DRAFT INTERIM FINDINGS OF THE INDEPENDENT LEWISHAM PEOPLE'S COMMISSION OF INQUIRY

HEARING:
SATURDAY 29th JUNE 2013
BROADWAY THEATRE, CATFORD, LONDON, SE6 4RU

PANEL:
MICHAEL MANSFIELD QC (CHAIR)
BLAKE MORRISON
BARONESS MARY WARNOCK

PREFACE

The Panel heard from a wide range and large number of witnesses who had submitted written testimony in advance and appeared on the day to give evidence in person. They were questioned by a team of qualified barristers from Tooks Chambers and the Panel. A list of these witnesses can be found at Appendix A. All those not giving live evidence on the day provided written evidence and some excerpts from pre-recorded filmed accounts of their evidence were shown on the day. This list is Appendix B.

It is intended that the final report of the Panel's findings will include all this material.

During the hearing it became clear that further documents were relevant and efforts would be made to obtain them. Once this has happened and the documents considered the report will be finalised.

Meanwhile these findings by the Panel are formulated in general terms without being referenced to the underlying evidence on which they are based. This will occur in the final version. This is done in good faith because of the urgency of the situation relating to the Trust Special Administrator (TSA) recommendations which have been accepted by the Secretary of State for Health, Jeremy Hunt. There is also a Judicial Review currently underway which raises specific issues about the legality of the decisions taken by the Minister based on those recommendations. For this reason the Inquiry did not consider the question of legality.

It is to be noted that the Minister, representatives of the Department of Health and the TSA were all invited to attend or at the very least submit responses. The People's Commission received nothing. This has relevance to our findings on the consultation process which equally failed to engage with the community.

REMIT

Terms of reference
The Commission will examine:

1a The original vision and principles underpinning the NHS, with particular reference to the community it serves and its accountability to that community.

1b The extent to which the vision and principles have been eroded by the imposition of the internal market and recent moves to open the NHS to external market forces; and the degree to which these changes have been openly debated.

2 The extent to which this process has culminated in the potential destruction of quality healthcare for the community of Lewisham and South East London, exemplified by the proposals for Lewisham Hospital.

THE MINISTER'S DECISION

1 that Lewisham Hospital be downgraded from major hospital status,

2 that A&E, all acute admitting wards including the children's wards, intensive care and all emergency and complex surgery be closed,

3 that 60% of the Lewisham Hospital Estate be sold off,

4 that a small but safe A&E service with 24/7 senior emergency medical cover be established,

5 that a small midwife-led birth unit without obstetric medical or emergency back up be established; and

6 that a walk-in paediatric urgent care service be established.

FOUR THRESHOLD TESTS

The Government set down four threshold tests in relation to decisions to close major services:

(i) Support from GP commissioners (Clinical Commissioning Group or CCG)
(ii) Clarity on the clinical evidence base for improvement
(iii) Strengthened public and patient engagement in the consultation process
(iv) Consistency with current and prospective patient choice – ie justification for any restriction of choice

PANEL FINDINGS

Having considered the evidence presented to the Panel we find as follows:

A WITH REGARD TO DEMOCRATIC ACCOUNTABILITY (THE DEMOCRATIC DEFICIT)

1 That the process of privatisation has produced fragmentation of the NHS and a diminution of democratic accountability never envisaged nor intended by the founders of this service.

2 That the areas of the NHS which remain for Parliament to decide are vulnerable to undue vested interest influence in which a substantial number of the decision makers themselves stand to profit from the commercial links they have from companies in the private medical sector. This conflict of interest subverts the democratic process.

3 That in respect of the decisions regarding University Hospital Lewisham the consultation exercise was a sham. In many cases there was none (Dr Chidi Ejimofo, consultant at Lewisham A&E). Where it did take place, notice was inadequate, no minutes were provided, and objections were overruled or dismissed (Jessica Ormerod, Lay Chair Maternity Liaison Committee). The consensus of those who attended consultations was that they were being told what had been decided.

There was no analysis whatever of children's needs and therefore recommendations on children's services formed no part of the consultation.

During the TSA engagement process with clinicians on maternity services and whether and where there would be maternity closures the model of a midwife-led maternity unit without obstetric and emergency back-up had been ruled out as too costly in advance and was not consulted on nor did it appear in the Draft TSA Report. And yet this was the proposal for the Lewisham site in the Final TSA Report the proposals from which were adopted by the Secretary of State, even though the TSA calculated that this would run at a loss, requiring annual subsidy of £800,000 because it would only cater for at maximum 12% of births - less than 500 per year (Dr Ruth Cochrane's related testimony).

As a result of this *volte face*, the adopted option was never consulted on with clinicians or the public.

This fails one of the Government's own threshold tests for such a scheme.

4 There was unanimous opposition from Lewisham GPs and the CCG to the option to close services at Lewisham Hospital. All the other CCGs raised significant concerns about the closure of services at Lewisham A&E and the lack of information on patient flow following Lewisham closures, pointing to the knock-on impact of A&E attendances in other hard-pressed A&Es locally, and questioning the lack of work on patient flow.

This therefore fails a further threshold test.

B WITH REGARD TO RATIONALE

1 That the decision to downgrade Lewisham in the manner described above has nothing to do with the provision of healthcare in SE London. Lewisham has consistently achieved standards of excellence recognised within the medical community and the community using the hospital (e.g. even within the last month the maternity services have been assessed at CNST Level 2 (Clinical Negligence Scheme for Trusts). This generally high level of clinical care is admitted by the authorities (letter 13 February 2013 from the Department of Health NHS Medical Director Professor Sir Bruce Keogh). The Panel finds this to be deplorable and contrary to the ethical obligations which arise from domestic and international legal instruments, e.g. the International Covenant on Economic Social and Cultural Rights. (Article 12 pursuant to the UNDHR (United Nations Declaration of Human Rights) enshrines the right of everyone to the enjoyment of the highest attainable standards of physical and mental health and this in turn requires availability, accessibility, affordability, acceptability.)

2 That the decision is based entirely on economic considerations. This is also made clear in the letter cited above and is equally deplorable because it is a deceit.

Firstly, Lewisham has not mismanaged its finances in any way and is not financially insolvent.

Secondly, the TSA was allocated the task of examining an entirely separate situation (the SLHT - South London Healthcare Trust). This comprises three hospitals (Princess Royal University Hospital Farnborough, Queen Mary's Hospital Sidcup and Queen Elizabeth Hospital Woolwich). By June 2012 this trust was running at a loss of £1.3 million per week.

Thirdly, this loss is largely due to onerous and misconceived PFI contracts (private finance initiative) which have nothing to do with Lewisham but everything to do with government policy.

3 That therefore the Minister's decision is an unvarnished sleight of hand to reconfigure finances not healthcare. The estate sell-off is consequently “a blatant land grab”, in the words of one witness, and is thoroughly irresponsible.

4 That the Panel's conclusion at paragraph 3 above is reinforced and informed by the compelling evidence of an independent witness and a report published during the first week of July 2013 by Professor Allyson Pollock and others at Queen Mary, University of London. The report is entitled *Blaming the victims: the trust special administrator’s plans for south east London*. There are two crucial factors disclosed by the analysis: 'The exorbitant, increasing and yet unclear cost of longstanding PFI deals' which incur massive costs of borrowing from banks, at least one of which has been bailed out by the taxpayer, and the requirement for non-foundation hospitals to return any surpluses to the Treasury. The report concludes that 'the government is sacrificing a thriving local hospital in order to protect the interests of bankers, shareholders and corporate stakeholders.' As a result the primary recommendation made is that the TSA regime for SLHT be revoked. These observations have wider ramifications for the 700 PFI contracts in existence throughout the NHS.

5 That this report echoes the findings of another inquiry into another NHS hospital – the Francis Report into Mid-Staffs – where it was observed that financial targets had become a greater priority than patient care.

C WITH REGARD TO IMPACT

1 That the proposals demonstrate a lamentable absence of evidence-led research. A necessary precursor for any reconfiguration of services is an awareness of the nature of the community being served and its needs. This has not been undertaken on any systematic and scientific basis (e.g. the 2-3 minute travel time estimates relating to removed facilities are particularly risible). Children's services were omitted altogether.

2 That where the proposals envisage new facilities there is no evidence to show how they would be implemented, nor what impact the removal of current resources would have on the community.

There is either a flawed use of old research and spurious use of statistics (e.g. saving "100 lives" per annum) or no evidence at all.

For example, use was made of research on data for emergency admission figures from 2005-6 (Aylin *et al.*, 2010, cited by Dr John O'Donohue) to argue that centralisation of services in South East London would save 100 lives per year (by reconfiguration including the closure of Lewisham Hospital's acute and emergency services). This ignores the point that significant changes had already been made in south east London 2009-11, centralising specialist services for stroke, heart attack, vascular emergency and major trauma. This was not taken into account, thereby introducing the risk of double-counting the estimate of numbers of lives to be saved. Secondly, simple maths was applied to these old research figures to extrapolate from a national estimate of lives saved to what a notional estimate for south east London might be. No reference was made to the researchers' own caveats. This substantially undermines the claim that 100 lives will be saved.

In relation to the future of paediatric care in SE London, the final paragraph of a letter from Professor Sir Bruce Keogh to the Minister dated 30 January 2013 is a prime example of pure speculation. Keogh states that 'any alternative' [to the respected high quality paediatric service in place in Lewisham] should be 'even better … in terms of outcomes and patient and parental experience...'. He then says this would be 'possible' and outlines several hypothetical service design aspects not previously considered by the TSA's planning exercise and therefore not consulted on. (Dr Tony O'Sullivan Consultant Paediatrician, Director of Children's Services Lewisham).

This fails yet another of the four threshold tests.

3 That there has been an unexplained unwillingness to reveal data despite repeated and considered requests (Dr John O'Donohue Consultant Physician and Dr Donal O'Sullivan, Public Health Consultant).

4 That alternatives put forward in the letter of interest by the Lewisham Healthcare Trust were either rejected or ignored.

D WITH REGARD TO SPECIFIC PROPOSALS

1 That the proposal for a small and safe A&E is a contradiction in terms and clearly does not accord with basic clinical requirements. It is not recognised by the College of Emergency Medicine. It places the patient at risk and involves travel to more distant facilities already under intolerable pressure.

This breaches the 4th threshold test.

2 That the midwife-led birth unit presents clinical nonsense. All the witnesses both lay and professional were adamantly opposed to this because it is never possible to predict satisfactorily what complications might arise and require urgent assistance within a matter of minutes. This creates an environment of uncertainty and insecurity for pregnant women. Lewisham serves a diverse and impoverished community which cannot accommodate these changes. It is within the 8% most deprived of the 326 local authority areas in England.

This also breaches the 4th threshold test.

3 That a walk-in paediatric urgent care service has no clear parameters, is unsafe and unsustainable. Any such unit needs to be co-located with an Emergency Department. Additionally standalone paediatric ambulatory care will be expensive.

This also breaches the 4th threshold test.

There were many testimonies from patients with acute conditions ranging from Parkinson's to sickle cell who will suffer serious adverse effects if the decision to downgrade is implemented.

The panel is further concerned that an admirable record of training will also fall victim to these proposed changes.

OVERALL CONCLUSIONS

- **That there is no legitimate medical or economic basis for the Lewisham decision by the Secretary of State for Health and that none of the government's 4 preconditions have been met.**

- **That the Minister and his Department have shown a cynical attitude towards the people of Lewisham, in concealing the real motivation for the reconfiguration, and the paper-thin pretence that patient care will improve and patient lives saved.**

- **That it is incumbent upon the present administration to honour the original vision for the NHS:**

  'It will provide … all medical dental and nursing care- rich or poor, man woman or child can use it or any part of it. There are no charge … no insurance qualifications. But it is not a charity. You are all paying for it mainly as taxpayers …' *(1948 Bevan letter to every household)*

- **That universal healthcare free at the point of delivery should remain the bedrock of government policy.**

- **That healthcare is not a commodity which can be subject to the exigencies of the marketplace and the profit motive.**

- **That patient needs and care is the paramount and determinative factor in healthcare provision.**

APPENDIX A

LEWISHAM PEOPLE'S COMMISSION OF INQUIRY

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WITNESS STATEMENTS AND SUPPORTING DOCUMENTS

APPENDIX B

LEWISHAM PEOPLE'S COMMISSION OF INQUIRY

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WRITTEN STATEMENTS AND SUPPORTING DOCUMENTS
