Saving the cancer, sacrificing the patient.

A critical response to the Special Administrator's Draft Report on South London Healthcare Trust

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Introduction

The first NHS Trust to be bankrupted by the excess costs of the Private Finance Initiative, South London Healthcare Trust (SLHT), is now in the hands of the Trust Special Administrator, Matthew Kershaw. His powers are draconian, and his recommendations devastating for South East London, especially for the population of Lewisham.

Until the "interim Report" was published in October, Lewisham Hospital had no direct connection with the financial meltdown of the neighbouring (and now bankrupt and soon to be dismembered) South London Healthcare Trust. His proposals go far beyond the brief under the Unsustainable Providers Regime, which centres on SLHT. They include changes in every acute hospital in SE London, and cutbacks including Guy's and St Thomas's Foundation Trust

Local people in Lewisham have turned out in their hundreds to angry public meetings, and in their many thousands on a vast demonstration on November 24 through pouring rain. They were protesting against the loss of the Accident & Emergency services and other services at Lewisham Hospital, the closure and sale of more than half its site, and its forcible merger with the Queen Elizabeth Hospital six miles away in Woolwich. Their anger is the greater because they know full well that their needs and interests have not been the starting point, or even a serious consideration, in the recommendations, which are driven by very different concerns.

But the protests against the scheme, coupled with detailed arguments from consultants, GPs and other clinicians in Lewisham, refuting key assumptions and challenging its central proposals, are falling on deaf ears. The token 30-day "public consultation" over the future of health services as mapped out in Matthew Kershaw's Draft Report is almost at an end, with not the slightest hint that any of the critical responses, especially from Lewisham, will be taken on board.

All of the final decisions are now to be taken behind closed doors between the Administrator and the Health Secretary, with no public accountability or right of appeal. By February 1, another London borough could well have lost vital hospital services, joining a growing list of London boroughs without local access to A&E.

First priority: look after PFI shareholders

There is one group of people who will NOT lose out, but continue to reap guaranteed, index-linked, long-term profits from the catastrophic Private Finance Initiative contracts that were signed in 1998

by the then Bromley Hospitals Trust and Greenwich Hospitals Trust. These are the private consortia which put up the cash to build the hospitals for a combined cost of £214m.

Treasury figures show payments already made since the hospitals opened in 2001 (Queen Elizabeth) and 2003 (Princess Royal University Hospital) stack up to £620m by next March – more than three times the initial cost. But further payments will rake in another £1,954m for the financiers and their shareholders by the time they are paid off – repaying more than 12 times the initial cost of the construction (Figures from HM Treasury website: PFI signed projects).

The total "unitary charge" payments, which are legally binding, include non-clinical support services. This means that any financial pressures experienced by the Trust have to be dealt with through savings from *clinical* services – cuts in medical, nursing and professional staff. However the building cost alone ("availability charge") is estimated at 60% of the total, giving a cost over the 30 year contracts of £1544m for buildings that cost £214m.

These PFI payments are being protected, even as more and more other hospital services are cut back, in South London and beyond, to pay the bill. The Trust Special Administrator (TSA) recommends a subsidy beginning at £22.7m a year to help the reconfigured Trusts which have been lumbered with this contractual obligation to pay an otherwise impossible bill – and these government hand-outs would run for the rest of each 30 year contract.

And on top of this, £207m of accumulated SLHT deficits – almost all of it from the two PFI hospitals – would be written off, sharing the misery across the NHS as a whole, where funding is facing an unprecedented squeeze for years to come. The PFI is being bailed out and propped up as NHS services are cut back.

Cross cutting cuts

And the cuts to be inflicted on Lewisham and on South London Healthcare will be painful indeed:

- Lewisham Hospital would lose not only its A&E, but also emergency surgery, complex surgery, emergency medicine, critical care and inpatient paediatric services – and almost certainly its obstetric unit, too. It would be reduced to an elective-only hospital handling non-complex cases, with a so-called 'urgent care centre' tacked on. More than half the site would be sold off.

- As a result of these changes, the TSA estimates 70 seriously ill emergency patients per day needing a bed would have to be taken the Queen Elizabeth Hospital (QEH) in Woolwich. This means almost 500 extra seriously ill patients per week, more than 25,000 per year, who would arrive at a hospital that is already struggling to cope with emergency demand after the closure of the A&E Department at Queen Mary's Hospital Sidcup. QEH currently has no beds spare, and no money to build any extra capacity.

- Queen Mary's Hospital would lose the remaining inpatient elective services that survived the previous cutbacks, and a "procurement exercise" would invite bids from various providers to run what will be little more than a large clinic ("Bexley Health Campus"), with day surgery, endoscopies, a satellite radiotherapy unit run by Guy's & St Thomas's, and outpatients. As

with Lewisham, the remaining buildings and land would be sold off, limiting any future expansion.

- QEH Woolwich would effectively be merged with Lewisham Healthcare Trust in another shotgun marriage, with all of the complex treatments to take place at QEH, and all the minor treatments at Lewisham. Although this is described by TSA as a take-over by Lewisham, whose "excellent leadership" receives patronising praise even while they are made to carry the can for failures elsewhere, the balance of power in terms of the most prestigious services would be at QEH.

- For the Princess Royal Hospital in Bromley, there seem to be a number of options. It might (as the TSA's preferred option) be "acquired" by King's College Hospital Foundation Trust and become a satellite unit of the Camberwell teaching hospital. Alternatively its management might be offered up for "franchised contract" [i.e. a takeover] by "an NHS organisation or a national or international independent sector provider." This franchise plan would be "similar to the approach taken for Hinchingbrooke Hospital in Cambridgeshire" – despite the recent sceptical and often critical assessment of that arrangement by the National Audit Office. Another alternative is for there to be a process of tendering for the provision of clinical services.

- But on top of this, the TSA is proposing a raft of other cuts in South London Healthcare, aiming to slash a massive 5.4% of "cost improvements" from spending each year for three years. £20 million over the three years is supposed to come from medical pay – cutting 140 doctors – 16% of its current medical workforce.

- £14m, equivalent to over 400 staff nurses, is to come from cutting nurse staffing. This proposal, like the plans to get rid of doctors, is calculated in pure abstraction – apparently by comparing SLHT with other very different trusts elsewhere.

- Scientific and Technical staff are to be cut to save £4m.

- £4m is also the target for cuts in the "non-clinical" pay bill.

- Patients are to be hurried out of hospital by a squeeze to reduce Average Length of Stay, which it is hoped might save £6m and enable the Trust to close 90-100 of the beds for which, under PFI, it is forking out a queen's ransom – and which it will have to pay regardless of whether they are used.

- The TSA wants to outsource some clinical support services to save money, with pathology and pharmacy topping the list: he hopes it could save £5m, although as Guy's and St Thomas's have discovered, such savings can come with strings and problems attached.

- And on top of all of these proposals, which at least have the merit of being identified, with a guesstimate of the amount that TSA believes might be saved, the Trust is also expected somehow to generate an extra 2% per year "to reflect the continued improvement of peers over the period of the modelling". This target is large enough to be unattainable on top of everything else, and vague enough to be a source of confusion for years to come.

In other words every single section of the SLHT workforce would be downsized, shaken up and subjected to sustained pressure to shoulder additional workload for the next three years, while the Trust itself would broken up, its services reorganised, and Lewisham Hospital would also be downgraded – with potentially serious consequences under the Payment By Results system that pays hospitals only per item of treatment they deliver.

The chaos does not stop there. The TSA plans include a complete reorganisation of hospital services across all six boroughs, with long-term plans not only for SLHT and Lewisham as NHS Trusts, but also affecting Guy's and St Thomas's and King's – Foundation Trusts which were thought to have a degree of autonomy. Even further afield, the TSA proposes "moving" 23 beds from South East London to Croydon's University Hospital.

The 5-year plan to 2017, apparently hatched up by the TSA in just under three months, involves closing 618 of the existing 4053 beds, including 119 at St Thomas's and 105 at Guy's, 173 at Lewisham and 221 of the 240 at Queen Mary's, and opening 196 new ones (39 at PRUH, 78 at QEH, and 79 at KCH) (Appendix K p54) –a net loss of 422 beds, over 10% of the present total[1].

Where would the money come from?

The dismantling of Lewisham's services would cost £56m out of a £77m capital programme: but it's not clear where this money, or the transitional costs estimated at another £46.6m, are to come from, or when any of these changes are expected to take place.

Clearly there is no excess cash in SLHT or in Lewisham Healthcare to pump prime the changes. Yet if these costs are added to the £207m required to write off the accumulated SLHT deficit, the total is £331m of cash needed up front, plus the increasing £23m-plus annual subsidy to the PFI contracts into the 2030s. We have to hope the TSA is not looking to set up another PFI deal!

Could services cope?

The real problem is that the resulting services seem unlikely to be able to cope with the levels of demand for emergency services and elective care in South East London, while the "aspirations" towards community-based care, to which the TSA often refers, (as set out in the so-called 'Strategy' in Appendix I) are purely abstract visionary statements without any of the necessary concrete plans, resources, timelines or management commitment to make them happen at all, let alone in the next three years in which the first big changes are supposed to take effect.

Without these services in place, proven, staffed, running and sustainable, there is no basis for the TSA to assume that fewer people will require hospital care, or that discharges can be accelerated by improved community-based health services.

[1] There is however some confusion created by the TSA's use of bed figures which do not correspond to the latest figures published by the Department of Health. They identify significantly fewer general and acute beds than the TSA (3,089, compared with 4,053): the gap is larger than the number of beds (448) which the TSA lists as "mothballed". DoH figures show SE London has already lost almost 500 beds (14%) since 2008. This discrepancy raises doubts over the accuracy of the information used by the TSA.

COULD IT WORK? Flawed assumptions that undermine the plan

1) A non-existent "Strategy" for Community Based Care

The viability of the entire plan drawn up by the TSA hinges on the effectiveness of a new expanded system of community based care, achieving hitherto unprecedented levels of substitution for hospital services, allowing them to be scaled down.

However these proposals, accurately described by the TSA Draft report as "aspirations" (page 14), prove on examination to completely insubstantial, and lacking any concrete plan (or resources) for implementation. They are used by the TSA in the way the proverbial drunk uses a lamp-post – more for some form of support than illumination.

One complication that would stand in the way of developing a coherent plan to expand community health services in the area is that the Health and Social Care Act has added to the fragmentation of the NHS. The introduction of the new "market" in health care means that Bromley's community health services are now run by a business style "social enterprise", while the others are still within the NHS (Greenwich and Bexley services are run by Oxleas NHS Foundation Trust, and Lewisham's by Lewisham Healthcare NHS Trust). In the new style market, providers compete, they don't collaborate.

The "Community Based Care Strategy" outlined in Appendix I, however, does not engage with any such detailed issues. Indeed it is remarkable for its complete lack of details, concrete proposals or commitments.

This is made plain in the TSA Draft Report's summary (page 39):

> **"In line with this vision, and as a key building block in developing the draft recommendations, the CCGs have produced a Community Based Care strategy for south east London.**
>
> **At the heart of this strategy is *a set of aspirations* for how care will be delivered in the future so that the population of south east London receives the best possible care in the community, including their homes, where possible.**
>
> **This will support people to live healthier and more independent lives. *These aspirations are essentially a set of shared standards of care, which will be delivered locally as determined by each CCG.*" (emphasis added)**

Yet further on in the Draft Report the Strategy is talked about as if it was genuinely able to deliver concrete results, including £72m in reduced acute care costs, and even save lives:

> **"Alongside this, implementation of the Community Based Care strategy *could save around 700 lives a year* through early detection and management of diabetes and the number of cancelled appointments would reduce."** (page 70)

It is interesting to note that senior McKinsey partner Penny Dash is among those who were involved in drawing up this "strategy", which clearly echoes some of the highly questionable, evidence-free

assumptions and assertions from the so-called McKinsey "report" of 2009 which set out ideas on how to make £20 billion 'efficiency savings' across the NHS.

The McKinsey plans, despite their woeful lack of substance or evidence, have become the blueprint for evidence-free cuts in services in London and elsewhere. Moreover the Community Based Care Strategy in Appendix I of the TSA's Draft report is nothing more than an extended wish list, with no discussion of resources, facilities, locations, staffing, management, timelines, milestones, or anything that might give conviction that the plan is serious and capable of being implemented.

There are equally illusory plans for alternatives to hospital care in North West London. Indeed, NHS North West London eventually admitted in debate that these had not been discussed in any concrete detail and do not exist as a plan. The general propositions cited by the TSA are equally vacuous and lacking in management commitment – and serve as no more than a smokescreen to mask serious actual reductions in services.

This point has been stressed by a number of the groups of hospital consultants and other professionals registering their objections to the TSA's proposals, and explaining why they won't work in the way the TSA expects.

2) 30% of A&E attenders to be diverted to management in the community

Following on from the non-existence of any actual plan to develop and expand community-based care in general, it is clear that the extremely high level of 30% of A&E attenders who might successfully be diverted to forms of treatment in the community is an illusion. As the Emergency Department consultants have pointed out in their letter to the TSA:

> **"This has not been achieved anywhere in the UK before. There is no robust evidence to support this claim (certainly it is not contained in the report or its appendices).**
>
> **"Such a change would require significant infrastructure and personnel investment**
>
> **"There is no indication as to the facilities that would have to be put in place**
>
> **"There is no detailed financial costing of what is needed to achieve this"**

3) 77% of A&E attenders to be cared for by an Urgent Care Centre (UCC)

The even more extravagant claim made in the TSA report is that only 23% of the 115,000 patients a year attending Lewisham A&E would need to be treated elsewhere if it were reduced to a standalone Urgent Care Centre[2].

[2] This also assumes that if patients are not admitted they were not ill enough to need an A+E in the first place. That ignores medical practice. There are cases where it is not clear, until after assessment by an ED doctor, that a person does not need to be admitted. GPs often send cases they are not sure of for ED assessment, and even if the patient is not admitted it does not mean they did not need to be seen by an ED doctor to make that judgement. This is another example of plans been drawn up by management consultants.

This allows the TSA to claim that 77% of patients could still be handled through the UCC and community based services. This misleading claim also forms the basis for the plan to be given a spurious clean bill of health by the (superficial and unconvincing) outline of a Health Equalities Impact Assessment drawn up for the TSA by Deloitte consultants, to which we will also return below. This does its best to ignore Lewisham, and the cutbacks in Lewisham, and in particular the knock-on problems for local people in other boroughs (see for example HEIA page 23). But it does reluctantly admit that Lewisham's population suffers high levels of deprivation, and that this deprived population will suffer if journey times to access treatment are increased. This is immediately downplayed using the spurious 77% figure:

> **"As Lewisham has a number of deprived wards, this impact will need to be considered in greater detail. However it is estimated that between 70% and 80% of patients currently receiving treatment at University Hospital Lewisham (UHL) A&E could be treated at its urgent care centre, potentially abating the scale of this impact".** (HEIA p24)

The "estimate" is grossly misleading and not backed by any evidence. Emergency Department (ED) consultants point to gross factual inaccuracies in the starting assumptions in the TSA plan, notably the drastic under-statement of the number of "blue light" ambulances bringing the most seriously unwell patients to Lewisham's A&E each day (figures which the TSA could easily have obtained from the computerised data kept by the Department).

And they underline the thousands of adults and children who are treated in the Rapid Assessment and Treatment Unit or the Short Stay Unit in the Children's ED – all of whom are omitted from the TSA summary and ignored as part of the caseload that would need to be redirected to QEH Woolwich or elsewhere.

They point out that the present UCC at the hospital works because it runs alongside and jointly with the A&E, and as a result has been able to deal with patients **"with problems far greater than those that can be handled in a typical UCC"**. However this also means that if the A&E is closed, **"a standalone UCC will not be able to handle the number or acuity of patients that we presently see".**

Another important issue if the Lewisham unit is scaled down and the A&E service removed is staffing: Emergency Nurse practitioners currently working in Lewisham's UCC **"have chosen to work in an integrated department, and there are real concerns about the retention of a very experienced workforce and future recruitment."**

The ED consultants' own estimate is that no more than **30%** of the current caseload could be safely managed in a standalone UCC, while the residual caseload is too large to be dealt with in neighbouring A&E units:

> **"The remaining 70% 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."**

The origin of the TSA's wild guess of 77% A&E patients to be treated in the UCC is a bit of a mystery. Back in 2007, Lord Darzi started the rot with the proposal (set out in his 2007 McKinsey-researched

Technical Report[3]) for 50% of London's A&E attenders to be shifted into polyclinics. This was then arbitrarily jacked up to 60% by NHS London's Planning Guidance. The source of Darzi's original assumptions and these revised figures has not been publicised. There has been no proper scrutiny of the evidence base or the methodology used.

NHS London has also made use of a report researched by PA Consulting, published in 2008. However the *Study of Unscheduled Care in 6 Primary Care Trusts Central Report*[4] offers little support for those seeking to inflate the numbers of minor cases in A&E. It is a detailed and nuanced 180-page study of caseload in six varied London Primary Care Trusts, which is repeatedly at pains to stress the potential for bias in its findings and the complexity of the issues it is analysing. It makes much more limited claims than NHS London on the level of "inappropriate" attendances at A&E, pointing out (page 45) that:

> "It is important to note that approximately 50% of patients attending the A&E departments in the study were non-major."

But in that same study, of the "minor" patients attending A&E departments for treatment, only one in three "were assessed to require an A&E clinician in the appropriate skill mix to treat them". That would leave the proportion who could be managed in a stand-alone Urgent Care Centre at just one third.

Another report, commissioned by the Department of Health, has also questioned the assumption that anything like 60% of A&E attenders could be adequately treated in a primary care setting. *Primary Care and Emergency Departments* by the Primary Care Foundation was published in early March 2010[5]. It reports research that was commissioned by the Department of Health with a specific brief to: "provide a viable estimate of the number of patients who attend emergency department with conditions that could be dealt with elsewhere in primary care" (p 4).

It found that relatively few patients attending hospital Accident and Emergency departments could be classified as needing only primary care – suggesting that NHS London had drastically overstated the case for shifting work out of hospital A&E. **The 102-page report specifically takes issue with "widespread assumptions that up to 60% of patients could be diverted to GPs or primary care nurses", and argues that the real figure is as low as 10-30%.** (page 5).

The extensive study of patients in actual A&E departments found no evidence that providing primary care in Emergency Departments "could tackle rising costs or help to avoid unnecessary admissions." The report authors argue that: "Cost benefits may exist, but the evidence is weak" (page 8).

4) Actual circumstances of Lewisham population ignored

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[3] http://www.healthcareforlondon.nhs.uk/assets/Publications/A-Framework-for-Action/FFA-Technical-Paper.pdf

[4] Healthcare for London (2008) *Study of Unscheduled Care in 6 Primary Care Trusts Central Report*

[5] *Primary Care and Emergency Departments* is available at http://www.primarycarefoundation.co.uk

The other overriding assumption that helps the TSA pain his proposals as reasonable is to ignore the specifics of the main population adversely affected: 274,000 Lewisham residents. This is facilitated by a flimsy and superficial outline Health Equality Impact Assessment (HEIA) compiled for the TSA by highly-paid management consultants from Deloitte, which manages to ignore or downplay almost every key issue, beginning by failing even to mention Lewisham on the opening page.

The TSA report refers to benefits of super-centres for stroke, heart attack, vascular and major trauma emergency as an argument supporting the loss of Lewisham's A&E to concentrate these specialist services elsewhere; but this ignores the vast majority of urgent medical situations of the local population, many of which are linked to deprivation and the specific needs of a multi-ethnic population like that of Lewisham, such as:

- Diabetic emergencies
- Bleeding in pregnancy
- Sick children
- Sickle Cell crises;

Lewisham is one of the more deprived areas of SE London, sharing with Lambeth and Greenwich the lowest life-expectancy. The HEIA notes glibly in passing that **"those who are economically deprived may [!] find it more difficult to afford transportation to access healthcare services"**:

> **"In this context, and with high economic deprivation in Lewisham, this group may be impacted if UHL no longer provides A&E services for complex injuries/illnesses. The full HEIA assessment will need to consider the degree to which economically deprived populations are impacted by the minority of services which will no longer be provided at UHL."** (page 19)

Indeed the HEIA time and again goes out of its way to understate the scale of the changes proposed in Lewisham and the impact this will have. The word "emergency" is carefully avoided, as indeed is anything negative:

> **"It is proposed that acute services will be focused across a smaller number of locations, as some non-elective [i.e. emergency!] services move from UHL to surrounding hospitals, and UHL becomes a dedicated centre for routine procedures (inpatient, daycase and outpatient)."** (page 20)

Itemising the TSA's claims of the benefits, the HEIA, after postponing any view on the impact on Lewisham of the closure of A&E, complex surgery and complex medical care, concludes:

> **"These potential positive impacts will need to be considered in the full HEIA assessment."**

The assessment of the loss of A&E services at Lewisham is only really examined as an issue affecting patients from other boroughs accessing A&E Departments elsewhere in South East London: at Queen Elizabeth Hospital Woolwich, Princess Royal University Hospital Bromley, and King's College Hospital. This, frets Deloitte, "could potentially impact on the quality of care they deliver," reduce their physical comfort, and even worsen the "patient experience" (page 23).

The HEIA's work on travel times is especially superficial, almost risible. The main TSA Draft report has to concede that while "average" travel times across the whole of South East London may not be vastly increased by the closure of Lewisham A&E, all of the average travel times for the population of Lewisham – from "blue light" ambulance journeys to private and public transport – are increased by more than 50% (TSA Report page 69).

The HEIA tiptoes around this issue, leaving out the tell-tale figures. Instead it says:

> **"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. However, it is estimated that between 70% and 80% of patients currently receiving treatment at UHL A&E could be treated at its urgent care centre, potentially abating the scale of this impact."** (page 24)

One brief glimmer of insight does reach Deloitte, however:

> **"In addition to increased travel times, there could be further impacts in terms of changes to journey complexity (this will also be influenced by the relative proportion of public/private transport use); journey expense; ease of access to facilities for those with disabilities, wheelchairs and pushchairs; and parking availability at different locations."**

Turn the page, however, and the nonsensical rhetoric is resumed: to put the most optimistic gloss on the travel times, Deloitte researchers have chosen to present data on those brief instants – perhaps in the early hours of Sunday morning – when there is "no traffic". A footnote points out that **"Travel times may be higher during periods of heavy traffic."** We should be told how much the TSA has paid Deloitte's for this useless research.

For most people likely to face these journeys in real life, such figures are purest fantasy – an insult, confirming that the Health Equality Impact Assessment is constructed more to give a rubber stamp to the TSA, and to secure a fat fee for Deloitte, than to address the actual needs of Lewisham people.

The HEIA document goes on largely to discount the impact of the Lewisham closures on the elderly, children[6], and people with disabilities (for which Lewisham has the highest levels in SE London). They even discount the impact on the black and ethnic minority population, again wheeling out the dodgy claim for the proportion to be treated in the UCC after the A&E Department closes:

- [6] The HEIA makes nothing of the fact that Lewisham is set to lose its maternity and children's services, despite having:
    - The highest birth rate in SE London;
    - The highest population of children under 5;
    - The youngest age profile of children under 16;
    - The highest projected growth of population 2012-22
    - The 2nd highest teenage conception rate in London & joint 3rd highest in England

> **"Relatively larger populations from BAME backgrounds are present in Lambeth, Lewisham and Southwark. The proposal to no longer provide A&E services for complex injuries/illnesses at UHL may therefore differentially impact the BAME population. However, as noted in Section 3.4.4, it is anticipated that the proposed UCC at UHL will be able to deal with between 70 and 80 per cent of the patients currently receiving treatment at UHL A&E."** (Page 31)

One thing is quite clear from the contortions of the HEIA and from the fact that the promised "full" HEIA report will not be part of the public consultation. The credibility of the TSA proposals hinges on *ignoring* and belittling the actual needs and problems facing people, especially the most vulnerable and deprived, in Lewisham – the main epicentre of the cutbacks to salvage the PFI projects for SLHT.

It is a token exercise, a smokescreen to divert attention from the fact that the TSA's main cuts land with pinpoint accuracy on some of the most deprived people in SE London, widening health inequalities.

COULD IT WORK? Questions of capacity

The plan to divert emergencies, complex surgery and medicine, critical care and inpatient paediatrics from Lewisham Hospital raises major logistical problems: thousands of patients will have to travel further for treatment – but at the end of their journeys they also need to find services and staff to address their needs.

The TSA plan is striking in its lack both of evidence for its clinical service assumptions, and of any detailed numbers to indicate that a proper analysis has been made. It therefore lacks any real conviction.

To put it in perspective, even if the wider caseload of the A&E is ignored, Lewisham Hospital currently admits 18,400 A&E patients a year: this is equivalent to 41% of the total A&E admissions for QEH Woolwich and PRUH Bromley combined. In other words this tidal wave of seriously ill patients, each needing immediate treatment and a bed, would completely swamp QEH.

In fact if the proportional split of A&E caseload between QEH and PRUH is the same (40:60) now as it was in the year prior to merger (when Queen Mary's Hospital Sidcup still provided A&E services), Lewisham's 18,000 extra emergency admissions would **double** the QEH caseload.

The TSA estimates suggest 70 patients per day on average would need this treatment – ignoring the 6,000-plus patients admitted each year for up to 48 hours to Lewisham's Rapid Assessment and Treatment Unit, which would also be forced to close. Another 1,500 children are seen in the Short Stay Unit, which would also close. This is another 116 adults and around 30 children per week who would also need to be found beds and treatment elsewhere.

On top of this would be the urgent GP referrals, who would no longer be admitted to Lewisham. **The total of urgent and emergency admissions will come out well in excess of 600 per week, 31,000 per year.**

But the bed requirement would be even greater, because Lewisham would no longer be doing any complex surgery or any surgery requiring Critical Care beds, which would also be axed. And paediatrics is also to be moved out. The most recent Hospital Episode Statistics (HES) figures show that Lewisham treated 35,000 elective inpatients in 2011-12: the TSA does not bother to identify what proportion of these would also have to be admitted to hospitals elsewhere. Even if it were only 25% this is equivalent to another 168 per week: beds would therefore be needed for an EXTRA 768 complex and emergency cases every week.

Does the capacity exist at QEH Woolwich to receive and treat all these extra patients promptly, safely and effectively? **The answer is clearly 'NO'.** South London Healthcare Trust's 944 beds are currently averaging 88% occupancy, already higher than the 85% figure which this month's Dr Foster Hospital Guide report[7] emphasised as being needed to maintain safe and good quality care. This leaves , on average, just 114 beds across PRUH Bromley and QEH Woolwich for these 768 complex patients. And given the mean length of stay in Lewisham and SE London is 4.1 days, closing Lewisham A&E would within a couple of days create a permanent crisis for SLHT's two hospitals.

The 370 pages of Appendices to the TSA Draft carry contradictory figures and projections for new beds in some places, and even bigger closures in others. In Appendix K it appears that the TSA is proposing to increase bed numbers at QEH Woolwich (78) and PRUH Bromley (39) to help deal with this increased caseload. However the TSA's "efficiency" plans elsewhere propose to *reduce* the number of beds in South London Healthcare Trust by 90-100: so this would leave a maximum of 27 extra beds to cope with the tidal wave of seriously ill emergency patients who would otherwise have been treated in Lewisham.

Over the five years, the plan would bring a net reduction of 422 beds in SE London. And since the funding for extra beds is not identified, and the new beds suggested by the TSA are not planned to come on stream immediately, it is not clear how many of these new beds that are proposed would be built at all, completed in time or suitable to bridge the gap that would be triggered by closing Lewisham A&E, at the heart of the 3-year plan.

In any case it's clear that there would not be anywhere near as much as three years to put everything in place: once the closure of Lewisham A&E is announced it would immediately blight the hospital and the department, making it more difficult to recruit or retain the consultant and medical staff, nurses and others without whom services would become unsafe, swiftly triggering partial or total closure.

It's also clear that the fall-out from axing Lewisham A&E would not just be felt in SLHT, but would inevitably ripple across south London, and possibly even north of the river, in a desperate search for beds. It would pile massive new pressures on other surrounding hospitals, which in any case are not necessarily in any fit state to cope. King's College Hospital, which may be the first choice for many people in Lewisham, notes in its most recent Annual Report (2011-12) that it is already facing

[7] http://www.drfosterhealth.co.uk/hospital-guide/

problems with the high level of emergency demand that has "affected the ability to treat elective patients" and is seeking to expand capacity to cope with this demand[8].

DoH figures show Guy's & St Thomas's Trust has more bed vacancy, but these are not necessarily at St Thomas's Hospital where the A&E unit is located: the journey is longer and more awkward – effectively travelling past King's to get there.

Other more desperate options might include travelling an extra 2 miles to Croydon's busy University Hospital (where the TSA apparently wants to redirect 23 beds from SE London); an extra 4 miles to the hectic and crowded St George's in Tooting; an hour-long trek out of London to the struggling Dartford & Gravesham Trust; or a slightly shorter haul north of the river to the Royal London in Whitechapel or Newham General – both now part of the Bart's Healthcare Trust.

Nowhere is there a reliable surplus of beds to take such a large caseload of seriously ill patients. London's acute hospital services have already been scaled back to leave substantial gaps and increased journey times.

The TSA proposals will be finalised by the end of January and announced as an unchallengeable decision by the beginning of February. But the situation will be further disrupted as a result of the government's Health and Social Care Act.

The impending abolition of NHS London on April 1 will remove the last pretence of London-wide planning and coordination of services. The Act will hand commissioning over to local Clinical Commissioning Groups (CCG) theoretically led by GPs with no experience of planning services, and operating with no framework for collaboration between them. This means that there would be no mechanism to recognise and respond to these problems or gaps in care, or plan the rational allocation of resources and services to meet demand.

CLINICAL OBJECTIONS

The TSA report has been remarkable compared with other similar consultation documents in recent years for the number and variety of groups of clinicians who have spoken and written in opposition to the proposals, and the depth of the clinical objections they have raised. These reveal the extent to which the TSA's flimsy case is based on only the most superficial analysis.

- ### Maternity Services

Nine consultant Obstetricians and Gynaecologists have written to express their unanimous view that the proposals put forward by the TSA are inappropriate for Lewisham, a multi-ethnic borough with areas of significant deprivation. The proposals, they say, ignore the strengths of the maternity unit which delivers 4,000 babies a year, 2,400 of them in the highest risk category.

[8] Note that according to King's this comes "despite commissioner attempts to manage demand and redirect patients to more community based healthcare provision"

They challenge the TSA's novel notion of a "low risk obstetric-led unit" as an oxymoron, and question the viability of a "stand alone obstetric unit", especially since 60% of the caseload at Lewisham is high risk. They note that switching these to another hospital would significantly increase the numbers of births at the QEH Woolwich site, requiring significant expansion in physical capacity. But it would also mean increased travel time to hospital for women in labour, and difficulties accessing the QEH by public transport for pregnant women and their families. Many would opt instead to travel to King's or St Thomas's, bringing an increased workload there which in turn would require resources.

The consultants also warn that

> **"if there is a significant reduction in 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."**

The quality of training at UHL currently ranks high – but there is a danger that a "low risk" unit would lose its allocation of trainees because it could not offer a broad enough range of experiences to develop the necessary skills and knowledge. This in turn would undermine the possibility of delivering 24/7 obstetric cover.

Staffing standards require a minimum of 10 consultant anaesthetist sessions per obstetric unit per week, and that a consultant obstetric anaesthetist should be available 24/7. The TSA's proposed reduction in caseload would mean this could not be sustained at Lewisham.

The loss of other clinical back-up vital for a "stand alone" obstetric unit also undermines the possibility of a "low risk" unit at Lewisham: ITU would no longer be available, and nor would interventional radiology, emergency general surgery, or the 24-hour blood bank: all of these would be relocated to QEH Woolwich.

The consultants also warn of the loss of continuity of care, especially for high risk patients:

> **"The consultant obstetricians at UHL have considerable experience in management of high risk pregnancies and would expect to continue to look after these patients antenatally in both models.**
>
> **"However, if a 5 site approach is chosen with UHL a "low risk obstetric" site, these 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 UHL 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."**

Rejecting both of the options floated by the TSA, the consultants call clearly and unanimously for consultant-led obstetric services, offering a full range of services, to remain at Lewisham "with appropriate back-up from other clinical specialties with redistribution of high risk patients".

This plan would focus expertise at Lewisham Hospital:

> **"As UHL has a long established fetal medicine service, under these arrangements, UHL would become the site where women at high risk for preterm births, multiple pregnancies and fetal conditions would be cared for by the fetal medicine team antenatally and remain on site in the higher level NICU (Neonatal Intensive Care Unit) at UHL for neonatal care."**

Lewisham also has a Level 2 neonatal unit which provides services to other parts of SE London. Paediatricians feel strongly it should stay on site supporting the obstetric service.

Will the TSA take note of this (or any other) medical advice?

- ## Children's services

22 consultants working in the Children and Young People's Service at Lewisham Healthcare have also written to challenge the TSA plans, emphasising the scale of the changes that are being made without any proper consultation, and the established high quality services that could be lost:

> **"Children's services have been a larger part of this Trust since 1992 when Sydenham Children's Hospital was closed and merged with existing services on site. Indeed, the principle behind the consultation for the closure of Sydenham was based on the premise that a substantive children's service would be re-provided and be maintained on the Lewisham site.**
>
> ***"If acute children's ED and inpatient services are compromised by the TSA proposals, this commitment to the people of Lewisham will have been broken without any public consultation."***

The consultants declare that they expect the TSA to take note of the local track record and not make "precipitate changes" without consultation or full clinician involvement. They point out that the TSA report is silent on the fate of the Children's A&E, again despite the high calibre of the service currently in place:

> **"Emergency Department attendances are rising year on year. Our Children's ED, with attendances of over 30,000 children per year, is one of the busiest in London. Improvements in the children's ED were included in a £12 million ED refurbishment programme at Lewisham Hospital, giving additional space and enabling patient flows to be streamlined hence creating a quality service in line with current recommendations and practices.**
>
> **"Over 70% of children attending the department are seen within the Children's ED, with only 30% seen in the Urgent Care Centre.**

"We have a model of care that matches that provided only in large teaching hospitals, with a full complement of children's trained nurses, a high level of recruitment and retention, and a very active model of care for children and young people on arrival at the "streaming" end of the process (early analgesia, nurse requesting of x-rays).

"We have a high level of medical supervision by paediatric trained staff. This reputation is recognised by parents who preferentially choose to bring their children here for care even if they are not Lewisham Borough residents. Furthermore, training and experience for medical staff is widely regarded and many trainees choose to come to Lewisham for this experience."

Not all of the sick children arrive by ambulance. Many children are carried in by their parents living locally. Some are extremely sick:

"We are one of the largest referrers of children to the paediatric intensive care services in the south east – interestingly these numbers are matched only by those referred from Queen Elizabeth Hospital. We are recognised by our local paediatric intensive care colleagues at the Evelina Children's Hospital as providing a very high quality service to these extremely sick children."

Lewisham's children's ED is dependent on many of the acute services available to the adult ED; these include access to specialist opinions, laboratory services, and anaesthetic services. Closure of the adult ED will therefore also result in closure of the Children's ED

In-patient paediatric services largely provide care to acutely ill and injured children; closure of the Children's ED will therefore inevitably lead to loss of acute children's inpatient services on this site. The consultants sound the alarm:

"***We believe this has not been made clear to the local population during the consultation process: there is no mention of what will happen to Lewisham's Children's services in the TSA report nor indeed is there any discussion of the effects of these changes on services for children in SE London as a whole."***

But they also warn that the TSA proposals would not only undermine the hospital based services but also remove vital support for integrated care pathways developed to link acute services with community health care. Their opposition to the TSA proposals is not a rejection of any change, but a reminder that the professionals must be allowed to reshape services to deliver appropriate care:

"We must be allowed to work together with QEH, and with our CCGs and local partners, to plan to develop in considered fashion, a holistic service most suited to the needs of the local populations of vulnerable children and young people."

- ## Critical Care

This letter, signed by the consultants, embraces the entire team in rejecting the TSA proposals:

"The physiotherapists, pharmacists, nutritionists, speech therapists, radiographers, clerks, cleaners, 66 nurses, 9 doctors in training and 7 consultant intensivists who are proud to call Lewisham Critical Care Department their place of work ask you to reconsider your plans."

Their letter, like the others, helps to make clear that Lewisham hospital is no second-string hospital, but contains a concentration of highly specialist skills, and features in the top 40 hospitals in the respected CHKS rankings:

"The Lewisham ICU (Intensive Care Unit) opened in 1968, the first intensive care in a District General Hospital in England. In December 2006 we expanded into a combined ICU and High Dependency Unit (HDU) in a State of the Art facility in the new Riverside building, providing up to 21 patients with their own bay. We have space to allow us to open an additional 3 ICU and 3 HDU beds above current funding and would therefore be able to provide a significant proportion of the critical care workload currently provided within SLT without any changes to our existing floor plan."

Lewisham ICU is one of the better performing ICUs in the country, with excellent infection control standards with no patients having contracted an MRSA infection this year.

"A patient admitted to Lewisham ICU is significantly more likely to get better than a patient admitted to a unit representative of the national standard of care."

In the last 12 months Lewisham ICU/HDU has looked after 772 patients at 94.9% capacity, with 34.8% on full life support and 12.6% requiring renal support. Lewisham's ICU is a net importer of critically ill patients from all over London via the Emergency Bed Service.

According to Lewisham consultants, it is also the only District General Hospital ICU in London that has been recognised by the Faculty of Intensive Care Medicine (FICM) as of sufficient quality to train the intensive care doctors of the future. The loss of this training provision has also not been consulted on or even considered.

The consultants warn that the TSA proposals would result in the net closure of 6 fully funded ICU and 8 fully funded HDU beds in the South East London Sector, while these facilities are in desperately short supply nationally.

"No consultation with the critical care community about the impact of losing this vital ICU capacity has taken place."

The track record and prestige of the department has been ignored by the TSA, despite the fact that:

"Lewisham ICU conducts regular patient, relatives and staff wellbeing surveys. We receive universally positive responses and these results have been presented at international meetings."

Unless there is a change of heart by the TSA, the consultants warn, all the hard work over many years of continuous improvement and dedication to helping the sickest patients in the borough of Lewisham will be destroyed.

- **A&E**

Seven Emergency Department (ED) consultants have written to challenge the TSA plan to axe the A&E service at Lewisham. Some of their arguments have already been alluded to above.

They challenge the figures used by the TSA to justify the view that more than three quarters of A&E attenders could be treated in the UCC or the community, and in particular:

> **"The report claims that UHL ED receives on average 2 'Blue-light' ambulance attendances per day. This figure is not derived from any data that we as a department have provided. Lewisham ED receives on average 4-5 'Blue-light' ambulance attendances/day. These verifiable numbers are derived from our departmental software which automatically logs all ED attendances."**

However they point out that:

> **"The use of 'Blue-light' ambulance attendances as an indicator is flawed as it does not address the considerable number of patients admitted through other areas of the ED who subsequently deteriorate to such an extent that they then require transfer to our Resuscitation room. Analysis of our Resuscitation room records reveals a *daily average* (2011-12) of 10-11 patients being admitted to the Resuscitation room for intensive/critical level care."**

They also stress the ongoing high performance of Lewisham's ED: it consistently exceeded the 4-hour national standard, exceeding the old standard of 98% in 2009/10 (98.7% of patients seen) and 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 closure of the ED and its services would put at risk the training of new doctors and nurses:

> **"Our trainees are unlikely to be sanctioned by the Deaneries and Colleges if there is no acute hospital service at the UHL site. The loss of trainees would lead to severe challenges in providing physician cover for any UCC and increasing our dependence on locum doctor cover."**

> **"UHL ED has had a relatively low dependence on locum doctors due to its strong educational record, which has proved to be attractive to both trainees and non-training grade doctors. We also provide a training environment for pre and post registration nursing and medical students from Greenwich and Kings College Universities, which will be threatened by the loss of the ED."**

The ED consultants make a direct challenge to the TSA:

"It is our opinion that as the draft report has been based on demonstrably incorrect figures and assumptions, its findings cannot be relied upon. An issue as important as the acute care of patients in South-East London cannot be determined by a hasty and flawed process, which was never designed to be used to reconfigure NHS services.

"We have no objections to change, and strongly support all moves that promote the safe and effective care of patients.

"Thus we strongly urge that the proposed merged trusts (QEH and UHL), the local GPs and the wider public be left to decide at a local level how our services should be reconfigured. This would not only be a safer and more considered, but would also be in line with the Government's ethos of greater local control with a patient-centred approach to healthcare."

In addition to the points made by the ED consultants it is worth noting that the impending loss of services, and the longer-term loss of trainee doctors and nurses, would swiftly result in serious problems in staffing the A&E Department in the aftermath of the TSA report. Once a decision has been made to close, any Emergency department becomes blighted, and finds itself on a fast track to closure that will make a nonsense of any plans for a more gradual preparation of the TSA proposals.

- ## Physicians and consultants in Acute, Elderly and Speciality Medicine, Radiology and Pathology

46 consultants and physicians have written a further hard hitting critique exposing fatal flaws in the TSA's plans and assumptions, challenging yet again the assertion that community based care would be expanded to fill the gaps caused by reduced services at Lewisham Hospital. They show that this idea is not new, and that there has been a long-standing failure to deliver:

"There is no evidence given, beyond the anecdotal, for the assertion in the report that community based care can result in a 30% reduction in acute admissions to hospital. A similar assertion made in 2008 in 'A Picture for Health' has not been met with any reduction in the need for secondary care."

Uniquely the consultants describe the initiatives that are already being taken by these specialists and their staff to minimise referrals and admissions to hospital:

"Lewisham Healthcare NHS Trust, as a community-integrated organisation, is in any case already engaged with admission avoidance. Our COPD community and outpatient intravenous antibiotic therapy teams provide support for patients in their own homes to prevent the need for admission and our admission avoidance team have access both from the acute Trust and the community to consultant led bed-based rehabilitation.

"Our community and hospital heart failure nurses working together to support patients discharged from hospital and reduce re-admission. There is rotation of our staff through the community and LHNT, which helps staff. Although we continue to support fully the development of any initiative to enhance out of hospital care and care closer to home,

there is no compelling evidence yet that this has had a significant effect on overall numbers of admissions – indeed admission rates have not fallen and the frail elderly population is increasing inexorably."

Far from making hospital services more efficient, and generating the required reductions in Average Length of Stay, the consultants point out from experience that the TSA's plan could have the opposite effect:

"There is a strong likelihood of an increased length of stay if patients are admitted outside Lewisham; *residents of Lewisham Borough admitted to Lewisham Hospital have a 2.7 day shorter stay than patients admitted from other boroughs*. Excellent existing relationships with social services in Lewisham would be lost and not replicated in neighbouring boroughs. "

The medical consultants make a valuable point on the difficulties for Lewisham residents travelling to other hospitals to visit relatives, given the inadequacies of public transport, and the profile of poverty in the borough:

"Car ownership in Lewisham is low, with 42.8% of Households in Lewisham without access to a car or van, compared to an average of 37.5% in London. Many residents would have to take at least two buses and there is no train station nearby."

The consultants argue that removing complex treatments and emergency medicine from Lewisham would severely limit its usefulness to local GPs, and its abilities to discharge some patients quickly:

"GP colleagues are unlikely to refer to an emergency facility (whether termed a minor injury unit or urgent care centre) that has neither the specialist skills to assess the patient, or the facility to admit that patient, should that be necessary.

"Many elderly patients are rapidly assessed by the specialist elderly medicine acute team and are discharged with enhanced community support. These functions simply could not be substituted by extended nurse practitioners or general practitioners in a non-admitting facility without the support of specialist medical teams on site."

And they point out that the result could be that outpatient referrals to Lewisham would fall far more than the 15% drop predicted by the TSA plan:

"Without an acute medical service there would be a significant reduction in the number of outpatients at Lewisham Hospital. This implies that Lewisham Hospital would lose income as other trusts would increase their outpatient share. This loss would be substantially greater than that allowed for by the financial modeling in the report."

And, picking up on yet another important issue that has been missed in the Deloitte Health Equality Impact Assessment, they argue that the TSA cutbacks at Lewisham more difficult to diagnose cancer:

"In many cases the first presentation of chronic illness is through an acute admission, and initial diagnosis is made by the specialty team at the acute site. Of new cancer diagnoses

nationally, 23% come through as emergency presentations. This proportion is higher in deprived areas such as Lewisham where presentation with cancer is later."

Their conclusion is blunt and uncompromising:

"The recommendation to close the acute medical services is unsound, based on evidence which is unfounded and on inadequate consultation. There is no robust alternative provision for acute medical needs, either by other acute providers or in the community. We have grave concerns for the safety of our patients and the impact on their quality of care if these proposals are carried out."

- **GPs**

The opposition to the TSA plan has by no means been restricted to the dozens of consultants who have spoken out, backed by other members of their staff: local Lewisham GPs too are profoundly worried by the consequences of the cutbacks on services they and their patients rely upon.

One practice that has written to express its concerns is the Sydenham Green Group Practice, which takes up a number of issues, but goes in especially hard on the disruption to the links in local services

"Relationships carefully built up in recent years between Lewisham GPs and Hospital Consultants and between medical teams and Social Services will be lost and links between the acute admitting hospitals (QEH, KCH or PRUH) and Lewisham GPs and Social Services will not approach this model of close integration.

"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.

"Fragmentation of care is perhaps the biggest pressure facing every modern health service and is at the root of rising costs, poor quality of care and rising health inequalities.

***"*What evidence do you have that your planned closure of acute medical and surgical beds at Lewisham, the former in particular occupied by older patients with complex medical and social care needs, will not lead to expensive fragmentation of care?"**

The GPs also challenge the TSA's failure to address the implications of extended journey times, and the costs for local families in Lewisham:

"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. The additional travelling times quoted for the people of Lewisham do not bear any resemblance to the experience of our patients in using public transport at peak travel times in this part of London.

"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?"

And while the TSA, echoing a McKinsey proposal from 2009, suggests reducing GP consultation times as a way to give the impression of increased productivity, the GPs highlight the very different approach of the Royal College of General Practitioners, which recommends increased consultation times as a way to improve the quality of care.

They also challenge suggestions that a new system for "referral management" could be attached to "incentives" to reward GPs for referring fewer patients for hospital treatment:

> **"A figure of 20% reduction in referrals is quoted for 'Incentivized referral management systems'. Limiting referrals by incentives is highly controversial mainly because the concept is unethical and may result in choices not being made according to clinical need. Referrals can be reduced but this drop is grossly over estimated."**

And the GPs also single out the issue of mental health care, which would also be threatened by the plans to close Lewisham's A&E services:

> **"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 (on the Lewisham Hospital site) 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?**
>
> **"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."**

In this report we have only summarised the firm rejection of the TSA plans by local health care professionals: but it is clear that they have identified a number of obvious weaknesses in the information used, the assumptions, and the vision of the mix of services to be provided if the TSA gets his way.

The question is: will evidence and medical opinion be taken into account?

Or will the TSA's final report be driven by the balance sheet and simply restate the plans that so visibly lack local support in the area most affected?

DO THE SUMS ADD UP? The financial side of the TSA plan

£56m cost of closing services at Lewisham

More than two thirds of the capital investment called for in the TSA plan is to be "invested" in the run-down of University Hospital Lewisham, a high-performing, viable and solvent Trust – in order to bail out two bankrupt PFI projects in the adjacent Trust.

Hospital resources in one of the most deprived boroughs in the country would be run down, and the most seriously ill, poor, and people with disabilities required to travel further for treatment, to hospitals which are hard to access by public transport, while services in the wealthier areas of Bromley remain undisturbed.

The net loss of 422 beds involves closing over 600 and opening almost 200 new ones as resources are juggled across London. The plan as a whole will cost the taxpayer £330m up front and a steadily rising subsidy for the PFI payments for the next 20 years. Is this value for money, or throwing good money after bad to avoid facing up to the need for assertive government action to tackle the running sore of PFI that is now threatening other trusts around the country?

Closing beds

One of the biggest contradictions of the finances of PFI hospitals like QEH Woolwich and PRUH Bromley is in the current regime of "payment by results." This system pays hospitals only for each item of work they do, so once they run into deficit, it is impossible to balance the books by cuts. The overheads of the PFI are fixed in advance, with a unitary charge, combining the contract for support services, and the "availability charge" for use of the building. This charge grows year by year, most commonly by inflation, or by 2.5%, whichever is the higher.

So although some savings in nursing and other professional staff can be made, the core costs of the building and support services are locked in to a binding contract. And of course if fewer clinical staff are in post, it's likely fewer patients can be treated – and therefore the Trust's revenue is held back or reduced.

The TSA plan to close 90-100 beds in SLHT therefore makes little financial sense. And as we have seen above, it raises questions over the capacity to deliver services for the local catchment, especially if acute services are cut back at Lewisham.

Lewisham PFI costs ignored

The TSA report laboriously notes the cost of the six PFI contracts which milk a hefty £70m per year from South London Healthcare Trust. These contracts cover the two hospitals QEH Woolwich and PRUH Bromley, plus separate deals for the equipment in the hospitals, and two much smaller PFIs, one in Queen Mary's Sidcup costing £0.8m a year and a "power" contract in Bromley at just £0.1m.

Interestingly the detailed figures on PFI in the Draft report (page 58) are at odds with the much higher figure for PFI costs set out in the 'Case for Applying the Unsustainable Provider Regime' (page 15). According to the TSA main report the £70m costs represent 16% of SLHT income: in the

other document (grasping for any justification to dismember the Trust) the PFI costs are put at £89m which is said to be 18% of SLHT income. The difference of £19m (27%) is very substantial, but no explanation is offered for the two contradictory figures, and it is not clear which is correct.

But nowhere does the TSA discuss the costs of the £58m block built at Lewisham Hospital using PFI funding, which opened in 2007 and is set to cost £314m by the time of the contract completion in 2037. On Treasury figures, it seems there is still another £270m to pay, although higher inflation is likely already to have increased the unitary charge from the £7.7m projected for this year, and expected to rise to £14m by 2035.

The only reason this quite substantial PFI commitment would be ignored, while the much smaller ancillary PFI contracts at SLHT are laboriously listed, is because the TSA has taken the tactical decision to sell off almost all of the remainder of the Lewisham Hospital site (58% of the current Trust estate) reducing the resultant capital charges, and hoping this will allow the PFI contract to be serviced, even on a much reduced income (Appendix K page 38).

Squeeze on tariff, reducing referrals

Another feature of the 2012 NHS financial landscape is the expectation of a year by year reduction in the "tariff" of charges paid to hospitals for treatment under "payment by results": in other words, the NHS is trying to pay less each year for the same work, while inflation remains above target, and demand for care is constantly increasing from an ageing population.

The TSA's 'Case for Applying the Unsustainable Provider Regime' makes the point that a combination of reduced referrals from commissioners, reduced operating revenue and reduced tariffs has already brought a £24m cut in Trust income at SLHT in the last three years. So most of the £32m cut in costs achieved over the same period was wiped out.

This squeeze on tariffs is hard to cope with in hospitals with no PFI or relatively small PFI schemes, but it's a major problem for hospitals with large-scale PFI schemes swallowing up a steadily larger lump of revenue each year. SLHT, with two over-priced hospitals draining its resources, is especially poorly positioned to ride through a squeeze on tariffs.

Agency staff bill criticised

The TSA Draft report makes a big issue of the costs of using temporary staff because SLHT has had trouble recruiting:

> **"Temporary staff expenditure is a problem for the Trust. For example, in 2011/12 agency staff costs were budgeted to be under £3.4m, whilst the actual cost was £13.3m; SLHT's target for agency usage is 1.0% of total workforce and yet, in 2011/12, it was 4.4%. Compared to its peers, the Trust has consistently underperformed on its levels of usage of temporary staff. In 2012/13, the Trust's plan was to spend £23.9m on temporary staff, but at the half year point the Trust's forecast has risen to £33.8m indicating that the Trust is still struggling to control temporary staff costs and the balance between permanent and temporary staff is sub-optimal."** (page 29)

The Case for Applying the Unsustainable Provider Regime builds this into a full scale critique of the Trust:

> **"The Trust's inability to contain temporary staff costs suggests a broader problem: a combination of the challenges of planning, rostering, staff utilisation and staff recruitment and retention. It demonstrates short term operational planning, with permanent positions being removed, only to be replaced with more costly temporary staff. … The lack of a clear plan for financial and operational viability and the worsening financial position compounds this issue, making the Trust an unattractive organisation for potential recruits"** (page 11).

However, despite this withering criticism of the Trust, drastic and poorly justified reductions in the numbers of staff - doctors, nurses, technical and admin staff – both permanent and temporary, are a prominent feature of the TSA's own plans for cash savings:

> **"The Trust has the lowest income per consultant in its peer group, a very high ratio of junior doctors to consultant staff and high use of locum and agency staff. This suggests that the level of activity delivered by the Trust could be achieved with a lower number of medical staff, if the productivity of other Trusts was matched"** (page 51)

But TSA plans offer no evidence that the cuts in permanent staff will not once again force an increase in temporary staff to deal with excess workload. And they take no account of the fact that the high profile of the Trust's financial crisis, the TSA's own plan for the break-up of the Trust, and the drive for a new, still uncertain configuration of PRUH Bromley services, and the Lewisham-QEH merger, will exacerbate the problems still further. It will add a new instability to the workforce, and make it increasingly impossible to recruit staff to SLHT services.

Increased throughput?

One lazy way for desperate managers to imagine a quick and easy way to reduce costs is to assume hefty reductions in average length of stay for in-patients. Some of the most extreme fantasy projections were hatched up by management consultants in the 1990s trying to make the case for early PFI schemes, and justify them having far fewer beds than the hospitals they replaced.

Very big increases were achieved in surgical 'throughput' in the 1980s and 1990s as new anaesthetics and less invasive techniques allowed swifter recovery times, but since then the achievement of even more reductions has time and again been restricted by the lack of adequate community health services and primary care support for those discharged earlier.

The TSA however "assumes" savings of £6m from a 10% reduction in average length of stay in SLHT by 2015/16 – offering no evidence, and outlining no proposals that might enable this reduction to be achieved.

Sadly the complete absence of any actual plan to expand community based healthcare in SE London, combined with severe pressures on local authority social services budgets, mean that this is unlikely to be achieved.

Unidentified savings

In arguing the case for invoking the "Unsustainable Provider Regime"(page 15) the TSA also makes use of Audit Commission comments on the Trust having included £4m of "unidentified" savings into its Cost Improvement Plan. This is used to argue that SLHT had no coherent plan or "medium term financial plan".

So it comes as some surprise to find that the TSA's own plan (page 54) calls for SLHT to make unidentified savings equivalent to 2% of its turnover (in cash terms £8m-£9m) as part of the plan to rescue the PFI hospitals.

The TSA, having (whether credibly or not) identified other specific amounts to be saved from specific budgets, throws in this call for another 2% which the trust must deliver "to reflect the continuing improvement of peers over the period of the modelling". So that's as clear as it gets. Nothing says more unmistakeably that the sums still don't add up, and that the TSA has felt obliged to lob in a bundle of mystery cuts to give the impression that they do.

New elective centre a non-starter

A prominent feature of the TSA attempt to sell the Lewisham hospital changes is the suggestion that it become the site of a new SE London elective operating centre, modelled on the highly successful SW London Elective Orthopaedic Centre (SWLEOC) at Epsom Hospital[9].

The TSA suggests it could be handing up to 44,000 cases a year by 2015/16 – but this appears to be based on wishful thinking, guesswork and fantasy. Having closed the ITU at Lewisham, the range of operations that could be safely carried out at an elective unit would be very restricted, to the most minor and uncomplicated that can be considered "safe" by consultants concerned with avoiding risk.

Many of the operations in this category would logically be day cases, and the plan is for the bulk of these to be treated at Queen Mary's Hospital Sidcup, where two theatres would churn through patients ten hours a day, 6 days a week, 50 weeks per year, although only minimal numbers of recovery beds would remain on site.

The financial viability of the TSA's Lewisham elective unit scheme also depends upon a Soviet Union-style regime of super-human productivity in the use of operating theatres (and surgical staff) working factory-style twelve hours a day, six days a week, 50 weeks a year, with an average of 1 case per hour and 90% utilisation. This level is well above that achieved anywhere, and appears to have been made up by management consultants rather than discussed with clinicians. The implications

[9] It is especially unfortunate for the TSA to be invoking the name of SWLEOC at a time when the future of that unit appears to be uncertain, with some of the partner Trusts, notably Kingston, seeking to repatriate work which is currently dealt with at SWLEOC (*Sutton Guardian*, 23 November http://goo.gl/1VVWH). More recently the partnership board has proposed that the management of the unit be transferred to Kingtston Hospital Trust, seven miles away. Staff at the unit could be TUPE transferred to Kingston which would take over the HR management role – the costs of this exercise are have not been revealed but will be considerable. The question marks over the future of this well established and highly successful unit in the new dog-eat-dog health care market serve to emphasise the even greater doubts that would hang over the TSA's proposed SE London equivalent.

for support services, the availability of recovery beds, and of adequate support services in the community and primary care, are not discussed

Lewisham's existing theatres are already in the top quartile for performance, but deliver only half of the productivity target set by the TSA. There are fears that work at this pace and intensity would reduce the elective unit to the type of cream-skimming of uncomplicated cases that is normally the preserve of the private sector. This would leave many of the most deprived and vulnerable sections of local communities in SE London excluded from treatment, and would raise the question of where the more complex elective work would be carried out.

The TSA plan would also make teaching and training of junior doctors impossible, as indeed does the similar SW London system (SWLEOC).

But all this leaves out another major underlying problem. There is no commitment from any of the neighbouring PCTs or CCGs to commission elective services from the new unit, and every reason to assume that the Foundation Trusts would fight hard to retain their existing elective caseload, since this work is the most lucrative for hospitals. This is why uncomplicated elective surgery is the focal point of private hospitals.

So the probability is that an elective unit at Lewisham would prove a white elephant. In the same way, building a similar unit at Hinchingbrooke Hospital helped to destabilise the finances of that Trust when neighbouring PCTs reneged on their verbal commitments to refer patients and to commission services from it.

In other words far from helping to revive the finances of UHL, it could prove the final straw in undermining the financial viability of a hospital that even after much of the site is demolished and sold off would still have a PFI liability, but with inadequate flow of income to sustain the remaining services.

COUNTDOWN TO CHAOS

The dramatic step of wheeling in the Special Administrator under the Unsustainable Provider Regime may have taken place only in the summer of 2012, triggering a rapid timescale of intervention. But the crisis of South London Healthcare had been building for many years, with its roots dating back to before the ludicrous merger that welded SLHT together like a 'cut and shut' old banger from three bankrupt Trusts – Queen Elizabeth, Princess Royal and Queen Mary's Hospitals.

The pressures that made it impossible for this Trust to survive come from a variety of sources, all of them with their roots in the private sector.

Pre-history of the Private Finance Initiative

PFI is the system for funding the vast majority of new hospital development since Tony Blair's "New Labour" took office in 1997. But it is a policy devised under John Major's Tory government to privatise the provision of capital for the NHS. From 1992, continued cuts in public sector capital for the NHS, and a prolonged hiatus in new hospital building led to the notion that PFI was "the only

game in town." This helped press-gang desperate Trust bosses into signing unaffordable contracts in the final stage negotiations with their "preferred provider."

In 1997 the companies that had refused to sign PFI contracts under the Tories were encouraged to do so by a one-clause bill in Labour's first parliamentary term which committed the Secretary of State for Health to pick up the tab if an NHS Trust went bust and failed to pay its PFI bills. The same clause also encouraged a degree of irresponsibility among Trust managers keen to sign off early deals. This, and a woeful lack of expertise on the NHS side, compounded by dubious advice from management consultancies – on occasion working for both sides – meant that some of the first wave PFI hospitals, such as QEH Woolwich and PRUH Bromley, have been the most expensive as a multiple of the original investment.

The NHS Plan of 2000 allocated large year by year increases in real terms funding to the NHS from 2001 to 2010. But it also included other "reforms" which also centred on the growing involvement of the private sector.

In particular the Payment by Results system was established as the mechanism to allow a growing share of NHS budgets to be spent in purchasing care from private providers. But this is nothing to do with "results:" it is a cost-per-case system of paying NHS hospitals for treatment on the basis of a single national tariff of fees. This rigid tariff system systematically under-funded PFI hospitals, by calculating overhead costs at a much lower level than the actual costs of unitary charge payments under PFI.

First wave PFI hospitals were built with a reduction of previous bed numbers by an average of more than 25%. The result was that Trusts with substantial PFI payments were not only struggling to deliver services with an inadequate number of beds, but they were also unable to work their way out of financial problems with extra caseload. And on top of that, they were also paid less in real terms for each treatment they delivered.

"Technically insolvent"

By the end of 2005, just four years after it opened, but still in the midst of rising year by year NHS spending, QEH Woolwich, projecting a £19.7m deficit for the year, was pronounced "technically insolvent" by auditors PricewaterhouseCoopers in a "public interest report" published by the Audit Commission. The PFI deal had added £9m a year to the cost of the hospital compared to the cost if the government had lent the capital. This had been hidden for two years by support payments: but these came to an abrupt halt, and the Department of Health wanted the money repaid.

The warning signs were ignored. The Trust declared how happy it was with its PFI "partners", who were already coining in profits. The London Strategic Health Authority told the *Guardian* they were very happy with the Trust's financial management, who, they said, were "tackling" the issues[10].

Similar problems were also being experienced by the PRUH Bromley, which opened in 2003-4. The initial PFI contract, specified unitary charge payments rising from £27m per year for a hospital with

[10] Carvel J (2005) Flagship PFI hospital 'technically insolvent', *The Guardian,* December 16, available http://www.guardian.co.uk/uk/2005/dec/16/publicservices.topstories3

17% fewer beds than the previous hospitals. These had only been made to look affordable by the Department of Health promise of a so-called "smoothing payment" to subsidise the cost (the PFI "availability charge" for the buildings was equivalent to 14.5%. of the Trust's 1996/97 income[11]). But by the end of 2005, the Department had already reneged on this commitment, leaving Bromley Hospitals Trust lumbered with the full cost and already facing a deficit of £15m.

2006 brought Patricia Hewitt's famously unsuccessful attempt to squeeze deficits out of the NHS. This triggered a wave of protests against hospital cuts and rationalisation across the country, opportunistically supported at the time – and sometimes even led – by Tory MPs.

Darzi

In 2007 Lord Darzi took the stage, having been invited by NHS London to outline plans to rationalise hospital services in the capital. The specialist surgeon, with statistics and ideas furnished by McKinsey, came up with plans for a massive downsizing of hospitals, with many downgraded from District General Hospitals to "local hospitals" with few beds or inpatient services.Outpatient care was to be shifted wholesale into new "polyclinics", in which primary care services were to be concentrated.

NHS London conducted a farcical "consultation" exercise on the Darzi proposals in which a microscopic fraction of London's electorate registered a view. This resulted in NHS London declaring, after a far from transparent process, that a "majority" had backed the Darzi plan. In fact fewer than 4,000 of London's 5 million voting age population supported the scheme, with a near identical number opposing it.

However the Darzi exercise triggered a new round of hospital rationalisation schemes, among which was an exercise in SE London bizarrely entitled "A picture of health". Beneath a flurry of rhetoric and endorsement for motherhood and apple pie lurked a serious intent: to cannibalise Queen Mary's Hospital, Sidcup, with its minimal PFI obligations, in order to bail out the floundering Queen Elizabeth Hospital and Princess Royal University Hospital, weighed down by their rising PFI bills.

Queen Mary's Hospital on the chopping block

At that time QMH was a fully functioning general hospital handling almost 42,000 admissions a year, more than a third of which were day cases: of the 27,000 who were admitted for longer, around 47 percent were emergencies.

But QMH found itself in the wrong place at the wrong time: a King's Fund seminar on SE London in July 2007 pointed out that the four Trusts in outer South East London (QEH Woolwich, PRUH Bromley, QMH Sidcup, and Lewisham) were saddled with "legacy debt" totalling £180m of which around 70 percent was in QEH Woolwich and PRUH Bromley. A later slide makes clear that this £180m "cannot be repaid", and that some other formula needed to be found.

[11] Gaffney D, Pollock AM (1999) Pump Priming the PFI: why are privately financed hospital schemes being subsidised? Public Money and Management, available http://www.web.net/ohc/pollock.pdf

It also revealed that the two foundation Trusts in inner London (Guy's & St Thomas's, and King's College Hospital) which were nominally included in the 'Picture of Health' reconfiguration (but not expected to make any changes) were sitting on huge unspent surpluses "greater than the aggregate deficit of the four District General Hospitals". However since they were Foundation Trusts, these surpluses are no longer available to the wider health economy, and certainly of no benefit to the residents of Sidcup.

The Picture of Health project engaged in a purely cosmetic "consultation" in which it was clear from the beginning that no notice would be taken of any opposition to the plans, which would downsize and downgrade QMH Sidcup and University Hospital Lewisham (UHL). In the event minuscule percentages of those responding supported the core proposals, an embarrassment that could not be concealed by the desperate contortions of IPSOS MORI spin doctors: their report on the consultation focused all the discussion on the minority view and ignored the majority – which was against the plans and in favour of no change.

In the spring of 2009 local health chiefs decided to press ahead regardless with a plan that would:

- Strip QMH Sidcup of its A&E Department, a brand new children's A&E, and maternity services,
- Turn it into a planned surgery base with an Urgent Care Centre (UCC) for minor injuries.
- Concentrate vital services at PFI-burdened hospitals in Woolwich and Bromley.
- Cut A&E coverage at University Hospital, Lewisham to just 12 hours a day.

Even as they pushed on with the plan, Bexley Care Trust board decided to cut back spending on community services that were to compensate for axed A&E services in the borough, slashing over £5m from projects including its polyclinic and GP led health centre.

In what appears to have been a last despairing cry of opposition by Bexley council to the destruction of local health care services in the borough, Sharon Massey, Bexley council's cabinet member for health, told the local press:

> **"We were told that whilst we would lose our A&E, we would also gain all these excellent community services. Now they're planning to cut millions from their budget that would have been spent on community services. It's unfair on residents."**

A merger of bankrupt trusts

The proposal to cut back Lewisham's A&E Department was eventually sidetracked by the proposal to merge QEH Woolwich, PRUH Bromley and QMH Sidcup into one large, bankrupt Trust, SLHT, which was steamrollered through in 2009. It appeared for a while that by escaping the clutches of this merger Lewisham would have been able to hold on to its local services. However it's now clear that if the TSA gets his way this will be no more than a temporary reprieve.

2009 was the year of publication of the now notorious McKinsey master-plan for cuts, commissioned by Labour ministers, but strenuously disavowed as soon as information about it began to leak into the public domain. The 'report' consisted of more than 150 power point slides, with no linking

narrative, little evidence, and no explanation or attempt to rank the various proposals in terms of their varying levels of credibility and desirability.

Together the suggestions were claimed to be a plan that could save the NHS in England a total of £20 billion by 2014. The document was kept a closely guarded secret by ministers until Andrew Lansley made a great show of publishing it after the 2010 election – only to drive forward the process of implementing the plan he had appeared to criticise in opposition.

Broken promises

The merger of hospitals into SLHT was always going to spell the death knell of Queen Mary's Sidcup: integration into a single Trust made it much simpler to carve up and plunder the assets. However the closure of its A&E was not immediate and in the run-up to the 2010 general election the Tory candidate for Old Bexley and Sidcup, James Brokenshire, made a big play of his commitment to save the services at the hospital. He claimed to have the ear of Andrew Lansley, then Shadow Health Secretary.

There were photo calls outside the hospital, with Cameron, Boris Johnson, Lansley and others. Of course the promises were worthless, as was the Conservative promise to halt the closures of A&E Departments and maternity units. The brief "moratorium" imposed immediately after the election was lifted by the autumn, with the squeeze on spending and drive for the £20 billion of cuts.

Queen Mary's A&E was blighted by the closure decision: by September, just a few months after the election, it was being announced that it would close over the winter because of staff shortages.

The downsizing of QMH Sidcup was not enough to rescue the floundering PFI hospitals in Woolwich and Orpington: inflation rates were driven up by the rampant financial crisis drove up PFI payments, and during 2011 the PFI crisis intensified. By September the Department of Health had drawn up a list of 20 Trusts endangered by the costs of unaffordable PFI schemes.

In February 2012 Andrew Lansley, battling to avoid distractions and force his controversial Health & Social Care Bill through the House of Lords, set up a £1.5 billion PFI bail-out fund. However only seven of these Trusts were eligible to apply for support.

"Long Term Financial Plan"

The hot breath of PFI creditors was plainly being felt by South London Healthcare Trust's directors when they drew up the "Long Term Financial Plan," which was published on Dec 31 2011. It aimed to deliver cost improvements of £112m by 2016/17. A major share of this was to land on staff, with a combination of the ongoing pay freeze and a reduction of 695 jobs.

To save £3m, substantial cuts were proposed in ward based nursing, with a reduction in the number of hours worked and reduction in skill mix; downgrading of already low-paid theatre staff; and a reduction of 1 hour of nursing care per patient day across all units– even though NHS London was advising an increase in nursing hours per patient day.

Non-ward nursing numbers were also to be downsized and re-banded to cut salary costs (page 32-33). Big cuts were also to come from admin and clerical staff, axing posts, and seeking to outsource back and middle office functions.

The job cuts were to continue, in order to axe 1100 jobs by March 2016: the document declared its hopes that this would result in a workforce that would be "flexible, agile and resilient".

Other savings were to come from estates rationalisation, reducing from three to two large sites, selling off the Kent Women's Wing and leasing out the Frognal Centre at QMH Sidcup. The Trust was also looking for a £21m annual subsidy towards its "excess" PFI costs. It admits (page 21) that:

> **"Since its inception the Trust has only been able to operate as a going concern because of direct non-repayable cash support from the DH"**

Interestingly it noted that bed capacity was already a problem at PRUH Bromley while "balancing the admission and discharge profile" was the problem at QEH Woolwich.

Administrators and hit squads

In July 2012 the Trust Special Administrator was brought in to SLHT, invoking the Unsustainable Provider Regime, and the following month "hit squads" of accountants and management consultants were sent in to attempt to sort out SLHT and six other Trusts struggling with PFI costs.

Since then more evidence has emerged on the scale of the deficits and accumulated debts of SLHT. But it has become more and more clear that the overriding government plan is to patch up PFI Trusts to the point that they can keep up their PFI payments. The schemes that have brought them to their knees remain in place.

As this report is drafted the Conservative-led Coalition has announced that a new variant of PFI, "PF2", is to be developed, with government money involved from the outset. This makes it obvious that PFI, despite all the rhetoric from Conservative politicians about the cost of schemes signed off by Labour, is what they are determined to rescue. At whatever the price that has to be paid in the form of axed services, jobs, and taxpayers' money thrown in to long-term subsidies.

They are determined to keep the cancer alive – and sacrifice the patient.

John Lister
December 6 2012