Out of Hospital Strategy

- Strategy not accepted by patients, politicians and public
- Primary care not robust enough and ready to support acute shifts in activity
- Stakeholders across the system may not be able to facilitate implementation of new pathways of care and deliver the new models of care and associated savings
- Stakeholders may not be able to deliver service transformation

'Consequences

- Poor Patient experience and outcomes
- Financial consequences – system becomes unaffordable and unsustainable
- Service gaps'

Alarmingly, there are no 'Mitigating Actions' under that heading (and this is two months into the 'consultation'!) and the Risk Owner is 'TBA'. NHS NWL displayed a remarkable talent for ignoring or sidestepping complaints and criticism - Ipsos MORI described (Final Report, page 154) the concerns of Ealing GPs at 3 meetings held to allay their fears:

'The issues raised in each of these meetings were broadly consistent. These covered:

• Opposition to closure of A&E at Ealing Hospital
• Importance of/concerns about ability to sufficiently improve primary care and community-based services
• Concerns about A&E capacity elsewhere
• Concerns over the loss of maternity and paediatric services at Ealing Hospital
• Concerns about ability of Ealing Hospital to recruit/retain/train doctors/consultants
• Concerns about the distance/time/access to alternative hospitals
• Concerns about disadvantaged and vulnerable groups; notably the population in Southall
• Suggestions to slow the process and introduce an Option 4 of reducing from 9 hospitals to 6
• Criticisms of the consultation process regarding public engagement and complexity of issues/lack of understanding/ reaction to proposals'

Yet the NWL *PAPER 6.0 Next steps in considering issues raised in consultation, November 2012* makes no mention of these concerns. My own attempts under the FoI Act to establish the degree of clinical support for *SaHF* in Ealing were met with simply details of the membership of the CCG which, it must be admitted, had and has a vested interest in the completion of the plans, as it is the successor agency.

For the risk management to remain unresolved two months into the 'consultation' period and for major clinical objections to be brushed aside must severely vitiate the probity of *SaHF*.

NHS NWL – Asymmetric Hospital Promotion

During the consultation, it was recorded that the two hospitals favoured by NHS NWL, Chelsea & Westminster and West Middlesex, indulged in promoting Option A, yet there was no activity from the two to which they were set up in opposition, Charing Cross and Ealing.

Your vote counts

Vote for Chelsea and Westminster as a 'major hospital' with a full A&E service in the *Shaping a healthier future* consultation—Option A*

If we are downgraded to a 'local hospital' without a full A&E, most of our services including maternity and children's services would close

Tick this box to vote Option A

We would like to submit your vote for Option A to the full public consultation in addition to this postcard:

Yes—I consent for you to submit my vote for Option A

No—I will complete the consultation response form myself

Your name

Your postal address

Your email address
(If you would like to receive news about our campaign)

*See p67 of the *Shaping a healthier future* consultation document and Q24a of the response form at www.healthiernorthwestlondon.nhs.uk

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Your vote counts

Vote for Chelsea and Westminster as a 'major hospital' with a full A&E service in the *Shaping a healthier future* consultation—Option A*

If we are downgraded to a 'local hospital' without a full A&E, most of our services including maternity and children's services would close

Tick this box to vote Option A

We would like to submit your vote for Option A to the full public consultation in addition to this postcard:

Yes—I consent for you to submit my vote for Option A

No—I will complete the consultation response form myself

Your name

Your postal address

Your email address
(If you would like to receive news about our campaign)

*See p67 of the *Shaping a healthier future* consultation document and Q24a of the response form at www.healthiernorthwestlondon.nhs.uk

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Please hand in this postcard at Reception or M-PALS by 1 Oct 2012

Help West Middlesex keep A&E, children's and maternity services

ACT NOW

Complete a **consultation form** from the hospital or go online

Shaping a healthier future

Option A
'Strongly support'
Why? We keep our award winning maternity, high performing A&E and other services, and give best value for money

Option C 'Strongly oppose' Why?
We lose these services and you travel to a different hospital to access them

Consultation forms in our main atrium
(freepost envelopes included)
or complete online:
www.healthiernorthwestlondon.nhs.uk

Please support West Middlesex in securing Major Hospital status

NHS North West London is consulting to improve healthcare for the two million people it serves

Under the preferred option (option A) West Middlesex would become a Major Hospital - expanding our award winning maternity, high performing A&E and other services

Under another option (option C) West Middlesex would lose these services and you would need to travel to a different hospital to access A&E, maternity and children's services

To have your say, please:
pick up a consultation pack from the hospital or visit www.healthiernorthwestlondon.nhs.uk
call 0800 881 5209
or email consultation@nwlondon.nhs.uk

Why was it acceptable for West Mid to stress that: 'West Middlesex would lose these services and you would need to travel to a different hospital to access A&E, maternity and children's services' whereas the whole thrust of the *SaHF* rationale was that distance did not matter? For example, 'The evidence is getting to the right place matters more than getting to the closest place.' (Dr Mark Spencer, *The Ealing Gazette*, 4 August 2012)

Why was it acceptable for C&W to warn: 'If we are downgraded to a 'local hospital' without a full A&E, most of our services including maternity and children's services would close'? Surely the Board had read the consultation document: 'It [any 'Local' Hospital] basically provides the kinds of services that most people going to hospital in NW London currently go there for.' (Consultation document, page 34) And Dr Mike Anderson was Medical Director for both C&W and *SaHF* – did he not spot this contradiction? It is noteworthy that he approved the description 'downgraded' even though the sunny optimism of *SaHF* seeks to persuade us that this is all about 'improvement'.

The result of this asymmetric promotion, predicted by us and by Ipsos MORI, was to distort the findings. Worse, it was an abuse of process for the two preferred hospitals to use public funds in their own interest whereas the opposed Trusts seemed to have been inhibited from doing likewise.

C&W spent just short of £8,000 if their FoI response is to be believed:

Cost of printing and distributing promotional material including campaign postcards, flyers and posters – £6,601 + VAT.
Cost of website – no cost as part of existing hospital website.

West Middlesex admitted to £691 and provided this summary:

£284 – 8000 A5 leaflets
£239 – 5000 A5 leaflets
£168 – large display poster
Use of existing A4 / A3 paper stock to print colour posters
Website – no extra cost
Total: £691

VAT would bring this to £829.20. No costs are included for the A3 window poster, but if they were the 'existing A4 / A3 paper stock' there should have been at least an estimate for the very expensive coloured ink.

The display in the entrance to West Middlesex Hospital had all the questionnaire response forms folded open at Q26a, the only one the management were really interested in:

For C&W, as the Panel has already been informed, it was just perhaps an unfortunate coincidence of timing which put Dr Mike Anderson in the position of Acting Chief Executive and gave him the responsibility of signing off the expenditure:

You requested the following information:
a) Who authorised the expenditure on print and distribution of your promotional material;

The Trust response is as follows:
a) Acting Chief Executive

It might, of course, have been more transparent to have given the ACE a name in this FoI Act response, but it was not hard to discover that one of the 4 Medical Directors charged, presumably, with overseeing a balanced and purely evidence-based public consultation was also spending other NHS monies on a campaign whose only predictable result, as confirmed by the *SaHF* Programme Manager, would be to distort and vitiate it. 'Obviously, this may make the overall feedback harder for NHS NWL to understand and respond to.' (Kate Woolland e-mail, 26 July 2012)

Personally I should have sought to avoid such an apparent conflict of interest, but I am certain that Dr Anderson is a man of great honour and simply enacted only what his Board had, on 28 May, discussed – 'There was some discussion about the approach to a campaign – this should reinforce our reputation. It is important not to alienate the people who support us such as politicians. It was noted that the consultation is not very clear that this does not include paediatric A&E.'

Since his services were retained from C&W by NHS NWL at £14,000 for a one and a half day week, it must at times have been difficult to know which instinct to follow.

This is a matter not, perhaps, so much of probity as of appearance.

And perhaps it would have been better for another authorised person to sign off a campaign whose sole purpose was to condemn a rival hospital to 'downgrading'.

NHS NWL Conflicts of Interest

It has been impossible to determine the possibility or the extent of conflicts of interest among those responsible for *SaHF* and among members of Clinical Commissioning Groups, despite requests and despite the use of the Freedom of Information Act. It is likely that there has been no lack of probity but the appearances, and the lack of transparency in the responses, belie this underlying integrity.

It was, of course, just an accident of history that many GPs became involved in out-of-hours service provision through banding together in companies which later became significant players in the privatised health market. Their shareholdings would not have been a problem until they became involved in the development of *SaHF* or in the running of the successor entities to NHS NWL. One of the GP consortia, Harmoni, became largely involved in the provision of the 111 service which could be considered a major beneficiary of the *SaHF* reconfiguration.

The Independent on Sunday reported on 25 March 2012: 'Another reform champion is Dr Ian Goodman. Dr Goodman chairs the Hillingdon CCG and is also a board director of Harmoni, the largest UK provider of primary care services, specialising in out-of-hours services. Andrew Gardner, chief executive of Harmoni, said the company expected a "big chunk" of the estimated £150m 111 service – a new 24-hour-a-day non-emergency phone line for patients. He estimated increased earnings for the company of £13m as a result.

'Dr Goodman holds shares in Harmoni, but insists he had declared his interests and would "quite rightly be excluded from any decision-making process where Harmoni was bidding".'

We still do not know whether Dr Goodman still has his shares or what they are, or were, worth. We do not know at what stage he knew about the takeover by Care UK, reported in *The Guardian* on 9 November, or whether he was at any stage involved in the planning of or support for the reconfiguration plans, or whether he was aware of any positive impact on Harmoni earnings, which his Chief Executive is reported to have seen as benefitting from any expansion of 111 services. Any enhanced earnings could have increased the value of Harmoni shares.

But it was presumably with no heavy heart that he wrote to Mr Zitron, then Chair of NHS NWL, on 24 May 2012 beginning: 'As the Chair of the Hillingdon Clinical Commissioning Group, I am writing to confirm that the Board of the Clinical Commissioning Group has considered the plans for NHS North West London's reconfiguration programme and support the planned public consultation in respect of the proposed options for change.'

Not that he wrote the letter, of course: the 8 CCG 'Letters of Support' are identical except for the names and dates (but Dr Ruth O'Hare qualifies the end of 'her' letter with 'and given adequate resources' rather than 'as appropriate') and would appear to have been written under instruction rather than as spontaneous and autonomous expressions of agreement; all 8 have the same error in switching from the singular to the plural verb as the paragraph above.

It is clear from the Minutes of the Extraordinary Executive Committee of the Ealing CCG on 25th May 2012 that Dr Parmar was notified, before any discussion or vote, that she would be *required* to sign the letter: 'Mark Spencer presented – "Improving healthcare for two million people in North West London" to the group and advised that following the meeting the Chair would be asked to sign a letter on behalf of the CCG Board giving support to the planned consultation for "Shaping a healthier future".' It is hard to see this as anything other than coercion, and it was presumably replicated across all 8 CCGs.

Confusion in Registers of Interests

The NHS NWL Registers of Interest are, in any case, unreliable. I had to point out that, in the entries posted on the website in connection with the NW London Cluster Board, both Jeff Zitron and Martin Roberts had registered the same interests in TIAA Ltd, Altair Consultancy, DMJ, Soho Housing and K&C Tenant Management. I was told that this had been corrected at a Board Meeting, but not on the website. It should not have happened in the first place if due attention had been paid to the Register.

When it came to Ealing CCG there was, however, a more worrying concern over the many GP Commissioners who had interests in Harmoni and SMART.

In the Ealing CCG Register updated on 30 October last year were the following entries: Dr Mohammad Alzarrad (Director SMART Primary Health 2010); Dr Arjun Dhillon (Shareholder in SMART Health Ltd); Dr Mohini Parmar (Share holder in SMART (Dormant GP Provider Company); and Dr Vijay Tailor (SMART Primary Health Ltd since 2010. Limited Company by shares - each member has 10 shares. 57 members in total, dormant company currently with NO business interest within the NHS or outside) – all these doctors registered interests in SMART and two of them said it was a 'dormant' company.

But the Accounts of Hammersmith and Fulham PCT and of Kensington and Chelsea PCT both showed Related Party Payments to Dr Mark Spencer in the year ending March 2012 in respect of this 'dormant' company. Did it become dormant only after April? The K&C figure was £10,000 and the H&F was £3,000 - not vast sums in the broader scheme of things, but not indicative of a dormant company, unless there has been some creative accounting.

I asked why Drs Dhillon and Parmar put their shareholdings under the 'Ownership' heading and why they had all put their interests on the Knowsley Shadow CCG Register of Interests, but received no reply to these or any other questions.

It is not acceptable or transparent for influential officers to state simply 'Shareholder in...' without giving the quantum of the stake they own – in Dr Spencer's case, we have been unable to establish whether or not he has disposed of his shareholding in Harmoni (and if so, when); nor can we establish whether it was just, say, a 10p share to keep his name on a mailing list or a £35,000 share as estimated by *The Guardian* on 9 November 2012. The newspaper points out: 'Harmoni's finances are complex, with hundreds of shareholders and different classes of stocks.'

Attempt 1 to Resolve Questions about Conflicts of Interest

I sought to achieve some clarity over the matter of conflict so interest, first through the FoI Act and, there being no reply within 20 working days, then through a series of direct questions to the Chief Executive:

Subject: **Harmoni, Care UK and Conflicts of Interest**
Date: 18/12/2012
To: anne.rainsberry@london.nhs.uk
CC: jeff.zitron@nhs.net, andy.slaughter.mp@parliament.uk, PoundS@parliament.uk, sharmav@parliament.uk, angie.bray.mp@parliament.uk, onkar.sahota@london.gov.uk, ruth.carnall@london.nhs.uk

Dear Dr Rainsberry,

1. In a Freedom of Information response NW327 of 13 June Dr Mark Spencer is listed as a shareholder in Harmoni, based on a Register of Interests he signed on 15 October 2011.

2. In a freedom of Information request of 12 November I sought clarification of shareholdings by NWL Staff and GPs in Harmoni before and after its purchase by Care UK, as well as assurances about the financial viability of Care UK.

3. Not having received a reply after the time allowed, I made a formal complaint on 11 December, of which you have a copy. I have still heard nothing.

4. I am concerned by reports yesterday and today in *The Guardian* which allege unsafe practices at Harmoni, although these claims are 'rejected' by Harmoni: 'Harmoni out-of-hours GP service putting patients at risk, say doctors'; 'Former Harmoni clinician warns of 'dangerous' pressure on appointments'; and 'Family sues out-of-hours GP provider and nurse over death liability'.

5. Until the various cases are settled, do you think it appropriate that your Medical Director retain any interest in Harmoni? May I remind you that, under the *SaHF* plans, Harmoni will have an enhanced role, not least in providing the 111 service, and Dr Spencer has been very active in driving these plans forward.

6. Are you satisfied that no member of the *SaHF* team or of any Commissioning Group has any actual or perceived conflict of interest in Harmoni or Care UK?

7. Are you satisfied that there is no basis for the claims made in *The Guardian*?

8. In the last-mentioned of the reports in The Guardian, the relevant PCT is quoted as saying: 'In the rare and unfortunate event that things go wrong, it is the provider of that care that will be responsible for paying any damages in the event that liability to do so is established.' Are you satisfied about the insurance and indemnity arrangements of Care UK and Harmoni as they apply to NHS NWL?

I need hardly add that a timely response to my request would have obviated the need for this e-mail and am hoping that the FoI Act will not have to be used to clarify these matters.

Colin Standfield

This may have prompted, finally, a response under the Act two days later:

Subject: **NW668 RE: FoI Request: Financial Viability of Care UK**
Date: 20/12/2012 18:00:07 GMT Standard Time
From: foi@nw.london.nhs.uk
To: ColinStandfield@aol.com, foi@nw.london.nhs.uk

Dear Mr Standfield,

Further to your Freedom of Information request. Please see the attached letter response. I apologise for the delay in responding to your request.

Regards

Dominic Mallinder
FOI Lead
NHS North West London

From: ColinStandfield@aol.com [mailto:ColinStandfield@aol.com]
Sent: 12 November 2012 12:53
To: FOI NWL
Subject: FoI Request: Financial Viability of Care UK

Dear Sirs,

The Independent on 5 November reports that Care UK has debts of £480 million and that 'the debts of many [of the 10 largest care home providers] leave them at the mercy of the market. The debts of Four Seasons, Care UK and NHP are rated as risky (junk bonds).' (pp 12 and 13)

Since Care UK also provides the UCC at Ealing Hospital among others and since it has bought Harmoni, which will play an enhanced role under the *Shaping a healthier future* plans, not least in an expanded '111 service', please tell me under the terms of the Freedom of Information Act:

1. What enquiries has NHS NWL made to satisfy itself of the financial sustainability of Care UK?

2. What risk assessment has been put in hand and what contingency plans are in place should Care UK cease to be financially viable?

Furthermore, it has been reported in *The Daily Telegraph* ('GPs cash in on sale of out-of-hours provider', 10 November) and *The Guardian* ('Healthcare sell-off makes GPs millions', 9 November) that a group of GPs in NW London will share more than £25m between them as a result of the buyout of Harmoni by Care UK.

Under the terms of the FoI Act, please tell me:

3. How many of these GPs or clinical leaders and other staff in NW London with current or recent shareholdings in Harmoni have been involved in developing, promoting or supporting the *SaHF* plans, either as members of the *SaHF* team or as Chairs or members of Clinical Commissioning Groups?

4. What diligence has NHS NWL applied to ensure that there has been no possibility of an actual or perceived conflict of interest arising from such a pecuniary relationship through a shareholding in any organisation which will benefit or may be seen as likely to benefit from the *SaHF* plans, including Harmoni and Care UK?

You may reply by e-mail.

Colin Standfield

NW668/SAHF 1494 Response letter follows:

North West London

NHS North West
London
15 Marylebone Road
London
NW1 5JD

foi@nw.london.nhs.uk

20 December 2012

Ref no: NW668/SAHF 1494

Dear Mr Standfield,

I am writing from NHS North West London which administers Freedom of Information Act 2000 (FOIA) requests on behalf of Westminster, Hammersmith & Fulham, Kensington & Chelsea, Brent, Harrow, Hounslow, Hillingdon and Ealing PCTs. This response in on behalf of al PCTs.

I apologise for the delay in responding to your Freedom of Information request sent and received on the 12 November 2012.

You requested the following:

Since Care UK also provides the UCC at Ealing Hospital among others and since it has bought Harmoni, which will play an enhanced role under the Shaping a healthier future plans, not least in an expanded '111 service', please tell me under the terms of the Freedom of Information Act:

1. *What enquiries has NHS NWL made to satisfy itself of the financial sustainability of Care UK?*
2. *What risk assessment has been put in hand and what contingency plans are in place should Care UK cease to be financially viable?*

Furthermore, it has been reported in The Daily Telegraph ('GPs cash in on sale of out-of-hours provider', 10 November) and The Guardian ('Healthcare sell-off makes GPs millions', 9 November) that a group of GPs in NW London will share more than £25m between them as a result of the buyout of Harmoni by Care UK.

Under the terms of the FoI Act, please tell me:

3. *How many of these GPs or clinical leaders and other staff in NW London with current or recent shareholdings in Harmoni have been involved in developing, promoting or supporting the SaHF plans, either as members of the SaHF team or as Chairs or members of Clinical Commissioning Groups?*
4. *What diligence has NHS NWL applied to ensure that there has been no possibility of an actual or perceived conflict of interest arising from such a pecuniary relationship through a shareholding in any organisation which will benefit or may be seen as likely to benefit from the SaHF plans, including Harmoni and Care UK?*

The response to your request is:

1. What enquiries has NHS NWL made to satisfy itself of the financial sustainability of Care UK?

Responsibility for commissioning any services is within the remit of the clinical commissioning groups (CCGs). If additional services were later required as a result of *Shaping a healthier future* (SAHF) then CCGs would need to develop specifications and determine the appropriate procurement route. The financial viability of bidders would be tested as part of that process.

The current UCC services are provided by a mix of NHS, NHS/third party consortia and external providers. There is no assumption under *Shaping a healthier future* that any particular providers – including Harmoni or Care UK - would provide an enhanced role. It is important to note that the SAHF proposals include the provision of an urgent care centre (UCC) at each of the nine NW London hospitals. Each of these hospitals already has a UCC. There is no intention to increase the number of UCCs - only to standardise them. The proposals are to develop a consistent set of minimum standards for all UCCs to ensure that each offers the same range of services to patients and is able to manage the same range of conditions.

2. What risk assessment has been put in hand and what contingency plans are in place should Care UK cease to be financially viable?

See 1) above. Shaping a healthier future (SAHF) has no remit or role in contracting of these services and therefore has no risk assessment of providers of care.

Under the terms of the FoI Act, please tell me:

3. How many of these GPs or clinical leaders and other staff in NW London with current or recent shareholdings in Harmoni have been involved in developing, promoting or supporting the SaHF plans, either as members of the SaHF team or as Chairs or members of Clinical Commissioning Groups?

All GPs in North West London have had the opportunity to be involved in developing the SAHF proposals. We do not have a list of the shareholders of Harmoni. The shareholders of all registered companies are held by Companies House.

The NWL Cluster Medical Director has disclosed his one share in Harmoni in line with our governance requirements. However, as explained above, no decisions have been, or will be taken as part of SAHF to tender or commission services.

4. What diligence has NHS NWL applied to ensure that there has been no possibility of an actual or perceived conflict of interest arising from such a pecuniary relationship through a shareholding in any organisation which will benefit or may be seen as likely to benefit from the SaHF plans, including Harmoni and Care UK?

Shaping a healthier future (SAHF) has no remit or role in the contracting of services. Where decisions are; have been; or will be taken regarding the *Shaping a healthier future* proposals decision-makers are asked to declare their interests in keeping with governance arrangements. All declared interests are recorded in a public Register of Declaration of Conflicts of Interests which is presented to a public Board meeting annually and is formally recorded within the minutes of that meeting.

If you are dissatisfied with how your request has been handled or the response you have received, you can write outlining your complaint by emailing foi@nw.london.nhs.uk. If you remain dissatisfied you can request an Internal Review of your response by emailing foi@nw.london.nhs.uk. This would be conducted at a senior level of the organisation and the outcome reported back to you. Where you feel your request has still not been dealt with properly, you can appeal to the Information Commissioner by writing to:

The Information Commissioner
Wycliffe House
Water Lane
Wilmslow
SK9 5AF

Further information on the Freedom of Information Act is available at: http://www.ico.gov.uk.

If you require any further information please do not hesitate to contact me.

Yours sincerely,

Dominic Mallinder
Freedom of Information Lead

This letter creates an artificial distinction between those responsible for reconfiguration and those charged with commissioning as a result of it, many of whom will be the same people. It is the height of disingenuousness to pretend that involvement in *SaHF* and in discussions entailing the possible opportunities for SMART, Harmoni, Care UK or the 111 service can be divorced from personal pecuniary interests, if they exist.

Since NHS NWL have not troubled themselves to find out whether there are conflicts and rely only on the Registers of Interest, their only answer is 'We do not have a list of the shareholders of Harmoni.' Their answer to Question 4 is clearly *not* an answer to Question 4, and it leaves the matter of conflicts of interest unresolved.

It is absurd to consider that the financial stability of providers should not be part of the *SaHF* planning – 'The financial viability of bidders would be tested as part of that [CCG commissioning] process'– whereas the financial stability of the 4 Hospitals under threat appears to be part of the rationale for their closure – 'Unless things change, we predict that most of the hospitals in NW London will end up in financial difficulties'. This letter admits that there are already 9 UCCs - why are NHS NWL feigning ignorance of their financial status?

It is disingenuous to state that: 'There is no assumption under *Shaping a healthier future* that any particular providers – including Harmoni or Care UK - would provide an enhanced role.' It is clear that there will be greater business opportunities for anybody running non-hospital services as this is very much the direction of travel within *SaHF*.

There is an unreasonable reliance on the artificial distinction between reconfiguration and commissioning: 'Shaping a healthier future (SAHF) has no remit or role in the contracting of services.' This is mere sophistry. *SaHF* could very easily be designed to give greater prominence to non-NHS providers, many of which are already contracted to work in the sector and many of which have owners or shareholders among those making or endorsing those designs. It is impossible to say whether any conscious or unconscious influence was allowed to play a part in the planning.

Dr Rainsberry did not answer my final three questions:

6. Are you satisfied that no member of the *SaHF* team or of any Commissioning Group has any actual or perceived conflict of interest in Harmoni or Care UK?

7. Are you satisfied that there is no basis for the claims made in *The Guardian*?

8. In the last-mentioned of the reports in The Guardian, the relevant PCT is quoted as saying: 'In the rare and unfortunate event that things go wrong, it is the provider of that care that will be responsible for paying any damages in the event that liability to do so is established.' Are you satisfied about the insurance and indemnity arrangements of Care UK and Harmoni as they apply to NHS NWL?

All we ask for is complete transparency about such ownerships or shareholdings as there are and reassurance about the financial stability of a major private-sector health provider These do not seem to be unreasonable requests

.

Attempt 2 to Resolve Questions about Conflicts of Interest

Andy Slaughter MP has tried to establish the truth in correspondence with Dr Anne Rainsberry and I have no evidence that he has succeeded. He e-mailed on 10 November 2012:

I attach the front page article from today's Guardian, which you may have seen, regarding the sale of out of hours GP service provider Harmoni to Care UK. The article states that a number of GPs will make substantial sums from the sale.

I note that four of the CCG chairs in NW London declare shareholding or directorship in Harmoni, as does your Medical Director. It would be helpful to know if they are beneficiaries of the sale and by what amount.

Looking the future, I note a number of other private medical interests in the declarations made by those who will be making decisions on the future of our local NHS. What assurances can you give that those making decisions on your 'shaping a healthier future' programme will see no direct or indirect financial benefit therefrom?

The reply eventually came on 6 December, and after Dr Rainsberry had referred to the Registers of Interest, she included the following:

In relation to the issue you raise regarding the sale of an Out of Hours provider Harmoni to Care UK. I am aware through the Cluster Register of Declarations of Interests that some GP Chairmen of the emerging Clinical Commissioning Groups (CCGs) have declared holding shares in Harmoni. This is normal practice in private and public sector that Registers of Declarations of Interests are held to ensure openness and transparency in all business meetings.

The NWL reconfiguration programme 'Shaping a Healthier Future' (SaHF) proposals are overseen and governed by the North West London Joint Committee of Primary Care Trusts. The membership does not include any CCG Chairs but the NWL Cluster Medical Director is a member and has disclosed his one share in Harmoni in line with our governance requirements. I can assure you that no decision will be taken as part of SaHF to tender or commission services as this programme is about the reconfiguration of services to enable the optimum levels of services for patients and carers.

The members of the JCPCT who are the decision making body for the SaHF programme have all declared their interests for anything they perceive to require disclosure in line with our policy and nothing has been disclosed by a member that indicates they will realise direct or indirect financial benefit.

Dr Spencer had declared 'one share in Harmoni' (but not what it was worth) and 'nothing has been disclosed' about direct or indirect benefits. The important question – whether any of those involved in *SaHF* could receive any direct or indirect financial benefit – remained unanswered.

Mr Slaughter responded with, *inter alia*:

You replied to my email of 10 November on 6 December, but failed to answer the questions I raised therein. You gave no adequate explanation for the delay or the

refusal to deal with what are very significant matters that are subject to daily comment in the national press.

It is simply not good enough to say members of NHS NWL, the CCG or PCT boards can declare interests in private companies, absent themselves from decisions, and otherwise carry on as normal. As the Chair of the Royal College of General Practitioners has said: 'it is not about excluding yourself from the room whenever there is a discussion; it is about how it will drive your decision-making overall".

The current changes in NHS NWL mean the following:

1. A shift in funding from hospital to primary care.
2. A greater involvement of private companies in the primary care sector.
3. An opportunity for those companies to increase their profits by cutting back on the level of service offered.

If senior decision makers in the NHS have financial interests in those companies there will inevitably be conflicts of interest which are fatal to their ability to make independent choices in the interests of patients.

However, even the limited information which you should make available is not supplied on the Register of Member's interest forms. This is incomplete or absent in many cases. The forms ask for the scope and value of any interests of CCG chairs and other members of the NWL Cluster. I repeated this request in my email of 10 November, ie for a comprehensive statement of the scope and value of the value of shareholdings in Harmoni and any other relevant companies. You have so far failed to supply this, so I would request that you do by close of business tomorrow.

The Guardian article of 9 November, for example, refers to a profit of £2.6 million made by the Hillingdon CCG chair from the sale of Harmoni to Care UK. Could you confirm whether this is the case?

Much of the information on the declaration of interest forms is incomplete or needs clarification, as to the scope of the interest being declared or its value or both. The following entries need clarification:

- Dr Mark Spencer - no scope or value is given concerning the Partnership at Hillcrest Surgery; no scope or value is given regarding the shareholding in SMART nor is there any indication of the scope or value of any business sought with the NHS.

- Ruth O'Hare – The scope and value of the several interests mentioned is not stated. What is the value of the paid Chair post declared?

- Tim Spicer – What is the nature and value of the part share in the "primary care surgery facility" declared? What is the scope and value of the research money declared in respect of Richford Gate, and who provides it?

- Ian Goodman – What is the scope and value of the Directorships in Harmoni declared? What effect on this declaration has the recent sale of Harmoni had? What is the scope and value

of the shares held in Harmoni? What is the scope and value of the shares held in a) Hillingdon Health? B) Mountwood Surgery?

- Fiona Butler – Scope, value and name of company mentioned in declaration of ownership needs stating.

- Amol Kelshiker Scope and value of shareholdings in Harrow Health not declared

- Dr Mohini Parmar - Scope and value of shareholding in "Smart"

- Dr Etheldreda Kong – Scope and value of shares in Harmoni needs stating; scope and value of holding in the other (illegible on form) company need stating.

I would also like you to send me a copy of the *Register of Declaration of Conflicts of Interests*, to which you refer in your letter of 6 December.

I hope all the above information will be readily forthcoming, as of course it should already be in the public domain: but for the avoidance of doubt, if for any reason you are cannot give the information as requested voluntarily, then I make this request under the provisions of the Freedom of Information Act.

Further Unresolved Register of Interests Problem

The quality of record-keeping within organisations under the aegis of NHS NWL related to Registers of Interest is challenged by the Charing Cross Hospital Register entries for Mark Davies, Chief Executive. There was some confusion about his and his wife's interests in a number of companies which had had dealings with Imperial College Healthcare and through one of which he was paid for all but one month of 2011/12.

The Daily Telegraph on 29 October 2011 ran a story about the matter, and I have received e-mails on the subject.

One of these companies was Redlands Equestrian which ran equestrian training courses for 'a small group of senior [Imperial] clinicians and managers' some 2 years before his appointment. This was confirmed by a Trust spokesperson quoted in *Felix Online*, the Imperial student magazine.

I asked the following questions, *inter alia*:

Under the terms of the Freedom of Information Act, please tell me:

1a Who was the highest paid director in that year?
1b What was the third party through which that director was paid?
1c What was the total paid through that third party?
1d Is Mark Davies still a Director of Redlands Equestrian? (See Companies House report attached)
1e If so, why is it not declared in either the 2011/12 or 2012/13 Report?

The response included:

1d. Is Mark Davies still a Director of Redlands Equestrian? (See Companies House report attached)
Mark Davies has stated that he is not a director of Redlands Equestrian and the information available from companies' house does not reflect an amendment to the company register which he submitted.

Unfortunately, the amendment he had submitted was made only on 8th July – 4 days *after* my enquiry.

In accordance with Section 167 of the Companies Act 2006

TM01

Termination of appointment of director

Companies House — for the record

You can use the WebFiling service to file this form online.
Please go to www companieshouse gov uk

✓ **What this form is for**
You may use this form to terminate the appointment of a director (individual or corporate)

X **What this form is NO**
You cannot use this for terminate the appointr secretary To do this, ple TM02 'Termination of a of secretary'

THURSDAY

A2CV9ABH
A29 18/07/2013 #8
COMPANIES HOUSE

1 Company details

Company number	0 6 1 6 1 5 7 9
Company name in full	REDLANDS EQUESTRIAN LIMITED

→ **Filling in this form**
Please complete in typescript or in bold black capitals

All fields are mandatory unless specified or indicated by *

2 Director's current details on the Register

Please give us the current appointment details of this director held on the public Register

Date of birth* ❶	d1 d5 m0 m8 y1 y9 y5 y8
Title*	MR
Full forename(s)	PHILIP MARK REDVERS
Surname/Corporate name	DAVIES

❶ **Date of birth**
Providing a date of birth will help us identify the correct person on the public record This is voluntary information and if completed it will be placed on the public record

3 Termination date ❷

Date of termination of appointment: d0 d8 m0 m7 y2 y0 y1 y3

❷ Only one director appointment can be terminated per form

4 Signature

I am signing this form on behalf of the company

Signature: X [signature] X

This form may be signed by
Director ❸, Secretary, Person authorised ❹, Liquidator, Administrator, Administrative receiver, Receiver, Receiver manager, Charity Commission receiver and manager, CIC manager, Judicial factor

❸ **Societas Europaea**
If the form is being filed on behalf of a Societas Europaea (SE) please delete 'director' and insert details of which organ of the SE the person signing has membership

❹ **Person authorised**
Under either section 270 or 274 of the Companies Act 2006

It would have been perhaps more honest to say: 'Mr Davies was indeed a Director of Redlands until he was prompted by your enquiry to make a change he should have effected earlier. We apologise for the consequent error in the Registers of Interest for the applicable years.'

I have not yet had a reply to my response of 2 August, which concluded:

Since this Directorship is not disclosed in either the 2011/12 or 2012/13 Report, the inference is that he became a Director only at some time after the start of the Financial Year and terminated his appointment on 8 July 2013.

Is that correct?

I have no evidence that he disposed of his 50% share in Coalescence Consulting, as disclosed in the 2010/11 Report; was he still a 50% owner while he was either Chief Executive or Interim Chief Executive at the time any of the £16,423 (2010/11) or £63,114 (2011/12) was paid to Coalescence?

Would it be normal practice for a company owned, part-owned or run by a Board Member or his or her spouse to be paid by an NHS body?

I hope we can clear up this apparent anomaly quickly.

I am sure there will be a straightforward explanation; it is just unfortunate that it takes persistence to secure it.

Conclusion

It should not require these various and repeated attempts to establish what conflicts of interest there are or may be among those charged with the responsibility of framing, endorsing or implementing the proposals under *SaHF*.

It should not be too onerous for an organisation with the heavy responsibilities of NHS NWL to answer straightforward questions about the financial standing of one of their major suppliers.

It should not be impossible for one of the NHS NWL Hospital Trusts to be able to answer for the business dealings of its Chief Executive, especially where there has been a history of payments to companies with which he was, or had been, an associate.

The obfuscation and delay give rise to continuing doubts about the probity of the reconfiguration plans and the capacity for their fulfilment.