UNDER THE KNIFE

an analysis of the planned changes in hospital and health services in South East London that threaten the future of Queen Mary's Hospital, Sidcup

Drafted for staff side unions at Queen Mary's
by Dr John Lister of London Health Emergency

Introduction

The publication in July of Professor Sir Ara Darzi's review of London's NHS has had at least one beneficial impact. It has forced a postponement in South East London of the proposed consultation on running down front line A&E and acute services at Queen Mary's Hospital (QMH) in Sidcup, the only acute hospital in the London borough of Bexley.

The consultation process, which began in May under the misleading title "A picture of Health," purports to be addressing issues such as equality of access to services, new possibilities arising from the latest technology, and "affordability". But in reality the key (and only significant) driving force is this third point – the official website makes the claim that SE London's health services are facing deficits totalling £65m. The original intention was to fast-track the plans for rationalisation and push through a "consultation" in September which would be completed by the end of the year. This timescale has now slipped – but the wheels are still grinding in the backround, driven by the cash crisis.

In fact the consultation has little or nothing to do with addressing equality issues or increasing use of new technology and techniques. Instead it is increasingly clear that Bexley and its residents are expected to accept a drastic worsening of their access to health care – in order to bail out the other three neighbouring health Trusts.

This is because QMH is unfortunate in sharing a geographical sector with three other London NHS Trusts (Lewisham Hospital, Bromley Hospitals (Princess Royal University Hospital) and Queen Elizabeth Hospital, Woolwich) which face massive financial pressures arising from substantial building projects financed through the controversial Private Finance Initiative (PFI). In addition, another major PFI hospital project, the Darenth Valley Hospital run by Dartford & Gravesham NHS Trust is located immediately to the east of Bexley.

Under the knife

Since PFI contracts involve legally-binding, index-linked payments over 30-40 years and carry punitive costs for cancellation, the one hospital without a PFI contract is most at risk in a scenario in which four Trusts are struggling to pay their "unitary charge" and deliver services at NHS flat-rate tariff cost despite soaraway, PFI-fuelled overhead costs.

The situation facing Queen Mary's is not of its own making, but a product of government "reforms" which have fragmented the NHS, forced Trusts into unwise PFI commitments, and which are now allowing Primary Care Trusts like Bexley to ignore the wishes of local people and take the perverse decision to prioritise spending in hospitals outside their own catchment area rather than support the hospital most local and accessible for their residents.

QMH, which also faces financial pressures of its own, is effectively picking up the tab for serious blunders made by other Trusts, and policy errors at government level. A recent King's Fund seminar on SE London (July 2007) pointed out that the four Trusts between them are saddled with "legacy debt" totalling £180m "of which around 70 percent in QEH and Bromley". A later slide makes clear that this £180m "cannot be repaid", and that some other formula needs to be found.

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

Catchment and access

Queen Mary's own publicity states that it provides services to at least 60 percent of Bexley residents: but its catchment population of at least 300,000 also includes sections of Greenwich, Bromley (especially Chiselhurst) and Dartford.

The hospital handled almost 42,000 admissions in 2005-6, more than a third of which were day cases: of the 27,000 who were admitted for longer, almost 47 percent were emergencies.

One significant factor of the outer SE London Trusts is that their caseload includes significantly more older patients than the two inner London foundation Trusts, with more than 21 percent of admitted patients aged over 75, compared with just 13 percent in inner London (QMH average is even higher at 22 percent). This tends to be the age group of patients with greater mobility problems, less likely to have access to a car, and more likely to spend longer in a bed once admitted to hospital. This in turn, therefore potentially places more of a burden on relatives and visitors if they face longer journeys to visit someone in hospital.

With bed occupancy in the outer SE London Trusts running at or above the recommended maximum (82 percent) level for safe handling of MRSA and other hospital-acquired infections, there would seem to be little scope to switch the caseload without substantial capital investment to expand services elsewhere.

However the King's Fund seminar was told that there were "400 excess beds" across the six Trusts in SE London in 2006-7 "projected to increase to more than 700 by 2009-10".

Staff in QMH and other hospitals are bemused by the claim that their Trusts are running "excess" beds: these are clearly not in outer SE London, where on average over 95 percent of geriatric beds and 87 percent of general and acute beds are occupied.

Under the knife

Available and occupied beds, England, and SE London 2005-06										
Year	Name	General & Acute (Available)	Acute (Available)	Geriatric (Available)	General & Acute (Occupied)	Acute (Occupied)	Geriatric (Occupied)	General & Acute (percent Occupancy)	Acute percent Occupancy	Geriatric percent Occupancy
2005-06	**England**	133,033	108,113	24,920	114,044	91,270	22,774	85.7 percent	84.4 percent	91.4 percent
		(Available)	(Available)	(Available)	(Occupied)	(Occupied)	(Occupied)	(percent Occupancy)	percent Occupancy	percent Occupancy
2005-06	Bromley Hospitals NHS Trust	522	170	352	472	133	340	90.6 percent	78.3 percent	96.5 percent
2005-06	Queen Elizabeth Hospital NHS Trust	433	366	67	377	312	65	86.9 percent	85.1 percent	96.5 percent
2005-06	**Queen Mary's Sidcup NHS Trust**	**383**	**257**	**126**	**324**	**209**	**114**	**84.5 percent**	**81.4 percent**	**90.9 percent**
2005-06	The Lewisham Hospital NHS Trust	515	419	96	446	354	92	86.6 percent	84.5 percent	95.8 percent
Outer SE London Totals		**1,853**	**1,212**	**641**	**1,619**	**1,008**	**610**	**87.4 percent**	**83.2 percent**	**95.3 percent**
		(Available)	(Available)	(Available)	(Occupied)	(Occupied)	(Occupied)	(percent Occupancy)	percent Occupancy	percent Occupancy
2005-06	Guy's And St Thomas' NHS Foundation Trust	1,099	992	107	864	765	98	78.6 percent	77.1 percent	91.7 percent
2005-06	King's College Hospital NHS Trust	854	736	118	757	640	117	88.6 percent	87.0 percent	98.9 percent
Inner SE London Totals		**1,954**	**1,729**	**225**	**1,621**	**1,406**	**215**	**83 percent**	**81.3 percent**	**95.5 percent**

A closer look at the latest Department of Health figures shows that if there is any slack in SE London it is in the Foundation Trusts in inner London, which have far lower occupancy levels, especially Guy's and St Thomas's with an occupancy of just 78 percent. General and acute beds across the two Foundation Trusts are running just on the recommended safe level of 82 percent occupancy – well below those in the outer boroughs.

We are NOT calling for cuts in inner London: we think the available hospital beds are the minimum number to maintain services. But we do note that while the six acute Trusts are supposedly part of the review, they are not all expected to take part in the cutbacks. **ALL of the cuts are set to be shared by the four NHS Trusts on the outer edge of the area – where services are already under greatest pressure.**

A cutback of 400 beds on the existing bed total in the four Trusts would exceed the total number of vacant beds, and amount to a 22 percent reduction in the availability of general and acute beds. It would leave the whole area desperately short of hospital capacity, with each Trust running well above recommended safety levels and incurring huge potential risks of uncontrollable MRSA and C-Diff outbreaks.

Even across all six Trusts, a cutback of 400 beds would amount to an 11 percent reduction in general and acute beds, again having the heaviest impact on the Trusts which are already running at above recommended levels. The consequences of the potential reduction of 700 beds would be even more serious: this would equate to a 37 percent cut in bed provision across the four Trusts, or an 18 percent cut across all six Trusts.

Under the knife

Outside London the situation is no easier. The neighbouring Darenth Valley Hospital, run by Dartford & Gravesham NHS Trust, is also currently running its 416 available general and acute beds at an average of more than 91 percent occupancy: where is the scope for it to accommodate almost 3,500 additional emergency admissions from Bexley each year?

There is no case for any reduction in front-line capacity in SE London unless – and until – a major investment in expanded and enhanced primary care and community-based services is proved successful in achieving an unprecedented reduction in demand for emergency admissions and hospital care.

Given that the driver for these cuts is the desperate financial situation confronting local Trusts and PCTs, any such investment programme (which requires the recruitment and training of additional staff, the establishment of new centres and facilities and a sophisticated management structure to match services to localised and individual patient needs) will need substantial external funding to cover capital costs and revenue for a prolonged period of "double running" until such time as the new services show themselves able to reduce the need for hospital care.

Emergency services

Even more alarming are the assumptions on where patients are expected to go if QMH is downgraded and its A&E scaled down. According to the King's Fund discussions, more than a quarter of emergencies (27 percent) are expected to be diverted to Dartford, 27 percent to Bromley, just 6 percent to Lewisham, but almost – half a staggering 47 percent – to Queen Elizabeth, already the busiest hospital in the area, with no sign of spare capacity, and an awkward journey away along congested roads.

Department of Health figures show that QEH is already handling an average of 129 admissions per general and acute bed, while Lewisham, Bromley and QMH all handle between 105 and 109.

Without some clear explanation of how this turnover of patients per bed could be dramatically increased it seems obvious that QEH is in no position to treat an extra 6,000 emergency in-patients per year, an increase equivalent to almost 40 percent of the Trust's current emergency caseload. The increase in Darenth Valley would be over 19 percent, and Bromley would face an influx equivalent to over 17 percent of its existing emergency caseload.

Despite this plan to divert thousands of patients away from QMH, there is no corresponding commitment to allocate any additional investment to expand capacity in these neighbouring hospitals. Far from investing in any additional capacity, the plan is to squeeze even more activity into the existing buildings. King's Fund seminar was told that "excess capacity at QEH and Bromley" would "absorb much of diverted emergency work at QMH at low marginal cost".

Nor does the plan correspond with the experience of staff at QMH, who at the moment frequently receive caseload diverted from QEH because that hospital lacks beds or staff.

Under the knife

Attendances at accident & emergency departments and minor injury units, SE London 2006-07		
		A&E first attendances
2006-07	Guy's And St Thomas' NHS Foundation Trust	151,801
2006-07	King's College Hospital NHS Foundation Trust	109,999
	Inner London total	**261,800**
2006-07	Bromley Hospitals NHS Trust	86,132
2006-07	Queen Elizabeth Hospital NHS Trust	98,798
2006-07	Queen Mary's Sidcup NHS Trust	**71,802**
2006-07	The Lewisham Hospital NHS Trust	144,613
	Outer boroughs total	**401,345**
	QMH as percent	17.9
Outside London		
2006-07	Dartford And Gravesham NHS Trust	83,527

Source: Department of Health May 2007

Frontline A&E services will also be stretched beyond the limit in surrounding hospitals if any significant number of QMH's 72,000 A&E attendances are diverted to already busy units in the outer boroughs. Although the plans appear to show a 24-hour urgent care centre remaining on the site, it is clear that this will not receive ambulance cases and will only handle minor injuries – leaving many more to travel to alternative A&E units.

Department of Health figures from the last few years confirm that SE London is continuing to experience one of the most rapid periods of growth in demand for A&E services anywhere in the country, with attendances up by a massive 28 percent in the last four years, and no sign of any slowing in the trend.

Number of attendances at Type 1 A and E departments, in England and in South East London, 2002-03 to 2006-07					
	Attendances				percentage increase 2002-2006
	2002-03	***2003-04***	***2004-05***	***2005-06***	
England	11,994,874	12,665,482	13,265,820	13,553,686	**13 percent**
SE London SHA	472,742	499,162	568,346	605,915	**28.2 percent**

By contrast England as a whole saw A&E attendances rise by less than half as much (13 percent): only four areas of the country experienced increases of over 20 percent – three of them being sectors of London (NE,NW, SE), and the other being Essex. **On the basis of these figures and established trends it seems completely irresponsible to expect a rapid reversal and reduction in demand for A&E – especially in SE London.**

In other words we are facing a plan for a cash-driven cut in local services that would leave an entire London borough without a front-line hospital, but also put impossible additional pressure on Darenth Valley, Bromley and Queen Elizabeth, all of which have been struggling to maintain a semblance of full-scale services as a result of the financial problems arising from inflated costs of their PFI hospitals.

And at a time when ministers have been so keen to stress the central role of "patient choice" in the NHS, the scale of public anger at the proposals, as reflected in local meetings and coverage in the local press also helps to underline the fact that the plans to slash back hospital services in Bexley not only do not arise from "patient choice" but ran flatly counter to the views of most local residents.

Clinical concerns

Despite the claims that the "redesign" of services to close most of those available at QMH is "clinically-led" there is little attention paid to the clinical consequences of the proposals.

It is important, for example, to note the implications of the proposed changes in terms of increased journey times and pressures on the London Ambulance Service. The recent study by Sheffield University academics has pointed to the potential negative impact on patients' chances of survival if they have to be transported further to hospital, and concludes:

> "Our data suggest that any changes that increase journey distance to hospital for all emergency patients may lead to an increase in mortality for a small number of patients with life-threatening medical emergencies, unless care is improved".

The explicit objective of the clinicians is to reduce local hospital services across the four outer boroughs not just to three units, but ideally to just TWO full acute hospitals to serve a catchment population of 1 million people: this is clearly re-stated in the September 26 joint briefing from the Picture of Health project. The medics have had to accept that a reconfiguration as radical as this would be politically unsaleable, and so the focus has shifted to a three hospital solution, with QMH the major loser of services.

However the eagerness of some top consultants to press for a policy that would leave the whole area desperately short of hospital beds and services does not give any grounds for confidence that the less radical cutback is any more sound in its approach of viable in terms of services.

The reduction in hospitals is based on the assumption that specialist care can be more effectively delivered with a more developed team of clinicians working from a larger unit dealing with more cases. This same assumption lies at the heart of the Darzi report for London (where he proclaims the end of the era of the district general hospital) and last year's influential IPPR report The future hospital: the progressive case for change.

However this assumption was only ever based on extremely partial evidence, while in fact only a very small minority of patients are likely to benefit from enhanced specialist treatment while a majority of patients needing emergency treatment would face additional stress, pain and unnecessary delay in travelling further for treatment.

The evidence to support the widespread assumption that bigger hospitals equal better treatment has now been reviewed in a major study by the Academy of Medical Royal Colleges, and the resulting 150-page report *Acute health care services* concludes that:

> "There is some hard evidence that outcome for a select group of patients is improved in specialist centres where surgeons can maintain their specialist skills by treating a greater number of people. People who have experienced major trauma and those requiring specialist neurosurgery and vascular care do fare better if they are treated in specialist units.

Under the knife

"However, there is conflicting evidence that specialist centres are beneficial for other kinds of surgery. At this stage, any decision to withdraw 24-hour surgical cover from some hospitals in favour of centralisation is not supported by current clinical evidence.
[…]
"The Royal College of Surgeons considers that care must be delivered as locally as possible providing there is no compromise on the safety and quality of that care. Our March 2006 report Delivering High Quality Surgical Services for the Future 75 outlined what we believe to be the three main drivers for reconfiguration:

- clinical need (for example, the need to reconfigure specialised services such as paediatric cardiac surgery, or the need to reconfigure services in smaller hospitals);
- the introduction of contestability and competition in the health service; and
- the cost of providing services.

"The RCS insists that any reorganisation of health services has a sound clinical and evidence base. Financial, political and managerial expediency must not be primary drivers for service reorganisation."

(3.11, A71, emphasis added)

There can be no great grounds for confidence in the clinical judgment of consultants who wish to ignore this medical evidence and press forward to a 2- or 3-hospital system in South East London without even considering the numbers of beds and the extended facilities that would be needed to ensure the additional caseload can be treated swiftly and safely.

The medical directors of the four Trusts issued a statement in the joint briefing document from the "Picture of Health" project at the end of September claiming that:
"We have looked at the best way to provide hospital services for the whole population. We have not been talking about which site provides which service, but rather how we can best meet the hospital needs of the 1 million people in the area as a whole." (page 2)

However we know this is only half true: they have been discussing where to reallocate services in the assumption that services at QMH will be run down. This starting assumption leaves the population of Bexley at a disadvantage from the very outset: no matter what their health needs may be, their hospital has been deemed expendible – while the other three are seen as too expensive to run down.

Interestingly there is little if any attempt to show how the people of Bexley might benefit from any improved services as a result of the proposed changes. We are repeatedly told that "no change is not an option": maybe, but that is not an argument to prove we have to accept support of the particular proposals that have been brought forward.

Management insist in their Powerpoint slides that "the case for change is now generally accepted within the local NHS and our communities". They are kidding themselves, but probably nobody else. The section below on the 'consultation' questions the evidence that any significant number of local people have been persuaded to accept the plans.

Finances

In April the "Picture of Health" Project Team gave a revealing insight into the principal factors driving their decision-making process when they published a document exploring the "Implications of Fixed Costs and PFI Schemes for Service Redesign in SE London". Noting the very substantial costs of PFI hospitals in Bromley, Woolwich and Lewisham and the extremely long-running binding agreements which restrict any possible attempt to use these assets more flexibly, the document points out that:

Under the knife

"· The sites where there is least scope to reduce fixed costs are QEH and Bromley. This suggests that redesign options that seek to increase capacity utilisation at those sites will do most to improve the financial prospects of the sector.
· The site where there is greatest scope to reduce fixed costs is QMS. If hospital infrastructure is reduced at QMS then the surplus estate can be sold or leased with a resulting improvement in the recurrent financial position across the sector.
· Lewisham must, irrespective of service redesign, seek to realise value from its 'old' estate. Meanwhile the imperative for the trust is to ensure the highest possible utilisation of the services provided in the new PFI building. Currently a large part of the new capacity is idle."

In other words the proposals for the redesign of services in Bexley are little or nothing to do with the health needs of Bexley residents or the quality and affordability of care at Queen Mary's Sidcup: the decisions flow largely from the succession of extremely unwise investment decisions made by other Trusts in other boroughs that have saddled themselves with huge overhead costs for the next 30-38 years.

While the process is driven above all by cash pressures, it is important to draw out the financial consequences of the proposed changes

Steering all emergency cases away from QMH would of course have a serious financial impact as a result of the government's market-style "payment by results" system which means hospitals only get paid (on a flat rate tariff) for the patients they actually treat. Removing over 12,600 emergency admissions from QMH, even on a conservatively estimated average tariff cost of £2,000 each, would switch over £25 million away from the Trust's revenue budget, and pull the rug financially from beneath the Trust, making it difficult to sustain other services.

In addition the loss of first attendances at A&E, which currently a tariff payment of £81 per episode (according to the Darzi Report technical paper, p23) would potentially cost QMH as much as £5.8 million if all 72,000 cases were transferred elsewhere, resulting in a massive combined reduction in the resources available to maintain other services at QMH.

The most recent figures show QMH projecting a deficit this year of £6.15m even before any decision that would cut off future income. Already the process has begun, with the PCT decision to open a new primary care urgent care unit on the QMH site, which the Trust expects will siphon off around £1.5m per year in revenue.

The King's Fund seminar heard that among the perverse incentives built in to the current financial and organisational regime in the NHS is the fact that when services are transferred from hospitals into the community and primary care, NHS Trusts lose more income than they can hope to recoup through reduction in costs. Every service switched away destabilises local services.

At face value the management plan is a nonsense: there is no sensible financial case for switching services away from one of the lowest-cost and most efficient of the local hospitals to focus them in the high-cost PFI hospitals. Only when we take account of the full misery of the PFI contracts, and their total inflexibility for a whole generation to come , is it clear why QMH has been singled out as the weakest link.

Putting the "con" into "consultation"

The joint briefing document from the "Picture of Health" project at the end of September makes the ludicrous claim that "We have already listened to local people's view on health services, which has resulted in the 'people's priorities' for service development": nothing could be further from the truth. The process has been one of hiding the level of public opposition and wilfully distorting the findings of the exercise that took place to give the impression of majority support for the views of a tiny minority.

Under the knife

The report written up by Ipsos MORI from the laborious "consultation" exercise is especially revealing in its clasping at straws of comfort.

Interestingly the term "choice" or "patient choice" does not seem to have been put forwards either as a potential question by those conducting the consultation, or by those adding their own comments. There is really very little, if anything, in the consultation report to support the conclusion that local people – especially in Bexley – are eager to see services at their local hospital closed and the consequent longer journeys to access more pressurised services in other hospitals. The shoddy and shallow report avoids even defining who or what might be regarded as a 'stakeholder' or how many people participated in the claimed 182 "consultations", and includes this tell-tale sentence:

> "Stakeholder groups, on the other hand, do not appear as concerned as residents about service redesign having an effect on the quality of care delivered." (page iv)

If 'stakeholders' are not residents, and do not share the same concerns as residents, ***who are they?*** And why should we take any notice of what they may or may not say or think?

And why was it thought to be appropriate to lump together the much larger number of meetings in the boroughs which do NOT stand to lose access to their local hospital services with the much *smaller* number of meetings in Bexley, where this is the key issue for local people?

The Ipsos/MORI report focuses almost obsessively on small numbers of responses which say what the sponsors wanted to hear, giving a wilfully false impression of the process: take this list of minority views (as few as 3 percent overall) portrayed as mainstream opinion (page iv).

- 7 percent cite 'More care in the community e.g. at home or locally' as one of their top three most important issues (20 percent among groups who provided a response to this question),
- 3 percent cite 'Services should be based locally/closer to home' (10 percent among groups who provided a response to this question),
- and 3 percent cite 'Move resources out of hospitals into the community' (8 percent among groups who provided a response to this question).
- Job security and staff morale (6 percent),
- public and staff education about health service redesign (5 percent),
- and better integration and working partnerships (5 percent) are other issues which are commonly mentioned as important.

It might be more accurate to point out that the issues were NOT raised by 93 percent, 97 percent, 97 percent, 94 percent, 95 percent and 95 percent respectively of those taking part in this largely spurious consultation. **Where else but in the process of trying to sell a hugely unpopular hospital closure would public approval ratings of 3 percent be depicted as a mandate of support?**

Worse, the 3 percent who argued for services to be based closer to home quite possibly had no idea that in saying so they would be interpreted as supporting the rundown of a district general hospital that would CLOSE services close to home and force many patients to travel further for treatment.

Again on page vi we are told how important are the views aired by one in seven, one in ten and one in twelve of those responding.

Only on three issues – that there should be walk in primary care centres (73 percent) more services offered in pharmacies (65 percent) and a bigger role for nurses (64 percent) does the report suggest that the consultation proposals enjoy a substantial body of support, and even here we do not know where or in what circumstances people agreed with the idea.

Indeed on page vi the report reveals that 58 percent of people prefer to get their outpatient and other services grouped together in hospitals, while just 36 percent opt for fewer larger hospitals and more services delivered through primary and community services. Ipsos/MORI is grudgingly forced to admit that there is a credibility issue in selling the reconfiguration proposals:

> "Previous Ipsos MORI research, though, does suggest that there may be some resistance within the public to this fundamental shift in service delivery. **In research conducted for NHS London, a greater proportion of residents indicated they would prefer the NHS invest in services developed together in hospitals, as they are now, rather than invest in more health services delivered closer to home and fewer, but larger, hospitals.**
> "Further, in the feedback from the public consultation in South East London we see that respondents are not as keen on having GPs in fewer, bigger centres alongside other services as they are on other proposals such as walk-in centres. This suggests further consultation on perceptions of GP accessibility will be key to meeting the needs of patients and the public."

This is a more realistic assessment than the bulk of the claims and assertions in the Ipsos/MORI report: in reality there is no popular support for the proposals, even when large numbers who would be marginally affected if at all are included in the numbers.

Even the expert spin merchants have not been able to manufacture any pretence of a public mandate for the changes. NOBODY is asking for their local hospitals to be closed, and when given a sensible choice of policy, most people prefer the current pattern of service provision to the new plans being drawn up at such labour and expense by teams of PCT and other managers, accountants and lawyers.

Interestingly the IPSOS/MORI report also reveals a substantial degree of healthy scepticism among older (and generally better-informed) local people on the genuine motives behind the reconfiguration process:

> "Older people's groups were concerned about privatisation and financial waste. Some think the changes are driven by the desire to save money rather than improve services; others think the 'real' agenda of the reforms is ultimately to privatise the NHS. Concerns are raised about the cost of Private Finance Initiatives, the takeover of general practices by private healthcare companies, and the establishment of Independent Treatment Centres, which some see as the break-up the NHS prior to privatisation. They object to the idea of the NHS as a business, particularly one that is 'in deficit'." (page 12)

Conclusion

There is no public mandate, clinical case or valid financial argument for running down services at Queen Mary's Sidcup – the whole case hinges on the pattern of PFI investment and the dead weight of debts and overhead charges dragging down Trusts in Bromley, Greenwich, Lewisham and Dartford. The pretence that the reconfiguration has any popular support or offers any benefits to the people of Bexley is both cynical and hollow.

The argument that "no change is not an option" is not a justifiable argument for THESE changes, especially for THIS local population in Bexley which stands to be the main loser in the reorganisation. The King's Fund seminar ended with proposals for payments ("income supplements") to "bridge the gap" for service providers struggling for financial viability. We would go further: the government which promoted PFI should bail out the Trusts in trouble with PFI bills – and allow QMH to continue to deliver health services to the people of Bexley.

October 23 2007