01 February 2013

Professor Sir Bruce Keogh
NHS Medical Director

Dear Professor Sir Bruce Keogh,

We noted with great interest your letter to the Secretary of State for Health dated 30th January 2013[i] following his request for an independent clinical view on the recommendations by the Trust Special Administrator (TSA) for South London Healthcare NHS Trust (SLHT). The Secretary of State for Health's decisions were influenced by your advice, including the amendments made to the TSA's recommendations regarding Lewisham Healthcare NHS Trust.

We write with particular reference to the Secretary of State's decision to recommend the downgrading of University Hospital Lewisham's (UHL) emergency admissions and maternity services. We consider it a matter of public interest that you make available the evidence on which you have based your advice to the Secretary of State. This advice may ultimately have proved pivotal, since it has underpinned the assertions he made during the announcement to parliament on 31 January and has therefore provided clinical justification for the changes now proposed at UHL.

1. We would be grateful if you would supply us with the clinical evidence behind the Secretary of State for Health's claim[ii]:

   "Already, her constituents who have a stroke or a heart attack do not go to Lewisham hospital. They go to Tommy's or Guy's or other places where those specialist services can be delivered, and they get better treatment. We are expanding that principle through what I am announcing today, and it will save around 100 lives a year. That is something that she should welcome."

   In your letter to the Secretary of State, there is no mention of, or clinical justification for, the assertion that extending 'that principle' would save around 100 lives a year.

   We have investigated the origin of this assertion. A similar assertion has been made by NHS London: *Adult emergency services: Acute medicine and emergency general surgery; Case for change*.[iii] In pages 16-17, the main source for this assertion is the analysis performed by Aylin et al of the Dr Foster Unit at your own institution[iv] of 4.3m emergency admissions from 2005-6. Reference is also made to smaller studies which present similar results [v] [vi] [vii].

The interpretation of the Aylin study by NHS London ([viii]page 17) is as follows:

In a national study Aylin et al found that this effect is of the order of 10% nationally for in hospital mortality, and may be even greater if the period extended to 30 days post admission.

London data is [sic] in line with these findings. This suggests that across London there will be a minimum of 500 deaths each year which may be avoidable if services functioned more effectively.

From the Aylin study, the excess mortality for England is estimated as 3369 deaths. We can see how, proportional to population share, a London figure of 500 can be derived from this by NHS London as above, and a figure of 100 could be derived for SE London for use by the Secretary of State for Health.

But if we examine the Aylin study itself from which this figure was derived, there are fundamental flaws with this deduction.

<u>The calculation of excess mortality makes an unwarranted assumption:</u>

On the assumption that patients admitted at the weekend have the same risk of death as those admitted on weekdays, we estimate a possible excess of 3369 deaths (95% CI 2.921 to 3.820) occurring at the weekend for 2005/2006, equivalent to a 7% higher risk of death.

This is indeed a heroic assumption: that patients admitted as an emergency to hospital have the same risk of death (prior to admission) as patients admitted during the week. In the discussion, the authors themselves acknowledge the limitations of this assumption:

There could have been differences in case mix between patients admitted during the week and at weekends. We attempted to take some account of case mix in our model, but there may be still some residual confounding, which could lead to either an overestimation or underestimation of risk. There were indeed fewer patients admitted on average at the weekend, and this might point to a different case mix for which we have not adequately adjusted.

A major weakness of the study is the lack of calculation of severity score of the presenting illness. This cannot be resolved without the source data. A proper analysis would also require the severity score at time of admission and the duration from point of admission to death. The fact that the daily emergency admission rate at the weekend is only 75% of that during the week may well indicate that patients who present at the weekend are a sicker subset of those who present through the working week, with heir more severe illness explaining their higher mortality. That the weekday-admitted and weekend-admitted groups were matched for age, sex, co-morbidity and deprivation in no way proves that the severity of the presenting illness leading to death was equivalent. A more recent study[ix] has found similar differences in mortality in patients admitted at the weekend, in particular Sunday, but has cautioned against the interpretation that this is as a result of differences in quality of care.

A second weakness is the assumption that higher mortality in patients admitted at the weekend results from a decreased level of staffing at the weekend. There are other explanations, including a reduced level of specialist intervention and access to diagnostic services at weekends. It is noteworthy that Lewisham Hospital has had a robust system of twice-daily consultant ward-rounds and access to out-of-hours diagnostics for 8 years.

The conclusion made by the Secretary of State is therefore not founded on robust clinical evidence. It is troubling that such an unsafe conclusion could be used to make an assertion that has obviously influenced his decision, not just in the case of Lewisham Hospital but in general, that larger units will achieve better clinical outcomes.

2. We would also be grateful for your urgent clarification of the evidence for the following assertions made by Mr Hunt in parliament[x]:

   To meet the London-wide clinical quality standards, which are not being met in south-east London at present, it is necessary to centralise the provision of more complex services in the same way that we have already successfully done for heart attacks and strokes. That principle applies as much to complex births and complex pregnancies as it does to strokes and heart attacks, and it will now apply for the people of Lewisham to conditions including pneumonia, meningitis and if someone breaks a hip. People will get better clinical care as a result of these changes.

   Our maternity care is well-regarded: of women booked into antenatal care at Lewisham, there have been no maternal mortalities in the past 7 years. This is despite the fact that high-risk pregnancies form the majority of our maternity workload[xi]. A free-standing midwifery-led birthing unit at Lewisham could only be expected to accommodate low-risk women who had already had at least one baby (RCOG, 2011), amounting to only 12% of the present total, rather than the "up to 60%" claimed by Mr Hunt.

   You may in fact be unaware, or have not informed the Secretary of State, that UHL is in fact one of the highest performing Trusts nationally for the management of hip fractures.

   Guidance on the management of meningitis emphasise the speed of administration of definitive treatment and not the size of the hospital it is treated in. Furthermore, a recent UK study of over 19,000 patients with meningococcal disease shows that mortality is the same (4.9%) whether the patient is admitted during the week or at the weekend[xii]. Neurology guidance recommends that that the patient with suspected bacterial meningitis should be transferred immediately to the nearest secondary care hospital[xiii]. There is therefore no basis in clinical evidence for the assertion made by the Secretary of State.

   The overall standardised hospital mortality index for UHL is 0.91 (NHS Choices), which compares favourably with hospitals in the South London Healthcare Trust. Lewisham ICU is one of the better performing ICUs in the country[xiv]

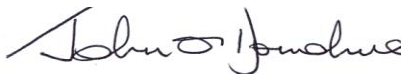
We are aware of the need for financial prudency and the drive towards the proposed clinical standards. Our alternative proposal put to the TSA was that the future merged Lewisham/ Greenwich Trust would achieve these clinical standards and within budget, but retain its discretion to allocate emergency and elective services across the Lewisham and Woolwich sites as commissioners require.

We are sure that you, a fellow medical professional, would agree that the evidence-base upon which we practice should be sound in order to deliver high-quality care to our patients. This duty extends to those members of the profession, like you, who have put themselves forward to provide medical advice on matters of public policy. This is especially true where that evidence is being used to inform a decision on reconfiguration and centralisation of acute services: if the clinical evidence base is wrong, or the deduction from the evidence is flawed, patients may actually be harmed. We believe that there is a significant risk of this resulting in Lewisham, if high-quality local emergency services are withdrawn in the mistaken belief that they will be provided to a higher standard elsewhere.

Your advice to the Secretary of State may also have a profound impact nationally if these specious grounds for centralisation of most emergency admissions are accepted, and as a result other high-quality DGHs are sacrificed as a result.

We believe that the clinical evidence underlying last week's decision is deeply flawed, and therefore call on you to reconsider urgently your advice to the Secretary of State.

Yours sincerely,



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References

[i] https://www.wp.dh.gov.uk/mediacentre/files/2013/01/SLHT.pdf

[ii] Hansard-31 Jan 2013: Column 1080, the Right Hon Jeremy Hunt, in reply to Dame Joan Ruddock

[iii] http://www.londonhp.nhs.uk/wp-content/uploads/2011/09/AES-Case-for-change_September-2011.pdf

[iv] Aylin P, Yunus A, Bottle A, Majeed A, Bell D. Weekend mortality for emergency admissions. A large, multicentre study. Quality and Safety in Health Care 2010; 19:213-217

[v] Bell, M. D., Redelmeier, D. A. (2001). Mortality among patients admitted to hospitals on weekends compared with weekdays The New England Journal of Medicine 345: 9

[vi] Barba, R., Losa, J. E., Velasco, M., Guijarro, C., Garcia de Casasola, G. & Zapatero, A. (2006). Mortality among adult patients admitted to the hospital on weekends The European Journal of Internal Medicine 17: 322-324

[vii] Riciardi, P. (2011) Mortality rate after non-elective hospital admission. Arch. Surg. 2011; 146(5): 545-551

[viii] http://www.londonhp.nhs.uk/wp-content/uploads/2011/09/AES-Case-for-change_September-2011.pdf

[ix] Freemantle N, Richardson M, Wood J, et al. Weekend hospitalization and additional risk of death: An analysis of inpatient data. Journal of the Royal Society of Medicine. Published online on February 2 2012

[x] Hansard, 31 Jan 2013 : Column 1081

[xi] In 2012, there were 4,129 Lewisham deliveries: 898 women delivered in our Birth Centre, of whom 509 were multiparous women.

[xii] Mortality from meningococcal disease by day of the week: English national linked database study J Public Health (Oxf) 2013;0:2013 fdt004v1-fdt004 RCOG (2011) http://www.rcog.org.uk/what-we-do/campaigning-and-opinions/statement/rcog-statement-results-npeu-birthplace-study

[xiii] EFNS guideline on the management of community-acquired bacterial meningitis: report of an EFNS Task Force on acute bacterial meningitis in older children and adults. European Journal of Neurology 2008, 15: 649–659 doi:10.1111/j.1468-1331.2008.02193.x

[xiv] www.ICNARC.org