LHC

SAVE LEWISHAM HOSPITAL CAMPAIGN'S RESPONSE TO THE TRUST SPECIAL ADMINISTRATOR'S DRAFT REPORT INTO THE FAILURE OF SOUTH LONDON HEALTHCARE TRUST (SLHT) AS REQUIRED UNDER S18 OF HEALTH ACT 2009

Principles

We note the first principle of your report that patients' interests should always come first so that they have the necessary access to the services on which they rely. We do not see in the report any convincing evidence that proves a case for the closure of facilities at Lewisham. We are convinced that the plans outlined in the report will lead to *worsening* health care and for that reason we are opposed to them.

Our approach

We focus on the patient and citizen experience of care and its safety.

We see these challenges to the viability of SE London health economy as largely the result of a market-driven NHS and we foresee easier solutions if the market were excluded from planning and delivering the NHS. In any case, added expenditure is part of the TSA plan, so we see this principle extended to ensuring improved safety and convenience.

On a larger canvas, the NHS made a surplus. In our view, as an organisation based on national solidarity, NHS surpluses must be driven back into patient care, not given back to the Treasury. And this principle also applies to Trusts surpluses, such as those in King's and Guy's. So, we see it as entirely reasonable that extra expenditure should ease the perceived need for these transitions.

On a larger canvas still, we see the nation's austerity programme as damaging and based on poor evidence. An alternative approach, seen to be working in the US and China, is to stimulate growth by government investment, creating the conditions for innovation and development. Investing in the NHS would be more likely to assist in growth and jobs than almost any other investment.

The Four Tests

The Coalition have agreed that any changes must pass the four tests which were added to the reconfiguration process in 2010 by the previous Secretary of State for Health and which must be applied to any reconfiguration:

1. **A Clinical evidence base underpinning the proposals.** Evidence presented here shows that the clinical evidence in the TSA report is flawed.
2. **The changes have the support of the GP commissioners involved. Significantly,** 110/140 GPs have signed a petition against the reforms.

3. **They must genuinely promote choice for their patients.** We provide evidence here that challenges this claim within the TSA document.

4. **The public, patients and local authorities have been genuinely engaged.** Local opinion is clearly against these recommendations with at least 32000 local people signing a petition, as well as in the region of 15,000 taking to the streets in the largest local protest demonstration of its kind in decades. The local authority has also formally made its opposition clear.

This document shows that in relation to proposals for Lewisham, three – and probably four, of these tests have not been met.

Summary Response in Relation to University Hospital Lewisham

For reasons which are far from clear the TSA has decided to bring clinical changes at Lewisham Hospital into the proposals – seemingly going beyond any acceptable remit. The key recommendation is to shut the £12m, newly furbished, A&E at Lewisham which then has consequences for other services. We set out below why any decision to close this facility would be flawed – notwithstanding that any such proposal should and must only be taken after a full clinical case is set out and full and proper consultation is carried out. The report also suggests the possibility of restrictions on the maternity service which is also dealt with below.

In part to justify this closure it is suggested that the Community Based Care Strategy will significantly reduce urgent care demand – which we refute as set out below.

As a counterweight it is suggested that Lewisham should become a major site for simple elective surgery across South London – although it is unclear how this might impact on other trusts and how in the new architecture there could be any guarantees around future patient flows. This lack of clarity is one reason why the rushing through of this process is unacceptable.

If there are issues around quality or viability of services in Lewisham then it is for the trust board to address – we oppose having arbitrary external top down imposed solutions. The issue of the lack of financial sustainability in SLHT must not be conflated with UHL and threaten its viability.

We consider that the PFI deals financing QEH and PRUH are a major component of the SLHT's bankruptcy. We believe that the over-riding priority of your proposals is to ensure that, whatever the cost to patient services, QEH and PRUH PFI payments are guaranteed. The proposal for the government to pay £25 million a year does not negate this. It is the PFI that is being bailed out, not the clinical services which people in south east London depend on. This prioritising of debt repayment over service provision is, in our view, the principal

reason that Lewisham Hospital, without a significant PFI, was chosen to take the brunt of the cuts.

If an elective care centre for South London (of some sort) is required and Lewisham is the best place for it to reside then this proposal should be set out and properly consulted on in a different process.

The reconfiguration of services in Lewisham must be left to the management of the trust, local people and commissioners, not imposed on the people of Lewisham by a top down process which subverts the established principles around managing reconfiguration.

In summary:

- The proposals reduce patient choice and are unsafe and dangerous
- Lewisham Hospital is successful, solvent and needed by its community
- Ongoing service plans for integration and better care will be halted
- There is no justification to include Lewisham Hospital at all
- The process has been nasty, brutish and short, probably illegal and has inadequately consulted

Detailed Response

Focus on Lewisham

Our response to the draft report is focused on those parts of the report which deal with Lewisham Healthcare Trust. Whilst we set out our analysis and response to those parts, our view is that including recommendations about Lewisham is outside the legal remit allowed to the Trust Special Administrator (TSA).

The relevant legal provision is from S18 of the Health Act 2009 which sets out the role and process for special administration. In particular:-

> *65F Draft report*
>
> *(1) Within the period of 45 working days beginning with the day on which a trust special administrator's appointment takes effect, the administrator must provide to the Secretary of State and publish a draft report stating the action which the administrator recommends the Secretary of State should* ***take in relation to the trust****.*

There is no provision for recommendations which do not relate to the "failing" trust; in this case SLHT.

This is highly important since using this "failure" process to carry out reconfiguration, as is proposed, removes the requirement placed on those considering reconfiguration to follow the process and to conduct consultation as required under S242 and S242 of the NHS Act 2006. The limited and truncated consultation required in the special administration process is not as comprehensive and denies stakeholders their right to be heard. It evades the need for proposals to be independently assessed by the National Clinical Advisory Team and assured through a Gateway Review as set out in the letter from David Nicholson dated 29 July 2010.

Urgent Care

The TSA recommendation is that University Hospital Lewisham will provide 24/7 urgent care service for those that do not need to be admitted to hospital which will treat around 77% of the people currently attending the A&E and Urgent Care Centre (UCC) now. This means that around 70 people per day, who would currently attend University Hospital Lewisham, will be taken to a different location by London Ambulance Service, self-select to attend elsewhere or will be treated, stabilised and then transferred.

The 70 will be expected to be treated at Princess Royal, Queen Elizabeth, St. Thomas's or Kings. Whilst some increased journey times are obviously implied, the report states that these will still be amongst the shortest in the country; however the estimates of increased travel times are grossly underestimated.

Closure of the A&E facility at Lewisham should be opposed since:-

- a recent comprehensive study (2009) under "A Picture for Health" concluded that Lewisham A&E should be retained and as a result significant investment took place
- closure reduces choice and so is contrary to one of the four principles
- there would be increased travel times and travel complexities which will impact on everyone in the Borough of Lewisham. The closest point in the borough to QEH is still closer to UHL.
- there are no significant issues around waiting times or mortality rates which require short term attention
- it is an acknowledged centre of excellence as regards training and development and this would be put at risk (it was rated the best site in London for training for GPVTS trainees in the 2010 PMETB survey)
- there are real concerns about the retention of a very experienced workforce and future recruitment (especially of Emergency Nurse Practitioners)
- there is no impact assessment of how additional patient flows to other local hospitals, some of which currently do not meet waiting time targets, would be managed or what costs could be involved

- the management capability at Lewisham is acknowledged and they should be free to manage A&E access across the two sites (Lewisham and Queen Elizabeth).

Number of patients affected:

The report claims that UHL ED receives on average 2 'Blue-light' ambulance attendances per day. Analysis of Lewisham Resuscitation room records reveals a daily average (2011-12) of 10-11 patients being admitted to the Resuscitation room for intensive/critical level care.
25,550 patients per year will be affected by the downgrading of Lewisham A&E.
This estimate is based on the following paragraph on pages 67-8 of the Draft Report:
"It is estimated that around 77% of the patients that currently attend University Hospital Lewisham for emergency or urgent care would be able to continue receiving their treatment from the urgent care centre. This means that around 70 people per day, who would currently attend University Hospital Lewisham, will be taken to a different location by London Ambulance Service, self-select to attend elsewhere or will be treated, stabilised and then transferred."

Choice:

The Scoping Report makes it clear that "The transformation of non-elective services at UHL could lead to some reduction in patient choice, particularly for patients in Lewisham.1

Travel times

The Scoping Report makes it clear that "The reduction of non-elective services at UHL will increase the travel times for patients in the relevant catchment area as they travel to other hospitals in the health economy to receive required treatment. As Lewisham has a number of deprived wards, this impact will need to be considered in greater detail." 2
Again the Health and Equalities Impact Assessment suggests that people with disabilities "may face greater transport and access constraints, increased travel time and travel complexity from changes in the location of the services being delivered." 3

This will have a detrimental impact on the conditions of some of these patients. Travel costs for people in this group are also likely to be prohibitive, particularly given the forthcoming changes in disability travel allowances. These impacts will also increase the numbers of DNAs.

The travelling times quoted for the people of Lewisham do not bear any resemblance to the experience of patients using public transport at any time in this part of London. The travel times quoted are for "no traffic".4 This is quite unrealistic. Even a brief look at the TfL

---

[1] Health and Equalities Impact Assessment – scoping report p26

[2] Ibid p 24

[3] Ibid p30

[4] Health and Equalities Impact Assessment – scoping report p25

website shows that transport from Lewisham A+E to QEH would take 55min @ 1730 and 1430 on a Tuesday. It would involve no less than 2 buses and usually 2 buses, a train journey – and sometimes two, plus 2 walks – in each direction

Crucially, there are some extremely opaque figures as to the estimated length of time it will take a blue light ambulance to get to Woolwich A&E from Lewisham. The question should be asked: if someone is knocked down outside Lewisham bus station in Loampit Vale at 6.30pm on a dark winter's evening, what is the exact route an ambulance would take to get to Woolwich A&E, bearing in mind that it will have to get to the other side of the A2 during rush hour?

Admission Rates

The report's assumption that only 23% of Lewisham A&E patients require admission, specialist intervention and/or referral to another (tertiary) unit does not take into account the approximately 6,036 patients per annum admitted to the Rapid Assessment and Treatment Unit under the care of the Emergency Department (ED) for periods up to 48 hours. It also does not take into account the 1,498 paediatric attendances/year who require admission to the Short Stay Unit in the Children's ED

The suggested use of a 'UCC plus' model

A review of case mix by Lewisham consultants estimated that at most only 30% of the total attendances to the present-day combined A&E and UCC could be safely managed in a standalone UCC. This is a huge variation from the 77% assumed in the report.

A 'UCC plus' is an untested model that shows no real advantage over other models in the absence of the other acute services you propose to cut and there is no reference to such a precedent.

77% of Lewisham ED patients are expected to attend the future UCC. This would rely on paramedics, ambulance technicians and GPs being able to determine before sending patients to the UCC that they will not require admission. These practitioners send their patients to an ED precisely because they cannot make this determination beforehand.

At the present time approximately 7 in 10 patients referred by GPs to the ED are managed by the emergency doctors with access to hospital systems and services in such a way that they are able to be discharged home. This ability would be lost in a UCC of any variety.

A 'UCC plus' would still be deprived of a Resuscitation room; this would present a major risk to patient safety risk given that a significant number of ED patients deteriorate after initial presentation to the GP/London Ambulance Service.

The proposed 'UCC plus' would have to function in the absence of a HDU/ITU; critical patients who deteriorate after initial assessment will therefore require transfer to another trust, yet another (unnecessary) risk to patient safety risk

GPs requiring a clinical opinion from A+E.

It is facile to suggest that a UCC will meet the needs of local GPs. When they send a patient to A+E, it is to receive a rapid opinion not from their peers, but from a specialist. The TSA's recommendations are likely to lead to GP and patient frustration and more admissions long-term.

Patient Flows and Capacity

As mentioned above, a review of case mix by Lewisham consultants estimated that at most only 30% of the total attendances to the present-day combined A&E and UCC could be safely managed in a standalone UCC. This is a huge variation from the 77% assumed in the report.

Thus, the remaining 70% of attendances would have to be seen in an ED setting; there is no provision in the report as to how this could be catered for by surrounding services. Consultation with our neighbouring ED colleagues suggests that they do not have the capacity to absorb these numbers.

We consider that downgrading Lewisham A&E to an UCC will lead to more than expected patient flows to KCH and not to QEH. In the absence of plans to invest in greater capacity at KCH, clinically this would be an extremely unsafe scenario. What evidence do you have that Lewisham residents will choose QEH if they consider they have a condition requiring emergency hospital admission?

Quality

Part of the justification used for placing SLHT under the TSA regime was that "the Trust has a record of weak emergency department performance failing to achieve the 4-hour standard in 2010/11 and 2011/12." In fact, Lewisham consistently exceeded the 4-hour national standard

- they exceeded the old standard of 98% in 2009/10 (98.7% of patients seen)
- they exceeded the updated standard of 95% both in 2010/11 (98.2% of patients seen) and 2011/12 (96.4% of patients seen).

The ED at Lewisham was rated as the best site in London for training for GPVTS trainees in the 2010 PMETB survey and was in the top quartile of training sites in the same survey among F2 doctors.

The ED to date has managed to keep a largely full rota of substantive middle-grade doctors unlike many other London EDs and this will be destroyed by the proposals of the TSA.

Families

Nothing is mentioned in your report of the opportunity costs for the 70-80 families daily whose relatives will be transferred to units at considerable distance from their homes. What health economic instrument did you use in your assessment of opportunity costs for the population of Lewisham? What evidence can you provide which shows that clinical recovery times will not be affected if visiting by relatives is reduced by a lack of accessibility?

Training

Fewer than 77% of Lewisham ED patients will be seen in the UCC in future
ENPs currently have the resource of ED doctors being available for advice and decision making input thus increasing the number of patients that can safely been seen and treated by them. In their absence they would need to transfer patients to a full ED rather than discharge them at the initial consultation. The ENPs have chosen to work in an integrated department and there are real concerns about the retention of a very experienced workforce and future recruitment.

ICU and HDU

Lewisham CCU is a ground breaking facility, saving Lewisham lives since 1968 and expanding into a combined ICU and HDU in 2006 – with the capacity for even further expansion. It is one of the better performing ICUs in the country with excellent infection control standards. This means that the 772 patients admitted to Lewisham ICU in the past 12 months were significantly more likely to recover than those in units representative of the national standard of care. Indeed, Lewisham ICU is a net importer of critically ill patients from all over London.
The closure of this facility will result in the loss of vital beds and also a unique training resource. Our consultant intensivist led outreach service is also threatened – which puts our cost-saving prevention work at risk.

The loss of this provision will be a huge detriment to patients in Lewisham and beyond.

Community Based Care

The report refers to the Community Based Care strategy, to be funded by £78million of investment, developed across SE London. It aims to boost primary care and community services to enable better care closer to home and to prevent emergency attendances and admissions to A&E. The plan depends on the Community Care Strategy reducing hospital work by 5% in A+E; 20% in OPD and 35% elective. These suggested savings are based on unrealistic assumptions.

We note the plans to reduce the overall bed numbers in south east London by 422 beds (Appendix K p.54). The proposals do not provide evidence that demand for hospital care will be reduced by that amount. We fear that this reduction will put unfeasibly high demand on existing beds leading to unsafe occupancy rates and bed crises at times of peak demand. The idea that the community based care strategy will reduce demand for hospital care sufficiently to justify the closure of 422 beds is unsupported by any evidence or serious plans.

The report cites as evidence the possibility of a 25% increase in GP capacity by increasing the minimum number of appointments offered per week. This would be unachievable without a significant increase in primary care clinical staff (GPs and nurses) in which there is no planned investment. The Royal College of General Practitioners has stated that there is an urgent need for GPs to spend *'Longer with patients to deliver evidence-based, effective health interventions, to prescribe safely, and to allow those patients with multiple-morbidities who need more, time to have it.'*

How does the Community Based Care Strategy take account of the recommendation by the RCGP that GPs spend a minimum of 15 minutes (rather than the current normative 10 minutes) with each patient?

A figure of 20% reduction in referrals is quoted for 'Incentivized referral management systems'. Limiting referrals by incentives is highly controversial mainly because it risks choices not being made according to clinical need.

The studies quoted as evidence for the possibility of large savings from a new Community Based Care Strategy are isolated pilots without proven generalisability and the true effects of these interventions are bound to be much smaller when wider pragmatic implementation takes place.

In addition, it is unrealistic to expect any additive effect between these multifaceted service changes. What statistical methods have you used to combine the effects of individual studies to predict a combined effect size equivalent to a 30% reduction in demand for secondary care services?

It is implied that the strategy would require significant infrastructure and personnel investment but there is no indication as to the facilities that would have to be put in place and no detailed financial costing of what is needed to achieve this.

Significantly, Lewisham Council notes that the TSA's modelling does not appear to include any additional resources for primary care, let alone for the increased demand on social care.

Maternity

The report sets out two options to ensure that a high quality of care is provided for women needing to be in hospital during pregnancy and for women when giving birth. Obstetric-led deliveries could be centralised in line with critical emergency care across King's College, St Thomas's, Queen Elizabeth and Princess Royal; alternatively, there could also be a 'stand-alone' obstetric-led delivery unit at University Hospital Lewisham. The first option aligns closely to the contested proposal to close the A&E unit at Lewisham.

The Lewisham unit, including the highly regarded state-of-the-art Birth Centre, opened as recently as May 2010, delivers approximately 4000 babies a year, with just under a quarter of these births happening in the purpose built co-located midwifery led unit. It is estimated that around 55-60% of women (about 2400 births per year) delivering in this unit fall into the categories indicating the highest risk.

We have serious reservations regarding the proposals to either close the maternity unit or have a downgraded maternity unit at Lewisham without adequate support from other acute specialities. We feel that these models are unsustainable and unsafe for the reasons detailed below.

1. **Low risk obstetric led unit**

   We do not think that an obstetric led unit can be a low risk one. Births considered to be low risk are managed under the midwifery led model of care and births considered to be high risk are managed under an obstetric model of care.

   Childbirth is inherently unpredictable and any maternity service should have the flexibility to manage the acute and often predictable emergency. (Maternity services: future of small units. RCOG, 2008). A significant proportion of the risk (and subsequent litigation) arises from events that occur during labour that were not predictable antenatally.

   We are not aware of maternity services reconfigured to have a "stand-alone obstetric unit". We feel that this concept of "lower risk obstetric- led births" is a nebulous one and does not reflect the realities of clinical practice.

2. **Redistribution of high risk cases and impact on number of deliveries at UHL**

   Around 2400 births would be considered high risk. This would mean many more births at the QEH site. This would entail a significant expansion in the physical capacity of this site as well as additional medical staff to deal with the increased births. The increased travel time to the acute site and difficulties in accessing the QEH site by public transport for these pregnant women and their family must be taken into consideration.

Patient flow pathways explored in the "Picture of Health" consultation showed that a significant number of patients will transfer to King's or St. Thomas's Hospital. The impact of a further increase in high risk births in these units must be taken into consideration.

If there is a significant reduction in the number of obstetric led births at UHL, it would make it very difficult to provide adequate and sustainable medical cover for this site in the long term.

These proposals will result in the contravention of the recommended continuity of care for those mothers who are forced to transfer at the last minute, or mid-labour from Lewisham to QEH, causing trauma and potentially avoidable deaths.

Currently, Lewisham ranks highly among trainees for the quality of training that it provides. If the unit was converted into a "low risk unit", it is possible that it would lose our deanery allocation of trainees as it would not be able to provide them with enough experience and the breadth of knowledge and skills that they require. This in turn would make it very difficult (if not impossible) to provide 24/7 obstetric cover as the unit would be reliant on locums/ speciality doctors who would be very difficult to recruit and retain for a "low risk" unit.

3. Impact on anaesthetic and neonatal staffing

Safer Childbirth (2007) states- "for any obstetric unit, there should be 10 consultant anaesthetist programmed activities or sessions per week, to allow full working hours consultant cover". The Clinical Quality Standards for Maternity endorsed by NHS London specify that obstetric units should have access 24/7 to a supervising consultant obstetric anaesthetist who undertakes regular obstetric sessions as well as a separate consultant anaesthetist for elective section lists.

These standards are difficult enough to achieve in a busy unit with adequate workload (Lewisham currently achieves this) but it would not be achievable in a "low risk" obstetric unit as the workload could not justify the number of consultant anesthetists required.

The neonatal unit/ special care baby unit is commissioned to look after babies > 25 weeks gestation. Converting to a low risk unit would mean that high risk pregnancies (including preterm births) would be managed at the QEH whose special care unit will be unable to look after these babies. This may mean that these babies (and their mothers) may need to be moved to either St. Thomas's or Kings unless the special care unit at Woolwich is significantly expanded and upgraded to deal with these babies.

These plans would have significant repercussions on the provision of neonatal care in the SE London neonatal network and on the ability to retain staff and trainees without an adequate workload.

4. Lack of support from acute services and ITU to a "stand alone" obstetric unit

We are particularly concerned regarding the proposal to establish an obstetric service without ready access to other acute services particularly ITU. Consultant- led services should have adequate facilities, expertise, capacity and backup for timely and comprehensive obstetric emergency care, including transfer to intensive care (NSF for Children, Young people and Maternity- DH, 2004).

The consolidation of emergency care, complex elective surgery and high risk obstetrics at the QEH site will increase demand for interventional radiology and ITU beds. Given the proposals to close the ITU at UHL, services will need to be expanded at QEH to ensure safe transfer from the stand-alone maternity site at UHL.

In addition, the inability to obtain opinions from physicians and general surgeons in a timely manner will have a detrimental impact on the care of pregnant women admitted as emergencies to the stand-alone maternity unit. This will necessitate the transfer of these women to the QEH site to obtain the multi-professional input required to provide optimum care.

It was suggested that the "low risk obstetric unit" would not have a 24 hour blood bank on site. Any obstetric unit must have 24/7 access to transfusion services as bleeding in obstetric patients can be unpredictable and can rapidly become life–threatening. Several enquiries have highlighted the risks associated with not having on-site transfusion services for an obstetric unit.

5. Lack of continuity of care for high risk patients

If the second option (a 5 site approach) is chosen with Lewisham a "low risk obstetric" site then high risk patients would need to travel to QEH to deliver their babies. Unless there is cross site cover by consultants for intrapartum care, these women with complex pregnancies will have to be delivered at QEH without the input or supervision of the clinician who has looked after them throughout their pregnancy.

It would be difficult for the clinicians to provide cover for intrapartum care at QEH while also having to contribute to the consultant cover required for the obstetric led unit. This would lead to a fragmentation of care for these high risk patients with dissatisfaction for both patient and clinician and possible adverse outcomes.

This scenario describes the exact situation which the RCOG in its report warns against- "a woman having received expert care antenatally, enters a lottery, where for lack of specialist obstetric cover, she is transferred during labour to a unit where specialist cover is available but where she is not known, and has minimal continuity of care" (Tomorrow's specialist. RCOG, 2012).

For these reasons, we feel that the proposal to have a "low risk obstetric unit" at University Hospital Lewisham is a misnomer – it is unsustainable, unsafe, not economically feasible and does not provide the quality improvement that the reorganization is supposed to deliver.

Number of births – flawed modelling.

There is a serious concern that the projected number of births used to model the maternity options 1+2 is flawed. In the TSA's draft report App H, figures for births in 2010 (2011 census) were 26643 approx. TSA data presented to model Option 1 had births in 2015/16 at 25895 approx. For Option 2, the projected figure was 26117. That is, the TSA has projected births 2015/16 at more than 1% less than 2010.

Given that all parties are predicting an annual increase in births, the TSA is underestimating births by 2-3000. The modeling is significantly flawed. This undermines the argument for the 4 site option.

When a maternity unit's births pass 8000, safety recommendations of the RCOG suggest a separation into two operational units and two obstetric rotas. If the 4-unit model has to manage 2-3000 additional births, patient choice will mean that Kings and St Thomas' units are highly likely to pass 8000 (being close already) and a 4-unit model becomes a six operational units/six rotas model. The five unit model retains Lewisham as a popular choice for women and is therefore potentially more sustainable, with Kings and St Thomas' units more likely to remain under 8000 deliveries annually.

Safety and quality conclusions of the Public Health Report[5]

- Research indicates that 'bigger is not better' in the provision of maternity services
- Option 1 in the TSA report poses potential serious risks in healthcare delivery due to the increased number of 'hand-offs' that will occur during each woman's continuum of pregnancy.
- There will be a significant increase in travel distance for all women accessing their nearest alternative provider. For many women this will include a more complex journey too.

[5] [5] Analysis of the Potential Impact of the Trust Service Administrator's Proposals for Health Services in SE London. Public health Lewisham p16

services. It is essential to the emotional wellbeing of paediatric in-patients that visitors are able to access the location of treatment without unnecessary difficulty.

We know that UHL was one of a very small number of Trusts, and the only one in London, to gain an "Excellent" rating from the Health Care Commission for the quality of its care of newborn infants and children. This quality is replicated in Lewisham Children's A&E. Such a quality service needs to be preserved, not destroyed

Queen Elizabeth Hospital, Woolwich, does not currently have the capacity to absorb the work of the Children's ED carried out at Lewisham Hospital. The QE site would require a huge amount of capital investment and this must be recognised and taken into consideration. Many parents will take their children to KCH or St Thomas Hospital both of which would require significant investment, especially if ED targets are maintained. It is also unlikely that they would have capacity to accommodate the in-patient admissions for Lewisham children, due to the volume of tertiary services within a limited bed base.

There is an assumption that patients will go to QEH; there is no robust modelling to support this and therefore this assumption is almost certainly be flawed – particularly in view of the removed locus of the QEH site.

The Neonatal Unit has been assessed and positively peer reviewed to the level of service it offers; 85% of the nursing staff are intensive care trained. **We firmly believe that the NICU should remain on this site, supporting a full obstetric service on the Lewisham site.**

The recent report by the Public Health Dept of Lewisham concludes that children living in the immediate vicinity of consultant-led paediatric A&E departments are much less likely to be admitted to hospital 3. This means that if the Children's A&E department at Lewisham closes, children in the area will be at increased risk.7

Integration

There is close cooperation between sectors on safeguarding for the vulnerable population of Lewisham. The impact of the loss of integration between children's hospital services and community health, mental health and social services without an acute paediatric service at Lewisham Hospital is of major concern. These problems would be exacerbated by Option 1 for maternity services. [8]

---

[7] Analysis of the Potential Impact of the Trust Service Administrator's Proposals for Health Services in SE London. Public health Lewisham

[8] Ibid p3

Mental Health

The hugely important area of integration between mental and physical health care is absent from your report. You may be aware that current policy highlights poor access to health services for people with mental illness. We are concerned your report does not make clear whether Lewisham residents will have an acute psychiatric facility co-located on the Lewisham Hospital site. Where will psychiatric patients at the Ladywell Unit receive their care under the suggested arrangements should they develop acute medical or surgical emergencies? Where will Lewisham residents with mental illness requiring admission receive their care should the land on which the Ladywell Unit be sold as a short term financial strategy? How will young people in emergency distress be encouraged to seek help when it is removed from their community?

These patients, because of their social isolation and often associated disadvantage, deserve comprehensive services located close to their places of residence and not in facilities far removed from their community.

Social Care and Health

Some older residents who are currently admitted to Lewisham have their care needs worked out by the Council and Lewisham Healthcare working together in partnership will be dispersed to other hospitals where the borough will not have the same close working relationship. This will have implication for the patients but is also likely to make it harder for both the council and the NHS organisations to be as efficient as necessary in the current financial climate.

Elderly people who are infirm will find it very challenging to attend the QEH site when it requires complex public transport journeys from their home. This group are amongst the most likely to miss appointments and experience deterioration and complication as a result. This will not be cost effective in either the short or the long term and will impact on the drive to keep the elderly well cared for at home.

Capital Works

The TSA recommends selling 66% of the site to raise funds, keeping only the PFI site.

£55 million allocated to clearing old buildings and altering a site which it is anticipated will sell off for only £20 million - and where the final development was only completed this year to the cost of £12million (A&E 2012) ; Birth Centre addition in 2010 (£700K) and the Riverside block ('06 - £70 million) – all currently sustainable under their agreed PFI deal with money following patients through the doors.

Has the TSA taken into account the need for buildings to support ancillary and administrative services – which will otherwise entail additional costs to be re-located elsewhere? There is insufficient space for the elective work suggested by the TSA. More of the site is needed – the TSA has underestimated the resources required to sustain his own proposals.

The TSA plan leaves only ONE THIRD of the current hospital site operational – but with largely only rental income from teams using it for pre-booked ops. Meanwhile more funds will need to be spent on the QEH site to being it up to standard and for alterations to the remaining Riverside development. Far from improving matters, this will completely ruin any chance of sustainability.

Notably – Lewisham Council estimates that if said issues are taken into account, an indicative assessment indicates that 25 per cent of the land currently shown for disposal would need to be retained

Issues of Equality

In our view the TSA should have carried out an Equalities Assessment before releasing the document for consultation. Annex H to the report comprises a "Health and equalities impact assessment scoping report".

A high-level desk exercise has been conducted to try to understand the potential impacts of the TSA's recommendations for people and communities whose characteristics are protected by the Equality Act. Various conjectures are put forward about the positive and negative impacts of the recommendations which will be further explored in a full Health and Equalities Impact Assessment (HEIA).

In our view the TSA should have paid due regard to the general duties imposed on any public authority as he put his programme of work together and executed it, and drew up his recommendations. In doing so, he should have engaged with local communities and stakeholders, in all their diversity. This was not done.

The TSA's recommendations should only have been published once he had fully understood the impacts of them on the diverse communities of South East London. There is little or no point carrying out a full HEIA if the only purpose of it is to help think through how to mitigate any adverse impacts of the TSA's recommendations or enhance the positives. The full HEIA should have helped shape the recommendations.

The TSA falls foul of the public sector Equality Duty (PSED) of the Equality Act on three counts.

First, the TSA should have paid due regard to the general duty of the PSED as he put his programme of work together and executed it, and drew up his recommendations. In doing so, he should have engaged with local communities and stakeholders, in all their diversity.

The general duty requires that a public authority must, in the exercise of its functions, have due regard to the need to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under the Act.
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Having due regard to advancing equality of opportunity includes making serious consideration of the need to

- remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
- take steps to meet the needs of person who share a protected characteristics that are different from the needs of persons who do not share it;
- encourage persons who share a relevant protected characteristics to participate in public life or in any activity in which participation by such persons is disproportionately low.

There is no evidence that the recommendations made by the TSA reflect any of the above legal requirements. In fact, the desk exercise carried out by the TSA is superficial, random and shows little or no appreciation of the lives led by the public including NHS staff. The TSA's recommendations should only have been published once he had fully understood the impacts of them on the diverse communities of South East London. If he had fully understood all these consequences, then his recommendations might have turned out to be different.

Second, there is little or no point in Deloittes carrying out a full HEIA if the only purpose of it is to help think through how to mitigate any adverse impacts of the TSA's recommendations or enhance the positives. The full HEIA should have helped shape the recommendations that are being consulted on.

There is little mention of the impact on staff, other than to speculate on potential staff savings through various efficiency improvements, and no evidence that any consideration has been given to future workforce planning or the commensurate impact upon patient care and patient safety.

Reducing services at Lewisham has other knock on effects: e.g.to GP training, to the attractiveness of Lewisham to specialists who might not now come to work there. Currently, there is a highly regarded GP training scheme based there, and the hospital is part of a prestigious rotation with the teaching hospitals, so specialists compete to come and work there.

Lewisham has the highest number of people with disabilities in the 6 boroughs (p31 AppH). People with disabilities are users of our hospital. We see the TSA recommendations as threatening for people with disabilities.

People in this cohort report that the additional travel requirements will pose challenges which will impact on both physical and mental health conditions, as well as having financial implications due to the pending changes in the benefit system.

The overall reduction of services as proposed will hit the disabled hardest and are likely to lead, among other things, to more missed appointments and late presentations to clinical services of health problems.

Collaboration and Integration between Sectors

The proposals will affect community services too, as the PCT and the new GP commissioners have been working closely with both Lewisham Council and Lewisham Hospital to work out new partnership ways of working, and new pathways. These largely depend on the hospital being able to provide a range of services. Some of these new pathways are working very well, but will not be able to continue under the TSA plans.

Under the proposals relationships carefully built up in recent years between Lewisham GPs and Hospital Consultants and between medical teams and Social Services will be put at risk as will links between the acute admitting hospitals (QEH, KCH or PRUH) and Lewisham GPs and Social Services. We consider there to be a high likelihood that this will result in admitted patients having longer lengths of stay, thereby increasing overall costs to the sector.

In another example of integrated care, local work between GPs, consultants and nurses on care pathways for patients with Chronic Obstructive Pulmonary Disease has led to significant reduction in admissions. It will not be possible to replicate these pathways across three separate admitting Trusts in the proposed configuration.

Another example is plans for Collaborative Commissioning. These were close to agreement before the current disruption. The programme intends to develop new financial incentives aligned to support integration and collaboration. These developments can only take place within a stable health economy and with good reliable and trustworthy relationships. The TSA plan will disrupt these.

Impact on the Local Economy

Lewisham is a borough where there are currently 30 people chasing each job vacancy. Lewisham Hospital is a major local employer. Workers at the hospital are also key purchasers of goods from local retailers.

Many hospital workers also live in the borough and this will also impact on the local housing market.

The decimation of the Lewisham Hospital site and its' workforce will have a major detrimental impact on our already challenged local economy.

At a time when we are crying out for economic stimulus and growth this is a detrimental action.

Overall, we believe that the TSA plan will have a catastrophic effect on the Borough of Lewisham and the people who live and work here.

Veracity

We note that Lewisham Council calls on the TSA to make his risk analysis available – we would re-iterate such a request.

Overall, we question the TSA figures (such that have been released) which seem to be at some variance with existing calculations based upon approved methods of modelling. Careless mistakes will cost lives and we are not prepared to accept any plans which will cause avoidable death or injury.

Inequalities in the TSA consultation.

We are pleased that the consultation document is available in Braille. However, it is noteworthy that only the summary is available and it arrived with no instructions nor covering letter.

We also note that this is not the only barrier for people with disabilities to engage with the consultation process. There was a lack of availability of the printed response booklets and freepost envelopes, with the clear assumption that most people would contribute to the consultation on-line. This disadvantaged people in low income groups and the elderly who are less likely to have access to a computer.