BISHOP OF WOOLWICH AND COLLEAGUES

RESPONSE TO THE DRAFT PROPOSALS OF THE SOUTH LONDON HEALTHCARE TRUST SPECIAL ADMINISTRATOR AS THEY RELATE TO LEWISHAM

This response is submitted by the Bishop of Woolwich with colleagues. The Bishop of Woolwich has oversight within the Church of England Diocese of Southwark for the 90 parishes of the Woolwich Episcopal Area, covering the London Boroughs of Southwark, Lewisham and Greenwich, together with parts of Bromley and Bexley. This response focuses specifically on the proposals of the TSA as they relate to University Hospital Lewisham. A response focusing on the impact on Queen Elizabeth Hospital, Woolwich, has also been submitted by the chaplaincy team there.

INTRODUCTION

We are aware that a number of specialist responses to the draft proposals have already been made, or are being prepared, by clinicians and legal experts. For the most part, we shall not seek to duplicate the points made in them. This document, however, is also a specialist response; it is framed in the light of the Gospel injunctions that the followers of Jesus Christ should have a special care for the most vulnerable of God's children; those who have least power to make their voices heard in the world. This response will therefore focus on the perceived impact of the draft proposals on those in the communities affected who are old, poor, disabled and mentally vulnerable, and makes no apologies for doing so.

In addition to this overriding focus, our reading of the proposals and our access to the responses of others have given rise to two main concerns which cannot be ignored. The first is that of process, in that there are aspects of the TSA's process that are, to our mind, severely flawed, compromising natural justice. The second relates to content, where arguments seems to us to be in several places seriously flawed, in that statements are made which are either unattested by evidence, or seem to be built on evidence that does not substantiate the case asserted.

This response will deal first with these two areas, and then move to those aspects of the draft proposals that seem to us to impact particularly on the most vulnerable in society.

MATTERS OF PROCESS

The unwarranted extension of the TSA's brief

The first matter that presents itself is the inclusion of University Hospital Lewisham in the proposals at all. Leaving quite aside the suggested justification of doing so in the light of UHL's supposed future financial difficulties – which can only represent a very small fraction of its annual budget – there is the question of how the Special Administrator's brief can be extended to a Health Trust not subject to the Special Measures that are the basis of his remit. This would seem to be in direct conflict with the Secretary of State for Health's reply in the House of Commons in July last year, where he made clear that "The trust special administrator's regime is not a day to day performance management tool for the NHS or a back door approach to re-configuration"[1]. The part of the proposals relating to UHL must therefore be considered fundamentally flawed.

[1] Official Report, 12 July 2012; Vol.548, c.48WS

The lack of a proper Health Equalities Impact Assessment

The second matter relates to the issue of the Health Equalities impact assessment – or rather to the lack of one. Our understanding is that there is a legal obligation upon the TSA to have carried out an HEIA before releasing the document for consultation. The piece of work carried out by Deloitte's in Appendix H of the proposals is self-confessedly only a scoping report, and thus does not qualify. The Appendix points out, in a number of places, where further detailed work needs to be carried out properly to address the legal requirements. This is therefore an additional underlying flaw to the entire proposals. Particularly, it gravely undermines the proposals' claim to satisfy the Secretary of State for Health's fourth criterion, 'that any proposals should improve patient choice'. Without a proper impact assessment, how can any such claim be made?

Patchy distribution of the Proposals for consultation

Persistent feedback at Consultation meetings has been that hard-copy distribution of the proposals – which of course contain advice on how to respond to them – has been poor and patchy. This will of course differentially disadvantage that portion of the community with limited access to the internet – the poorest of it.

Lack of consultation of others affected

Anyone with any knowledge of the health economy of South East London would know that changes to one A&E would inevitably impact on others in the area. It is therefore surprising that among the multiple references to King's College Hospital in the report, no reference is made to any consultation of clinical staff and management on this issue at the Hospital, whose already stretched A&E Department would receive at least part of the proposed overflow from UHL.

It is notable that the only place in the report where this issue is considered is in the HEIA scoping exercise by Deloitte's in Appendix H, where it is stated[2] "The transformation of services could potentially impact patient experience. For example, a reduction in A&E services at Lewisham could place increased pressure on A&E capacity at other hospitals, such as QEH, PRU and King's Hospital. If the transformation imposes additional constraints on these providers, this could potentially impact upon the quality of care they deliver.....These impacts will need to be considered as part of a full HEIA assessment". It is not Deloitte's who are at fault; they have pointed out the possibility to the limit of their ability within the remit of their scoping exercise. What is extraordinary is that the TSA has been prepared to make a recommendation – the closure of Lewisham A&E – of such moment without a full assessment as prescribed by law.

Taken together, these four issues can only give rise to grave concern as to the integrity of the process itself.

[2] Appendix H, para 3.4.2. page 23

MATTERS OF CONTENT

The competence of the proposed Lewisham Urgent Care Centre

It would seem that in calculating what proportion of Lewisham A&E's existing workload the proposed Urgent Care Centre could absorb, the TSA has made a major underestimate.

The report claims that UHL A&E receives on average 2 'Blue-light' ambulance attendances per day. However, Consultants at the A&E report[3] that Lewisham A&E receives on average 4-5 'Blue light' ambulance attendances per day. In addition a recent analysis of Lewisham Resuscitation room records apparently reveals a daily average (2011-12) of 10-11 patients per day being admitted to the Resuscitation room for intensive/critical level care. This latter figure is a daily rate of emergency treatment approximately five times that implied in the Report.

We further understand that a recent review of case mix by Lewisham A&E Consultants[4], estimates that only 30% of the total attendances to the present-day combined A&E and UCC could be safely managed in a standalone Urgent Care Centre.

Taken together, these two findings must place in question the Report's assertion that the proposed UCC would treat 77% of Lewisham A&E's existing patients. This assertion is a major plank of the Report's argument that the changes proposed could be made without unduly affecting patient choice or overloading already stretched A&E Departments in South East London.

The doubtful adequacy of the Community commissioning strategy

The Report[5] describes the Community Based Care strategy for south east London as "a key building block in developing the draft recommendations". This strategy aims, through the new NHS Commissioning arrangements, to enhance the capacity of joined-up preventive services so that pressure on acute services in the area will lessen. The strategy is stated to be taking place over the next five years. The concern must be that this period is longer than the 3 year period projected for the reduction in capacity of Lewisham acute services outlined in the proposals. The proposal is therefore effectively to reduce acute capacity before its community replacement is fully developed. The problem is in fact more serious than that. It is well known that community services, being more disaggregated than those in the acute sector, take longer to develop and 'bed in'.

[3] Lewisham Emergency Department response to the Trust Special Administrator
[4] ibid
[5] Para 108, page 39

THE IMPACT UPON THE MOST VULNERABLE

Increased travel time

The proposed closure of Lewisham A&E and critical Maternity Care services have obvious implications for the people of Lewisham Borough, who, together with their families and friends, will have to travel either to Kings', QEH or PRU for those services. The increase in travel times for Lewisham residents is explicitly referred to in the Report[6]. It is therefore disappointing that the sections of the proposals that relate to increased travel times are based on such flimsy and misleading evidence. In Appendix H, page 222, Deloitte's state "Private transport times are calculated on the basis of average speeds and travel times during *periods of no traffic* (emphasis ours). They add "Travel times may be higher during periods of busy traffic" - a breathtaking understatement in the circumstances. There is no indication in the main body of the proposals that the (minimally) additional travel times quoted in respect of blue light and public transport journeys are calculated on any other basis, as quoted in table 30 in paragraph 176. Again, the fault is not Deloitte's. They are clear [7] that 'further detailed travel analysis will be necessary to understand more fully the travel access implications' of the proposed closure of UHL's services.

In Appendix 1 to this response is a Table examining the impact of the proposed closure of UHL A&E upon travelling times for patients and their visitors within the London Borough of Lewisham. Six representative sites within the Borough were chosen as starting points for journeys – Ladywell station, Sydenham Green Health Centre, Lewisham College, Lee Green, Bellingham, and Downham Health Centre.. The distance by road was in every case included from each point to the various Hospitals containing A&E departments – UHL itself, and King's, QEH and PRU. The Transport for London site was consulted to discover journey times and methods. It is notable that this exercise, though detailed, only took a few hours, which makes the superficiality of the Report's data on this crucial issue all the more striking.

We have focused on the public transport journeys and times because public transport is overwhelmingly the option of the poorer sections of society, who have less access to cars. What the exercise reveals is a very substantial difference between reality and the TSA's own estimates of journey time outlined in Table 30, already referred to. This therefore, together with the cost of that travel, impacts on the poor, and disabled and elderly people, who will find it more difficult to visit those in Hospital, with adverse effects, as we know, upon the speed of their friend or family member's recovery.

As might be expected, in not a single case is the travel time from any one of those starting points to any outside Hospital, <u>less</u> than it would be from those places to Lewisham Hospital. The additional times taken from the 6 chosen locations to an A&E other than UHL's were 32, 14, 28, 27, 25 and 30 minutes respectively more than it would have taken to go from those places to Lewisham A&E. Likewise, in not a single case was the complexity of the journey less to any outside hospital than to UHL, and in terms of the changes of transport required, was often double or treble those needed to travel to UHL.

It is not surprising that Deloittes remarked[8] "In terms of the impact on patient choice, the indicator considered was the level of choice and ease provided to the patient at every stage of interaction with the hospital. All proposed options with four 24/7 acute emergency admitting hospitals impacted negatively compared to the option of developing five 24/7 acute emergency admitting hospitals".

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[6] Appendix H, para 3.4.4. page 24
[7] Appendix H page 22 Table 3 'Travel considerations'
[8] Appendix E, paragraph 13

The threat to joined up care

Lewisham is a standard-bearer for the integration of community services with those of acute care. The recent integration of the Lewisham Hospital NHS Trust and Lewisham Community Health services into the Lewisham Healthcare NHS Trust has enabled care for the most vulnerable patients to be significantly improved. Liaison between this combined body, Lewisham Council services and the South London and Maudsley Mental Health Trust services, is likewise well-developed.

The irony is that in many ways, services in Lewisham are already fulfilling two of the stated aims of the proposed Community based care strategy referred to in the proposals[9]. The first is "that people living in south east London will know that their GP is working within a multi-disciplinary group of health professionals to co-ordinate and deliver care, incorporating input from primary, community, social care mental health and specialists". The second is that they will "be confident that as soon as they are referred to hospital their Community Based Care Team will be working with staff in the hospital to coordinate an individual discharge plan, including intermediate care, reablement and rehabilitation, to support efficient discharge from hospital within 24 hours of being declared medically fit, knowing they will receive the right continuing care in the community".

The reason that this is ironic is that this two-way link between local acute services and those in the community can only be gravely compromised by the proposed transformation of Lewisham Hospital into an elective care centre, in the following ways:

1. The link between children admitted to A&E and the local Health Visiting service through the Hospital HV liaison worker will no longer be 'in house' but will have to function across two and possibly three different Trusts. With no obvious local A&E, it will also be easier for abusive or neglectful carers intentionally to evade local networks by going to a number of different A&E Departments. Both factors will weaken the network surrounding children at risk;
2. The links built up between the Hospital and local Social Services over the discharge of babies born prematurely or with a disability (with the closure of the NICU[10]) will be compromised for the same reason. The same will hold true for the discharge of elderly patients into the community. The financial arrangements for the community support of these vulnerable groups will also be complicated by cross-border issues that will make joint agreements between Health Trust and Local Authority / Mental Health Trust more complicated to create and maintain. It is these joint arrangements that prevent duplication of services, also thus saving money;
3. For people with fragile mental health, the absence of the local crisis service provided by the A&E is particularly worrying. Their capacity to negotiate complicated transport arrangements when in crisis is minimal; their link to a local community psychiatric support service following acute intervention will likewise be more remote under the draft Proposals. Their disadvantages will be compounded were the Ladywell Unit to vanish because the site, it would appear, has been designated as part of the proposed sell-off of property by the TSA.

The groups of people who would be affected by this dislocation of local networks are thus precisely those most vulnerable to such dislocation. Babies, children, elderly and mentally infirm people are least likely to have the social, organisational and financial networks that might compensate for their absence in the wider community.

[9] Figure 17, paragraph 108
[10] Neonatal Intensive Care Unit

CONCLUSION

The NHS has been, and needs to be, a changing organism. Changes in the demographics of its population, the emergence of new techniques and technologies, and of new health conditions mean that this cannot be otherwise. However, the magnitude of the impact of any change, particularly on the most vulnerable elements of the population, places a heavy responsibility on anyone proposing that change. It is with regret that we have to say that the Trust Special Administrator has not taken that responsibility on board. The flaws in process and in the evidential base outlined in this response and by others more technically qualified than ourselves, and the negative impact of the changes proposed on the most vulnerable elements of society, in our view undermine the arguments he makes for the transformations proposed to the services provided by University Hospital Lewisham.

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APPENDIX – TABLE 1 – Analysis of the impact of the proposals on journey times

FROM	TO - HOSPITAL	ROAD MILES	METHOD	JOURNEY TIME	ADDITIONAL JOURNEY TIME
Ladywell Station	Lewisham	0.7	On foot	< 10 mins	-
Ladywell Station	Kings	4.9	1 Bus	42 mins	32
Ladywell Station	QEH	4.5	2 Buses	50 mins	40
Ladywell Station	PRU	8.3	2 Buses	52 mins	42
Sydenham Green Health Centre	Lewisham	2.6	1 Bus	27 mins	-
Sydenham Green Health Centre	Kings	4.7	O'grnd, 1 Bus	41 mins	14
Sydenham Green Health Centre	QEH	6.8	O'grnd, U'grnd, 1 Bus	55 mins	28
Sydenham Green Health Centre	PRU	7.3	3 Buses	68 mins	41
Lewisham College	Lewisham	1.5	1 Bus	22 mins	-
Lewisham College	Kings	3.7	2 Buses	55 mins	33
Lewisham College	QEH	4.6	3 Buses	50 mins	28
Lewisham College	PRU	9.4	2 Buses	60 mins	38
Lee Green	Lewisham	2.2	1 Bus	13 mins	-
Lee Green	Kings	4.6	2/3 Buses	40mins	27
Lee Green	QEH	4	2/3 Buses	40 mins	27
Lee Green	PRU	7.5	2 Buses	60 mins	47
Bellingham	Lewisham	1.9	1 Bus	25 mins	-
Bellingham	Kings	5.8	2 Buses	57 mins	32
Bellingham	QEH	6.4	2 Buses	69 mins	44
Bellingham	PRU	6.2	2 Buses	50 mins	25
Downham Health Centre	Lewisham	3.1	1 Bus	30 mins	-
Downham Health Centre	Kings	7	2 Buses	60 mins	30
Downham Health Centre	QEH	7.5	3 Buses	76 mins	46
Downham Health Centre	PRU	6.5	3 Buses	78 mins	48

Times and journey details taken from the TFL website